CLIENT/THERAPIST CONTRACT AND CONSENT

Thank you for choosing CWM Counseling. We realize that beginning mental health treatment is a major decision and you may have questions. This document is intended to inform you of our policies, your rights, and state and federal laws. Please feel free to ask at any time if you have questions.

HIPAA requires that we provide you with a Notice of Privacy practices for use and disclosure of PHI for treatment, payment, and health care operations. The notice, included during the intake session, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information.

CONSENT TO EVALUATE AND TREAT

I voluntarily consent that I will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from CWM Counseling LLC. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:

a. The benefits of the proposed treatment

b. Alternative treatment modes and services

c. Probable consequences of not receiving treatment

The evaluation or treatment will be conducted by a licensed therapist, or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Wisconsin/Iowa Law for Psychological, Psychiatric, Social Work, Professional Counseling, or Marriage and Family Therapy.

BENEFITS TO EVALUATION/TREATMENT

Psychotherapy and/or Psychological assessment or testing, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

CONFIDENTIALITY, HARM, AND INQUIRY

Information from my evaluation and/or treatment is contained in a confidential record at CWM Counseling LLC, and I consent to disclosure for use by CWM Counseling LLC for the purpose of continuity of my care. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions:

1. If you threaten to cause severe harm to yourself, we are permitted to reveal information to others if we believe it is necessary to prevent the threatened harm.

2. If you express intent to harm someone else, we are required under the law to take appropriate steps to inform the intended victim and law enforcement agencies.

3. If you reveal, or we have reasonable suspicion, that any child, elderly person or incompetent person is being abused or neglected, the law requires that we report this to the appropriate county agency.

4. If a court of law orders us to release information, we are required to provide that specific information to the court.

5. If you have been referred to us by a court of law for therapy or testing, the results of the treatment or tests ordered may have to be revealed to the court.

6. If you are or become involved in any kind of lawsuit or administrative procedure where the issue of your mental health is involved, you may not be able to keep your records or therapy private in court.

7. If you see us in couples or family therapy, we ask that each member of the therapy promise to keep whatever happens in treatment confidential. However, we cannot guarantee that others will keep this agreement.

8. In order to provide you the best treatment we can, there may be times when we seek consultation from another licensed mental health professional. In these consultations, we make every effort to avoid revealing your identity. The consultant is also legally bound to keep the information confidential, although the exceptions to confidentiality apply to them as well.

9. When and if your provider is away, their practice may be covered by another licensed provider. We may inform the other provider about your citation to facilitate appropriate support should you need it in the provider's absence.

Please discuss any questions or concerns you may have about these exceptions of confidentiality as they arise. We are not able to give you legal advice. If you are in a situation in which you need advice regarding special or unusual concerns, we strongly suggest that you talk to an attorney to protect your interests. If you ever want us to share information with someone else (ex. your physician), we will ask that you sign a written authorization form (Release of Information) that meets certain legal requirements imposed by HIPAA.

There is a chance that we will see each other in a public setting. In these cases, we will not acknowledge you in an effort to protect your confidentiality. You may feel free to acknowledge us first and we will respond; however, please note that this may cause others nearby to understand that we possibly have a therapeutic relationship.

INSURANCE REIMBURSEMENT

In order to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide coverage for outpatient mental health treatment. It is your responsibility to determine if your insurance covers outpatient mental health counseling and whether it needs to be pre-authorized. If you have questions about individual coverage, call your plan administrator. We will provide you with whatever information we can based on our experience, and we will be more than happy to help you in understanding the information you receive from your insurance company. Insurance companies require us to provide them with a code number that indicates a clinical diagnosis. The insurance company will sometimes ask for more information, including treatment records. Please understand that we have no control over how these records are handled at the insurance company. Please note that the insurance contract is between you and your insurance company and the responsibility for your fees is *yours.* Consequently, disputes concerning coverage must be resolved by you with your insurance carrier. Furthermore, even though payment may be sent from the insurance company directly to us, it is your responsibility for any balance not covered by your insurance (ex. copays, coinsurance, deductibles). Unpaid bills may be turned over to a collection agency and/or an attorney and, if so, you will also be responsible for collection and/or legal costs.

MISSED OR CANCELED APPOINTMENTS

Please notify your therapist at least 24 hours in advance if you need to cancel or reschedule your appointment, by phone or email. A $75 fee will be charged for late cancellations and no-shows. If you miss or cancel your appointment, it is your responsibility to reschedule. This will also be your responsibility to pay, as insurance does not cover these fees. If you miss more than one appointment without cancellation or have 3 cancellations in a 12-month period, your provider may no longer be able to provide services to you. Please communicate any barriers you may have attending appointments so we can determine a solution. In case of our need to cancel, your therapist will notify you via phone, email, or text.

COMMUNICATION BETWEEN SESSIONS - Phone calls will not be returned on Holidays or weekends.

<u>*IF YOU ARE IN AN IMMEDIATE CRISIS, CALL 911 OR GO TO THE NEAREST EMERGENCY ROOM</u>

Grant County Crisis Line: 800-362-5717

National Suicide & Crisis Lifeline: Call or Text 988

EMAIL/TEXT MESSAGE

Unfortunately, your therapist has no way to ensure confidentiality over the internet or text messaging. If you choose to contact us by email or text, you are assuming all risks regarding the confidentiality of any information you send by either.

SOCIAL MEDIA

Therapists do not respond to potential or established client interaction on their personal social media platforms. For confidentiality purposes, and in respect to the therapeutic relationship, individuals may be blocked from our personal social media accounts. Clients are invited to interact with CWM Counseling's social media pages.

COUPLES/FAMILY

During the initial couple/family session, one individual will be identified as the client for billing and documentation purposes. A release of information will be obtained for all non-client individuals involved in order to continue sharing of information between all involved. Any information shared between sessions will be disclosed with all persons involved in therapy.

MINORS

If you are under 18 years of age, be aware that the law may provide your parents the right to examine your treatment records. Typically, we will only provide them with general information about our work together. If you feel there is a high risk that you will seriously harm yourself or someone else, we will immediately notify them of the concern.

FEES

Our full fee list can be found below. Payments may be made via cash, credit/debit card, or check at the beginning of each session. We ask that payment be authorized/written to CWM Counseling, LLC. All copays, private pay and payments toward insurance deductibles are due at the time of service unless we agree otherwise, or unless you have insurance coverage that requires another agreement. Upon beginning treatment, we will request that you have a credit card on file to charge for any unpaid charges that incur (please see the credit card authorization form). Periodically, our fees may increase due to inflation and cost of living increases.

90791 (60 mins - intake)	$275
90792 (90 mins - intake)	$350
90837 (60 mins - individual therapy)	$250
90834 (45 mins - individual therapy)	$200
90832 (30 mins - individual therapy)	$150
90847 (60 mins - family therapy w/ patient present)	$225
90846 (60 mins - family therapy w/o patient present)	$225
90839 (60 mins - crisis)	$250
Letter Writing	$50
Phone Calls	$50 per each 15 minutes
Professional Consultation	$200/hour+travel expenses+mileage

→Forms including the following but not limited to: Disability, FMLA, Leave of Absence, and letters to employers will be completed in a timely manner but are not guaranteed in a specific timeframe.

Records - Paper copies (per page)

- First 25 pages: $1.40
- Pages 26-50: $1.04
- Pages 51-100: $0.68
- Pages 101 and above: $0.40

If the requestor is not the patient or a person authorized by the patient

- Certification of Copies: $11.05
- Retrieval Fee: $27.63
- Actual Shipping Costs and Any Applicable Taxes

SEPARATION, DIVORCE, AND/OR CUSTODY DISPUTES

It is generally expected that custodial parents be aware of their child's participation in therapy. We will make reasonable efforts to ensure parents are notified and have reasonable access to participate in the treatment process. If any questions exist regarding the authority of a parent or guardian to give consent for therapy, we will require parents to submit supporting legal documentation, such as a custody order, prior to services being continued. Please be aware of our 'no secrets' policy for information obtained from each parent. This means we will not keep secrets between the parents and will not keep secrets from the minor client. The client's confidentiality will continue to be protected.

Please be aware that we will rarely participate in court proceedings without a court ordered subpoena. If testimony and/or court records are subpoenaed, we will provide a written summary of our treatment plan as well as progress. We will not provide expert testimony or our opinion on the court rulings. This position is based on the following:

1. Our statements may be seen as biased or in your favor because we have a therapeutic relationship.
2. Most, or even all, of the information we have about you has been provided by you and we do not have independent information about parenting or custody.
3. Our testimony might affect our therapeutic relationship and we must put this relationship first.

COURT-RELATED FEES

It is not within the scope of my practice to engage in any legal issues between clients, parents, and/or guardians as that would be the role of a child custody evaluator - which I am not. Your therapist and/or your child's therapist will also not share information with a guardian ad litem, lawyers, or anyone else involved in the legal process unless subpoenaed by a judge or otherwise legally required. In the unusual circumstance that you are involved in a legal proceeding that requires our participation, you will be expected to pay for all of our professional time, including preparation and transportation costs - even if we are called to testify by another party. Because of the complexity and difficulty of legal involvement, we charge separate legal fees noted below.

- A retainer of $1700 is due in advance.
- If a subpoena or notice to meet attorney(s) is received without a minimum 48-hour notice, there will be an additional $250 'express' charge.
- If the case is reset with less than 72 business hours notice, the client will be charged $500 (in addition to the $1700 retainer)
- Testifying in Court/Deposition - $1700 per day (will not be prorated)
- Time spent in Court not testifying - $1200 per day (will not be prorated)
- Contact between Therapist and Attorney(s) - $300 per hour
- Contact between Therapist and any other parties as legally required - $300 per hour
- Preparation time (including submission of records), phone calls, depositions, and testimony time -$300 per hour
- All attorney fees and costs incurred by the therapist as a result of the legal action
- Filing a document with the court - $100

***The minimum charge for a court appearance is $1700.

CWM COUNSELING, LLC
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We encourage you to ask any questions you have about services, our professional background, and about anything you have read in this agreement. In the unlikely event that problems arise during treatment that we cannot resolve together, we can refer you to other therapists for a consultation.

Your signature below indicates that you have read and understood the Patient-Provider Contract and Fees, Consent to Treatment and have been provided a copy of HIPAA Notice of Privacy Practice.

Client Signature_____ Date_____

Client Name (print)_____ Date of Birth_____

Parent/Guardian Signature_____ Date_____

Signature of person responsible for payment_____ Date_____

Person responsible for payment (print)_____ Date of Birth_____

Provider_____ Date_____ Private Pay Fee Arrangement_____Initials_____