MW COUNSELING

Consent for Treatment

SUMMARY OF THE CONTENTS OF THE WISCONSIN NOTICE FORM:

- Your protected health information (PHI) may be used or disclosed with your consent for purposes of Payment, and Health Care Operations. Your signature on our patient registration indicates your consent for the release of information, for the above underlined purposes ONLY.
- The use or disclosure for purpose of Treatment or for purposes outside those underlined above, is permitted ONLY with your written authorization on a separate form designated for this purpose.
- I may disclose information without your consent or authorization under circumstances of Child Abuse, Adult and Domestic Abuse, Health Oversight, Judicial or Administrative Proceedings, Serious Threat to Health or Safety, Worker's Compensation.
- Your rights and my duties are summarized in this document.
- I have received and reviewed the following policy: Wisconsin Notice Form

SUMMARY OF THE CONTENTS OF THE BILL OF RIGHTS

I acknowledge that:

- I have been informed of my rights as a client of MW Counseling, LLC, as outlined in the Client Bill of Rights.
- I have received and reviewed the MW Counseling, LLC, Client Bill of Rights and Client Information Form.
- I consent to treatment as outlined by my therapist and in accordance with the Client Bill of Rights.
- Unless otherwise specified, I give permission to contact my primary care physician, as well as to communicate with my insurance company and/or managed care provider for the purpose of billing and/or treatment.
- I understand that I am responsible for obtaining current referral on HMO policies. I understand that I am responsible for co-pay portions of benefits, for cost incurred during any period in which you do not have a current referral, and for services which are not covered by insurance, such as school consultation, telephone therapy, correspondence, report writing, marital counseling, psychological testing, and case management. *Ultimately, you are responsible for your entire bill.*
- My signature gives the insurance company permission to make payment directly form my account to MWCounseling, LLC. Any payment received will be applied directly to my account. We reserve the right to seek legal means to secure reimbursement. This may include releasing names and information to collection agencies, attorneys or to the Court.
- MW Counseling, LLC, practices under the group name of Madison Counseling and Wellness. I understand that each therapist's practice is separate and each is solely and entirely responsible for any liabilities resulting from that practice.
- I understand that all records within Madison Counseling and Wellness are separately maintained.
- I have read and understand the missed appointment and bad check fees/polices of MW Counseling, LLC.

COMMUNICATION

- I understand if I choose to communicate with my therapist through text messages or email that this communication may not be secure.
- I understand that the use of electronic communication should be used for the purpose of scheduling and/or business purposes and should not take the place of face to face communication.

CLIENT NAME:____

(please print)

Signed:____ Date:____________

Client Signature

Signed:____ Date:____________

Responsible Party Signature

Signed:____ Date:____________

Therapist Signature

CONSENT TO TREAT A MINOR AUTHORIZATION:

I give Melissa Walden, LPC, permission to give psychiatric treatment to ______________________________ DOB:____________ because client is a minor/incompetent.

Signature: ______________________________________Legal Authority: Parent of Minor/Legal Guardian Date: ___________