Consent for Intensive Outpatient/Outpatient Mental Health and Dietary Treatment

1. **Consent to Evaluate/Treat:** 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:
    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, Dietary Services or Marriage and Family Therapy.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to 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.

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

4. **Confidentiality, Harm, and Inquiry:** Information from my 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.

5. **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.

6. **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.

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

I have read and understand the above, have had an opportunity to ask questions about this information, and 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.

_____ _____

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

_____ _____

Authorized Provider Representative **Date**

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. **Copays and self-pay arrangements are due at time of service.**

Intensive Outpatient Program

3hr/day	375.00

Dietitian

Initial Intake	180.00
60 Minutes	180.00
45 Minutes	135.00
30 Minutes	90.00

Individual Therapy (LPC)

Initial Intake	215.00
60 Minutes	215.00
45 Minutes	160.00
30 Minutes	107.50

Individual Therapy (LPC-IT, SAC-IT)

Initial Intake	160.00
60 Minutes	160.00
45 Minutes	120.00
30 Minutes	80.00

Group Therapy (non-IOP)

*Group rates may vary

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

IOP per day	100.00
Dietitian	75.00
Individual Therapy	75.00

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

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.

Client Name (please print): _____ DOB: _____

Patient or Responsible Party Signature: _____ Date: _____

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: Intensive Outpatient from 5-8pm Monday, Wednesday and Thursday. Outpatient visits by appointment.

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, you may call the office 24 hours, 7 days a week at 608-695-0674 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 therapist return your call for emergencies. 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.

PLEASE SEE REVERSE

Informed Consent

It is the policy of EBH 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:

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.

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 EBH, 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 given a copy of this clinic information sheet, the "Consent for Treatment Form," and the "EBH Joint Notice of Privacy Practices".

Signature (adult or minor age 14 or older): _____ **Date:** _____

Signature of Guardian if signer is under the age of 18: _____ **Date:** _____

Authorized Provider Representative Signature: _____ **Date:** _____

Edelweiss BEHAVIORAL HEALTH

History and Background

Confidential: For Professional Use Only

Name: _____ Today's Date: _____

Date of Birth: _____ Age:_____ Sex: □ M □ F

Street Address: _____

City: _____ State: _____ Zip Code: _____

Main Phone:_____ call □ text □

Email Address: _____

Social Security Number: _____

Highest Year Completed in School:_____ Name of school: _____

Current or Last Job: _____ Major area of study: _____

Fathers age and Occupation: _____ Mothers age and Occupation: _____

Parents marital status: _____

Names of Brothers/Sisters, age, marital status and occupation:

_____

Do you have a family history of mental illness or substance abuse? Please explain.

_____

Spouse/partners name: _____ Age: _____ Occupation: _____

Children's names and ages: _____

Employers name: _____ Length of time in current job: _____

If unemployed, how long? _____ Other kinds of work done in the past: _____

How much do you use alcohol: _____ How often do you use recreational drugs: _____

Describe any legal problems that you may have: _____

Special health problems, handicaps, or physical limitations: _____

Current medications: _____

Please describe the problems that brought you here:

_____

_____

Others that you have seen about this problem (with dates):

_____

_____

Who referred you here?: _____

Emergency Contact Name:_____

Phone:_____ **Relationship:**_____

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

Name: _____Birthday: _____ Social Sec #_____

Address:_____

Phone Number: _____

Guarantor Signature: _____

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

Primary Insurance Info

Ins. Co. _____ Name of Policyholder _____
Relationship to Patient _____ Customer Service Phone # _____
Address _____ City, State, Zip _____
Subscriber # _____ Grp# _____ Effective Date _____
Policyholders Date of Birth _____ Policyholder Social Security # _____
Policyholder Address (if different than patient)
_____

Secondary Insurance Info

Ins. Co. _____ Name of Policyholder _____
Relationship to Patient _____ Customer Service Phone # _____
Address _____ City, State, Zip _____
Subscriber # _____ Grp# _____ Effective Date _____
Policyholders Date of Birth _____ Policyholder Social Security # _____
Policyholder Address (if different than patient)
_____

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

ASSIGNMENT OF BENEFITS: I hereby authorize 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: _____
(IF PATIENT IS A MINOR, PARENT/GUARDIAN OR ADULT RESPONSIBLE MUST SIGN.)

Printed Name: _____ **Date:** _____

Address: _____ **State:** _____ **Zip Code:** _____

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:

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

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 Health Privacy 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 Health for 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 to 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, 608-695-0674.

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 by 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) 695-0674.
Secretary of Department of Health and Human Services: (877) 696-6775.

Signature (adult or minor age 14 or older): _____ Date: _____

Signature of Guardian if signer is under 18: _____ Date: _____

Edelweiss Behavioral Health- Group Rules and Expectations

- No cell phone use during group and meal times; keep all cell phones on silent for limited interruptions. If cell phone is being used during group time, staff may ask to remove cell phone from group room until the end of the treatment day
- Be supportive and use positive language when giving feedback to other group member and when addressing staff; respect each other
- No glamorizing behaviors or past treatment
- Use appropriate physical boundaries with others patients and with EBH staff
- Do not discuss what others patients say during programming when you are with your family, peers, at school or work or in any setting outside of EBH.
- Refrain from swearing or making verbal threats toward others, both staff and patients.
- No crosstalk
- Process time during groups will be based on the number of individuals present so that each person has time to process; the expectations is that group members respect this rule and are aware of the time spent processing, and allow others to have time to share with the group
- No talk of numbers
- Make every attempt to use non-triggering comments and behaviors both during groups and at meal time
- Prioritize concerns/issues in all groups
- The group setting is intended to be goal driven, action oriented in all topics and conversations; if you are unable to communicate in this manner the expectation is that you meet individually with an EBH staff member

Program Rules and Expectations

- Inform Edelweiss Behavioral Health staff of absence at least two hours prior to program start time and inform staff of tardiness with as much notice as possible either via email at edelweissbh@gmail.com or by calling 608-695-0674
    - EBH staff reserves the right to interpret multiple absences/tardiness as treatment disrupting; this may result in a behavior contract and/or referral to a higher level of care
- Inform staff if you are having thoughts or are planning to harm yourself or another person; inform staff if someone tells you that they plan to hurt themselves or someone else.
- Never bring weapons or items that could be considered dangerous, to treatment at EBH at any time.
- No recording devices or cameras are to be used.

- Please dress appropriately to account for the temperature in the room, bring layers as necessary; any use of blankets will need to be appropriate and approved by EBH staff
- Set intentions, make plans and always ask yourself if you are giving 100% of your effort
- Weights will be obtained on Mondays (for those in IOP); refusal of being weighed will need to be approved by Clinic Administrator and may also need documentation from another member of your treatment team

Please review the following to maintain your safety and the safety of others, while you are a patient at EBH:

- Safety concerns should be reported immediately to any staff member; we are committed to addressing these concerns as soon as possible
- If at any time you feel that your medical/mental health condition is declining, please alert a member of the treatment team immediately so that the proper intervention can take place
- If you have any questions or concerns about your treatment, including any medications that you have been prescribed, please speak with EBH staff as soon as possible.

Mealtime Expectations

- We expect that you are able to independently finish your meal in accordance with your meal plan
- We expect that you identify your feared foods and challenge yourself to these foods while in IOP
- We expect that you select meals that allow you to challenge yourself in a safe setting
- We expect that you ask for help/assistance when needed during the meal
- We expect that you are not using triggering language around others (i.e. talking about calories, specifics of your meal plan, commenting on others meal plans/portion sizes, etc.)
- We expect that if you are struggling and feeling unable to complete your meal, that you ask to speak to an EBH staff member one on one in order to prevent triggering others
- Overall, the expectation is that you follow the meal plan that you have spoken with the dietitian about, and that you discuss any struggles during the meal in as non a triggering fashion as possible

I, _____ agree to follow these rules and to seek individual help from an EBH staff member if I am struggling to do so.

Patient: _____ Date: _____

Staff: _____ Date: _____

Acknowledgement of Intensive Outpatient Program Binder Receipt

This section of the program binder contains information that will help you to be aware of your rights as well as the expectations of EBH staff. Please sign below acknowledging that you have read and agree with this material. If you have any questions, please ask an EBH staff member.

I hereby acknowledge receiving a copy of the patient program binder and I understand that it is my responsibility to review the rules, patient rights and responsibility and the grievance procedures and to ask questions for clarification, if needed. I agree to follow these rules to the best of my capability and ask for help when needed.

Signature: _____ Date: _____

Staff Witness: _____ Date: _____

Patient Rights and Responsibilities

What follows is a three-page document outlining your personal rights, treatment and related rights, and your responsibilities as a patient at Edelweiss Behavioral Health. 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, 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 608-695-0674, emailing 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

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, and that there is a copy of these rights and responsibilities in my patient program binder.

Name (print): _____

Signature: _____ Date: _____

Edelweiss
BEHAVIORAL HEALTH

24-Hour On Call Services

In the case of a life threatening emergency,

go to your nearest emergency room or call 911 immediately.

In the case of a therapeutic emergency you may call 608-695-0674 for the on call clinician.