Patient's Name ______________________ DOB: ______________

MRN: ______________

Beloit Health System
COUNSELING CARE CENTER
SERVICE AGREEMENT AND INFORMED CONSENT

The Counseling Care Center of Beloit Memorial Hospital is a certified clinic by Wisconsin statute (DHS 35 & HFS 75.13), and is able to receive mandated benefits from Wisconsin-based insurance companies. Our staff consists of licensed psychiatrists, psychologists, nurses, social workers and counselors. Staff psychiatrists and psychologists provide clinical supervision for each client. Initial assessments generally last 50 to 120 minutes while psychotherapy sessions consist of 25 to 50 minute visits. Other individual and group sessions typically last from 15 minutes to 2 hours, as scheduled. A fee schedule has been provided and discussed with you and is available on request.

CONSENT FOR TREATMENT: Your signature authorizes the staff of Beloit Health System's Counseling Care Center to provide mental health services to the identified client, understanding that you will be responsible for payment of all charges incurred in the course of such services.

TELEMEDICINE SERVICES: Your signature authorizes the staff of Beloit Health System's Counseling Care Center to provide mental health services, including psychiatric care, psychiatric medication management, and counseling/psychotherapy telemedicine services via phone or internet (video) to the identified client. Your signature also confirms that you have been fully informed about and understand the following:

The nature of the treatment, the risks and benefits, and the available treatment options, including:

1. In-person treatment at the physical location of Counseling Care Center
2. Telemedicine services via the internet or by phone

Your signature also confirms that:

- You have had the opportunity to have all questions answered to your satisfaction.
- Your consent has been given voluntarily.
- You are legally competent and have the authority to provide consent for treatment.
- You are responsible for payment and verifying insurance.
- You are responsible for securing a private location during telemedicine services.
- You are responsible for providing your practitioner with your physical location and emergency information at the beginning of each telemedicine session.
- You understand if you are experiencing a psychiatric/medical emergency your provider will contact emergency services.
- You are responsible for your own internet access and equipment in order to receive telemedicine services.
- You have the right to withdraw your consent for this treatment at any time.
- Withdrawing consent for this treatment will not prejudice your continued treatment relationship.

GUARDIAN CONSENT FOR TREATMENT: Minor's guardian(s), or guardians of adults termed not competent, will complete all consents and agreements for treatment. Guardians or approved caregivers (i.e., foster parent given rights by the state, step-parents with guardian permission, approved nurses' aide) will be present for all appointments. You agree to respect the confidentiality of communication between your child (or ward) and his/her therapist.

AGREEMENT FOR ATTENDING, RESCHEDULING AND CANCELING APPOINTMENTS: In order to provide prompt mental health services to you and to our other clients, we need your cooperation in being on time and attending all scheduled appointments. Our staff will also make every effort to be on time, but because of emergencies, there may be short delays. If a significant delay is anticipated, you will be informed.

In order to avoid being charged for a missed appointment, if you know that you will need to change or cancel a scheduled appointment, you must do so at least ***one business day prior to the day of your scheduled appointment, during normal business hours.*** "Business days" are Monday through Friday, excluding holidays.

If an emergency arises, we still ask that you call our clinic to inform us that you cannot attend your appointment. You will not need to provide any explanation in such a circumstance. Because of client demand for services, if there are more than three instances in any six month period in which:

a) you miss or fail to appear for any scheduled appointments and/or
b) you do not give advance notice for cancellations (as defined above)

Then all of your treatment in the Counseling Care Center will be closed for six months, allowing new patients access to services. By signing below, I confirm that I have read and understand the importance of the above agreement, and I understand that my failure to comply will result in termination of all of my services in the Counseling Care Center.

PAYMENT FOR SERVICES: The billing department of Beloit Memorial Hospital will cooperate with you in filing for reimbursement with your third party payer. By signing below, you give consent for release of information, including photocopies of your record as requested, which may be necessary to obtain reimbursement. However, the hospital does not accept responsibility for collection of your claim or for negotiating a settlement on a disputed claim. **I understand that it is my responsibility to contact my insurance company regarding coverage limits at the Counseling Care Center and its providers. I further understand that any fee not covered by insurance will be made my responsibility unless prior financial arrangements have been made with the hospital's billing department.**

CONFIDENTIALITY POLICY: The Counseling Care Center places a high value on the confidentiality of the information our patients share with us. We understand that this information is often highly sensitive. This policy has been prepared to clarify our legal and ethical responsibilities, in reference to federal law 42 CFR, Part 2 S.51.30, and Ch. 51 of the Wisconsin Statutes as well as HSS Regulation 61.23 of state law, under the licensing statutes DHS 35 and HFS 75.13

If there is a need to share your records with someone not employed by the Counseling Care Center (for example, your physician, family members, or another agency) you will be asked to sign a form authorizing a transfer of the information. Only if you provide a written, informed consent will information about your history and treatment be shared with others. If oral communication is to occur between your provider and another person, this will occur with similar consent. You can revoke your permission at any time.

EXCEPTIONS TO CONFIDENTIALITY:

There are several important instances where confidential information may be released to others, without your consent. These include the following:

First, if we have reason to suspect abuse or neglect of a child or elderly person, we are obligated by law to report this to an appropriate state or county social service agency. This law is designed to protect the vulnerable from harm and our obligation to report suspected abuse or neglect is clear. Social Service agencies may/may not choose to investigate the report.

Second, if you are involved in a litigation of any kind criminal or civil, (including a pending divorce), and inform the Court of the services you received from us, the Court may subpoena the records.

Third, if you threaten to harm either yourself or someone else and our staff believes your threat is serious, they are obligated under Wisconsin law to take actions necessary to protect you and/or others from serious harm. This may include our staff having to divulge confidential information to police or others in order to assure your and other's safety. Such confidential information would be divulged only under unusual circumstances where someone's life or physical safety appeared to be in significant imminent danger.

Fourth, if you have been referred to this agency by a Court (Court Order), you can assume that the Court expects to receive formal updates regarding your treatment. You should discuss with us exactly what kind of information would be included in the report *before* you disclose any kind of confidential material.

ELECTRONIC MEDICAL RECORDS: With a focus on comprehensive care and quality communication, since 3/18/13, all services completed by the Counseling Care Center are documented, stored, and billing services completed, through a united Beloit Health System medical record. Access to Counseling Care Center records by employees of Beloit Health System or its affiliated must follow system policy and procedures. Some examples of access may include releasing records with your permission, or a medical physician/nurse prescriber may review your medications and care for consideration of ongoing medical care. Efforts to maintain your privacy are consistent with HIPAA and Chapters 35 & 75 of the Wisconsin Administration Codes.

CONFIDENTIALITY AND PATIENT RIGHTS: You have received and have had explained to you the Counseling Care Center's description of its confidentiality policy and patient rights for being treated in the Counseling Care Center.

I agree to participate in services for the Counseling Care Center, in accord with my service agreement. Customary fees have been discussed with me, and I know I may request a copy of the fee schedule. I have also received a copy of the Counseling Care Center's confidentiality statement. I understand the terms of the above and assign insurance benefits by my signature. I may receive a copy of this document. This consent shall remain in effect for 12 months from the date signed unless otherwise revoked in writing.

Patient Signature Date | In the Presence of Date

Parent/Guardian/Power of Attorney Date

Beloit Health System
COUNSELING CARE CENTER
DESCRIPTION OF PATIENT RIGHTS

The following is a brief summary of your rights as a patient treated in the Counseling Care Center. Please feel free to ask questions about your rights at any time during meetings with your treatment providers or other Counseling Care Center staff.

1. You have the right to be informed of your treatment plan including:
   a. Possible outcomes and side effects of treatment recommended in the treatment plan.
   b. Treatment recommendations and benefits of the treatment recommendations.
   c. Approximate duration and desired outcome of recommendations in the treatment plan.
   d. The rights of the patient receiving outpatient mental health services, including the patient's rights and responsibilities in the development and implementation of an individual treatment plan.
   e. The outpatient mental health services that will be offered under the treatment plan.
   f. The nature of care, procedures and treatment that you will receive;
   g. Potential treatment risks, including potential adverse affects of medication;
   h. Treatment alternatives.
   i. The time period for which you will provide informed consent for treatment, which is one year unless otherwise specified;
   j. The right to withdraw your informed consent at any time, in writing.
   k. Under what circumstances you may be involuntarily discharged from care, and resulting referral needs.

2. You have the right to treatment in the least restrictive setting available, consistent with your and others' safety and your health and well-being.
3. You have the right to receive prompt and adequate treatment.
4. You have the right to refuse medication, unless ordered by a court.
5. You have the right to request a second opinion of a consultant, at your expense (or as covered by your public or private insurance), if you do not agree with any/all of your treatment plan.
6. You have the right to review your treatment records with your treatment provider(s).
7. You have the right to confidential treatment except as otherwise provided by law.
8. You or your guardian may inspect or receive a copy of your treatment records and challenge any inaccuracies. Records will be copied without a due delay only upon your written request.
9. You have a right to know the fees you will be expected to pay for services.
10. You have a right to be informed of means to obtain emergency mental health services during periods outside the normal operating hours of the clinic.
11. You have the right to file a grievance concerning any aspect of your treatment, and to have your grievance investigated.
12. You have the right to be provided assistance in exercising your rights if you request it.

I understand these rights and have been offered a copy of this document. I understand that I may contact or Laura Neece, Director of the Counseling Care Center at 364-5686 for patient grievance or advocacy needs.

____ ____

Patient Signature Date Parent/Guardian Signature Date