FAMILY

THERAPY ASSOCIATES, LLC

150 W. First Street, Suite 270, New Richmond, WI 54017
250 S Washington St, St Croix Falls, WI 54024
700 Wolske Bay Rd Suite 140, Menomonie, WI 54751
3610 Oakwood Mall Dr #104, Eau Claire, WI 54701
715-246-4840
www.ftacounseling.com

INFORMED CONSENT FORM

OFFICE HOURS

Office hours are generally Monday through Thursday 8am - 5pm and Friday 8am - 3pm. Some evening and weekend appointment times are also available.

FEES FOR PSYCHOTHERAPY SERVICES

$260 for a Diagnostic Evaluation (Intake Session)
$240 Psychological Testing, Interpretation, and Reporting (Per Hour)
$120 Psychotherapy (16-37 minutes)
$190 Psychotherapy (38-52 minutes)
$240 Psychotherapy (53 minutes plus)
$240 for Family/Couples Therapy
$260 for Psychotherapy for Crisis (60 min)
$130 Psychotherapy for Crisis (each add'l 30 min)
$120 Group Psychotherapy
$30 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 the 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 vary 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 above $600. If your account goes above this limit services may be put on hold until the balance is back in the allowable range or payment arrangements have been made.

As part of our financial policies, our office requires a credit card guarantee is kept on file for the purpose of payment for services rendered including copayments, deductibles, and Pay Same Day services. By signing this Credit Card Guarantee Payment Enrollment form you understand that Family Therapy Associates will automatically charge the credit card you provide to this office for the payment of services rendered as outlined on the Credit Card Guarantee Payment Enrollment form. This form of payment may also be used should an account become delinquent.

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 you choose the Pay Same Day discount, you will be asked to sign an automatic Credit Card Guarantee Payment Enrollment 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 as payment was not received on the date the service was rendered.** If clients forget their payment, they may either retrieve it prior to the beginning of the 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 the scheduled session.

PAY SAME DAY FEES

$160 Diagnostic Evaluation (Intake Session)
$100 Psychotherapy Session
$60 Group Psychotherapy Session
$750 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 $150 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 $600 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 $300 per hour.

Testimony in person:
A minimum of $900 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 therapist's schedule to accommodate court, attorney or client with additional travel time, testifying and wait time, and preparation time charged at the rate of $300 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 $300 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.

The subpoenaing party remains responsible for payment of court fees for any subpoenaed clinician who has blocked off time as requested to testify regardless if court or their appearance at court is cancelled for any reason.

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 8am - 5pm and Friday 8am - 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 may not be 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 $80.00 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.

OTHER CANCELLATION POLICIES

In the event you are unable to attend your appointment in the office for any reason, including inclement weather, illness, transportation or childcare limitations you do have the option to attend your appointment via telehealth should this be covered by your insurance in order to avoid a late cancellation and any interruption in therapy services.

We understand that clients look forward to attending their therapy appointments as scheduled, however, at times an appointment may need to be cancelled by a provider for reasons outside of anyone's control including illness, an emergency, or inclement weather. Please know that we make every effort to keep existing appointments as scheduled and we appreciate your understanding in the rare instance your therapist needs to cancel or reschedule an appointment unexpectedly.

Likewise, we understand that clients may also experience emergencies and thus we are able to excuse late appointment cancellations due to hospitalizations, medical emergencies, accidents, deaths, and illness where a doctor's note is provided. Please do not come to your appointment if you have had a fever within the last 24 hours. Children who have stayed home sick from school should not attend office appointments. Likewise, children who have been discovered to have lice should not attend office appointments until they are cleared to return to school. Telehealth may be utilized in such situations in order to avoid a late cancellation and any interruption in therapy services.

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 you/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. Likewise, if you feel like your therapist is not a good fit for you for any reason, you may request to see another therapist.

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

TELEHEALTH

Telehealth services include the practice of mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications.

At Family Therapy Associates, LLC, the provision of telehealth services is provided primarily via secure interactive audiovideo platform. Telehealth services will be delivered via the audiovisual platform RingCentral or Doxy.me. These platforms do not permanently store Protected Health Information (PHI) and as a result this data cannot be stolen from servers. Both platforms are HIPAA Compliant. Point-to-

point NIST-approved AES 128 bit encryption is used for all video & audio communication. Full volume encryption and 256-bit AES encrypted keys used on data stored at rest.

TECHNOLOGY FAILURE FOR TELEHEALTH SERVICES

In the case of technological failure (internet not streaming properly, computer error, power outage, etc.), it is important to have a backup plan. The most common backup plan is to contact one another via telephone. In the case of technological failure causing interruption in an appointment, the therapist will call the phone number listed in your file, unless given alternate information at the beginning of any appointment. If, during a phone session, your call is disconnected, please call your therapist back or contact your therapist to schedule another session.

If you experience technological issues in joining the appointment, you should notify the therapist via phone or email. In the case that you have not joined the appointment 10 minutes after the start time, the therapist will make an attempt to reach the client via phone.

Please note that the field of Telehealth is continuing to grow and change. Family Therapy Associates, LLC reserves the right to make changes to these policies at any time as relevant to current standards.

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 their provider about medication changes.
-Clients have the responsibility to keep their appointment.
-Clients should call 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 any time.

CLIENT'S RIGHTS AND RESPONSIBILITY STATEMENT - TELEHEALTH

Statement of Client's Rights For Telehealth: In addition to all rights outlined above, clients have the following rights with respect to telehealth services:

-Clients have the right to withhold or withdraw consent at any time without affecting the right to future care or treatment nor risking the loss or withdrawal of any program benefits to which they would otherwise be entitled.

-Clients have the right to be protected by laws that protect the confidentiality of medical information. Information disclosed by clients during the course of therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child,

elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and if mental or emotional state becomes an issue in a legal proceeding. (See also Informed Consent and HIPAA Notice of Privacy Practices forms for more details of confidentiality and other issues.)

- Clients have the right to know about potential risks and consequences from telehealth services. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of the therapist, that: the transmission of medical information could be disrupted or distorted by technical failures; the transmission of medical information could be interrupted by unauthorized persons; the electronic storage of medical information could be accessed by unauthorized persons, and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous (text or e-mail based) manner. In addition, telehealth-based services and care may not yield the same results nor be as complete as face-to-face service. If the therapist believes another form of psychotherapeutic service (e.g. face-to-face service) would better meet the client's needs, a referral will be made to a therapist in the client's area who can provide such service. Finally, there are potential risks and benefits associated with any form of psychotherapy, and that despite the best efforts of the client and therapist, conditions may not improve and in some cases may even get worse.

- Clients have the right to equally know about potential benefits from telehealth services, with the balancing knowledge that results cannot be guaranteed or assured. The benefits of telehealth services may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

- Clients have the right to access personal medical information and copies of medical records in accordance with Wisconsin law.

Statement of Client's Responsibilities For Telehealth:

-Clients must complete and submit intake paperwork sent at least 24 hours prior to the initial telehealth intake appointment or risk forfeiting the appointment.

-Clients have the responsibility to provide basic emergency information to aid in planning for continuous safety during the course of telemental health treatment. This is outlined later in this document. Should any of this information change during the course of treatment, clients are responsible to communicate this to the therapist.

-Clients have the responsibility to be prepared for scheduled telehealth appointments by ensuring they are in a private location where the session cannot be overheard by others. It is preferred that clients use headphones with a microphone for best privacy and optimization of communication. Minimizing background noises and distractions is encouraged.

- Clients have the responsibility to let the therapist know of their physical location during an appointment at the therapist's request. This may be done routinely at the beginning of telehealth sessions.

-Clients have the responsibility to attend appointments or reschedule according to the organization's cancellation policy. The link for joining the appointment will be sent to the client via email the evening prior to the appointment. If you have not received this link by 8am the day of your appointment, please contact our office.

- Clients have the responsibility to inform the therapist if another person is present or if they wish to take screenshots, record audio or video, or take photos. Breaking this policy may result in immediate termination of session, online services, and may result in discharge.

--Clients have the responsibility to update the therapist if their Emergency Contact Person or other local emergency information changes.

Emergency Contact Person Name: _____

Emergency Contact Person Phone number: _____

Name of Nearest Hospital: _____

Hospital Phone Number: _____

Name of General Physician: _____

General Physician Phone Number: _____

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

-Therapists 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.

-Children under the age of 10 are not to be left unattended in the lobby for office-based appointments.

-PLEASE TURN OFF cell phones while in our office or in a telehealth session.

-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:

Amy Hering
150 W First St Ste 270
New Richmond WI 54017
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 the 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.

Date of Signature: _____

For Adult Clients:

Client Name: _____

Client Signature: _____

For Minor Clients:

Client Name: _____

Client Signature if client is 14 years old or older: _____

If client is a minor, parent or legal guardian name: _____

If client is a minor, parent or legal guardian signature: _____

For Couples Therapy:

Client Name: _____

Client Signature: _____

Client Name:_____

Client Signature: _____