FAMILY RESOURCES ASSOCIATES, INC.

1315 West Main Street
Watertown, WI 53094
(920) 261-4100

Fax (920) 261-8801

www.familyresourcesinc.com

331 North Main Street
Lake Mills, WI 53551
(920) 648-3896

CLIENT INFORMATION & CONSENT

SERVICES

Family Resources Associates, Inc. provides evaluations and psychotherapy services conducted by licensed psychologists, professional counselors, clinical social workers, AODA counselors, and physician assistants. These services may include individual, family or group therapy, psychological testing, medication management, as well as an Initial Intake/Assessment with each servicing provider seen. The Initial Intake/Assessment(s) may result in a referral to another facility or facilities for ongoing treatment.

FEE SCHEDULE

ALL CO-PAY, CO-INS. & DEDUCTIBLE AMOUNTS ARE DUE AT TIME OF SERVICE

Admission Evaluation

Physician Assistant	240.00 per evaluation
Licensed Psychologist	185.00 per evaluation
Clinical Social Worker	170.00 per evaluation
MS level psychotherapist	170.00 per evaluation
AODA Counselor	170.00 per evaluation

Individual Therapy

Licensed Psychologist	110.00 per 20-30 min.	165.00 per 45-60 min.	235.00 per 75-80 min.
Clinical Social Worker	95.00 per 20-30 min.	140.00 per 45-60 min.	175.00 per 75-80 min.
MS level psychotherapist	95.00 per 20-30 min.	140.00 per 45-60 min.	175.00 per 75-80 min.
AODA Counselor	95.00 per 20-30 min.	140.00 per 45-60 min.	175.00 per 75-80 min.

Family Therapy

Licensed Psychologist	175.00 per 45-60 minutes
Clinical Social Worker	155.00 per 45-60 minutes
MS level psychotherapist	155.00 per 45-60 minutes
AODA Counselor	155.00 per 45-60 minutes

Medication Management	125.00 per 15 minutes	160.00 per 20-30 minutes
Psychological Testing	165.00 per 45-60 min.	
Group Therapy	90.00 per 60 minutes	135.00 per 90 minutes

FEES NOT BILLABLE TO INSURANCE

Court Testimony (including travel, records review, face-to-face & phone testimony, & time spent on-call for testimony) will be billed at the regular hourly rate ($140.00-$165.00-$320.00). A retainer equivalent to two billed hours ($280.00-$330.00-$640.00) is required to be paid at least 24 hours prior to the scheduled testimony.

Structured Co-Parenting	185.00 per 45-60 minutes
Correspondence, forms, specific reports	billed at the regular hourly charge (based on time spent)
Telephone calls/consultations	billed at the regular hourly charge (based on time spent)
Copies of Records (requested by the patient)	.31 per page plus the actual cost of postage if applicable
Copies of Records (requested by others)	12.50 (4 pages or less), 15.00 (5 pages or more) plus .31 per page & postage
Returned Checks	35.00 per check
Missed Appointments*	90.00 up to full hourly charge
Late Cancellations (less than 24 hours)*	90.00 up to full hourly charge

***Failure to attend three or more scheduled appointments without proper cancellation notice (24 hours or more in advance of appointment time) may result in termination of services.**

There is more information on the back of this form including a place for a signature. Please read, fill-out and sign this document and return it to Family Resources Associates, Inc. along with the Intake Questionnaire, Acknowledgement of Receipt of the FRA Privacy Policy, and insurance card copy (if applicable).

FEE PAYMENT & INFORMED CONSENT

Therapy costs are the responsibility of the client, or in the case of a child, the child's parent or legal guardian regardless of insurance coverage. Many insurance companies will reimburse Family Resources Associates, Inc. for mental health services; however this is not a guarantee of payment. **As a courtesy to our clients the office staff will check insurance benefits prior to the first appointment, however any information conveyed regarding insurance payment is an estimate. It is still the client's responsibility to pay for any balance after insurance payments and adjustments have been applied regardless of any estimates made.** In order to bill a client's insurance company the client, or client's parent or legal guardian, must authorize Family Resources Associates, Inc. to do so by signing this document. It is also the client's responsibility to provide Family Resources Associates, Inc. with all current insurance information if they request that their insurance be billed. Therefore, any portion of the client's bill not paid by insurance, or any balances resulting from services that can not be billed to insurance because a signed *Client Information & Consent* is not on file or because there was not enough information provided to Family Resources Associates, Inc. to bill insurance, is the responsibility of the client or client's legal guardian. In the event that Family Resources Associates, Inc. needs to use collection or legal services to obtain payment, it is understood that copies of bills, work or home telephone numbers, and social security numbers will be provided to the professionals involved. Please bring billing concerns to the attention of your therapist.

In the case of a divorce situation, the parent seeking therapy services and signing this document will be solely responsible for payment of charges incurred at Family Resources Associates, Inc. However, according to federal collection law, in the case that the account is turned over to collection both parents will be held 50% responsible for the balance and any applicable interest charged by the collection agency, regardless of any amounts paid prior to being turned over.

Insurance companies are required to pay for services only for certain diagnoses and conditions. It is the policy of this clinic to release the minimum amount of information necessary to successfully process your claim; often this is just the diagnosis and dates of visits, but in some cases more information may need to be released. By signing this form the client/client's representative authorizes Family Resources Associates, Inc. to release information sufficient to the processing of their insurance claims, including diagnosis, admission and discharge summaries, progress reports and other relevant medical information to the insurance carrier(s).

The staff at Family Resources Associates, Inc. believes that communication with physicians provides optimal treatment for the client. By signing this consent form the client/client's representative gives permission for Family Resources Associates, Inc. to contact and exchange information with the client's primary physician. To refuse consent to contact the primary physician please check this box [ ].

CLIENT RIGHTS, AFTER-HOURS CARE & DISCHARGE POLICY

In Wisconsin clients in outpatient mental health clinics like Family Resources Associates, Inc. have many important rights. These rights are enumerated in the *Client Rights and the Grievance Procedure for Community Services* and given to all clients upon intake. There are also additional rights for clients under 18 years of age that are addressed in the *Rights of Children and Adolescents in Outpatient Mental Health Treatment*, which is given to all clients under 18 years of age upon intake. By signing this form it is acknowledged that the client/client's legal representative received a copy of the above mentioned brochure(s). It is the responsibility of the client or client's legal representative to read over these rights and procedures.

Twenty-four hour assistance is available for our clients via our answering service at 262-569-3968. This service is for **emergencies only** occurring outside of regular business hours. For non-emergencies occurring outside of business hours messages can be left in the therapists' voicemails or in our general delivery mailbox.

It is this clinic's policy to discharge clients after their goals have been met, or if they have not contacted our clinic/been seen for services in 60 days. There are also circumstances which would merit an involuntary discharge including inability to pay for services (including account delinquency), and behavior deemed inappropriate and/or disruptive by the therapist and/or office staff.

CONSENT

I, the undersigned, have read the *Client Information*. I understand and agree to the following:

The services | **The fee payment responsibilities & informed consent**
The fee schedule | **The client rights, after-hours care & discharge policy**

I, the undersigned, also agree to assign to Family Resources Associates, Inc. the insurance benefits to which I am entitled for professional services rendered.

I understand that this consent may be revoked by me at any time with written notice to the Director of Family Resources Associates, Inc. This consent will otherwise remain in force for 12 months. I can request a copy of this form at any time.

Client: ____ DOB: ______________ Date: _______________
(PLEASE PRINT)

____

Signature (Check all that apply) ☐ Client (14 & older) ☐ Parent (if under 18) ☐ Legal Guardian

Revised 1/5/11