REGENT MENTAL HEALTH GROUP: INFORMATION FOR PATIENTS

_____ _____

Patient's full name **Patient's DOB**

Regent Mental Health Group SC (RMHG) is dedicated to the effective treatment of mental illness. We work to alleviate the suffering induced by major mental illness. We strive to give comfort, support and hope in our patient focused clinic. Our clinical staff consists of Psychiatrists, Licensed Social Workers, Licensed Professional Counselors, and a Licensed Psychologists. This sheet contains important information about our policies and procedures. RMHG phone number is **(608) 238-5826**.

Eligibility: Eligibility for RMHG is based on the existence of a presenting psychiatric or psychological disorder. 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 to help you; or (3) there is a more appropriate service provider elsewhere in the community or your insurance company has another resource for you.

Services at RMHG 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.

RMHG 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 regularly missing appointments; (3) you fail to pay for services; or (4) upon the professional recommendation of your clinician.

Appointments: RMHG is dedicated to providing timely care to all of our patients. If you need to cancel an appointment, please do so at least 24 hours in advance. You, not your insurance, may be billed for missed appointments. RMHG reserves the right to terminate care after three no shows and/or same day cancellations.

Hours: RMHG Business Office is staffed weekdays from 8:00am to 5:00pm. Some clinicians offer additional appointment times. You may leave a voice message 24/7 for all non-emergencies on our office phone.

Emergencies: In a life-or-death situation, call 911. If there is an urgent situation during our office hours, you may call RMHG to speak to your clinician. During non-business hours, our answering service takes your urgent message and at your request, will have your clinician or the clinician on call return your call. Their phone number is 608-259-2876.

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

Consent: Each patient, or individual acting on behalf of the patient, will receive specific, complete, and accurate information regarding the treatment at RMHG. You will be asked to read and sign the Consent for Treatment Form. Those patients receiving medication prescribed by one of our psychiatrists will be asked to sign an Informed Consent specific to the medication being used.

Grievance Procedure: If you have a concern about the services you are receiving, you are encouraged to discuss it with any RMHG staff. If this does not resolve the issue, you may contact Maria Hanson, Client Rights Specialist directly at 608-446-8957. A copy of the grievance procedure is available upon request.

Record Access: Under Wisconsin law, you have a right to review your treatment record.

Involuntary Discharge: Patients may be involuntarily discharged for nonpayment, no shows or missed appointments, if deemed to be a danger or disrespectful to other patients or any RMHG staff. A letter will be sent indicating the effective date and the reason for discharge, sources for further treatment, and the patient's right to have the discharge reviewed.

(continued on next page)

Fee Policy: A fee is charged for professional services provided by our clinicians. If you do not have insurance, or if your insurance does not pay in full, you will be responsible for payment. Your signature on this form authorizes RMHG to release information necessary to process insurance claims.

Accepted forms of payment are cash, check and Visa or MasterCard. If you write a check with insufficient funds, RMHG will charge you an additional $25 NSF fee.

It is the policy at RMHG to collect copays and account balances at the time of service.

REGENT MENTAL HEALTH GROUP: FEE AGREEMENT

Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. You are responsible for charges not covered by insurance, including co-payments, coinsurance and deductibles. The initial session averages 45-60 minutes. Therapy sessions average 45-60 minutes. Medication Management sessions average 15-30 minutes. Fees are based on the total time spent on the patient's behalf and billed as follows:

Therapist-Master's (LCSW, LPC, MFT)	**Length in Minutes**	**Charge**
Initial Assessment/Evaluation:	45-60	$280.00
Psychotherapy:	30	$150.00 - $180.00
Psychotherapy:	45-50	$180.00 - $230.00
Psychotherapy:	50-60	$230.00 - $250.00
Crisis:	50-60	$250.00 - $375.00
Therapist-PhD (Psychologist)		
Initial Assessment/Evaluation:	45-60	$300.00
Psychotherapy:	30	$160.00 - $220.00
Psychotherapy:	45-50	$220.00 - $260.00
Psychotherapy:	50-60	$260.00 - $280.00
Crisis:	50-60	$280.00 - $405.00
Testing – Psychologist		
Evaluation		$415.00 - $450.00 / hour
Psychiatrist-MD		
Initial Assessment/Evaluation:	45-60	$450.00
Psychotherapy/Medication Management:	15-25	$175.00 - $475.00
Psychotherapy/Medication Management:	25-60	$200.00 - $500.00
Crisis:	50-60	$280.00 - $430.00

Phone calls are subject to billing at the above rates at the clinician's discretion.

No Shows and/or Late Cancellations	**Charge**
	$75.00

If you miss an appointment without a 24-hour notice, you will be billed for the no show/late cancellation. RMHG reserves the right to **terminate** your care after **three no shows and/or late cancellations** (not billable to insurance) It would be your responsibility to then find a new mental health provider.

My signature below indicates that I have been offered copies of the Fee Agreement, Information for Patients, and the Grievance Procedures.

_____ _____

Signature of Patient ages 14 years or older or legal representative **Date**

_____ _____

Signature of legal representative for patient under 18 **Date**

Regent Mental Health Group, SC

Consent for Child Mental Health Treatment

Full Name:_____

Date of Birth:_____

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1. **Consent to Evaluate/Treat:** I voluntarily consent that my child will participate in a mental health (e.g., psychological or psychiatric) evaluation and/or treatment by staff from Regent Mental Health Group SC (RMHG SC). 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 Licensed Social Worker, Psychologist, or Psychiatrist. Treatment will be conducted within the boundaries of Wisconsin Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, 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 my child, as well as the referring professional, to understand the nature and cause of any difficulties affecting my child's daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.

3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments, co-insurance, deductibles and no show charges. Fees are available to me upon request.

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

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

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

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

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

_____ _____

Signature of Patient (ages 14 years or older) **Date**

_____ _____

Signature of legal representative for patient under 18 **Date**

Regent Mental Health Group, SC

700 Rayovac Dr Ste 103, Madison WI 53711
Ph: 608-238-5826 Fax: 608-238-1221

Treatment Plan Acknowledgement Agreement

_____ _____

Patient's full name **Patient's DOB**

Appointment review date: _____

Provider name: _____

My signature below indicates:

- ***I have been offered copies of my treatment plan as detailed by my provider in my session; and***
- ***(If applicable) I have been informed about any medications prescribed as part of this treatment plan and their possible side effects.***

_____ _____

Signature of Patient (ages 14 years or older) **Date**

_____ _____

Signature of legal representative for patient under 18 **Date**

Regent Mental Health Group, S.C.

700 Rayovac Dr., Ste 103; Madison, WI, 53711

AUTOMATIC PAYMENT PLAN

I authorize **Regent Mental Health Group, S.C.** to automatically charge my credit card (*Visa, Mastercard, Discover, Am. Express)* listed below for items listed on the monthly statement for:

Client Name: _____

Date of Birth: _____

This authorization is to remain in effect until I cancel in writing.

The **Payment Plan** I prefer to be on is:

- ☐ Pay the entire amount after each visit
- ☐ Pay the entire amount at the end of each month*
- ☐ Decline Automatic Payment

**If this date falls on a weekend, payment will be processed the following Monday. **

***If you decline to use AutoPay, please type 'N/A' in the Card sections.**

CARD TYPE	CARD NUMBER	EXPIRATION DATE	CVV CODE
Mastercard			
Visa			
Discover			
Am. Express			

Name as it appears on the card (please print): _____

Home Telephone #: _____

Work Telephone #: _____

Home Address/City/State/Zip Code: _____

Please check one of the options below:

- ☐ I authorize a minimum charge of $_____ and a maximum charge of $_____
- ☐ No minimum or maximum charge
- ☐ Not applicable

Signature: _____

Date: MM-DD-YYYY _____