Client Rights & Informed Consent – Rainbow Marifrog, LLC

Client name: _____

Consistent with HFS 94, Wisconsin Administrative Code, Rainbow Marifrog, LLC wants you to be aware of your rights as a client and ask for your informed consent to receive treatment. You have also been given information about rights to privacy. My grievance procedure is available upon request.

PSYCHOLOGICAL SERVICES: Psychotherapy varies depending on the personalities of the psychotherapist and client, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings at times. Psychotherapy has also been shown to have many benefits, including better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our time together may include. You should evaluate this information along with your own opinion of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If needed, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

SESSIONS: Individual sessions are customarily 60 minutes, including time for scheduling appointments and paying fees. Longer or more frequent sessions can be arranged as necessary. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. It is important to note that insurance companies (if you use them) do not provide reimbursement for cancelled sessions, so the total cost of the session is your responsibility.

PROFESSIONAL FEES: My hourly fee is $120-150 for the initial evaluation session and for subsequent sessions. In addition to weekly appointments, I charge this amount for other professional services you may need, including report writing, telephone conversations lasting longer than ten minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, participation in legal proceedings, and the time spent performing any other professional service you may request of me.

CONTACTING ME: I have a 24-hour confidential voicemail, at which you may leave a message. I check messages regularly and will return calls as promptly as possible. I will make every effort to return your call on the same day you make it, with the exception of noted vacation time and holidays. If you need more immediate attention, you may reach out to a friend or another member of your support network, your psychiatrist or primary care physician, your local county mental health center, or go to the nearest emergency room, and/or dial 911. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

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LIMITS ON CONFIDENTIALITY: The law protects the privacy of all communications between a client and a psychotherapist. In most situations, I can only release information about your treatment to others if you sign a written authorization to do so. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides written advance consent for:

- Consulting with other health/mental health professionals. During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound by confidentiality. I will note all consultations in your clinical record.
- Sometimes I need to share protected information with professionals I work with for both clinical and administrative purposes (i.e., scheduling, billing, on-call coverage, quality assurance). All professionals are bound by confidentiality.
- If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by psychotherapist-client privilege. I cannot provide any information without your written authorization or a court order.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them. If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
- If a client files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all medical reports and bills.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about your treatment:

- If I have reasonable cause to believe that a child, a disabled adult or an elder has been abused, neglected or exploited, I am required by law to file a report with the Department of Human Services or an agency they designate. Once a report is filed, I may be required to provide additional information.
- If a client threatens to harm him/herself or others, I may be required to take protective actions including but not limited to, seeking hospitalization for him/her, contacting family members or others who can provide safety, notifying the potential victim, and/or contacting the police. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

PROFESSIONAL RECORDS: If you request it in writing, you or your legal representative may examine and/or receive a copy of your clinical record, except in circumstances involving danger to yourself or others, references to another person who is not a health care provider and I believe that access is reasonably likely to cause substantial harm to such other person, or if information is supplied to me confidentially by others. Because these are professional records, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional to discuss the contents. In most situations, I am allowed to charge a copying fee of 25 cents per page (and for certain other expenses). If I refuse your request for access to your records, you have a right of review (except for information provided to me confidentially by others) which I will discuss with you upon request.

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CLIENT RIGHTS: HIPAA provides you with rights regarding your clinical record and disclosures of Protected Health Information, including requesting I amend your record; requesting restrictions on disclosures to others; requesting an accounting of most disclosures of Protected Health Information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; recording in your record any complaints you make about my policies & procedures; and the right to a paper copy of this Agreement. I am happy to discuss these rights with you.

MINORS & PARENTS: Clients under 18 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment records unless I believe that doing so would endanger the child or we agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS: You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have coverage that requires another arrangement. I currently accept cash or check. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment.

INSURANCE REIMBURSEMENT: I currently accept M.A. (non-HMO) insurance.

DISCONTINUATION OF TREATMENT: Either of us may elect to discontinue treatment at any time. If you revoke this agreement, it must be in writing. I will gladly provide you with names of other referral sources if you so desire.

I have read the above information and have been notified of my rights and the grievance procedure available to me. I hereby give my informed consent to receive treatment.

Client Signature: _____ Date: _____

*Guardian Signature: _____ Date: _____

Print guardian name: _____

**Guardian means the parent, or legal custodian of a minor client and /or any person authorized by the client (this authorization must be in writing, witnessed and dated).