

MENTAL HEALTH SOLUTIONS

7633 Ganser Way, #204, Madison, WI 53719

608-829-1800

OUTPATIENT SERVICES AGREEMENT

Mental Health Solutions is a state certified/approved mental health clinic and, therefore, is required to provide you with the following information.

Informed Consent: The benefits of psychotherapy services are to help alleviate the problems and symptoms the client presents. Therapy is conducted in sessions between a therapist and client. If there are any expected side effects from therapy or medications, they will be discussed with you. During the first several sessions, you and your therapist will jointly assess the issues and goals of treatment and define them in writing. The potential consequences of not receiving therapy may be discussed with you.

Confidentiality: Law protects all communications between client and therapist; information can only be released with written permission from the client. There are some extreme situations when confidentiality is exempted: if there is serious concern about self harm or harm to another individual; all suspected cases of child abuse or neglect; in very rare cases, your record could be subpoenaed by the court.

The following pertains to the treatment of children:

Children under the age of 18 are considered minors by law but in Wisconsin adolescents 14 and older are required to consent to treatment in writing. They have the legal right to exclude others, including parents, from access to their treatment record. It is our policy to keep specific disclosures made by children confidential if they so desire, while keeping the parents informed of general treatment progress except in issues of abuse and/or potential harm to the child.

Clients Rights and Grievance Procedure: This process is posted in the waiting room and a handout, detailing this process, is available upon request.

You have the option of paying for your treatment directly or using insurance reimbursement if your policy covers the provided service. If you choose to use insurance, please remember that Mental Health Solutions is contracting with you, not with your insurance company. If they fail to provide payment, you are responsible for the fee. This may include deductibles, co-pays, costs incurred without a referral, or costs that exceed the benefit limit. All payments are due in full upon receipt of a statement. With your signed authorization, Mental Health Solutions will directly bill your insurance company.

On occasion, you may find it necessary to change or cancel an appointment. We ask for AT LEAST A 24 HOUR NOTICE. You will be billed for all appointments that are not cancelled in this time limit. We understand that sometimes emergencies or illnesses occur. Please discuss the circumstances with your therapist for consideration of the charges being waived.

Please make babysitting arrangements for children not here for treatment. Our staff cannot supervise children in the waiting room.

Please bring to our attention any concerns or complaints that you may have about our services. There is a client's rights handout available at the front desk.

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OUTPATIENT SERVICES CONTRACT

NAME: _____ THERAPIST: _____

The fee for mental health services is based on the length of time and the cost of the specific service. Individual psychotherapy sessions, lasting 45 minutes, cost \$ _____ per session. Longer sessions are prorated accordingly. Intake (first time) appointments often involve extra time both within and after the initial session and will be billed at \$ _____. It is our policy to charge on a prorated basis for other professional services, such as phone consultations, report writing, attendance at meetings, preparation of treatment summaries, *and missed appointments without 24-hour notice*. You are responsible for any charges not covered by your insurance carrier.

In very unusual circumstances you may become involved in litigation that requires your therapist's involvement. You will be charged for such services at the usual and customary litigation fee even if the request is initiated by a third party but mandated by the court.

A written copy of client rights (State regulations), which details the grievance procedure, has been offered and is available at the front desk.

Your signature below indicates that you have: (1) been informed of your rights and advised that a client's rights policy and procedure form is available; (2) have been advised regarding "informed consent"; (3) have read and understand this outpatient services agreement; (4) grant authorization for Mental Health Solutions to release information to your insurance company as necessary for the processing of claims; (5) authorize direct payment to Mental Health Solutions from your insurance carrier; (6) understand that you can withdraw from this agreement and/or stop treatment at any time.

Signature of Client: _____

Date: _____ Witness _____

Signature of Person Authorized by Client: _____

Relationship to Client _____
(Parent, Legal Guardian, Power of Attorney)