**CONSENT FOR INTENSIVE OUTPATIENT/OUTPATIENT MENTAL HEALTH AND DIETARY TREATMENT**

**Consent to Evaluate/Treat both in-person and/or via telehealth:** I voluntarily consent that I will participate in a mental health (e.g. psychological, dietary or psychiatric) evaluation and/or treatment by staff from Edelweiss Behavioral Health. I understand that following the evaluation and/or treatment complete and accurate information will be provided concerning each of the following areas:

* 1. The benefits of the proposed treatment
  2. Alternative treatment modes and services
  3. The manner in which treatment will be administered
  4. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
  5. 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, Dietary Services or Marriage and Family Therapy.

**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.

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

**Regarding Telehealth Specific Services:** I understand that my EBH provider may wish me to engage in a telehealth consultation, either exclusively or intermittently during the course of my treatment. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand. I understand that telehealth includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of mental health data and communication of my medical/mental health information. I understand that I may benefit from telehealth but that results cannot be guaranteed or assured. I understand that I need to be physically located in Wisconsin while receiving telehealth services through Edelweiss Behavioral Health LLC.

**If you are a member of our Intensive Outpatient Program:** While participating in telehealth treatment for IOP, I understand that it is my responsibility to be in a room with a closed door while participating in telehealth with the group, in order to protect the other group members’ confidentiality.

**I understand that I have the following rights with respect to telehealth:** The right to withhold or withdraw consent at any time without affecting my right to future care or treatment. The laws that protect the confidentiality of my medical and mental health information also apply to telehealth services, and that there are mandatory exceptions to this confidentiality, including but not limited to reporting child, elder, and dependent adult abuse in addition to expressed threats of violence towards self and/or others.

**Consent to Use the Telehealth by Zoom Service:** Telehealth by Zoom is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and your provider will give you with the necessary information prior to your appointment time. By signing this document, I acknowledge:

1. Telehealth by Zoom is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through telehealth:

Service, neither Zoom nor the Telehealth Service, provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services. The Telehealth by Zoom Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care. I do not assume that my provider has access to any or all of the technical information in the Telehealth by Zoom Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by Zoom Service. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

### In Case of an Emergency: I agree to share my location with my provider at the beginning of my appointment. I understand that my therapist may contact my emergency contact and/or appropriate authorities in case of emergency.

**If you have a mental health emergency:** Call 911; Please call the Dane County Mental Health 24/7 Crisis Hotline (608) 280-2600; Call Lifeline at (800) 273-8255 (National Crisis Line); Go to the emergency room of your choice.

### Emergency procedures specific to Telehealth services: There are additional procedures that we need to have in place specific to Telehealth services. These are for your safety in case of an emergency and are as follows:

*By signing this document, I understand that if I am having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that my EBH clinician cannot solve remotely, my clinician may determine that I need a higher level of care and Telehealth services are not appropriate. My Emergency Contact Person (ECP) that I have specified in my intake paperwork will be contacted on my behalf in a life-threatening emergency only.*

*I will verify that my ECP is willing and able to go to your location in the event of an emergency. If I am unable to do this, my EBH clinician will do this on my behalf. Determination of what is needed will be made in collaboration with myself, my ECP and my EBH clinician, which may include, but is not limited to, my ECP driving me to a hospital.*

Your signature at the end of this document indicates that you understand your clinician will only contact this individual in the extreme circumstances stated above.

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

***Edelweiss Behavioral Health 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 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.

**By signing this form, I certify that: I** **have read or had this form read and/or explained to me and I understand its contents~~,~~ including the risks and benefits of the procedure(s), I have been given the opportunity to ask questions, and those questions have been answered. I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.**

Click or tap here to enter text.Click or tap here to enter text.

**Signature of client ages 18 years or older or legal representative Date**

**CONSENT FOR PATIENT EMAIL AND TEXT MESSAGING**

I confirm that I wish to communicate with Edelweiss Behavioral Health, if given the option, by email/text and have read and understand the following information:

**Risks of using Email/Text Messaging:**

Transmitting patient information by email and/or text messaging has a number of risks that clients should consider prior to the use of email and/or text messaging. These include, but are not limited to, the following risks:

1. Email and text senders can easily misaddress an email or text and send information to an undesired recipient. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
2. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
3. Employers and on-line services have a right to inspect emails sent through their company systems.
4. Email and texts can be used as evidence in court.
5. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

**Conditions for the use of email and text messages:**

Providers at Edelweiss Behavioral Health cannot guarantee, but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by the provider’s intentional misconduct. Patients/parents/legal guardians must acknowledge and consent to the following conditions:

1. It is my request to use email/text.
2. Any decisions to use email/text communication will be discussed in staff supervision and an entry will be made into my electronic medical record.
3. I understand that email and text are not a secure way to communication, and that this communication is not protected and the confidentiality of this communication cannot be guaranteed.
4. No emails/texts with urgent messages will be sent. Email and texting are not appropriate for urgent or emergency situations. Providers cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
5. When sending emails/texts I will not identify anyone by name.
6. All communications will be documented in my medical record.
7. It is my responsibility to inform the providers at Edelweiss Behavioral Health of any changes in email addresses, mobile numbers or lost mobile devices as soon as possible.
8. Any decision by either me or the provider to stop the use of email/text will be respected. Any resumption will therefore require a new consent form.
9. Confidentiality will be respected by providers at all times.
10. Email and texts should be concise. The patient/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
11. All emails will be entered into the patient’s electronic medical record; texts may be filed as well.
12. Patients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
13. Provider is not liable for breaches of confidentiality caused by the patient or any third party.
14. It is the patient/parent/legal guardian’s responsibility to follow up and/or schedule an appointment if warranted.

**I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the use of text messaging and emails. I understand the risks associated with the communication of email and/or text messaging between my provider and me, and consent to the conditions and instructions outlined, as well as any other instructions that my provider may impose to communicate with me by email or text.**

Click or tap here to enter text.Click or tap here to enter text.

**Printed name of client ages 18 years or older or legal representative Date**

Click or tap here to enter text.

**Signature of client ages 18 years or older or legal representative**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Provider name (printed) and signature Date**

**HISTORY AND BACKGROUND**

**(Confidential: For Professional Use Only)**

**Client Background Information:**

Name: Click or tap here to enter text. Date of Birth: Click or tap here to enter text.

Emergency Contact Name: Click or tap here to enter text. Phone: Click or tap here to enter text.

Relationship: Click or tap here to enter text.

Highest Year Completed in School: Click or tap here to enter text. Name of school: Click or tap here to enter text.

Current or Last Job: Click or tap here to enter text. Major area of study: Click or tap here to enter text.

Employer’s Name: Click or tap here to enter text. Length of time in current job: Click or tap here to enter text.

If unemployed, how long? Click or tap here to enter text. Other work experience: Click or tap here to enter text.

Spouse/partner’s Name: Click or tap here to enter text. Age: Click or tap here to enter text.

Spouse/partner’s Occupation: Click or tap here to enter text.

Children’s Names and Ages: Click or tap here to enter text.

Father’s Age and Occupation: Click or tap here to enter text.

Mother’s Age and Occupation: Click or tap here to enter text.

Parent’s Marital Status: Click or tap here to enter text.

Sibling(s) Name, Age, Marital Status and Occupation:Click or tap here to enter text.

**Client History:**

Do you have a family history of mental illness or substance abuse? Please explain.Click or tap here to enter text.

How much do you use alcohol: Click or tap here to enter text.

How often do you use recreational drugs: Click or tap here to enter text.

Describe any legal problems that you may have: Click or tap here to enter text.

Special health problems, handicaps, or physical limitations: Click or tap here to enter text.

Current medications: Click or tap here to enter text.

Please describe the problems that brought you here: Click or tap here to enter text.

Others that you have seen about this problem (with dates):Click or tap here to enter text.

Who referred you here? Click or tap here to enter text.

**INSURANCE INFORMATION**

**Primary Insurance**

Name of Policyholder Click or tap here to enter text. Policyholder Date of Birth Click or tap here to enter text.

Policyholder Address (if different than patient) Click or tap here to enter text.

City, State, Zip Click or tap here to enter text.

Phone Number Click or tap here to enter text.

Policyholder Relationship to Patient Click or tap here to enter text.

Insurance Company Name Click or tap here to enter text.

Customer Service Phone Number Click or tap here to enter text.

Subscriber # Click or tap here to enter text. Group# Click or tap here to enter text.

Effective Date Click or tap here to enter text.

**Secondary Insurance**

Name of Policyholder Click or tap here to enter text. Policyholder Date of Birth Click or tap here to enter text.

Policyholder Address (if different than patient) Click or tap here to enter text.

City, State, Zip Click or tap here to enter text.

Phone Number Click or tap here to enter text.

Policyholder Relationship to Patient Click or tap here to enter text.

Insurance Company Name Click or tap here to enter text.

Customer Service Phone Number Click or tap here to enter text.

Subscriber # Click or tap here to enter text. Group# Click or tap here to enter text.

Effective Date Click or tap here to enter text.

**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 Edelweiss Behavioral Health LLC 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.

**Signature:** Click or tap here to enter text.

(If patient is a minor, parent/guardian or adult responsible must sign)

**Printed Name:** Click or tap here to enter text. **Date:** Click or tap here to enter text.

**FEE AGREEMENT**

Listed below are the fees for the most common services provided by clinicians at Edelweiss Behavioral Health. Your insurance company 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. **Copayments and self-pay arrangements are due at time of service.**

**Intensive Outpatient Program** 3hr/day 375.00

**Dietitian Group Therapy (non-IOP)**

Initial Intake 180.00 Group rates may vary

60 Minutes 180.00

45 Minutes 135.00

30 Minutes 90.00

**Individual Therapy (LPC) Individual Therapy (LP)**

Initial Intake 215.00 Initial Intake 290.00

60 Minutes 215.00 60 Minutes 285.00

45 Minutes 160.00 45 Minutes 210.00

30 Minutes 107.50 30 Minutes 142.50

**No Show or Late Cancellations (less than 24-hr notice)**

IOP per day 100.00

Dietitian 75.00

Individual Therapy (LPC) 75.00

Individual Therapy (LP) 85.00

The above fees are effective 4/1/2017 and may be subject to change. Our office is able to provide you any updated information or answer questions regarding your financial obligations. Clients are responsible for payment of fees by direct payment or by having the billing office file insurance claims on your behalf.

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 to be made prior to scheduling future appointments. Edelweiss Behavioral Health does not carry unpaid balances beyond 120 days.**

**COPAYMENT OPTIONS**

As required by your insurance companies, your copay will be due at the time of service.

Payment options include **(please indicate preference)**:Click or tap here to enter text.

1. Personal Check. 2. Credit Card

**If it is your preference to use a credit card for your copayment(s), please complete the “Payment Authorization Form” which can be found in the client portal as a separate document.**

By signing below, I acknowledge and understand that 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.

Patient or Responsible Party Signature: Click or tap here to enter text. Date: Click or tap here to enter text.

**CLINIC INFORMATION**

**POLICIES AND PROCEDURES**

The mission of Edelweiss Behavioral Health LLC is to provide quality mental health care using a specialized treatment team. This document contains important information about our policies and procedures. Please read it carefully. Ask your provider to answer any questions you may have.

**Eligibility**: Eligibility for Edelweiss Behavioral Health 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 Edelweiss Behavioral Health 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 therapist.

**Appointments:** All visits at Edelweiss Behavioral Health 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:** Adult Intensive Outpatient from 4-7pm Monday, Wednesday and Thursday.

Adolescent Intensive Outpatient from 8-11am on Mondays and Thursdays and 4-7pm Tuesdays.

Outpatient visits by appointment only.

**Confidentiality**: All contacts between staff and clients are strictly confidential and will not be revealed to any person or agency outside of Edelweiss Behavioral Health 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, please call the 24-hour crisis line at Journey Mental Health, 608-205-4450 or the National Suicide Prevention Lifeline at 800-273-8255. If you are experiencing a life-threatening 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. 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 Edelweiss Behavioral Health 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 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:** Edelweiss Behavioral Health 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.

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 Owner. 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 Edelweiss Behavioral Health. Please note that firearms and/or weapons of any kind are not allowed at Edelweiss Behavioral Health.

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 and are subject to a fee, under the discretion of the clinician.

**Fee Policy:** A fee is charged for professional services provided by the providers at Edelweiss Behavioral Health (please refer to the Fee Agreement). If you have private insurance accepted by Edelweiss Behavioral Health, we will 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, or an EAP, the agency 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 Edelweiss Behavioral Health to release any information necessary to process insurance claims.

**My signature below indicates that I have been offered a copy of this Clinic Information sheet, the Consent for Treatment, and the Joint Notice of Privacy Practices.**

**Signature (adult or minor age 14 or older:** Click or tap here to enter text. **Date:** Click or tap here to enter text.

**Signature of Guardian, if signer is under age 18:** Click or tap here to enter text. **Date:** Click or tap here to enter text.

**Authorized Provider**

**Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**JOINT NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW THIS NOTICE CAREFULLY**

When we refer to “you” or “your” in this Notice we refer to the person or persons receiving the services provided by Edelweiss Behavioral Health (EBH). When we refer to disclosures of information to “you”, we mean disclosures to adults or children, the parent of the children, guardian or other person legally authorized to receive information about the person or persons receiving services from Edelweiss Behavioral Health (EBH).

**Who follows this Notice:**

This Notice applies to all **protected health information** (**PHI**) maintained by Edelweiss Behavioral Health for services provided at any office of Edelweiss Behavioral Health or services provided at non-office locations by any employee of Edelweiss Behavioral Health in the course of their employment. If you have any questions after reading this Notice, please contact the Edelweiss Behavioral HealthPrivacy Officer.

Each time you receive services from Edelweiss Behavioral Health, a record of the services provided is created. Typically, this record could contain information about the type of service you have received, the dates of service and the results of the service provided. At times this will include the reason you have come to Edelweiss Behavioral Healthfor service and the agreed upon goals of the service provided.

This Notice applies to all of the records containing PHI created as a result of services provided by Edelweiss Behavioral Health.

**Our Pledge to Protect Your Health Information:** We are required by law to maintain the privacy of your PHI and provide you with a description of our privacy practices. We will abide by the terms of this Notice.

**How We May Use and Share Your Health Information with Others:**

**For Treatment:** Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. For example, a worker or therapist may use PHI about you or your child from a clinic record to determine which treatment option, such as family or individual therapy, best addresses your needs. Your provider may discuss information found in your record with our consultants, a colleague or their supervisor to assist in treatment planning for you or your child.

**For Payment:** We may use and disclose PHI to send bills and collect payment from you, your insurance company, or other payors, such as governmental agencies, for the treatment or other related services you receive from Edelweiss Behavioral Health, so Edelweiss Behavioral Health can receive payment for the treatment services provided to you. Examples of payment related activities are: making a determination of eligibility or coverage for insurance benefits, processing and sending claims to your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities.

**For Health Care Operations:** We may disclose PHI about you for business operations of Edelweiss Behavioral Health. These uses and disclosures are necessary for Edelweiss Behavioral Health to provide quality care and cost-effective services. The operations where we may need to disclose PHI includes, but is not limited to, quality assessment activities, employee review activities, and licensing activities. For example, we may share your PHI with third parties that perform various business activities (such as billing or typing services). We will require these third parties to have a contract with us that require them to safeguard the privacy of your PHI. Quality assessment activities may include evaluating the performance of your therapist or examining the effectiveness of treatment provided to you when compared to patients in similar situations.

**Appointments:** We may use your PHI for the purpose of sending you appointment reminders through the mail, email, or by telephone. Messages left for you will not contain specific health information.

**Required or Permitted by Law:** Edelweiss Behavioral Health is required by law to disclose your PHI in certain circumstances:

* For public health oversight activities
* To facilitate the functions of federal or state governmental agencies
* To report suspected elder or child abuse to law enforcement agencies responsible to investigate or prosecute abuse
* In response to a valid court order
* To the Department of Health and Family Services, a protection or advocacy agency, or law enforcement authorities investigating abuse, neglect, physical injury, death or violent crimes
* To your court-appointed guardian or an agent appointed by you under a health care power of attorney
* Prison officials if you are in custody
* Worker’s Compensation officials if your condition is work-related
* If necessary, to prevent or lessen a serious and imminent threat to the health or safety of a person or the public

When sharing PHI with others outside of Edelweiss Behavioral Health, we share only what is reasonably necessary unless we are sharing PHI to help treat you, in response to your written permission, or as the law requires. In these cases, we share all the PHI that you or the law requires.

**YOUR HEALTH INFORMATION RIGHTS**

You have the following rights regarding your PHI we maintain. To exercise any of the rights discussed in the remainder of this section, please contact the Privacy Officer for Edelweiss Behavioral Health, Anna Aufderhaar, located at 6402 Odana Road, Madison, WI 53719, 608-205-4450.

**Right to Request Restrictions:** You have the right to request certain restrictions of use and disclosure of your PHI by Edelweiss Behavioral Health for treatment, payment or health care operations. You also have the right to request a restriction on our disclosure of your PHI to someone who is involved in your care or the payment for your care. Edelweiss Behavioral Health is not required to agree to restrict the use and disclosure of your PHI. A request for restriction must be made in writing using the form available from the Privacy Officer.

**Right to Inspect and Copy:** With a few exceptions you have the right to inspect and receive a copy of your PHI. Should you wish to review or copy your PHI you should make a request using the form available from the Privacy Officer. We will arrange for your therapist or another health professional in our clinic to review the PHI with you in our office or to copy the information requested. We may charge you a reasonable fee if you want a copy of your PHI.

**Right to Amend or Correct Your Record:** If you feel the PHI we have about you is incorrect or incomplete, you may ask us to amend the information for as long as the information is maintained by Edelweiss Behavioral Health. Requests for amendment or correction should be made by submitting a form requesting amendment or correction available from the Privacy Officer. We will respond to your request within 60 days after you submit the form. We are not required to agree to the amendment.

**Right to an Accounting of Disclosures:** You have a right to request an accounting for disclosures. This is a list of those people with whom Edelweiss Behavioral Health may have shared your PHI, with the exception of information shared for purposes of treatment, payment or health care operations or when you have provided us with an authorization to do so. We may charge you a reasonable fee if you request more than one accounting for disclosures in any 12-month period***.*** The request cannot include any disclosures made prior to seven years from the completion of treatment, or until the individual turns 19, whichever is longer according to DHS 92.12. Requests for an accounting of disclosures should be made by submitting a form requesting an accounting of disclosures to the Privacy Officer. This form is available from the Privacy Officer. We will respond to your request within 60 days after you submit the request.

**Right to Request Confidential Communications:** You have the right to ask that we communicate your PHI to you in a certain way or a certain location. For example, you can request that we contact you only at work or via mail. We will accommodate reasonable requests.

**Right to Revoke Authorization:** Uses and disclosures of PHI not covered by this Notice or the laws that apply to Edelweiss Behavioral Health will be made only with your authorization. If you authorize Edelweiss Behavioral Health to use or disclose your PHI, you may revoke that authorization in writing at any time. We are unable to reverse any disclosures we have made previously with your authorization. To revoke an authorization, please contact your therapist or the clinic where you receive services.

**Right to Complain:** If you believe your privacy rights have been violated, you may file a complaint with Edelweiss Behavioral Health or with the Secretary of the Department of Health and Human Services. To file a complaint with Edelweiss Behavioral Health, contact the Privacy Officer. All complaints must be made in writing. The Privacy Officer will assist you in filing your complaint. Filing a complaint will not affect your care.

**We reserve the right to revise or change this Notice. Each time you sign a consent for treatment at a site covered by this Notice we will provide a copy of this Notice in effect at that time.** Effective Date: October 1, 2014

**How to Contact Us:**

Edelweiss Behavioral Health Privacy Officer: (608) 205-4450 x0.

Secretary of Department of Health and Human Services: (877) 696-6775.

Signature (adult or minor age 14 or older): Click or tap here to enter text. Date: Click or tap here to enter text.

Signature of Guardian if signer is under 18: Click or tap here to enter text. Date: Click or tap here to enter text.

**PATIENT RIGHTS AND RESPONSIBILITIES**

What follows is a two-page document outlining your personal rights, treatment and related rights, and your responsibilities as a patient at Edelweiss Behavioral Health (EBH). The following rights, in accordance with Wisconsin State Law, pertain to voluntary patients in a mental health facility.

**Personal Rights**

* You will be treated with consideration, dignity, and respect, free from any verbal, emotional, sexual or physical abuse, and with recognition of your own individuality and personal needs including the need for privacy in treatment.
* You have the right to participate in religious services, social, recreational, and community activities away from EBH, to the extent that you desire.
* You may make decisions about things like getting married, voting, and writing a will if you are over the age of 10 and have not been found legally incompetent.
* Your surroundings must be kept safe and clean.
* You must be given the chance to go outside for fresh air regularly and frequently, except for health and security concerns.
* You have the right to receive treatment in a psychologically and physically humane environment.
* You have the right not to be subjected to experimental research, and you or your legally authorized representative shall give prior informed consent for your participation in any form of research.
* You have the right to inspect all treatment records kept in confidence and to inspect these documents in the presence of an EBH staff member.
* You have the right not to be filmed or taped without your informed written consent.
* You have the right to an individual treatment plan and to be an active member in its planning.
* You have the right to make informed decisions regarding your care.
* You may not be denied appropriate clinical or hospital care because of your race, creed, color, national origin, ancestry, religion, sex, sexual orientation, marital status, age, newborn status, handicap or source of payment.
* You are entitled to know who has overall responsibility for your care.
* When requested, you, or your legally authorized representative, or any person authorized in writing by you shall receive written information from EBH staff about your diagnosis, course of treatment and prognosis for recovery in terms you can understand.
* Except in emergencies, your consent or that of your legally authorized representative shall be obtained before treatment is administrated.
* You may refuse treatment to the extent permitted by law and shall be informed of the medical consequences of the refusal.
* Except in emergencies, you may not be transferred to another facility without being given a full explanation for the transfer, without provision being made for continuing care, and without acceptance by the receiving institution.
* You are permitted to examine your treatment bill and receive an explanation of the bill, regardless of source of payment, and you shall receive, upon request, information relating to financial assistance available through the clinic.

**Treatment and Related Rights**

* You or your representative should receive information about your illness, course of treatment and prognosis for recovery in terms that you can understand.
* You will be informed of your treatment and care, including alternatives to and possible side effects of treatment, including medication if/when applicable.
* No medication may be given to you as treatment without your written, informed consent, unless it is needed in an emergency to prevent physical harm to you or others, or if a court orders it.
* You will be informed in writing of any costs of your care and treatment for which you or your relatives may have to pay.
* You will receive treatment in the least restrictive manner and setting necessary to achieve the purpose of admission to the facility, within the limits of available funding.
* Restraining measures, including locked seclusion rooms, are not utilized at EBH; in the case of an emergency when it is necessary to prevent physical harm to you or to others, the Dane County Police Department will be contacted for assistance. Any additional cost of this (e.g. ambulance) will be the responsibility of the patient.
* You may refuse treatment to the extent permitted by law, except if you are a danger to yourself or others. If you become a danger to yourself or to others, you may be held in an inpatient facility for up to 24 hours for an adult, and 48 hours for a minor, for further evaluation.

The following rights may be suspended by your treatment team as part of your therapy, but not without you being informed with a verbal warning first, and allowing you the opportunity to present your side:

1. The right to use your cell phone during group times (within reasonable limits)
2. The right to have a place to safety store your personal belongings
3. The right to have reasonable privacy in a toileting setting (i.e., if purging behavior occurs)
4. The right to review your medical record while receiving treatment

If you believe that any of your rights have been denied or violated, you may speak to the Clinic Director, Anna Aufderhaar Desai, by calling 608-205-4450, emailing [edelweissbh@gmail.com](mailto:edelweissbh@gmail.com), or speaking with Anna directly during IOP treatment hours. Your concerns will be documented and we will work to resolve any concerns that you may have in the quickest and most efficient way possible. You may also choose to submit a grievance or complaint about your care at any time, either in writing or orally, to the State of Wisconsin Bureau of Health Services at:

The State of Wisconsin Bureau of Health Services

Division of Quality Assurance

1 Wilson Street

PO Box 2969

Madison, WI 53701

(608) 266-8481 or 1-800-642-6552

Web site: [www.dhs.wisconsin.gov](http://www.dhs.wisconsin.gov/)

If you would like to file a grievance with the State of Wisconsin Bureau of Health Services, EBH staff will provide you with the form and assist you if needed.

**Patient Responsibilities**

As a patient at Edelweiss Behavioral Health you have the responsibility to:

* Provide, to the best of your knowledge, accurate and complete information about present complaints, past illness, hospitalizations, medications, and other matters relating to your health.
* Familiarize yourself with the Program Rules and Expectations, Group Rules and Expectations, and Mealtime Rules and Expectations documents included in your Intensive Outpatient Program Binder, and follow these rules and expectations.
* Participate in the development of your treatment plan.
* Be responsible for the outcome if you refuse to follow the instruction of your treatment team.
* Inform your treatment team or clinic director if you do not understand your treatment plan or what is expected of you.
* Report unexpected changes in your condition to the responsible clinician/physician.
* Follow the treatment plan recommended by the treatment team responsible for your care. This includes following instructions of EBH staff and health professionals as they carry out the coordinated plan of care and implement the responsible physician’s orders, and as they enforce the applicable rules and regulations.
* Accept responsibility for your actions if you refuse treatment or do not follow the physician’s instructions.
* Assure financial obligations of your health care are fulfilled as promptly as possible.
* Be considerate of the rights of other patients, EBH staff and personnel and show respect for the rights of other patients.
* Control your own behavior and language in terms of what could be triggering to others and be responsible for any difficulties in doing so.
* Be respectful of the property of other persons and of EBH.
* Provide the information necessary for insurance and processing and ask any questions you may have concerning the bill as soon as possible.
* Understand and acknowledge that if you have intentionally damaged EBH property, you could be held financially responsible.
* Inform us if you feel that your rights have been violated.

**I acknowledge the receipt of my rights and responsibilities at the time of intake at Edelweiss Behavioral Health.**

Name (please print): Click or tap here to enter text.

Signature: Click or tap here to enter text. Date: Click or tap here to enter text.

**IOP NO SHOW/LATE CANCELLATION POLICY**

The following No Show/Late Cancellation Policy will be enforced by Edelweiss Behavioral Health (EBH):

Any planned absence from programming should be discussed and **pre-approved** with the client’s case manager.

Edelweiss Behavioral Health reserves the right to charge a no show/late cancellation fee of $100 directly to the client for any no show/no call to programming or late cancellation.

Late cancellation is defined as cancellation within 24-hour of the start of programming.

If a client comes to programming but does not stay for at least 2.5 hours of programming time, the client will be charged with a no show/late cancellation fee. If this is for illness related reasons, this will be at the staff’s discretion and documentation from your primary care physician may be required.

If a client is unable to attend programming and the absence is not pre-approved, the client needs to notify Edelweiss staff with 24-hour notice prior to absence. The client should notify their **case manager** of the absence **by telephone call; email is not an acceptable way of notifying your case manager of an absence.**

If the client is not able to provide 24-hour advanced notice for any reason, they must notify Edelweiss staff at minimum of 2 hours prior to the start time of the program day that they will not be attending.

* Reasons for providing less than 24-hour notice of missing programming may include, but are not limited to: illness, medical emergency, or family emergency. Edelweiss staff reserves the right to determine if rationale for missing programming is appropriate or if client will be charged the No Show/Late Cancellation fee.
* EBH staff reserves the right to ask for written documentation confirming the late cancellation(s).
* EBH staff reserves the right to use attendance, or lack thereof, as a determining factor in deciding if an IOP level of care is appropriate, or if recommendations to a different/higher level of care would be warranted.

If Edelweiss staff do not receive notice that a client will be absent from programming, and the client has not arrived 15 minutes into the start of the program start time, the police will be called to complete a **wellness check** at the client’s home.

**I understand the above IOP No Show/Late Cancellation Policy and I accept the terms as outlined above.**

Name (please print): Click or tap here to enter text. Date: Click or tap here to enter text.

Signature: Click or tap here to enter text. Date: Click or tap here to enter text.

Printed Name of Parent/Guardian if under 18 years of age: Click or tap here to enter text.

Parent/Guardian Signature: Click or tap here to enter text. Date: Click or tap here to enter text.

**INTAKE PAPERWORK CHECKLIST**

Please initial that you have **read**, **reviewed**, and **understand** the following paperwork, and have had all of your questions **answered** regarding what you are signing today.

\_\_\_\_\_\_ Consent for Intensive Outpatient/Outpatient Mental Health and Dietary Treatment

\_\_\_\_\_\_ Consent for Patient Email and Text Messages

\_\_\_\_\_\_ History and Background

\_\_\_\_\_\_ Fee Agreement

\_\_\_\_\_\_ Copayment Form for IOP services

\_\_\_\_\_\_ Clinic information Policies and Procedures

\_\_\_\_\_\_ Joint Notice of Privacy Practices

\_\_\_\_\_\_ Patient Rights and Responsibilities

\_\_\_\_\_\_ IOP No Show/Late Cancellation Policy

By signing this form, I acknowledge that I have **read**, **reviewed**, and **understand** the forms that I have signed and have had all of my questions **answered** by a member of the Edelweiss staff.

Patient Signature: Click or tap here to enter text. Date: Click or tap here to enter text.

Parent Signature : Click or tap here to enter text. Date: Click or tap here to enter text.

(If patient is a minor)

Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_