MADISON PSYCHIATRIC ASSOCIATES

For Office Use Only
Patient ID:_____
Provider:_____

PATIENT INFORMATION

NAME: _____
FIRST MI LAST

ADDRESS: _____

_____
CITY STATE ZIPCODE

BIRTHDATE: _____ AGE: _____

SOCIAL SECURITY #: _____

MARITAL STATUS: _____ SEX: ☐ M ☐ F

CONTACT INFORMATION

(Check Box for **One Phone** Appointment Reminder)

Preferred Contact Name:_____

Relationship to Patient: _____ Voicemail Ok? YES □ NO □

Phone Number:_____ call □ text □

Email Reminder Address: _____

Secondary Contact Name:_____

Relationship to Patient: _____ Voicemail Ok? YES □ NO □

Phone Number:_____ call □ text □

Email Reminder Address: _____

Guarantor * (Person Responsible for bill, if other than patient) *MUST be completed if patient is a minor*

Name: _____ *Birthday:* _____ *Social Sec #*_____

Address: _____

Phone Number: _____ *Guarantor Signature* _____

***GUARANTOR DISCLAIMER:** If the Guarantor Signature is left blank, and/or, the listed Guarantor does not pay for services due, the responsibility will transfer to the patient and/or individual completing this form.

Primary Insurance Info

(if self-pay do not fill out)

Ins. Co. _____

Name of Policyholder _____

Relationship to Patient _____

Customer Service Phone # _____

Address _____

City, State, Zip _____

Subscriber # _____ **Grp#** _____

Effective Date _____

Policyholders Date of Birth _____

Policyholder Social Security # _____

Policyholder Address (if different than patient)

_____

Secondary Insurance Info

(if self-pay, do not fill out)

Ins. Co. _____

Name of Policyholder _____

Relationship to Patient _____

Customer Service Phone # _____

Address _____

City, State, Zip _____

Subscriber # _____ **Grp#** _____

Effective Date _____

Policyholders Date of Birth _____

Policyholder Social Security # _____

Policyholder Address (if different than patient)

_____

OBLIGATIONS OF RESPONSIBLE PARTY: Our clinic files for reimbursement with your insurance company. However, the ultimate responsibility for your account is yours. Insurance billing is a courtesy, and the clinic does not accept the responsibility for collection of your claim or of negotiating a settlement on a disputed claim. If the patient is responsible for a balance due, you will receive monthly statements.

ASSIGNMENT OF BENEFITS: I hereby authorize Madison Psychiatric Associates, Ltd., to release the minimum medical information necessary to process my insurance claims. I further authorize the above insurance company(s) to make payment directly to the provider for the benefits herein and otherwise payable to me:

****PLEASE NOTE:** You must notify MPA at the time of any change in your insurance status, including but not limited to a change in your insurance provider, loss of insurance coverage, or Medicare or Medicaid eligibility. If you fail to notify MPA timely of such a change and MPA is unable to bill for or collect fees from an insurer (including Medicaid or Medicare) due to your lack of notice, then MPA may require you to pay for all unbilled or uncollected fees to the extent allowed by law.

Signature: _____ **Printed Name:** _____ **Date:** _____

(IF PATIENT IS A MINOR, PARENT/GUARDIAN OR ADULT RESPONSIBLE MUST SIGN.)

MADISON PSYCHIATRIC ASSOCIATES

Consent for Child Mental Health Treatment

1. **Consent to Evaluate/Treat:** I voluntarily consent that my child will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from Madison Psychiatric Associates. 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. The manner in which treatment will be administered
    d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
    e. Probable consequences of not receiving treatment

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

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to my child, as well as the referring professional, to understand the nature and cause of any difficulties affecting my child's 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 performance, health status, quality of life, and awareness of strengths and limitations.

3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.

4. **Confidentiality, Harm, and Inquiry:** Information from my child's evaluation and/or treatment is contained in a confidential record at Madison Psychiatric Associates, and I consent to disclosure for use by Madison Psychiatric Associates staff for the purpose of continuity of my child's care. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: 1) if my child is deemed to present a danger to himself/herself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

5. **Discharge Policy:** There are circumstances under which my child may be involuntarily discharged. I have read and understand the discharge policy of the clinic.

    Madison Psychiatric Associates may discontinue services if: (1) all treatment goals have been met; (2) you fail to demonstrate an interest in actively pursuing treatment goals; (3) you fail to pay for services as agreed upon in your Fee Agreement; or (4) upon the professional recommendation of your therapist.

6. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment of my child at any time by providing a written request to the treating clinician.

7. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I.

MADISON PSYCHIATRIC ASSOCIATES

MPA
NOTICE OF PROVIDER PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

MPA is required by law to maintain the privacy of your health information. MPA is also required to provide you with a notice that describes MPA's legal duties and privacy practices and your privacy rights with respect to your health information. We will follow the privacy practices described in this notice. If you have any questions about any part of this Notice or if you want more information about the privacy practices of MPA, please contact our Clinic Administrator at 608-274-0355.

We reserve the right to change the privacy practices described in this notice in the event that the practices need to be changed to be in compliance with the law. We will make the new notice provisions effective for all the protected health information that we maintain. If we change our privacy practices, we will have them available upon request. It will also be posted at the location of service.

How MPA May Use or Disclose Your Health Information for Treatment, Payment or Health Care Operations

The following categories describe the ways that MPA may use and disclose your health information. For each type of use and disclosure, we will explain what we mean and present some examples.

Treatment. We may use or disclose your health care information in the provision, coordination or management of your health care. Our communications to you may be by telephone, cell phone, e-mail, patient portal, or by mail. Some forms of communication may also require your individual authorization. For example we may use your information to call and remind you of an appointment or to refer your care to another physician. If another provider requests your health information and they are not providing care and treatment to you we will request an authorization from you before providing your information.

Payment. We may use or disclose your health care information to obtain payment for your health care services. For example, we may use your information to send a bill for your health care services to your insurer.

Health Care Operations. We may use or disclose your health care information for activities relating to the evaluation of patient care, evaluating the performance of health care providers, business planning and compliance with the law. For example, we may share your protected health information (PHI) with third parties that perform various business activities (such as billing or typing services). If the activities require disclosure outside of our health care organization we will request your authorization before disclosing that information.

How MPA May Use or Disclose Your Health Information Without Your Written Authorization

The following categories describe the ways that MPA may use and disclose your health information without your authorization. For each type of use and disclosure, we will explain what we mean and present some examples.

1. **Required by Law.** We may use and disclose your health information when that use or disclosure is required by law. For example, we may disclose medical information to report child abuse or to respond to a court order.

2. **Public Health.** We may release your health information to local, state or federal public health agencies subject to the provisions of applicable state and federal law for reporting communicable diseases, aiding in the prevention or control of certain diseases and reporting problems with products and reactions to medications to the Food and Drug Administration.

3. **Victims of Abuse, Neglect or Violence.** We may disclose your information to a government authority authorized by law to receive reports of abuse, neglect or violence relating to children or the elderly.

4. **Health Oversight Activities.** We may disclose your health information to health agencies authorized by law to conduct audits, investigations, inspections, licensure and other proceedings related to oversight of the health care system.

5. **Judicial and Administrative Proceedings.** We may disclose your health information in the course of an administrative or judicial proceeding in response to a court order. Under most circumstances when the request is made through a subpoena, a discovery request or involves another type of administrative order, your authorization will be obtained before disclosure is permitted.

6. **Law Enforcement.** We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, or missing person, or complying with a court order or other law enforcement purposes. Under some limited circumstances we will request your authorization prior to permitting disclosure.

7. **Coroners and Medical Examiners.** We may disclose your health information to coroners and medical examiners. For example, this may be necessary to determine the cause of death.

8. **To Avert a Serious Threat to Health of Safety.** We may disclose your health information in a very limited manner to appropriate persons to prevent a serious threat to the health or safety of a particular person or the general public. Disclosure is usually limited to law enforcement personnel who are involved in protecting the public safety.

9. **Specialized Government Functions.** Under certain and very limited circumstances, we may disclose your health care information for military, national security, or law enforcement custodial situations.

10. **Workers' Compensation**. Both state and federal law allow the disclosure of your health care information that is reasonably related to a worker's compensation injury to be disclosed without your authorization. These programs may provide benefits for work-related injuries or illness.

11. **Health Information.** We may use or disclose your health information to provide information to you about treatment alternatives or other health related benefits and services that may be of interest to you.

When MPA is Required to Obtain an Authorization to Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without written authorization from you. For example, uses and disclosures made for the purpose of psychotherapy, marketing and the sale of protected health information require your authorization. If your provider intends to engage in fundraising, you have the right to opt out of receiving such communications. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use or disclose health information about you for the reasons covered by your written authorization, though we will be unable to take back any disclosures we have already made with your permission.

Your Health Information Rights

1. **Inspect And Copy Your Health Information**. You have the right to inspect and obtain a copy of your health care information. You have the right to request that the copy be provided in an electronic form or format. If the form and format are not readily producible, then the organization will work with you to provide it in a reasonable electronic form or format. This right of access does not apply to psychotherapy notes, which are maintained for the personal use of a mental health professional. Your request for inspection or access must be submitted in writing to the Clinic Administrator at 5534 Medical Circle, Madison, WI 53719. In addition, we may charge you a reasonable fee to cover our expenses for copying your health information.

2. **Request To Correct Your Health Information**. You have a right to request that MPA amend your health information that you believe is incorrect or incomplete. We are not required to change your health information and if your request is denied, we will provide you with information about our denial and how you can disagree with the denial. To request an amendment, you must make you request in writing to the Clinic Administrator at 5534 Medical Circle, Madison, WI 53719. You must also provide a reason for your request.

3. **Request Restrictions on Certain Uses and Disclosures**. You have the right to request restrictions on how your health information is used or to whom your information is disclosed, even if the restriction affects your treatment or our payment or health care operation activities. However, we are not required to agree in all circumstances to your requested restrictions, except in the case of a disclosure restricted to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and the protected health information pertains solely to a health care item or service for which you, or the person other than the health plan on your behalf, has paid the covered entity in full. If you would like to make a request for restrictions, you must submit your request in writing to the Clinic Administrator at 5534 Medical Circle, Madison, WI 53719.

4. **Receive Confidential Communications Of Health Information**. You have the right to request that we communicate your health information to you in different ways or places. We must accommodate reasonable requests. To request confidential communications, you must submit your request in writing to the Clinic Administrator at 5534 Medical Circle, Madison, WI 53719.

5. **Receive A Record Of Disclosures Of Your Health Information**. You have the right to request a list of the disclosures of your health information that we have made in compliance with federal and state law. This list will include the date of each disclosure, who received the disclosed health information, a brief description of the health information disclosed, and why the disclosure was made. For some types of disclosures, the list will also include the date and time the request for disclosure was received and the date and time the disclosure was made. For example, you may request a list that indicates all the disclosures your health care provider has made from you health care record in the past six months. To request this accounting of disclosures, you must submit your request in writing to the Clinic Administrator at 5534 Medical Circle, Madison, WI 53719. We must comply with your request for a list within 60 days, unless you agree to a 30-day extension, and we may not charge you for the list, unless you request such list more than once per year.

6. **Obtain A Paper Copy Of This Notice**. Upon your request, you may at any time receive a paper copy of this notice, even if you earlier agreed to receive this notice electronically. To obtain a paper copy of this Notice, send your written request to the Clinic Administrator at 5534 Medical Circle, Madison, WI 53719. The notice is also located on MPA's website at www.madisonpsychiatricassociates.com.

7. **Notified of a Breach.** Your provider is required by law to maintain the privacy of protected health information and provide you with notice of its legal duties and privacy practices with respect to protected health information and to notify you following a breach of unsecured protected health information.

8. **Complaint.** If you believe your privacy rights have been violated, you may file a complaint with the Clinic Administrator at 5534 Medical Circle, Madison, WI 53719 that will provide you with any needed assistance. We request that you file your complaint in writing so that we may better assist in the investigation of your complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services. There will be no retaliation against you in any way for filing a complaint.

If you have any questions or concerns regarding your privacy rights or the information in this notice, please contact the Clinic Administrator at 5534 Medical Circle, Madison, WI 53719, 608-274-0355.

We reserve the right to revise or change this notice.

Effective Date of This Notice: 12/21/16

MADISON PSYCHIATRIC ASSOCIATES

Client Rights, Responsibilities and Informed Consent

MISSION STATEMENT

Madison Psychiatric Associates, Ltd. (MPA) is an outpatient mental health clinic committed to providing its patients with the highest quality of mental health services.

DESCRIPTION

Client Rights and Responsibilities

- At Madison Psychiatric Associates, we respect the personal and unique needs and values of each client.
- We consider our clients to be partners in their mental health care.
- Our expectation is that the observance of Client's Rights will support mutual cooperation and greater satisfaction for clients and staff.

As a Client you have the right:

1. To know the name, identity, and professional status of all persons providing services to you and to know the staff member who is primarily responsible for your family's services.
2. To receive complete and current information concerning your assessment and/or treatment service plan in terms that you can understand.
3. To accept or refuse any service offered or treatment, and to be informed of the consequences of any such refusal. If there is conflict between you and your parents/guardian regarding your exercise of this right, you and parent/guardian may need to participate in conflict resolution procedures. If there is a conflict between you and your referring agency (DFCS, DJJ, probation), the referring agency will advise you of such consequences of lack of cooperation.
4. To receive and review the Notice of Policies and Practices to Protect the Privacy of your Health Information.
5. To supportive care including appropriate management and support of your psychological and spiritual needs without regard to sex, race, sexual orientation, age, pregnancy, religious beliefs, national origin, and physical disability.
6. To assistance in obtaining consultation with another therapist regarding your care when needed. This consultation may result in additional cost to you or your family.
7. To know if your care involves research or experimental methods of treatment. You have the right to consent or refuse to participate.
8. To voice complaints regarding your care, to have those complaints reviewed, and, when possible, resolved without fear of any harm or penalty to yourself. You have the right to be informed of the response to your complaint.
9. To expect reasonable continuity of care. You have the right to participate in the discharge planning process.
10. To be informed of any policies, procedures, rules or regulations applicable to you.
11. To freedom from financial or other exploitation.
12. To freedom from retaliation, humiliation, and neglect and/or abuse.

As a client it is your responsibility:

It is reasonable to expect and encourage clients to assume reasonable responsibilities. Greater individual involvement by clients in their care increase the likelihood of achieving the best outcomes and helps support a quality improvement, cost-conscious environment. Those responsibilities include:

1. To provide all personal and family health information needed to provide you with the appropriate services. This includes open and honest disclosure of family/individual social and mental health history and reporting any feelings of harming yourself or others.
2. To participate to the best of your ability in making decisions about your mental health treatment, and to comply with the agreed upon plan of service.

3. To ask questions when you do not understand any information or instructions.
4. To be considerate of others receiving and providing services.
5. To observe facility policies and procedures, including those regarding smoking.
6. To participate in the formulation of your Treatment Plan in discussion with the clinical staff.
7. To follow the Treatment Plan and take any prescribed medication in order to advance in treatment.
8. To provide the service delivery staff with all required information to maintain proper and correct records.
9. To keep all scheduled appointments and be on time.
10. To treat the Provider and MPA Staff with dignity and respect.
11. To inform the administrative staff of any changes in Demographics, Insurance Plans, Eligibility, or Employment status.
12. To pay for services as necessary, including co-pays. And to provide necessary information for the administrative staff to successfully seek reimbursement of insured services.

Additional Disclosures:

1. Due to ethical and legal guidelines, all staff members are mandated to report any indications, belief, or suspicion of harm to oneself, harm to others, or intent to harm self or others. This includes suspicions of child abuse or neglect and elder abuse or neglect.
2. If you have been referred by another agency, Madison Psychiatric Associates will request to obtain a release of information to share treatment progress, treatment plan, and participation in services with the referring agency. Case updates, client contact summaries, and assessment and intake information will be provided to the referring agency. The referring agency will be made aware of case plan recommendations and treatment progress throughout the course of treatment with Madison Psychiatric Associates.
3. Counseling and psychiatric services are often sought by individuals and families to alleviate difficulties that are occurring. As counseling service progress, clients may find themselves feeling worse rather than better. Understand that this is a common problem experienced by many. As problems that have never been discussed before are now being talked about during counseling, it can stir up difficult emotions. If you experience this, it is important to talk about this openly with your counselor. Your counselor will help you manage these feelings in a supportive manner. Often times, things can get worse before they get better. Know that the entire treatment team is here to support you, should you feel worse before feeling better.

Financial Disclosure:

You hereby give permission to Madison Psychiatric Associates to file any insurance claims with 3rd party payer sources and provide/receive information necessary to complete these transactions, including the ability to appeal any denial of claims for services rendered and to actively seek compensation for services as necessary.

Additionally, you understand that while Madison Psychiatric Associates will seek reimbursement through insurance or other payer sources, you (and/or the listed Guarantor) are ultimately responsible for payment for these services, or may be responsible for a co-pay, as designated by the payer source. You agree that it is your responsibility to provide accurate and updated information regarding alternate payer sources (such as insurance) to Madison Psychiatric Associates and assist the agency with recouping filed claims as necessary. In the event that a claim is denied, you understand that you will be responsible for the payment for service.

Should your insurance carrier change, notify our billing department immediately. Insurance changes may impact whether you are able to continue care with your current provider. This could be due to the provider not being contracted with your new insurance, their caseload of a specific insurance carrier may be full, or your new policy may not provide mental health coverage.

If you do not have insurance, you understand, and agree that it is your responsibility to pay any and all fees associated with the treatment decided between you and this agency.

Termination:

1. At any time, Madison Psychiatric Associates, or you, may terminate services
2. ***Services will automatically be terminated after 120 days of no contact with the Client.***

Right to have access to self-help and advocacy support services.

Clients can receive advocacy support services through the Department of Human Resources, Client Advocacy Department that can be reached at 770-720-3610.

Choice of Providers

Clients have the right to choice of provider (when available), in order to ensure access to appropriate high quality care. By signing this document, you acknowledge that you have chosen Madison Psychiatric Associates as your provider.

Access to Emergency Services

Clients have the right to access services 24 hours/day, 7 days/week in case of an emergency. The clinicians are available during normal business hours, between 8:00am and 5:30pm, Monday through Thursday, and 8:00am and 5:00pm Friday. After hours, should an emergency arise, please call 911 for imminent and/or life threatening issues. For all other crisis, emergency calls, you may contact the main office in order to obtain the after-hours number listed on the voice mail.

Respect and Nondiscrimination

Clients must not be discriminated against in the delivery of services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment. Clients and their families have the right to be treated with courtesy, respect and dignity at all times. Limitation to access to service does not infer or result in discrimination. These limitations (i.e. inability to effectively treat psychotic participants with active hallucinations, delusions, patients under the influence of drugs during the majority of face-to-face contacts, families without stable housing, autistic patients and children and adolescents without parent/guardian, sexual offenders who are predatory) are discussed with referring agencies and clients/families.

Complaints and Appeals

Clients have the right to a fair and efficient process for resolving disputes and difference with provider. Clients have the right to communicate freely with the Therapist, Psychiatrist, supervisor and Clinic Administrator. All clients should be given a complaint form by their Therapist or Psychiatrist, or referred to Maria Hanson, the agency Client Rights Specialist, at 608-446-8957.

MADISON PSYCHIATRIC ASSOCIATES

CLINIC INFORMATION
MADISON PSYCHIATRIC ASSOCIATES POLICIES AND PROCEDURES

The mission of Madison Psychiatric Associates is to provide the highest quality behavioral health care services. Madison Psychiatric Associates is Madison's first free-standing psychiatric practice providing counseling and psychotherapy for families. This sheet contains important information about our policies and procedures. Please read it carefully. Ask your therapist to answer any questions you may have.

Eligibility: Eligibility for Madison Psychiatric Associates services is based on the existence of a presenting problem. You may be referred to another community resource if you (1) do not meet the eligibility criteria; (2) there is not enough staff time available; or (3) there is a more appropriate service provider elsewhere in the community and/or your insurance company has another counseling resource for you.

After you begin working with Madison Psychiatric Associates, services may continue: (1) so long as there are identified treatment goals which have not yet been met; and (2) there is evidence that you are interested in pursuing these goals.

The agency may discontinue services if: (1) all treatment goals have been met; (2) you fail to demonstrate an interest in actively pursuing treatment goals, for example, by showing a pattern of regularly missing appointments; (3) you fail to pay for services as agreed upon in your Fee Agreement; or (4) upon the professional recommendation of your provider.

Appointments: All visits at Madison Psychiatric Associates are by appointment only. Patients without scheduled appointments will not be seen by the clinician. If you need to cancel an appointment, please do so at least 24 hours in advance. If you cancel in less than 24 hours, or do not attend a scheduled session, you will be charged a late cancellation fee as outlined in our Fee Agreement. A total of 3 late cancellations and/or missed appointments may result in termination of services. If you arrive late for any appointment, please be aware your appointment will be shortened. If you arrive more than 10 minutes late for a 30 minute appointment, or more than 20 minutes late for a 45-60 minute appointment, you may be asked to reschedule the appointment.

If you have not attended an in-person appointment within the last 6 months, per clinic policy, services will be terminated and your chart will be closed. Should this occur, transitional medication refills and emergency care will be provided for 30 days. Reopening a chart may require a discussion with the clinician to reestablish care.

Hours: The clinic is open Monday through Thursday 8:00 a.m. to 5:30 p.m, and Friday 8:00 a.m. to 5:00 p.m. Evening hours may be available by appointment.

Confidentiality: All contacts between staff and clients are strictly confidential and will not be revealed to any person or agency outside of Madison Psychiatric Associates without your written consent. The primary exception to this rule is those situations in which reporting is mandatory under Wisconsin law (e.g., child abuse, child neglect, sexual abuse, etc.) In addition, please note that your signature on the fee agreement gives the agency permission to release information necessary for the processing of claims for payment.

Emergencies: In a therapeutic emergency, you may call the office 24 hours, 7 days a week at 608-274-0355 to speak to your/a therapist. During non-working hours our answering service takes messages for non-emergencies and at your request, will have your/a provider return your call for emergencies. If you are experiencing a life threating emergency, please call 911 or go to the nearest emergency room.

Medications: Patients must contact our office with 7 days prior notice for prescription refill requests for controlled substances. Refill requests for any other medication should be made by calling the pharmacy directly with at least 48 business hours' notice. For any medication refill a follow up must be scheduled. New medications and complex medication changes should be discussed in-person at appointments with the psychiatrist, when

possible. An early medication refill or replacement prescription will only be provided once; the patient must call to provide the Psychiatrist the reason for the request.

Informed Consent: It is the policy of Madison Psychiatric Associates that each patient, or individual acting on behalf of the patient, will receive specific, complete and accurate information regarding the psychotherapy or other treatment they receive through the clinic. You will be asked to read and sign the Informed Consent Policy form prior to beginning work with your therapist. Those patients receiving medication from a prescriber will be asked to sign an Informed Consent specific to the medication being used.

Grievance Procedure: Madison Psychiatric Associates shall, as part of the intake process, share information with clients concerning informal methods for resolving client concerns and formal procedures by which clients may seek resolution of a grievance. At any time a complaint occurs, the client or other complainant shall be provided with a copy of the agency's Client Grievance Policies and Procedures. Clinic staff shall be familiar with client rights and with these procedures. The clinic staff and their supervisor will forward the complaint to the local Client Rights Specialist. If a client or parent wishes to contact a Specialist directly, they can be reached at: Maria Hanson 608-446-8957

No sanctions will be threatened or imposed against any client who files a grievance, or any person including an employee of the agency, the department, or a county department or a service provider, who assists a client in filing a grievance or participates in or testifies in a grievance procedure or in any action for any remedy authorized by law.

If you have a concern about the services you are receiving, you are encouraged to discuss it with your therapist. If this does not resolve the issue, you may present a written complaint to the Clinic Administrator. If you are still not satisfied, please request a written copy of the Grievance Procedure.

Client Access To Records: Under Wisconsin law, you have a right to review your treatment record. Ask your therapist for the procedures used in sharing your file with you. If you feel that it contains incorrect information, ask your therapist for the procedure used to request a change in record information.

Other: Verbal or physical abuse and/or threats to any clinician or staff will result in termination of services at Madison Psychiatric Associates. Please note that firearms and/or weapons of any kind are not allowed at Madison Psychiatric Associates.

Please note that outside paperwork (i.e. Disability, FMLA, Patient letter requests, etc.) will need to be completed in-person during an appointment with the clinician.

Fee Policy: A fee is charged for professional services provided by the therapists at Madison Psychiatric Associates (please refer to the Fee Agreement). If you have private insurance or medical assistance, we can bill for services at the established rate. If you do not have insurance, or if your insurance does not pay in full, you will be responsible for paying the rate established on your Fee Agreement. You are also responsible for continued payment at the agreed upon rate once your maximum insurance benefits have been used.

If you are receiving services under managed care, health insurance, medical assistance, or an EAP, MPA will need to obtain information about covered services, co-payments and deductibles, etc. The agency will either obtain the specific information required or ask you to obtain the information. Your signature on this form authorizes Madison Psychiatric Associates to release any information necessary to process insurance claims.

MADISON PSYCHIATRIC ASSOCIATES

Fee Agreement

Listed below are the fees for the most common services provided by clinicians at Madison Psychiatric Associates. Your insurance company, Medicaid, or Medicare may have a contract with your clinician that requires a write off of a portion of these fees. Please check with your insurance carrier regarding your benefits, co-pays, co-insurance, and deductible in your plan. Copays are due at time of service.

Psychiatrist Services (MDs)
Please note a range is given as fees vary based on level of complexity of the encounter and/or the amount of time spent providing services. The ranges are for the most common services provided and may vary depending on certain factors. Should you have questions please do not hesitate to discuss them with your provider or our billing office.
Initial Evaluation: $450
Follow-up medication management: $160-$320
Psychotherapy "add-on"*: $145-$245 *(therapy service provided during same visit as medication management)*
Late Cancel (less than 24 hr)/No Show Fee: (30 min, $100) (45 min, $125) (60 min, $150) (Initial, $200) not billable to insurance

Therapist Services

LCSW/LMFT/LPC
Initial Evaluation- 60 minutes: $215
Psychotherapy- 45 minutes: $160
Psychotherapy (Individual or Family) 60 minutes: $215
Group Therapy- 60 minutes: $47
Late Cancellation (less than 24 hrs)/No Show: $75 not billable to insurance

PhD
Initial Evaluation- $290/hour
Psychotherapy (Individual or Family) 30 minutes: $145
Psychotherapy (Individual or Family) 45 minutes: $210
Psychotherapy (Individual or Family) 60 minutes: $285
Group Therapy- 60 minutes: $58
Group Therapy- 90 minutes: $87
Late Cancellation (less than 24 hrs)/No Show: $75 not billable to insurance

Neuropsychological Testing/Psychology Testing
Initial Evaluation $290.00
Testing (per hour) $250.00
Feedback Session $250

Other Fees
A 30.00 fee will be applied for any returned checks. Not billable to insurance

The above fees are effective 1/1/2017 and may be subject to change. Our billing office is able to provide you any updated information or answer questions regarding your financial obligations. Please be aware that at times more than one type of service is provided in a typical session (i.e. medication management and psychotherapy). Clients are responsible for payment of fees by direct payment or by having the billing office file insurance claims on your behalf. Insurance does not cover phone sessions or any other services that are not face to face with the patient.

For late cancellations and/or no-show appointments, we understand emergencies can occur. This can be discussed at your next appointment with your clinician. If appointments are repeatedly missed or late cancelled, your clinician may discontinue services.

Please note, outstanding balances over $400 may require payment and payment arrangements to be made prior to scheduling future appointments.

MADISON PSYCHIATRIC ASSOCIATES

Patient Name:

DOB:

Informed Consent Signature Page

I acknowledge that I have read the above Information Sheet, Consent for Treatment, Notice of Privacy Practices, Client Rights, Clinic Information, Fee Agreement, and Grievance Procedure, and have had the opportunity to receive a copy of the same.

I give permission to Madison Psychiatric Associates to file any insurance claim with 3rd party payer sources and provide/receive information necessary to complete these transactions. Madison Psychiatric Associates has the ability to appeal any denial of claims for services rendered on my behalf. I assign all payment to Madison Psychiatric Associates for services rendered and claims filed.

I understand that while Madison Psychiatric Associates will seek reimbursement through insurance or other payer sources, I (and/or Guarantor) am ultimately responsible for payment for these services, or may be responsible for a co- pay as designated by the payer source. I agree that it is my responsibility to provide accurate and updated information regarding alternative payer sources (such as primary insurance) or changes in payer sources to Madison Psychiatric Associates, in order to assist with filing claims for services rendered and appealing these claims, as necessary. I acknowledge and understand that in the event a claim is denied, if insurance does not pay in full, and/or I do not have insurance coverage, I am responsible for paying the established rates in this Fee Agreement and/or the balance due.

I understand that treatment information, such as treatment plan, updates, progress, medical records, recommendations, and medications will only be released upon my expressed, written permission to Madison Psychiatric Associates. Madison Psychiatric Associates may be required by law to disclose your PHI in certain circumstances as outlined in our Joint Notice of Privacy Practices.

By signing this document, you are acknowledging you understand the information contained herein and that you give consent for interns to participate in, and provide services related to, you or your child's, treatment, under appropriate supervision as described.

By signing this form, I consent to the care and treatment as is prescribed by Madison Psychiatric Associates for myself; if I am the parent/guardian of a minor child under the age of 18, by signing this form, I consent to the care and treatment as is prescribed by Madison Psychiatric Associates. I understand that the purpose of treatment practices will be explained to me and is subject to my agreement.

My signature below indicates that I have been offered a copy of this information sheet, the "Consent for Treatment Form," the "MPA Notice of Provider Privacy Practices," the "Client Rights, Responsibilities and Informed Consent," "MPA Clinic Information," the "Client Rights and the Grievance Procedure for Community Services" brochure and the "Fee Agreement."

Please initial receipt of the following documents and that you have had the opportunity to ask questions about this information:

_____ Consent for Child Mental Health Treatment

_____ MPA Notice of Provider Privacy Practices

_____ Client Rights, Responsibilities, and Informed Consent

_____ MPA Clinic Information

_____ MPA Fee Agreement

_____ Client Rights and the Grievance Procedure for Community Services

I have read and understand the above information, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of my child. I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

Signature: _____ Printed Name: _____ Date: _____

(IF PATIENT IS A MINOR, PARENT/GUARDIAN OR ADULT RESPONSIBLE MUST SIGN.)

MADISON PSYCHIATRIC ASSOCIATES

MPA Policy Reminders

Our goal at Madison Psychiatric Associates to provide you with the best care possible and the following are a few reminders that will be helpful in ensuring we are able to do so.

1. **Please arrive at least 5 minutes early for any follow up appointment.**
   This will allow time for checking in and ensure you have the full appointment time with your provider. If you arrive late, you may be asked to reschedule to the next available appointment time.

2. **Always schedule a follow up appointment before you leave the clinic.**
   This will ensure that you get a follow up appointment with the time frame that your provider recommends.

3. **Please give 24 business hours' notice on any cancelled appointment.**
   Please call on Friday for any Monday cancellations to avoid a late cancellation charge. Proper notice will allow us to provide other patients an opportunity to be seen.

4. **Please let us know at least 24 hours in advance if you will need a handicap accessible office.**
   This will allow for us to ensure seamless access to an office location on the main level.

5. **We require 7 days' notice on all medication refill requests**.
   This will ensure that you do not go without your medications. The state of Wisconsin has put in place a new law regarding prescriptions that requires extra time in order to process refills.
   We are unable to process refills Friday through Sunday.

6. **Reminder calls are a courtesy, but please do not rely on them.**
   Technology can fail. Whether you received a reminder call or not, it is ultimately patient responsibility to remember your scheduled appointment. The scheduling desk is able to provide you a card with your appointment date and time for an additional reminder.

7. **Inclement weather policy.**
   We understand that inclement weather can happen at any time, however, we do not close due to cold temperatures alone. If you have any questions about whether or not our clinic is open, please call and confirm before you travel. If our clinic is open, you may be charged for late cancellations when less than 24 hours' notice is provided.

We appreciate your help in providing you the best care possible and look forward to continuing to work with you. By signing this form, you are acknowledging your understanding of these policies.

_____ _____

Signature of parent or guardian **Date**

- If you and the program manager agree with the CRS's report and recommendations, the recommendations shall be put into effect within an agreed upon time frame.
- You may file as many grievances as you want. However, the CRS will usually only work on one at a time. The CRS may ask you to rank them in order of importance.

Program Manager's Decision

If the grievance is not resolved by the CRS's report, the program manager or designee shall prepare a written decision within 10 days of receipt of the CRS's report. You will be given a copy of the decision.

County Level Review

- If you are receiving services from a county agency, or a private agency and a county agency is paying for your services, you may appeal the program manager's decision to the County Agency Director. You must make this appeal within 14 days of the day you receive the program manager's decision. You may ask the program manager to forward your grievance or you may send it yourself.
- The County Agency Director must issue his or her written decision within 30 days after you request this appeal.

State Grievance Examiner

- If your grievance went through the county level of review and you are dissatisfied with the decision, you may appeal it to the State Grievance Examiner.
- If you are paying for your services from a private agency, you may appeal the program manager's decision directly to the State Grievance Examiner.
- You must appeal to the State Grievance Examiner within 14 days of receiving the decision from the previous appeal level. You may ask the program manager to forward your grievance to the State Grievance Examiner or you may send it yourself. The address is: State Grievance Examiner, Division of Mental Health and Substance Abuse Services (DMHSAS), PO Box 7851, Madison, WI 53707-7851.

Final State Review

Any party has 14 days of receipt of the written decision of the State Grievance Examiner to request a final state review by the Administrator of the Division of Mental Health and Substance Abuse Services or designee. Send your request to the DMHSAS Administrator, P.O. Box 7851, Madison, WI 53707-7851.

You may talk with staff or contact your Client Rights Specialist, whose name is shown below, if you would like to file a grievance or learn more about the grievance procedure used by the program from which you are receiving services.

Your Client Rights Specialist is:

Maria Hanson, JD, CPS, PRC
Client Rights Specialist, Inc.
P.O. Box 14533
Madison, WI. 53704 608-446-8957

NOTE: There are additional rights within sec. 51.61(1) and DHS 94, Wisconsin Administrative Code. They are not mentioned here because they are more applicable to in-patient and residential treatment facilities. A copy of sec. 51.61, Wis. Stats. And/or DHS 94, Wisconsin Administrative Code is available upon request.

STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
Division of Mental Health &
Substance Abuse Services
www.dhs.wisconsin.gov
P-23112 (12/2008)

Client Rights and the Grievance Procedure for Community Services*

for Clients Receiving Services in Wisconsin for Mental Illness, Alcohol or Other Drug Abuse, or Developmental Disabilities

*The term Community Services refers to all services provided in non-inpatient and non-residential settings.

CLIENT RIGHTS

When you receive any type of service for mental illness, alcoholism, drug abuse, or a developmental disability, you have the following rights under Wisconsin Statute sec. 51.61 (1) and DHS 94, Wisconsin Administrative Code:

PERSONAL RIGHTS

- You must be treated with dignity and respect, free from any verbal, physical, emotional or sexual abuse.
- You have the right to have staff make fair and reasonable decisions about your treatment and care.
- You may not be treated unfairly because of your race, national origin, sex, age, religion, disability or sexual orientation.
- You may not be made to work except for personal housekeeping chores. If you agree to do other work, you must be paid.
- You may make your own decisions about things like getting married, voting and writing a will, if you are over the age of 18, and have not been found legally incompetent.
- You may use your own money as you choose.
- You may not be filmed, taped or photographed unless you agree to it.

TREATMENT AND RELATED RIGHTS

- You must be provided prompt and adequate treatment, rehabilitation and educational services appropriate for you.
- You must be allowed to participate in the planning of your treatment and care.
- You must be informed of your treatment and care, including alternatives to and possible side effects of treatment, including medications.
- No treatment or medication may be given to you without your written, informed consent, unless it is needed in an emergency to prevent serious physical harm to you or others, or a court orders it. [If you have a guardian, however, your guardian may consent to treatment and medications on your behalf.]
- You may not be given unnecessary or excessive medication.
- You may not be subject to electro-convulsive therapy or any drastic treatment measures such as psychosurgery or experimental research without your written informed consent.
- You must be informed in writing of any costs of your care and treatment for which you or your relatives may have to pay.
- You must be treated in the least restrictive manner and setting necessary to achieve the purposes of admission to the program, within the limits of available funding.

RECORD PRIVACY AND ACCESS

Under Wisconsin Statute sec. 51.30 and DHS 92, Wisconsin Administrative Code:

- Your treatment information must be kept private (confidential), unless the law permits disclosure.
- Your records may not be released without your consent, unless the law specifically allows for it.
- You may ask to see your records. You must be shown any records about your physical health or medications. Staff may limit how much you may see of the rest of your treatment records while you are receiving services. You must be informed of the reasons for any such limits. You may challenge those reasons through the grievance process.
- After discharge, you may see your entire treatment record if you ask to do so.
- If you believe something in your records is wrong, you may challenge its accuracy. If staff will not change the part of your record you have challenged, you may file a grievance and/or put your own version in your record.
- A copy of sec. 51.30, Wis. Stats., and/or DHS 92, Wisconsin Administrative Code, is available upon request.

GRIEVANCE PROCEDURE AND RIGHT OF ACCESS TO COURTS

- Before treatment is begun, the service provider must inform you of your rights and how to use the grievance process. A copy of the Program's Grievance Procedure is available upon request.
- If you feel your rights have been violated, you may file a grievance.
- You may not be threatened or penalized in any way for presenting your concerns informally by talking with staff, or formally by filing a grievance.
- You may, instead of filing a grievance or at the end of the grievance process, or any time during it, choose to take the matter to court to sue for damages or other court relief if you believe your rights have been violated.

GRIEVANCE RESOLUTION STAGES

Informal Discussion (Optional)

You are encouraged to first talk with staff about any concerns you have. However, you do not have to do this before filing a formal grievance with your service provider.

Grievance Investigation—Formal Inquiry

- If you want to file a grievance, you should do so within 45 days of the time you become aware of the problem. The program manager for good cause may grant an extension beyond the 45-day time limit.
- The program's Client Rights Specialist (CRS) will investigate your grievance and attempt to resolve it.
- Unless the grievance is resolved informally, the CRS will write a report within 30 days from the date you filed the formal grievance. You will get a copy of the report.

MADISON PSYCHIATRIC ASSOCIATES

Thank you for seeking consultation for your child. Please spend some time before the initial visit to complete this form as thoroughly as possible. This will allow for a more comprehensive evaluation. You may return it by mail if time allows for delivery, or bring it to the appointment. Please also attempt to collect any prior treatment documents and school records.

Person(s) completing this form _____ Today's date _____
Child's Name _____ Birthdate _____
Preferred name (if different) _____ Current grade _____
Primary Address _____
Primary home phone number _____
Child's School (with address and phone number)

Main teacher(s) (and school social workers/psychologists, if involved)

Parent 1 Information	Parent 2 Information
Name _____	Name _____
Address (if different)	Address (if different)
Main contact Number _____	Main contact number _____
Employer _____	Employer _____
Occupation _____	Occupation _____
Other Caregivers at home (stepparents, etc.)	Other Caregivers at home (stepparents, etc.)
Other persons at home (sibling, stepsiblings)	Other persons at home (sibling, stepsiblings)
Age	Age
Age	Age
Age	Age
Age	Age
Age	Age

Custody and placement arrangements, if any; please indicate if either parent's legal rights have been terminated.

MADISON PSYCHIATRIC ASSOCIATES

Medical History

Current pediatricians or family physician; please indicate clinic name and city:

Other Medical Specialists involved (neurologist, endocrinologist, etc.); please indicate clinic name and city:

Current Medical Conditions:	Previous medical conditions (including major illnesses, injuries, surgeries, hospitalizations):

History of seizures, head injuries or loss of consciousness, central nervous system infections (encephalitis, meningitis) if not already mentioned:

Current or prior evaluations and/or treatment by a psychiatrist, psychologist, therapist, social worker, or other mental health professionals; including clinic or practice location, approximate dates of treatment, and diagnosis made, if known:

Medications

Allergies to foods or medications:

Currents medications, please include dosages and name or prescriber(s):	Past medications, please indicate dosages (if known) and reactions/responses to medications:
Herbal medications, vitamins, supplements:	

Pregnancy

- ❑ Viral illnesses in the first trimester (including common cold)
- ❑ Other infections during pregnancy
- ❑ Bleeding during pregnancy
- ❑ High blood pressure during pregnancy
- ❑ Diabetes during pregnancy
- ❑ Seizures
- ❑ Thyroid or other endocrine problem
- ❑ Gained more than 50 pounds
- ❑ Gained less than 15 pounds
- ❑ Had previous miscarriages
- ❑ Hurt or injured during pregnancy
- ❑ Prescribed medications during pregnancy
- ❑ Alcohol, tobacco or drugs during pregnancy

Was child born near due date?

If not, how early/late?

Any other complications during pregnancy?

Delivery

Age of parents at the time of this child's birth

Mother: Father:

Birth Weight:

Birth Length:

- ❑ C-Section
- ❑ Induced labor
- ❑ Forceps or vacuum used
- ❑ Born with cord around neck (nuchal)
- ❑ Breech or unusual presentation
- ❑ Any other labor/delivery complications
- ❑ Child needed incubator
- ❑ Child turned blue after delivery
- ❑ Jaundice
- ❑ Infections or seizures at delivery
- ❑ Hospitalized more than 7 days after delivery
- ❑ Maternal postpartum depression

Infancy

As an infant, did/was your child:

- ❑ Have colic?
- ❑ Unusual quiet?
- ❑ Often cry inconsolably?
- ❑ Easily upset by strangers?
- ❑ Seem uncomfortable with cuddling?
- ❑ Generally fussy?
- ❑ Have an irregular sleep pattern?
- ❑ Have little eye contact?

If breastfed, mother's use of medications or drugs?

Early Childhood

As a young child (toddler), did/was your child:

- ❑ Overly active?
- ❑ Have irregular bowel habits?
- ❑ Easily upset by strangers?
- ❑ Easily upset by changes in routine or environment?
- ❑ Withdraw from new situations?
- ❑ Have difficulty persisting at one activity?
- ❑ Generally unhappy?
- ❑ Seem uninterested in toys?
- ❑ Seem bothered by touch or certain clothing?
- ❑ Make less eye contact than expected?
- ❑ Any problems with toilet training?
- ❑ Any problems sleeping through the night?
- ❑ Any delays in language development?
- ❑ Any delays in motor skills?

Age when first walked?

MADISON PSYCHIATRIC ASSOCIATES

Family History

Please indicate if any family members ("related by blood") have been diagnosed, treated or suspected of having any of the following psychiatric conditions. Describe history of treatments, if known, including positive and negative responses to medications.

Hyperactivity or ADHD	Depression	Schizophrenia/Schizoaffective Disorder
Learning or educational problems	Mania	Any psychiatric hospitalization
Autism/Asperger's Disorder	Bipolar Disorder/manic Depression	Alcohol or drug problems
Pervasive Developmental Disorder	Anxiety/Panic Attacks	Criminal offenses
Mental Retardation	Post-Traumatic Stress Disorder	Suicide Attempt/Suicide
Personality Disorder	Obsessive Compulsive Disorder	Dementia
		Seizures or other neurologic conditions

Full or half siblings

Biological Father's Side	**Biological Mother's Side**
Father	Mother
Grandfather	Grandfather
Grandmother	Grandmother
Father's siblings (child's aunts/uncles)	Mother's siblings (child's aunts/uncles)
Childs Cousins	Childs Cousins
Other relatives	Other relatives

MADISON PSYCHIATRIC ASSOCIATES

Educational History

Please describe your child's school attendance history. Include name of school, city, and age or grade of attendance. Please also indicate if any behavior or academic concerns were raised by any teachers or caregivers as well as any comments about your child's adjustment to school.

Daycare

Headstart/Preschool

Elementary School

Middle School

High School

Other programs

Have any developmental delays or learning problems ever been identified?

Any history of special education, extended tutoring, occupational therapy, physical therapy, or speech therapy?

Has your child ever had an IEP (Indvividualized Educational Program)?

Has your child ever been placed outside of the home (foster care, residential treatment center, etc.)?

MADISON PSYCHIATRIC ASSOCIATES

Current Concerns

Please describe your current concerns regarding your child. What led you to seek consultation at this time?

Please list your goals and expectations for this appointment.

What are some of your child's strengths?

Please describe any current concerns, not already mentioned about your child's:

Physical development

Sleep patterns

Eating patterns, diet or general health

Use of drugs or alcohol

Friends or social development

Academic or intellectual development

Is there any history of trauma (serious or life-threatening injury, assaults, abuse) not already mentioned?

If there is any information in this packet that you prefer to discuss without your child present (such as family history) please indicate: