NETT-WORK FAMILY COUNSELING, LLC
CONSENT TO TREATMENT

Thank you for choosing, _____, an Independent Practitioner at Nett-Work Family Counseling as your health care provider. I am committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of your Consent to Treatment and our Financial Policy, which you are required to read and sign prior to any treatment.

Regarding Insurance:

Please keep in mind that all charges are the responsibility of the patient regardless of your insurance coverage. We will be happy to file your claims with your insurance carrier(s). However, if your insurance hasn't paid within 60 days, we will expect you to work with your insurance company to receive reimbursement. If no payment has been received within 90 days of the date of service, you will be billed for the full service rendered. Co-payments & deductibles are due at the time of service.

Confidentiality:

Information regarding your treatment at Nett-Work Family Counseling is confidential and will not be released without your written consent. Information regarding your minor child will not be released without your written consent. Certain exceptions to these rules exist – should you be a danger to self or others, then the proper authorities must be contacted; or to the courts if records should be requested by them.

Minors:

All information pertaining to minors will be released to their parents or legal guardians upon their request, unless it would seriously affect the therapeutic process. The parents or guardian of the minor are responsible for full payment. **In divorce situations, the parent that brings the child to the appointment is responsible for payment regardless of the divorce decree.**

Treatment:

It is the policy of the clinic that each client will receive specific, complete and accurate information regarding the treatment that they receive at this clinic. This information will be in both written and verbal form. All clients are required to sign their treatment plan.

- Treatment shall be done in the following modes-individual, couple, family, or group.
- If you would like to receive a different treatment mode, transfer to another therapist, or to seek treatment elsewhere, then you are free to do so.
- You are free to withdraw this consent, which is good for 15 months, at anytime and to terminate your treatment.

Treatment Alternatives:

There are multiple alternatives to outpatient behavioral health/AODA treatment, including [but not limited to]: bibliotherapy (reading books), religious care, community support, AA/NA, holistic healing, alternative medicines such as acupuncture or energy healing, nutritional healing, and aromatherapy.

Possible Outcomes, Benefits, and Side Effects:

The overall benefits of treatment at Nett-Work Family Counseling include [but not limited to] improvement in mental health, physical health, family functioning, improvement in all relationships, social functioning, employment functioning, resolution of legal distress, and/or reduction of substance use concerns. As clients participate in outpatient treatment, many difficult and stressful issues might be addressed. Therefore, at times, side effects of treatment might include a temporary increase in negative symptoms. We encourage you to discuss this with your primary treatment provider as these issues arise. Also, by not receiving any treatment, it is probable that there will be no change, or an increase, in symptoms.

Emergencies:

The clinic has voice mail with an after hour's emergency cell phone number of the Director, Christine Nett, LCSW.

Cancellations and Changes of your Appointment Time:

Unless cancelled, at least 24 hours (one full business day) prior to your scheduled appointment time, our policy is to charge a $65 Fee for a late cancel or missed appointment.

Client's Responsibility:

All clients are responsible to provide the clinic with accurate insurance information and to contact us should coverage be changed. The office manager will verify policy benefits and limitations, but the clinic will not be responsible for any changes in your insurance benefits.

Statement of Agreement:

Thank you for understanding our Consent to Treatment. Please let us know if you have any questions or concerns.

I understand and agree to this Consent to Treatment policy.

- ***Copy Given to Client***

_____ _____

Client / Responsible Party Signature **Date**

HEALTH HISTORY

NAME : _____ AGE: _____ DATE OF BIRTH: _____ DATE: _____

Have you ever had or been treated for the following conditions? (please check)

☐ Allergies	☐ Low blood sugar	☐ Abortion/Miscarry
☐ Hay Fever	☐ Thyroid Problem	☐ Sexual Problems
☐ Asthma	☐ Liver Disease	☐ Sleep Problems
☐ Emphyema	☐ Hearing Problem	☐ Back Trouble
☐ Skin Problems	☐ Vision Problems	☐ Arthritis
☐ Constipation	☐ Dental Problems	☐ Chronic Pain
☐ Stomach Problems	☐ High Blood Pressure	☐ Headaches
☐ Irritable Bowel	☐ Heart Disease	☐ Injury/Fractures
☐ Weight Problem	☐ Kidney Problems	☐ Epilepsy/Seizures
☐ Blood Disease	☐ Bladder Problems	☐ Eating Disorder
☐ Cancer	☐ Prostate Disease	☐ Drinking Problem
☐ ADHD/ADD	☐ Menstrual Problems	☐ Drug Abuse
☐ Diabetes	☐ Autism Spectrum Disorder	☐ Tobacco -Smoke and/or Vape

Please list any hospitalizations (dates & reasons):

_____

_____

Please list all prior mental health services received:

With whom? Year? How Long? For What?

_____

_____

Are there any physical problems in the family that concern you? _____

_____

Are there any emotional problems in the family that concern you? _____

_____

Have you ever been physically abused (_____) or sexually molested (_____) ?

Are you currently under the care of a doctor for any physical or emotional condition? _____

If so, please list doctor's name, reason for treatment, date last seen: _____

_____

Current medication you are taking (list all, even non-prescription & occasional): _____

_____

Current Health Concerns: Please check any area where you think you may have a problem:

☐ Hearing/Vision	☐ Anxiety/Nervousness	☐ Interpersonal Relationships
☐ Speech	☐ Depression	☐ School Problems
☐ Dental Health	☐ Anger or Temper	☐ Work/Job/Career Problems
☐ Breathing	☐ Frequent Mood Change	☐ Marital Problems
☐ Circulation	☐ Guilt	☐ Parenting Skills
☐ Digestion	☐ Self-Concept	☐ Sexuality
☐ Bowel Function	☐ Tiredness/Fatigue	☐ Problems with Relatives
☐ Urinary Function	☐ Sleep Disturbances	☐ Legal (lawsuit,charges)
☐ Joint/Muscle Function	☐ Suicide Ideas	☐ Exercise, Hobbies
☐ Skin Condition	☐ Indecision	☐ Drinking Problem
☐ Pain	☐ Memory/Concentration	☐ Drug Problem
☐ Menstrual Cycle	☐ Eating/Appetite	☐ Behavior Problems
☐ Menopause	☐ Weight loss/gain	☐ Gambling Problem
☐ Smoking	☐ Phobias	☐ Other: _____

Name of physician seen in the past 12 months: _____

Nett-Work Family Counseling, LLC
2801 Calumet Drive
Sheboygan, WI 53083
920-451-6908

HIPAA
Consent to use and disclose your health information

This form is an agreement between you,_____and Nett-Work Family Counseling, LLC. When we use the word "you" below, it can mean you, your child, a relative, or other person if you have written his or her name here _____.

When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our privacy officer, Christine Nett.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to do as you asked.

After you have signed this consent, you have the right to revoke it (by writing a letter to our Privacy Officer telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

_____ _____
Signature of client or his or her personal representative Date

_____ _____
Printed name of client or personal representative Relationship

_____
Signature of authorized representative of this office

Nett-Work Family Counseling, LLC
2801 Calumet Drive
Sheboygan, WI 53083

AODA Outpatient Treatment

RELEASE OF INFORMATION FOR STAFFING DHS 75.03(14)

I, _____ (Client Name, Please Print), understand that information pertaining to my outpatient treatment for alcohol and/or other drugs will be regularly discussed in staffing by my counselor with the Independent Clinical Supervisor and consulting physician. Confidentiality will be strictly maintained under the guidelines of professional ethics and the procedures defined by my insurance.

(14) STAFFING.

(a) Staffing shall be completed for each patient and shall be documented in the patient's case record as follows:

1. Staffing for patients in an outpatient treatment service who attend treatment sessions one day per week or less frequently shall be completed at least every 90 days.

2. Staffing for patients who attend treatment sessions more frequently than one day per week shall be completed at least every 30 days.

(b) A staffing report shall include information on treatment goals, strategies, objectives, amendments to the treatment plan and the patient's progress or lack of progress, including applicable criteria from the approved placement criteria being used to recommend the appropriate level of care for the patient.

(c) The counselor and clinical supervisor shall review the patient's progress and the current status of the treatment plan in regularly scheduled case conferences and shall discuss with the patient the patient's progress and status and make an appropriate notation in the patient's progress notes.

(d) If a patient is dually diagnosed, the patient's treatment plan shall be reviewed by the counselor and a mental health professional and appropriate notation made in the patient's progress notes.

(e) A staffing report shall be signed by the primary counselor and the clinical supervisor, and by a mental health professional if the patient is dually diagnosed. The consulting physician shall review and sign the staffing report.

_____ _____
Client Signature Date

_____ _____
Therapist Signature Date

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Sheboygan, WI 53083
Phone (920) 451-6908
FAX (920) 458-6439

PATIENT BILL OF RIGHTS

When you receive services for mental health, alcoholism, drug abuse, or a developmental disability, as an inpatient or outpatient, you have the following rights under Wisconsin Statute Section 51.61.

TREATMENT AND RELATED RIGHTS

To be free from having unreasonable arbitrary decisions made about you.

To receive prompt and adequate treatment.

To refuse any treatment.

To be free from unnecessary or excessive medication.

To give informed consent to treatment.

COMMUNICATION AND PRIVACY RIGHTS

To refuse to be filmed or taped without your consent.

To have your treatment records and conversations about your treatment kept confidential (Sec. 51.30, Stats.).

To have access to your treatment records after discharge (or during treatment if the facility director approves it) and to have access at all times to records of medications you take or any treatment you receive for physical health reasons.

RIGHTS OF ACCESS TO COURTS

To bring a legal action for damages against those who violate your rights.

YOUR RIGHT TO COMPLAINT

If you feel that your rights have been violated, you have the right to a grievance procedure. Our agency has a grievance process through which you may file your complaint. Grievances must be filed in writing within 45 days of the incident or issue. Contact me or any staff member who will supply you with a copy of the Grievance Procedure upon request. You may at the end of the grievance process, or at any time during it, choose to take the matter to court.

Thank you for understanding our Patient Bill of Rights. Please let us know if you have any questions or concerns.

I understand and agree to this Patient Bill of Rights policy.

_____

Client / Responsible Party Signature **Date**

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INFORMATION ABOUT FEES

Fees for clinic services are, of course, ultimately your own responsibility. We will assist you, however, in every way possible to collect the maximum benefits from your health insurance or other resources, including filing the necessary forms. Monthly payments can be made according to what is affordable.

Most services consist of psychotherapy visits at this office. A psychotherapy "hour" consists of 45-50 minutes of interviewing time and 10-15 minutes set aside for preparation, making notes, and brief letters or telephone calls which you authorized. Longer or shorter visits are adjusted accordingly.

Most fees are covered in full or substantially under group health insurance. When calling to find out the benefits under your particular policy, the service you are receiving is called "outpatient psychotherapy". It is often covered under "Mandated Benefits". Nett-work Family Counseling is certified by the State of Wisconsin to receive mandated psychotherapy benefits.

If a third-party source is not available to substantially assist you with my fees, I will request payment at the time of service.

FEES:

Diagnostic Evaluation

Master's level (90791)	$225.00
Discounted Cash Rate	*$100.00**
Doctoral level (90791)	$285.00
Discounted Cash Rate	*$160.00**

Psychotherapy

Master's level		**Doctoral level**	
50-60 minutes (90837)	$185.00	50-60 minutes (90837)	$255.00
45 minutes (90834)	$155.00	45 minutes (90834)	$225.00
30 minutes (90832)	$145.00	30 minutes (90832)	$215.00
Family with patient (90847)	$200.00	Family with patient (90847)	$230.00
Family without patient (90846)	$200.00	Family without patient (90846)	$230.00
Discounted Cash Rate	*$100.00**	*Discounted Cash Rate*	*$160.00**

Group Therapy

50-60 minutes (90853)	$110.00
Discounted Cash Rate	*$80.00**

Other

Written report or letter	$80.00
Extended phone calls	$25.00

***Discounted Cash Rates must be paid at time of service with Cash or Check only.**

Unless cancelled, at least 24 hours (one full business day) prior to your scheduled appointment time, our policy is to charge a **$65 fee** for a late cancel or missed appointment.

_____
Please Initial

Testimony and Court Proceedings

We collect personal information for the purpose of helping you in treatment. We do not testify in custody cases, divorce proceedings or criminal court unless we are hired for that purpose from the start. If we saw you with your spouse, we can't ethically testify without permission from both partners in any divorce hearing. Legal hearings have different goals that treatment or therapy.

Statement of Agreement

Thank you for understanding our Information about Fees. Please let us know if you have any questions or concerns.

I understand and agree to this Patient Fee policy.

_____
Client / Responsible Party Signature **Date**

NIDA Clinical Trials Network

Alcohol Use Disorders Identification Test-Concise (AUDIT-C)

General Instructions

The Alcohol Use Disorders Identification Test-Concise (AUDIT-C) is a brief alcohol screening instrument. Please give a response for each question.

1. **How often do you have a drink containing alcohol?**

- ☐ Never
- ☐ Monthly
- ☐ 2-4 times a month
- ☐ 2-3 times a week
- ☐ 4 or more times a week

2. **How many standard drinks containing alcohol do you have on a typical day?**

- ☐ None
- ☐ 1 or 2
- ☐ 3 to 4
- ☐ 5 to 6
- ☐ 7 to 9
- ☐ 10 or more

3. **How often do you have six or more drinks on one occasion?**

- ☐ Daily or almost daily
- ☐ Weekly
- ☐ Monthly
- ☐ Less than monthly
- ☐ Never

Tobacco Use Screening Tool

1. **Do you smoke or vape tobacco?**
   - ☐ No
   - ☐ Yes
2. **Are you interested in quitting tobacco?**
   - ☐ No
   - ☐ Yes
3. **Would you like a Quit Line pamphlet to assist you in quitting?**
   - ☐ No
   - ☐ Yes

CRAFFT Screening Tool for Adolescent Substance Abuse

The following questions concern information about your potential involvement with alcohol and other drugs during the past 12 months. Carefully read each question and decide if your answer is "YES" or "NO." Then mark in the appropriate box beside the question. Please answer every question. If you cannot decide, then choose the response that is mostly right.

When the word "drug" is used, it refers to the use of prescribed or over-the-counter drugs that are used in excess of the directions and any non-medical use of drugs. The various classes of drugs may include but are not limited to: cannabis (e.g., marijuana, has). Solvents (e.g., gas, paints etc…), tranquilizers (e.g., Valium), barbiturates, cocaine and stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., Heroin, Oxycontin).

Part A: During the PAST 12 MONTHS, did you:		No	Yes
1.	Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)		
2.	Smoke any marijuana or hashish?		
3.	Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")		
Part B: CRAFFT		No	Yes
1.	Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?		
2.	Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?		
3.	Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?		
4.	Do you ever **FORGET** things you did while using alcohol or drugs?		
5.	Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?		
6.	Have you ever gotten in **TROUBLE** while you were using alcohol or drug?		

Tobacco Use Screening Tool		No	Yes
1.	Do you smoke or vape tobacco?		
2.	Are you interested in quitting tobacco use?		
3.	Would you like Quit Line pamphlet to assist you in quitting?		