MADISON PSYCHIATRIC ASSOCIATES

5534 Medical Circle, Madison WI 53719-1298
2702 International Lane, Suite 207, Madison WI 53704
p 608.274.0355 f 608.274.5546

PATIENT INFORMATION

Name: FIRST MI LAST Preferred Name:

Address:

CITY STATE ZIPCODE

Birthdate: Age: Social Security #:

Bio Sex: ☐ Female ☐ Male Gender Identity: Personal Gender Pronouns:

CONTACT INFORMATION

Primary Contact	Secondary Contact
Contact Name:	Contact Name:
Relationship to Patient:	Relationship to Patient:
Phone Number:	Phone Number:
Ok to leave a voicemail? ☐ yes ☐ no	Ok to leave a voicemail? ☐ yes ☐ no
Email Reminder Address:	Email Reminder Address:

*MPA is able to provide **one** phone number a reminder call <u>or</u> text message, please select below.*

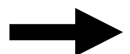
☐ Primary Contact or ☐ Secondary Contact ☐ Phone Call or ☐ Text Message

Emergency Contact Name: Phone #: Relationship:

PATIENT DEMOGRAPHICS

Ethnicity	Race	Language
☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ American Indian or Alaska Native ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian or other Pacific Islander ☐ Other	Primary Language: Preferred Language:

Please list any accommodations needed for disabilities:



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INSURANCE

☐ **I am self-pay and not billing insurance.**

Primary Insurance

Insurance Company Name:

Member Number: Group Number:

Policy Holder Name: Policy Holder Date of Birth:

Customer Service Phone Number: Effective Date:

Insurance Address:

Policy Holder Address (if different than patient):

Secondary Insurance

Insurance Company Name:

Member Number: Group Number:

Policy Holder Name: Policy Holder Date of Birth:

Customer Service Phone Number: Effective Date:

Insurance Address:

Policy Holder Address (if different than patient):

If you have any additional insurance coverage, please see reception for an additional form.

GUARANTOR: The person responsible for any unpaid balance.

Must be completed if patient is under 18 years old.

Name:	Birthdate:	Social Security Number:

Address (if different than patient):

Phone Number:	Guarantor Signature:

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.

Printed Name:

Signature: Date:

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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.)

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Treatment Consent

Consent for Child Mental Health Treatment.

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.
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 me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my 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/job performance, health status, quality of life, and awareness of strengths and limitations.
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.
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.
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.
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.
Expiration of Consent:	This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

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Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

> ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

> ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safetyissues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, lawenforcement, and other government requests
- Respond to lawsuits and legal actions

> ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to asubpoena.

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.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: February 7, 2018

This Notice of Privacy Practices applies to the following organizations.

Madison Psychiatric Associates

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

MPA
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MPA

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.

Client Rights and Responsibilities:	**Description** • 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.
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.

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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.
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.

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.

Madison Psychiatric Associates complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Madison Psychiatric Associates does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Madison Psychiatric Associates:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the MPA Clinic Administrator.

If you believe that Madison Psychiatric Associates has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: MPA Clinic Administrator**, 5534 Medical Circle, Madison, WI 53719, 608-274-0355, 608-274-5546, alyh@mpassociates.net.** You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Clinic Administrator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-608-274-0355 (TTY: 711)..

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-608-274-0355 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-608-274-0355 (TTY: 711)..

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-608-274-0355

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-608-274-0355 (TTY: 711)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-608-274-0355 (TTY: 711). 번으로 전화해주십시오.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-608-274-0355 (رقم هاتف الصم والبكم: 1-608-274-0355 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-608-274-0355 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-608-274-0355(TTY: 711).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte
ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-608-274-0355(TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-608-274-0355(TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod
numer 1-608-274-0355(TTY: 711).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë.
Telefononi në 1-608-274-0355(TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika
nang walang bayad. Tumawag sa 1-608-274-0355(TTY: 711).

ध्यान दें: यदद आप ह िंदी बोलते हैं तो आपके दलए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-608-274-0355 (TTY: 711). पर कॉल करें।

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2702 International Lane, Suite 207, Madison WI 53704
p 608.274.0355 f 608.274.5546

Clinic Information Policies & 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 & Hours

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. <u>A pattern of late cancellations and/or missed appointments may result in termination of services</u>. 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.

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 a situation 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.

M|P|A
MADISON PSYCHIATRIC ASSOCIATES

5534 Medical Circle, Madison WI 53719-1298
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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.

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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.

Pet Policy

For the health and safety of our patients, MPA has a No-Pets policy.

Although we love animals, we ask that you please leave your pet at home during your visit to MPA. MPA complies with the Americans with Disabilities Act (ADA) allowing access for all individuals to public places; therefore, we do allow working service dogs to accompany our patients. Service animals are individually trained to perform work or tasks for people with disabilities. Service animals are required to be leashed or harnessed except when performing work or tasks where such tethering would interfere with the dog's ability to perform the work or tasks.

Should you arrive to an appointment with a pet that is not a service animal, you will be asked to remove the animal from our healthcare facility. To avoid any disruption or inconvenience, we ask that you please leave your pet at home.

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.

Prescriber Services

Psychiatrist

Initial Evaluation: $450
Follow-up medication management: $160-$320
Psychotherapy "add-on"*: $145-$245 *(therapy service provided during same visit as medication management)*
Forensic Fees/other: $565 per hour

APNP

Initial Evaluation: $380
Follow-up medication management: $140-$270
Psychotherapy "add-on"*: $130-$210 *(therapy service provided during same visit as medication management)*
Forensic Fees/other: $475 per hour

Late Cancel (less than 24 hr)/No Show Fee: (30 min, $100) (45 min, $125) (60 min, $150) (Initial, $200) not billable to insurance

Therapy Services

LCSW/LMFT/LPC	PhD
Initial Evaluation- 60 minutes: $215	Initial Evaluation- $290/hour
Psychotherapy (Individual or Family)-30 minutes: $107	Psychotherapy (Individual or Family) 30 minutes: $145
Psychotherapy (Individual or Family)- 45 minutes: $160	Psychotherapy (Individual or Family) 45 minutes: $210
Psychotherapy (Individual or Family) 60 minutes: $215	Psychotherapy (Individual or Family) 60 minutes: $285
Group Therapy- 60 minutes: $47	Group Therapy- 60 minutes: $58
Group Therapy- 90 minutes: $70.50	Group Therapy- 90 minutes: $87
Forensic Fees/other: $270 per hour	Forensic Fees/other: $360 per hour

Late Cancellation (less than 24 hrs)/No Show: $75 not billable to insurance

Neuropsychological Testing/Psychology Testing

Initial Evaluation $290.00
Test Administration and Scoring (based on time) $1630 + $90 every additional 30min
Test Evaluation, Interpretation, Feedback (based on time) $1295 + $205 every additional 60min
Late Cancellation (less than 24 hrs)/No Show: see additional form

Other Fees

Patient Forms/Letters:

Forms or letters requiring less than 15 minutes of time for completion will be assessed a $25.00 fee.
Forms or letters requiring more than 15 minutes of time for completion will be assessed a $50.00 fee.

Returned Checks

A 30.00 fee will be applied for any returned checks.

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.

The above fees are effective 1/1/2019 and may be subject to change. Our billing office is able to provide you updated information or answer questions regarding your financial obligations. Please be aware that at time 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.

- 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.

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):

Herbal medications, vitamins, supplements:

Past medications, please indicate dosages (if known) and reactions/responses to medications:

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?

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

Father

Grandfather

Grandmother

Father's siblings (child's aunts/uncles)

Childs Cousins

Other relatives

Biological Mother's Side

Mother

Grandfather

Grandmother

Mother's siblings (child's aunts/uncles)

Childs Cousins

Other relatives

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.)?

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: