Regent Mental Health Group, S.C.

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

Consent for Adult Mental Health Treatment

Name:_____

Date of Birth:_____

1. **Consent to Evaluate/Treat :** I voluntarily consent that I will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from 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 me, as well as the referring professional, to understand the nature and cause 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, co-insurance, deductibles and no-show charges. The Fee Schedule is published annually and is available at any time upon request.

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

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 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 clinician about the above information at any time.

_____ _____

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

INFORMATION FOR PATIENTS

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, Nurse Practitioners, Physician Assistants, 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 patients. If you need to cancel an appointment, please do so at least 24 business hours in advance. You, not your insurance, may be billed for missed appointments.

Hours:

RMHG Business Office is staffed on weekdays from 8:00am to 6:00pm. 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 608-259-2876 takes your urgent message and, at your request, will have a clinician return your call.

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, suicidal ideation, threats of violence, 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 insurance 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 regarding the medication being prescribed.

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 the right to review your treatment record.

Involuntary Discharge:

Patients may be involuntarily discharged for nonpayment, no shows, missed appointments, inappropriate speech, or behavior if deemed to be a danger or disrespectful to other patients or 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.

If you miss an appointment without a 24 business hours advanced 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.

Medication:

Refills requests should go through our Med line 608-308-7473. When leaving a message the following information is required:

- Pharmacy name and location
- If you ask for an early refill, please specify reason and date medication is needed.

We ask for 7 days' notice for all medication refills.

Telehealth:

Telehealth is the delivery of therapy/psychiatry using interactive technologies between a provider and a client who are not in the same physical location.

Patients are required to be in the same state as the provider is licensed. Patients must provide the address of their current location at the start of the telehealth session.

Patients must have access to and familiarity with the appropriate technology, the necessary electronic devises and internet access.

Patients are responsible for maintaining privacy on the client end of the communication.

Telehealth fees are the same for telehealth and in-person sessions.

If a third-party payor does not cover telehealth services the patient will be responsible for the fee.

Fee Policy:

Please refer to the Fee Agreement page. 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.

Accepted forms of payment are cash, check and credit card. 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.

Please note, outstanding balances of over $250 or over 90 days past due may require payment and payment arrangements to be made prior to scheduling future appointments.

Email Communications:

RMHG will use email communication for administrative purposes only. Any emails outside of the Valant Portal is not HIPAA compliant. Patient initiated emails is expressed consent to have HIPAA information emailed outside of the Valant Portal. Please do not email your clinician about clinical matters unless you have a specific, written, agreement with your clinician.

In case of emergency, call 608.236.5826 or 911.

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	$300.00
Psychotherapy:	30	$170.00
Psychotherapy:	45	$230.00
Psychotherapy:	60	$270.00
Group Therapy	60	$90.00
Crisis:	60	$275.00

Therapist-PhD (Psychologist)	**Length in Minutes**	**Charge**
Initial Assessment/Evaluation:	45-60	$330.00
Psychotherapy:	30	$180.00
Psychotherapy:	45	$240.00
Psychotherapy:	60	$280.00
Crisis:	60	$315.00

Testing – Psychologist		
Evaluation 1st hour/each hour thereafter		$495.00/$460.00

Prescribers – MD, PA, & APNP	**Length in Minutes**	**Charge**
Initial Assessment/Evaluation:	45-60	$495.00
Evaluation/Medication Management:	10*	$210.00
Evaluation/Medication Management:	20*	$240.00
Evaluation/Medication Management:	30*	$300.00
Evaluation/Medication Management:	40*	$320.00
Psychotherapy addon Fees (determined by time)	16-37	$240.00
Psychotherapy addon Fees (determined by time)	38-52	$260.00
Crisis:	60	$320.00

* May also be determined by complexity of appointment rather than time alone.
Phone calls are subject to billing at the above rates at the clinician's discretion.

No Shows and/or Late Cancellations $90.00

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

Printed name of the client	**Client Date of Birth**
Signature of Patient ages 14 years or older or legal representative	**Date**
Signature of legal representative for patient under 18	**Date**

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 my patient account balance:

Client Name _____ Date of Birth _____

This authorization is to remain in effect until I cancel in writing or by speaking to the billing department.

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

- ☐ Pay the entire amount at the beginning of each month
- ☐ Monthly Payment Plan of $_____
- ☐ Maximum charge of $_____
- ☐ Decline Automatic Payment

- If the date falls on a weekend, payment may be processed on the following business day

Card Type	Card Number	Expiration Date	CVV Code
Mastercard			
Visa			
Discover			
American Express			

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

Home Telephone # _____ Work Telephone # _____

Home Address _____

Authorized Signature _____ Date _____

Regent Mental Health Group SC

Consent for Use of Email

By signing this form, you are acknowledging and agreeing to comply with the following:

- Your desire to send and receive messages to/from your service provider using the email address below
- The use of email is limited to *sharing resources, articles*, *setting up or canceling appointments and for sending appointments reminders*. Due to security, details of one's case cannot be discussed via email. Email may also not be used as a means of providing services. You also agree not to use the clinic's email address when trying to contact the clinic or your service provider in the event of an emergency, as RMHG cannot guarantee a rapid response.
- By signing below, you acknowledge your recognition and understanding of the inherent risks of communicating your health information via unencrypted email and hereby consent to receive such communications despite those risks. Messages containing clinically relevant information may be incorporated into the medical record at the provider's discretion. You also agree not to use the clinic's email address when trying to contact the clinic or your service provider in the event of an emergency, as RMHG cannot guarantee a rapid response.
- By signing, you are also aware that the email is not a guaranteed or secure way of sending and receiving information and that you may not hold RMHG or your service provider responsible for any breach of confidentiality that results from the use of the email address below.

Please print clearly

Patient email address: _____

Printed Patient name: _____ DOB: _____

Patient Signature: _____ Date: _____