Sun Prairie Psychological Services
705 W. Main Street, Suite 3
Sun Prairie, WI 53590

INFORMED CONSENT AGREEMENT

This Agreement contains important information about clinic professional services and business policies. It also contains summary information about the Heath Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPPA requires that you be provided with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. This Notice, which is enclosed with this agreement, explains HIPAA and its application to your personal health information. Your therapist can discuss any questions you have about the procedures. When you sign this document, it will also represent an agreement between you and the clinic. You may revoke this Agreement in writing at any time. That revocation will be binding unless action has been taken in reliance on it; if there are obligations imposed by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Fees and Insurance

1. Dr. Haseleu's initial evaluation is one hour and is billed at $175.00 for this hour. If this interview takes longer than 1 hour, it will be billed for additional time in 15 minute increments at $40.00 for each additional 15 minutes.
2. Dr. Haseleu's customary fee for treatment sessions is $160.00 per hour. This fee can be broken down into 15 minute intervals at $40.00 each.
3. The usual treatment session is 45 minutes at a charge of $120.00
4. Any unusual requests, such as preparing reports, psychological testing, or testifying in court, are charged at $250.00 per hour.
5. The payment of fees is your responsibility even though you may have insurance which will cover all or a portion of your bill. The clinic will submit your insurance claims and work with you regarding your financial responsibilities.
6. Payment for services, excepting that portion which is submitted to your insurance company for payment, is due within 30 days of when the bill was incurred. This includes payment for missed appointments and late cancellations.
7. If you will have difficulty keeping current with your bill, please discuss this with Dr. Haseleu. It is most likely that a payment plan or other financial arrangement can be made.
8. It is your responsibility to obtain the necessary information from your insurance company regarding your outpatient mental health benefits, the proper procedures for submitting claims, and to forward to us any special forms or information which your insurance company requires. Our office staff is available to help you with this if assistance is required.
9. Many insurance companies have deductibles and co-payments. Thus, you may be required to make a co-payment each month.
10. Your health insurance company will require information relevant to the services provided to you. This will include a diagnosis and may include additional clinical information, such as treatment plans or treatment summaries, or copies of your entire record. In such situations every effort will be made to release only the minimum information about you that is necessary. By signing this agreement you agree to allow this clinic to provide requested information to your insurance carrier for processing insurance claims.

Cancellations

Because the appointment time is reserved for you, it is necessary to charge for appointments which are not canceled 24 hours before the actual appointment time, unless the failure to cancel is due to an emergency or to an unpredictable or unavoidable circumstance. In this case, you are obliged to contact the clinic as soon as you can, and to discuss the circumstances of the situation with your therapist at your next appointment. Insurance companies do not typically pay for appointments that you fail to cancel.

Consultation

If you wish to speak to another member of the clinic staff during the course of your treatment to get a second opinion, receive a different type of therapy, make a complaint, or for other reasons, please make this known to your therapist or the clinic administration, who will assist you in making such an appointment as quickly as possible.

Messages

1. If you need to speak with your therapist between appointments you may call the clinic at any time to leave a message.
2. In an emergency you may reach your therapist by calling the clinic phone number and telling the person answering the phone that this is an emergency or by following the procedures described on voice mail.

Limits on Confidentiality

See attached Notice of Privacy Practices.

Professional Records

The laws and standards of the profession require that your therapist keep Professional Health Information about you in your Clinical Record. You may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, it is recommended that you initially review

them in your therapist's presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, copying will be charged at $.45 per page.

Client Rights
HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that your therapist amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; having any complaints you make about policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and privacy policies and procedures. Your therapist will be happy to discuss any of these rights with you.

You received a pamphlet explaining your rights. If you have any questions about your rights as a client here, please feel free to discuss such with your therapist or contact the Client Rights Specialist whose address and phone number are listed below. If you believe any of your rights have been violated, you may discuss your concerns informally with staff or may submit a formal grievance to the Client Rights Specialist.

The Client Rights Specialist for this program is: Maria Hanson, P.O. Box 14533, Madison, WI 53714-0533. Her phone number is (608)446-8957.

Involuntary Discharge
If the clinic decides to involuntarily discharge a patient, the clinic will notify the patient in writing of the effective date of the discharge, sources for further treatment and the patient's right to have the discharge reviewed, prior to the effective date of the discharge.

The patient may appeal the involuntary discharges under DHSA 35.24 to:

Behavioral Health Certification Section
Division of Quality Assurance
P.O. Box 2969
Madison, WI 53701-2969

Minors and Parents
Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records unless the therapist decides that such access is likely to injure the child. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is clinic policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, they will be provided with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Any other communication will require the child's authorization, unless it is believed that the child is in danger or is a danger to someone else, in which case, the parents will be notified. Before giving parents any information, your therapist will discuss the matter with the child, if possible, and try to handle any objections he/she may have.

Treatment Issues
At the completion of the intake evaluation when all information has been obtained and evaluated, your therapist will indicate the most effective means of the administration of treatment (i.e., individual, couples, family). The benefits of the prescribed treatment will be stated as well as any possible known risks. Any alternative modes of intervention that are available for treatment of your specific problems will also be indicated. The frequency and duration of treatment will also be discussed. Consequences of not receiving the proposed treatment will be stated. The time for this informed consent agreement is one year. You have the right to withdraw your consent at any time in writing.

Signatures
With my signature below, I acknowledge that I read or had read to me the above information. I have been notified of my rights as an individual receiving mental health treatment at this clinic and of the grievance procedure available to me. I understand this information, received a copy of this form, and hereby give my consent to treatment with the understanding that I may withdraw my consent at any time in writing. I have also received the HIPAA Notice of Privacy Policies.

_____ _____
Client Date

_____ _____
Parent/Guardian - if applicable Date