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Consent for Treatment and Telehealth and Payment Plan

Instructions: In order to consent to billing and communication with your insurance company and to enter mental health treatment, you need to know the following information. This document is also used for the patient or for the parent/guardian of a minor or guardian of an adult.

Client Name: ____

Contacting Me:
Shorehaven may CALL with appointment reminders and other information regarding appointments and services at the following number: ________________________

Shorehaven may TEXT me regarding appointment times and reminders at the following number (standard messaging rates may apply): ________________________

Shorehaven may EMAIL me appointment reminders and other correspondence regarding appointments and services at the following address: _____________________________________

Text Email my preference for appointment reminders.

Emergency contact name and phone number: ____

Billing and Fees. Please choose how you prefer that we bill or our services.

Shorehaven will bill my insurance. I will pay any amounts which the insurance does not, such as deductibles and co-payments, or for which my insurance is not responsible. If insurance benefits are exhausted, I will pay the fee we agreed upon. I will pay any co-payments or other amounts due at each visit or when I am billed.

I will pay the usual and customary fee, deductibles, and copayments by cash, check, or credit card. If by credit card, I will supply my credit card information separately from this document.

Other fee agreement negotiated with therapist using discounted fee scale documented on a separate authorization form.

I will submit the bill to my insurance company and collect from my insurance. I will pay the usual and customary fee (or negotiated rate) at each session.

Informed Consent. I understand I have the right to make an informed decision to receive psychotherapy. My signature below indicates voluntary consent for the treatment plan for myself or, if the client is my child, for that child and the family. If the client is a child, I attest I am the legal guardian of the child and have the right to consent to treatment for this child. This consent applies to all providers at Shorehaven who may provide services and permits the sharing of information among Shorehaven staff as necessary for my care and billing. A Shorehaven therapist explained the treatment plan and I received a brochure, "Helping You Find Your Strength and Serenity."

Client Name: ____

I have also been informed of the following information regarding my treatment.

1. Shorehaven is licensed under DHS35 and DHS75. Services begin with assessment/evaluation by a professional licensed to practice in Wisconsin or a person under supervision of a licensee.
2. Diagnostic or psychological tests may be administered to help understand the best treatment plan. After a diagnostic evaluation of the problem, appropriate recommendations will be provided.
3. The treatment plan includes the type of treatment along with the expected goals or benefits of the treatment.
4. The treatment plan includes estimated *frequency* & *duration* of treatment and any *alternative* treatments that may be available.
5. I was informed about possible *risks* associated with the treatment and possible risks from *not* receiving this care.
6. I was informed about the estimated *cost* of treatment & my ultimate responsibility for costs.
7. I was informed about the *provider* of treatment and his or her credentials.
8. I was informed about the procedures to follow in an *emergency.*
9. I understand I have a right to a *second opinion or a consultation with a supervisor or staff consultant.*

Duration of Consent. I understand that consent expires after 15 months and I have the right to withdraw this consent in writing at any time. I understand this consent is for treatment and does not include participation in research.

Emergency Care. In case of an emergency, I understand Shorehaven reserves the right to administer medical treatment on the premises or to contact and advise emergency personnel on the premises or at an emergency room or hospital intake department regarding my needs at that time, including relevant clinical information.

Patient's Rights. In addition to the posted Wisconsin Statement of Patient's Rights, I have the right to request a consultation with the Clinic Administrator or a Supervisor. The best care is often provided by a team including the therapist and a Clinical Supervisor, Psychiatrist, or Consulting Psychologist. Shorehaven therapists will usually consult with other skilled staff, as may be required by law, regarding the best treatment plan.

I will be informed if the psychotherapist is an intern or trainee practicing under the supervision of a licensed therapist under my insurance plan.

Hours of Operation. SBH is open Monday through Thursday 8:30 AM to 8:00 PM, Friday 8:30 AM to 5:00 PM, Saturday by appointment only. Therapists may see clients outside of the standard hours.

Limits to Confidentiality. The information I give in therapy is generally confidential and will only be released outside of Shorehaven with my written permission (or with the permission of a parent or guardian of a minor). However, I acknowledge these limits to confidentiality under Wisconsin & Federal Statutes: a) The therapist may use information within SBH and with its business associates for treatment, payment, and other health care operations, b) The therapist is usually *required to* consult with clinical supervisors in order to provide a high quality of care, to answer certain subpoenas or court orders, to report threats of homicide or suicide, to report the suspicion of child abuse or child neglect, and *may report* elder abuse, abuse of a handicapped person, or a crime which may occur in the future, c) The therapist may report physical assaults or crimes which occur on the clinic premises.

Limited Disclosures. All disclosures will be made to the appropriate parties as directed by law, such as authorities, parents of minors, or intended victims of violence. When the therapist must release information *without* my consent, the information revealed will be limited to what is necessary for that situation.

Payment Plan Agreement. I made this agreement with the understanding that I accept full responsibility and liability for any and all charges incurred and guarantee timely payment of the agreed upon charges. I also understand that I will be liable for any costs associated with collection activities necessitated by delinquent outstanding charges, including costs levied by collection agencies, legal fees, search fees, or other related collection costs. The charge for returned checks is $25.00. Shorehaven may charge interest (1.5% per month) on unpaid balances delinquent commencing one month following a statement being sent to me.

Payment for Missed Appointments. If, for any reason, an appointment cannot be kept, the therapist must be notified 24 hours in advance and, when applicable, I may be responsible for payment of the customary charge for the missed appointment.

Authorization to Bill. My signature authorizes Shorehaven Behavioral Health, Inc. 1) to file insurance claims with my insurer for services provided to without obtaining my signature on each and every claim to be

submitted and 2) to release any information needed to process my insurance claims or to collect on my bill and 3) to bill the credit card I provide to Shorehaven.

Assignment of Benefits. I authorize my insurance carrier to pay, and I assign directly to Shorehaven, all benefits from my insurance for services provided by Shorehaven. And I authorize release to the third-party payer information and records necessary for processing of claims.

Consent for Telehealth: Telehealth or tele-therapy uses an electronic interaction between client and clinician to enable Shorehaven to improve care to consumers. Using telehealth, Shorehaven can offer services for assessment, individual therapy, family therapy, planning treatment, and determining medications, etc., that may otherwise be unavailable in an area or for other reasons. We use electronic systems designed for reliable transmission, privacy, security, and confidentiality.

Expected Benefits of Telehealth: Telehealth enables us to connect clients to services more rapidly or in situations of emergency. We can provide services which may otherwise be unavailable. We can access experts who may not be available in the client's area. We can bring in a member of the treatment team from a distant site in order to improve our services. Telehealth also cuts down on travel and reduces costs.

Possible Risks with Telehealth: All technology can have unique problems, such as: risk of interruptions, technical difficulties, and problems with signal quality. The client or clinician can interrupt the session if the connection is inadequate for excellent two-way communication.

With Telehealth, I understand the following:

1. All regulations and laws protecting the privacy and confidentiality of medical information also apply to telehealth. No information over telehealth that identifies me will be disclosed to others without my consent, except for situations required by law, e.g., emergencies or if I am a danger or a risk to myself or others.
2. I have the right to withdraw my consent to the use of telehealth at any time, without affecting my right to future care or treatment. I have a right to referral to in-person services.
3. I will be instructed about the equipment used in telehealth and procedures to use in the event of technical difficulties.
4. My telehealth visit will not be recorded without my agreement. The clinician will keep records of telehealth services, just as when services are in person. HIPAA and Wisconsin Statutes govern client access to those records and I received a Shorehaven Privacy Notice.
5. Telehealth may involve clinicians communicating electronically from other areas and possibly from outside of Wisconsin.
6. Services are expected to benefit clients, but no results can be guaranteed. Most research finds the outcomes of telehealth to be comparable to the results of office therapy.
7. Telehealth sessions are scheduled by appointment. Procedures for contacting the clinician and support staff between appointments has been given to me.
8. A facility fee applies to charges for telehealth visits if I am seen in a clinic office and the provider is at a different location, and that fee may or may not be covered by my insurance company.
9. If my clinician determines telehealth is no longer appropriate to my needs, my healthcare clinician may discontinue telehealth services. Then, I will be set up with or referred for in-person services.

Consent for Medications. If medications are prescribed at Shorehaven, I understand I will be advised the proper way to take the medication, how this medication is likely to help me, side effects to watch for, more severe risks and side effects for which I should contact my physician, how to stop the medications, what to do if I miss a dose of the medication. I understand that under Wisconsin statutes, I have the right to refuse to take medications. I can call the office if I have question about the medication or concerns about side effects. I understand if I miss an appointment, the psychiatrist may not be able to refill my medications. I understand my Psychiatrist, who is prescribing this medication, communicates with my psychotherapist(s) at Shorehaven regarding my medication or psychotherapeutic treatment, and the Psychiatrist may consult, supervise, inform, or receive information from these other providers of care regarding my treatment. I consent to SBH sending my prescriptions electronically by Internet or fax to my pharmacy.

Informed Consent. I received an explanation of consent, the limits of confidentiality, and the proposed treatment plan. I received a copy of Shorehaven's HIPAA Privacy Policy, and the brochure "Helping You Find Your Strength and Serenity." I understand the risks and benefits of the telehealth and mental health services and I consent to the planned treatment.

Client Name: ____

In the client signing window, use your mouse or finger to sign your name below. You may sign a printed version of this form and fax it to 414-540-2171, attach it to an email to Referrals@Shorehavenbhi.com, or mail it.

Client if 14 or older:

Name: ______________________ Signature: ____________________ Date: ____________

Parent or Legal Guardian:

If the client is under 18 or is an adult with a legal guardian, type your name below. In the client signing window use your mouse or finger to sign your name as parent or guardian.

Name: ______________________ Signature: ____________________ Date: ____________

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