FAMILY
THERAPY ASSOCIATES, LLC

150 W First St Ste 270 New Richmond WI 54017
715-246-4840
www.ftacounseling.com

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) and Client Privacy Statement- Effective September 23, 2013

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

Federal and state privacy and medical records laws protect your rights as a client of Family Therapy Associates, LLC. This notice applies to your current contact with Family Therapy Associates, LLC and all future contacts, whether the contact is in person, by telephone, or by mail.

Family Therapy Associates, LLC is required to protect the privacy of your Protected Health Information (PHI). We are also required by the Health Insurance Portability and Accountability Act (HIPAA) to provide you with a notice of our legal duties and privacy practices with respect to PHI. The terms we, our, and us refer to Family Therapy Associates, LLC and the terms you and your, refer to our clients.

NOTICE INFORMATION

This Notice of Privacy Practices describes how we may use and disclose your PHI to carry out treatment, payment, and health care operations and for other purposes that are specified by law.

We reserve the right to change this Notice. The changes will apply for PHI we already have about you and PHI we receive about you in the future. We will provide an updated Notice to you when you request one.

If you have questions about this Notice, our privacy practices, or Family Therapy Associates, LLC that this Notice applies to, please contact us at:

PROTECTED HEALTH INFORMATION

Protected Health Information (PHI) is:

1) Information about your physical or mental health, related health care services.
2) Information that is provided by you, created by us, or shared with us by related organizations.
3) Information that identifies you or could be used to identify you, such as demographic information, address and phone number, social security number, age, date of birth, dependents, and health history.

HOW FAMILY THERAPY ASSOCIATES, LLC PROTECTS YOUR PHI

Except as described in this Notice or specified by law, we will not use or disclose your PHI. We will use reasonable efforts to request, use, and disclose the minimum amount of PHI necessary.

Whenever possible, we will de-identify or encrypt your personal information so that you cannot be personally identified. We have put physical, electronic, and procedural safeguards in place to protect your PHI and comply with federal and state laws.

YOUR RIGHTS

You have the following rights with respect to your PHI.

Obtain a copy of this Notice. You may obtain a copy of the Notice at any time. Even if you have agreed to receive the Notice electronically, you are still entitled to a paper copy.

Request restrictions. You may ask us not to use or disclose any part of your PHI. Your request must be in writing and include what restriction(s) you want and to whom you want the restriction(s) to apply. We will review and grant reasonable requests, but we are not required to agree to any restrictions.

Inspect and copy. You have the right to inspect and get a copy of your PHI for as long as we maintain the information. You must put your request in writing. We may charge you for the costs of copying, mailing, or other supplies that are necessary to grant your request.

We do have the right to deny your request to inspect and copy. If you are denied access, you may ask us to review the denial.

Request amendment. If you feel that your PHI is incomplete or incorrect, you may ask us to amend it. You may ask for an amendment for as long as we maintain the information. Your request must be in writing, and you must include a reason that supports your request. In certain cases, we may deny your request. If we deny your request for amendment, you have the right to file a statement of disagreement with our decision.

Receive a list (an accounting) of disclosures. You have the right to receive a list of the disclosures (an accounting) that we have made of your PHI on or after April 14, 2003.

The list will not include disclosures that we are not required to track, such as disclosures for the purposes of treatment, payment, or health care operations; disclosures which you have authorized us to make; disclosures made directly to you or to friends or family members involved in your care; or disclosures for notification purposes.

Your right to receive a list of disclosures may also be subject to other exceptions, restrictions, and limitations.

Your request for an accounting must be made in writing and state the time period for which you would like us to list the disclosures. We will not include disclosures made more than six years prior to the date of your request, or disclosures made prior to April 14, 2003.

You will not be charged for the first disclosure list that you request, but you may be charged for additional lists provided within the same 12-month period as the first.

Request confidential communication. You may ask us to communicate with you using alternative means or alternative locations. For example, you may ask us to contact you about medical records only in writing or at a different address than the one in your file. Your request must be made in writing and state how and when you would like to be contacted.

You do not have to tell us why you are making the request, but we may require you to make special arrangements for payment or other communications.

We will review and grant reasonable requests, but we are not required to agree to any restrictions.

Note: Special Rules for Psychotherapy Notes.

Only psychotherapy notes collected by a psychotherapist during a counseling session are considered PHI. If those notes are kept separate from a client's medical records, HIPAA requires that they be treated with higher standards or protection than other PHI.

It is not Family Therapy Associates, LLC practice to keep psychotherapy notes as defined by HIPAA, or to keep any client notes separate from the client's file.

WHEN FAMILY THERAPY ASSOCIATES, LLC MAY USE AND DISCLOSE PHI

Common reasons for our use and disclosure of PHI include:

Treatment. To provide, coordinate, or manage health care and related services for you to make sure you are receiving appropriate and effective care.

For example, we may contact you to provide appointment reminders, information about treatment alternatives, or to refer you to other health-related benefits and services that may be of interest to you. Or we might contact another health care provider or third party to share information or consult with them about the services we are providing to you.

Payment. To obtain payment or reimbursement for services provided to you. For example, we may need to disclose PHI to determine eligibility for treatment or claims payment.

Health Care Operations. To assist in carrying out administrative, financial, legal, and quality improvement activities necessary to run our business and to support the core functions of treatment and payment.

Health Plan Sponsor. We may disclose PHI to a group health plan administrator, which may, in turn, disclose such PHI to the group health plan sponsor, solely for purposes of administering benefits

Individuals involved in your care or payment for your care. We may disclose your PHI to a family member, other relative, close personal friend, or any person you identify, who is, based on your judgment, believed to be involved in your care or in payment related to your care.

As required by law. We must disclose PHI when required to do so by law.

LESS COMMON REASONS FOR OUR USE AND DISCOSURE OF PHI INCLUDE:

Legal proceedings. We may disclose PHI for a judicial or administrative proceeding in response to a court order, written notice, or protective order.

To avert serious threat to public health or safety. We may disclose PHI to avoid a serious and imminent threat to your health or safety or to the health or safety of others.

To provide reminders and benefits information to you. Disclosures may be used to verify your eligibility for health care and enrollment in various health plans and to assist us in coordinating benefits for those who have other health insurance or eligibility for government benefit programs

Worker's compensation.We may disclose PHI to comply with worker's compensation laws and other similarly legally established programs.

Abuse or neglect. We may make disclosures to government authorities or social service agencies as required by law in the reporting of abuse, neglect, or domestic violence.

To government agencies for compliance purposes. We may use or disclose PHI to the Secretary of Health and Human Services to assist with a complaint investigation or compliance review.

Law enforcement. We may disclose PHI to law enforcement officials for the purpose of identifying or locating a suspect, witness, or missing person, or to provide information about victims of crimes.

Business associates. We provide some services through contracts with business associates. Examples include certain diagnostic tests, a copy service to make copies of medical records, billing services, independently contracted clinicians and the like. When we use these services, we may disclose your health information to the business associates so that they can perform the function(s) that we have contracted with them to do and bill you and your third-party payer for services provides. To protect your health information, however, we require the business associates to appropriately safeguard your information. After February 17, 2010, business associates must comply with the same federal security and privacy rules as we do.

Notification. We may use or disclose information to notify or assist in notifying a family member, a personal representative, or another person responsible for your care, location, and general condition.

Marketing/continuity of care. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If we contact you to provide marketing information for the other product or services, you have the right to opt out of receiving such communications. Contact Jamie Mason or Amy Hering at 715-246-4840. If we receive compensation from another entity for the marketing, we must obtain your signed authorization.

Correctional institution. If you are an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Research. We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Your written permission: We are required to get your written permission (authorization) before using or disclosing your PHI for purposes other than those provided above, or as otherwise permitted or required by law. If you do not want to authorize a specific request for disclosure, you may refuse to do so without fear of reprisal.

You may withdraw your permission: If you do provide your written authorization and then later want to withdraw it, you may do so in writing at any time. As soon as we receive your written revocation, we will stop using or disclosing the PHI specified in your original authorization, except to the extent that we have already used it based on your written permission.

Rights of clients who pay "out-of-pocket" to not have information disclosed to their health insurance company: A client who pays cash or other "out-of-pocket funds" for their office visit and treatment may request this office to not disclose the information related to their visit and treatment to their health insurance company or other payer. The client can do this by completing the appropriate form. This form should be completed ***each time*** the client has a visit or treatment during which the client requested the information to not be disclosed.

YOU MAY FILE A COMPLAINT

If you believe your privacy rights have been violated, you can file a complaint with Family Therapy Associates, LLC's HIPAA Privacy Officer, or with the United States Department of Health and Human Services at:

Medical Privacy Complaint Division
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019

DATA PRIVACY

Why do we ask for information? We ask for information from you to determine what service or help you need, develop a service plan with you, and give you the services you want.

The information may also be used to determine your charges for services or for collection of payment from insurance companies or other payment sources.

Do you have to give information to us? There is no law that says you must give us any information. However, if you choose to not give us some information, it can limit our ability to serve you well.

What will happen if you do not answer the questions we ask? If you are here because of a court order, and you refuse to provide information, that refusal may be communicated to the Court.

Without certain information, we may not be able to tell who should pay for your services.

WHAT PRIVACY RIGHTS DO MINORS HAVE?

If you are under 18, you may request that information about you be kept from your parents. You must give us your request in writing, describe the information, and tell us why you don't want your parents to see it.

If, after reviewing your request, your therapist at Family Therapy Associates, LLC believes that giving information to your parents is not in your best interest, we will not share the information. If your therapist believes this information could be safely shared with your parents, we will inform you of that decision.

If you are 14, you may ask for mental health services without the consent of your parents, but you may have to pay for the services if you do not want your parents to know.

Please sign this form. Your signature shows that we have informed you of your privacy rights, that you are aware of the possible uses and disclosures of your protected health information and that you have received a copy of this information

Client Signature _____ Date: _____

Parent/Legal Guardian Signature _____ Date: _____

Witness Signature _____ Date: _____

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CHILD INFORMATION AND RELEASE TO BILL INSURANCE

NAME: _____ **DOB:** _____ **SEX:** _____

PARENT/GUARDIAN NAME: _____ **RELATION:** _____

MARITAL STATUS: **SPOUSE NAME:**

LEGAL CUSTODY: _____ **PLACEMENT:** _____

PRIMARY PHONE: _____ **Msgs OK?** _____

ALTERNATIVE PHONE: **Msgs OK?**

ADDRESS: _____

ADDITIONAL PARENT/GUARDIAN NAME: **RELATION:**

MARITAL STATUS: **SPOUSE NAME:**

PRIMARY PHONE: **Msgs OK?**

ALTERNATIVE PHONE: **Msgs OK?**

ADDRESS:

EMERGENCY CONTACT: **PHONE:**

PRIMARY PHYSICIAN/CLINIC:

PRESENTING CONCERNS:

Family Therapy Associates is able to send appointment reminders to your email address or as a text message to your mobile phone (if you have texting capability; available for most cell phone providers). Please be aware of any costs associated with texting to your mobile phone - check with your mobile service provider if you have questions before agreeing to receive text messages.

An email or text message would arrive to your email or phone from "info@ftacounseling.com" and would include the client's name, date and time of appointment, and the name of the provider you will be seeing.

I authorize Family Therapy Associates to send appointment reminders as follows **(please choose ONE):**

☐ *To the following email address:* **Initials:** _____

OR

☐ *To the following cell phone number as a text message:* **Initials:** _____

OR

☐ *Via phone call to the following number:* May we leave a message at this number? ☐ *Yes* ☐ *No*

*Please let us know if any of this information changes to ensure message delivery.

IS THERE ANYONE YOU THINK THE COUNSELOR WILL NEED TO COMMUNICATE WITH AFTER BEGINNING SERVICES?

SCHOOL COUNSELOR/SPECIAL EDUCATION CASE MANAGER:

DOCTOR/PSYCHIATRIST:

COUNTY SOCIAL WORKER:

PREVIOUS COUNSELOR:

OTHER:

PRIMARY INSURANCE: **POLICY HOLDER:**

PRIMARY INSURED DOB: **PRIMARY SSN:**

RELATION TO INSURED: **INSURED EMPLOYER:**

POLICY NUMBER: **GROUP NUMBER:**

STATEMENTS SHOULD BE MAILED TO (Financially Responsible Party):

REFERRED BY:

☐ Internet Search ☐ Website ☐ Psychology Today ☐ School
☐ Doctor/Clinic ☐ Friend/Other Client

1) I authorize the release of all information obtained by Family Therapy Associates, LLC to my referring doctor or funding source and I authorize payment from my funding source for services rendered to Family Therapy Associates, LLC.

2) I understand that I am responsible to pay for services that are not paid by my insurance policy,including all co-payments and deductibles. I agree that any outstanding charges may be submitted to the client credit/debit card on file and copy of receipt will be mailed to me along with an invoice should this occur.

3) I certify that I have the legal authority to consent for mental health services for this minor child/adolescent.

4) I recognize that this therapy will not yield considerations about custody and that my child/adolescent's therapist cannot side with familial disputes or make recommendations regarding custody. I understand that my child/adolescent's therapist does not testify in court and I agree that if his or her therapist is called to testify it will not be in my child/adolescent's best interest as my child/adolescent's counseling may suffer as a result.

I certify this information is true and correct to the best of my knowledge and I agree with points 1 through 4 on this consent form.

Client Signature: (age 14 and up) _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

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CLINICIAN IN TRAINING CONSENT

Client Name: _____

I understand that my therapist is a clinician in training and is under supervision; therefore, any services provided may be billed under the supervising provider's license. As part of supervision, the supervisor will be consulting and reviewing your case on a regular basis. I understand that I may request this supervisor to be more involved in my therapy services at any time.

Client Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

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INFORMED CONSENT FORM

OFFICE HOURS

Office hours are generally Monday through Thursday 9am - 5pm and Friday 9am - 3pm. Some evening and weekend times are also available.

FEES FOR PSYCHOTHERAPY SERVICES

- $200 for a Diagnostic Evaluation (Intake Session)
- $185 Psychological Testing, Interpretation, and Reporting (Per Hour)
- $80 Psychotherapy (16-37 minutes)
- $155 Psychotherapy (38-52 minutes)
- $185 Psychotherapy (53 minutes plus)
- $165 for Family/Couples Therapy
- $220 for Psychotherapy for Crisis (60 min)
- $110 Psychotherapy for Crisis (each add'l 30 min)
- $80 Group Psychotherapy
- $15 Interactive Complexity Add-On Fees

FINANCIAL POLICIES

The Fee to you will depend on whether and which insurance you have and any co-pays or deductibles associated. As a courtesy, we may verify your insurance benefits, however, any quoted benefits are not guaranteed. It **is your responsibility** to call your insurance carrier regarding the specifics of your coverage such as copays, deductibles, number of visits and covered services as well as to keep current of any changes in your benefits during course of therapy. It is required you inform us of any insurance changes you become aware of. The balance incurred is your personal responsibility whether your insurance company pays or not. Coverage amounts from policy to policy. Understand that your insurance policy is a contract between you and your insurance company. Our office will **NOT** be held responsible in the event your insurance company denies **ANY** claim. You may choose to pay at the time of service or be billed for any outstanding balances on a monthly basis. Payment plans are acceptable upon request. Your account must remain current in order to provide services. Please note we are unable to maintain account balances about $350. If your account goes above this limit services may be put on hold until the balance is back in the allowable range.

PAY SAME DAY

Discounted rates are available for clients who pay on the same day their service is received. Payments must be received prior to service in order to receive this discount. If clients forget their payment, they may either retrieve it prior to beginning session or reschedule for another day. Late cancellation policies will apply. Therapists are unable to perform counseling services utilizing pay same day rate without receiving payment prior to scheduled session. If you choose the pay same day discount, you will be asked to sign an automatic credit/debit card form authorizing your card to be charged in order to receive the discount offered at time of service. In the event that we need to bill you for services received, such as your card declining, you will be billed the **full** fee for that date of service.

PAY SAME DAY FEES

- $120 Diagnostic Evaluation (Intake Session)

- $80 Psychotherapy Session
- $40 Group Psychotherapy Session
- $500 Psychological Assessment Prepaid Discount (includes intake session, testing, test interpretation, report time, and feedback session up to 5 hours total)

SLIDING FEE SCALE

Sliding fee scale based on ability to pay is available. To be eligible for reduced fees, a completed application for sliding fee scale along with verification of income including last year's tax return and paystub is required. Reevaluation of income is completed at a minimum of one time per year. Clients utilizing sliding fee scale are required to inform the clinic of any changes of income.

Additional Fees

Summary Letters: The fee for summary letters is $120 and is due upon request. It is our policy that therapy for children or adolescents cannot yield considerations about custody and therapists cannot side with familial disputes or make recommendations regarding custody or placement. A notice of 5 business days is required to complete requests for letters or summaries of treatment.

Records Request: If you would like to request your records, the request must be in writing and may take up to 30 days to fulfill. The cost of records per Wisconsin state statute are: pages 1-25 $1 per page, 26-50 $.75 per page, 51-100 $.50 per page and 101 pages and up are $.30 per page. Payment must be collected before copies are picked up.

Returned Check Fee: the fee for a returned check is $30 per check. If more than one check is returned, we will no longer be able to accept checks as a form of payment.

Delinquency and Collection Fees: In the event your account becomes past due and is referred to an outside collection agency or attorney, you will be responsible for the collection costs (up to 33% of the balance due), along with reasonable attorney fees and court costs incurred by this office. Should your account go to collections, the balance must be paid in full before any additional appointments can be scheduled.

COURT

It is not our policy for therapists to testify in court, as it can negatively impact the therapeutic process. Should your therapist be subpoenaed or requested to testify in court, you agree to all the court fees below:

Testimony by phone:

A minimum of $500 fee which covers a scheduled testifying time up to one hour, one hour preparation time, and lost wages due to missed scheduled appointments.

Additional time is billed at the rate of $250 per hour.

Testimony in person:

A minimum of $750 fee is charged for testimony in person which covers up to one hour scheduled testifying/wait time, up to one hour of preparation time, and up to one hour travel time.

Cost of testimony in person is determined by the amount of time blocked off of the therapists's schedule to accommodate court, attorney or client with additional travel time, testifying and wait time, and preparation time charged at the rate of $250 per hour.

Court fees are due one week prior to court date to reserve this time and are nonrefundable should court be cancelled. Court fees are not covered by insurance and are invoiced directly to the requesting attorney. Retainers for assessments for court related issues are billed at the rate of $250 per hour. The retainer amount will be determined by the time necessary to complete the requested testing including time for testing interpretation and report writing. Retainers must be received prior to scheduling the initial assessment appointment.

PHONE CALLS AND EMAILS

We may be unable to answer the phone during the day when seeing scheduled clients or on another line. We will try to return all phone calls during business hours Monday-Thursday 9am - 5pm and Friday 9am - 2pm. It is not our office policy to return phone calls after 5pm or on weekends or holidays. We can address issues related to scheduling, insurance or payment questions by phone or email. Please consider that email correspondence carries with it a certain risk regarding confidentiality and is not protected by HIPAA. Anything related to the therapy process should be discussed at the next

scheduled appointment.

CANCELLED OR MISSED APPOINTMENTS

Please make every effort to keep your scheduled appointment. If you must miss, please call to notify us as soon as possible in order to make the time available for someone else who may need it.

- A $50.00 fee will be charged for any late cancellation (within 24 hours of the appointment) or no show after the first missed appointment.

- After two consecutive missed appointments, any additional scheduled appointments will need to be confirmed within 48 hours or these appointments will be released to other clients.

- As it is your responsibility to attend scheduled therapy sessions, we reserve the right to terminate therapy services if three or more appointments are missed due to late cancellations or no shows.

- If you have missed a scheduled visit and you do not call our office within 7 DAYS from the date of your missed appointment, your therapist will accept that as your notice that you have terminated this agreement and that you wish to discontinue counseling services with our office.

CRISIS SITUATIONS

You may attempt to call in a crisis situation; however, we may not always be available. You may call 911 in a police or life-threatening emergency. If you have an insurance carrier, they may also have a 24 hour nurse line available. Please check your insurance card for information about this service if available. We can discuss a more specific back-up plan as needed. A crisis situation may be: suicidal feelings or intentions, threat or incident of violence, intense verbal conflicts, or other urgent situations in which you aren't sure what to do. If a crisis should arise in our office, we reserve the right to call 911 or appropriate outside support to maintain safety. This exception of confidentiality is outlined in HIPAA.

ABOUT THERAPY

Together we will determine when the appointments will be, who will attend, how long they will last and how many times a month you would like to meet.
We will try to use your/your family's strengths and resources to create meaningful ways to assist you in coping with your challenges. Together we will determine appropriate goals or strategies to address our identified concerns and areas of growth. We consider ourselves to be a collaborator and consultant with you/your family.

We will try to use your/your family's strengths and resources to create meaningful ways to assist you in coping with your challenges. Together we will determine appropriate goals or strategies to address our identified concerns and areas of growth. We consider ourselves to be a collaborator and consultant with you/your family.

At times, the therapy may get uncomfortable or even painful as you discuss thoughts, feelings or events that were or still are difficult for you. You may make positive changes that could be difficult for your friends and family to cope with. There is no guarantee that the therapy will help with your problems. However, if you do not receive proposed treatment you may not see progress with your concerns. We encourage you to talk with your therapist if things are not going the way you would like them to in the therapy or if you have questions about the work we are doing. Together we can discuss if changes are needed and plan for them. You or your therapist may feel you need a referral to another mental health professional or service, and you are entitled to referral information at any time during treatment. You have the right to refuse any treatment strategy or treatment altogether, at any time.

*Please note that psychological testing does not indicate a therapeutic relationship and is not therapeutic in nature.

CLIENT'S RIGHTS AND RESPONSIBILITY STATEMENT

Statement of Client's Rights:

- Clients have the right to be treated with dignity and respect.

- Clients have the right to fair treatment; regardless of their race, religion, gender, ethnicity, age, disability, sexual orientation, or source of payment.

- Clients have the right to easily access timely care in a timely manner.

- Clients have the right to know about their treatment choices.

- Clients have the right to share in developing their treatment of care.

- Clients have the right to have a clear explanation of their condition and treatment options.
- Clients have the right to ask their provider about their work history and training.

Statement of Client's Responsibilities:

- Clients have the responsibility to give providers information they need so they can provide the best possible care.
- Clients have the responsibility to ask questions about their care. This is to help them understand their care.
- Clients have the responsibility to follow the treatment plan developed by provider and client.
- Clients have the responsibility to tell provider about medication changes.
- Clients have the responsibility to keep their appointment.
- Clients should call provider as soon as they know they need to cancel or reschedule visits.

It is our policy that Client Rights including Rights of Minors and Grievance Procedure will be reviewed at intake and annually thereafter. Copies of these rights are available in the lobby at any time.

CONSULTATION

At times, your therapist may consult other professionals regarding your presenting issues. This practice is intended to provide checks and balances to ensure the highest quality services for you and your family. Any recommendations regarding your treatment resulting from clinical collaboration will be documented in your file. Additional information is available upon your request. Please note that some of the clinicians in this office are in training and are closely supervised by an experienced therapist. You will be informed if the clinician you are seeing is in training and your consent will be obtained.

CONFIDENTIALITY AND RECORD KEEPING

Please read all statements related to your rights and confidentiality. Please let your therapist know if we can clarify any of this for you. Your therapist will strive to uphold your best interests in the therapy sessions and in our records. Therapists will maintain written records on every contact we have regarding your treatment. You have the right to view your records according to HIPAA guidelines. Your file will be stored in a secure, locked location when not in use.

ADDITIONAL POLICIES

- Therapist may not accept gifts from any client or buy any services or products from any client or their family members.
- Additional policies and procedures may apply to therapy groups and treatment programs.
- PLEASE TURN OFF cell phones while in our office.
- Please don't hesitate to discuss any questions, concerns or feedback you may have at any time.

You will receive a copy of this form for your records, if you wish.

GRIEVANCE POLICY

You are encouraged to first talk with your therapist about your concerns. If an informal resolution is not possible, you may submit your concerns in writing to:

Jamie Mason or Amy Hering
150 W First St Ste 270
New Richmond WI 54017
jamie@ftacounseling.com
amy@ftacounseling.com

Your concern must be filed within 45 days of the time you became aware of the problem. Complaints will be reviewed within 30 days from date you filed the grievance and you will receive a written response to your concerns. You may submit an appeal to the resolution within 14 days. You may also communicate your concerns to the Wisconsin Department of Health Services by going to www.dhs.wisconsin.gov/. Complete information of the Grievance Procedure is provided to you at intake and available in the lobby at any time. **Filing a complaint will in no way affect the care or services you receive from Family Therapy Associates, LLC.**

Family Therapy Associates reserves the right to make changes to these policies any time.

☐ Signing this form indicates I understand and agree to this informed consent including all fees. I acknowledge that I have received a copy of this form along with information on Client Rights and Grievance Procedure including Rights of Minors as applicable and that I consent to services. I understand this consent is valid for one year and may be withdrawn in writing at any time.

Signature: _____ Date: _____