Oshkosh Marriage and Family Therapy Center LLC
1000 Oregon Street ● Suite B ● Oshkosh, WI 54902
omftc.com ● (920) 479-1996 ● Fax (920) 479-1997

Informed Consent for Increased Individual/Couple Sessions

1. Client Services

You have the right to participate in the development and ongoing review of your treatment plans to meet your individual needs, reflect your strengths and cultural values, beliefs and traditions. You also have the right to understand the types of services you will receive, as well as:

1. How these services will operate and options for alternative services;
2. How these services can help you;
3. Any risks associated with these services;
4. The probable consequences of not receiving the proper services.

In certain circumstances, we may be unable to meet your individual needs for therapy, or may recommend specialized treatment, psychiatric care, or additional services. In that case, you will be provided with names and phone numbers to appropriate agencies that will be able to better meet your needs, and will discuss this with you as soon as we become aware of it.

2. Client Rights

You have the following rights under Wisconsin Statute Section 51:61:

1. To be provided specific, complete and accurate information about treatment.
2. To be free from having unreasonable arbitrary decisions made about you.
3. To receive prompt and adequate treatment.
4. To refuse any treatment, including medications
5. To have a safe treatment setting, free from sexual, physical and emotional abuse.
6. To refuse to answer any questions or give any information you choose not to give/answer.

3. Client Fees and Payment Policy

Program enrollment into extra individual/couple sessions will start March 1, 2019 and last until December 31, 2019.

1. For clients who see me every other week, they will be able to see me every week for the same cost as seeing me every other week.
2. For clients who see me once a month, they will be able to see me every other week for the same cost as seeing me once a month.

These costs are based on therapy flat rates and sliding scale reduced fees. All payments are expected at the beginning of your every other scheduled session, unless other arrangements have been made in advance. You may make a payment with cash, check, or credit/debit card. If you are paying a reduced fee, it is your responsibility to report any significant changes in financial status to me.

I am an "out of network" practice for all insurance companies. You are responsible for your therapy bill, payable at the time of services. If you would like to bill your insurance for your sessions, let me know and I will be happy to provide you with the "superbill" insurance form with my portion filled out, and a statement verifying your payments to me. You can then send that to your insurance company, and request they reimburse you.

4. Confidentiality

Every effort will be made to ensure that information about your case will be kept confidential. Confidentiality about your care is protected by Oshkosh Marriage and Family Therapy Center LLC's business policies and by state and federal regulations. Legal and ethical requirements specify certain conditions in which it will be necessary for confidential information about your care to be discussed with persons outside the agency. These conditions include the following:

1. Situations that involve danger to yourself or others.
2. Neglect or abuse of children, elderly, or disabled persons.
3. Court ordered release of your records.
4. In the case of minors under the age of 14, parents or guardians have the right to information about your case. (Minors can choose to be present.)

5. In the case of minors between the ages of 14 and 18, parents or guardians have the right to general information about your case. (Minor can choose to be present.)
6. According to state regulations, I am required to obtain supervision and/or consultation periodically for teaching purposes and will do so while maintaining your confidentiality as completely as possible.

This last regulation is in place to benefit you and I use this as an opportunity to get support and guidance when needed from Betty Rygiewicz, LMFT, P.O. Box 259422, Madison, WI 53725-9422. Phone: (608) 843-4660. If you have concerns about privacy, please discuss this with me (see supervision section for more details).

5. Crisis Line

If there is an emergency Monday through Friday between the hours of 9 am and 4 pm you can call (920) 479-1996. If there is an emergency on Monday through Friday 4 pm to 9 am or on weekends, please call 911 or go to a hospital emergency room for crisis care. You can contact the Winnebago Country Human Services Crisis Intervention Hotline at (920) 233-7707 or (920) 722-7707.

6. Grievance

If you feel that your treatment rights have been violated in the course of your work with your therapist, you may file a grievance. You will not be threatened or penalized in any way for filing a grievance and you have the right to fair, respectful treatment throughout the grievance process. You may use any or all of the following options to address your concerns:

1. Make a direct written complaint to your therapist
2. Make a direct written complaint to Betty Rygiewicz, P.O. Box 259422, Madison, WI 53725-9422. Phone: (608) 843-4660
3. Make a grievance to State Grievance Examiner, Division of Disability & Elder Services, Dept. Health & Family Services, 1 West Wilson Street, Room 850, P.O. Box 7851, Madison, WI 53707-7851. Phone: 608-266-9369 E-mail: Lauraoflanagan@dhfs.state.wi.us
4. Seek outside legal counsel

7. Client Signatures

I have read and understand this document and have asked any questions I have regarding the above information. I agree to participate in treatment under the conditions described. By signing this form I:

1. Give consent for services.
2. I acknowledge that I have been informed about my rights and responsibilities.
3. Understand that this consent is valid for one year from the date I sign and that I may withdraw my consent either verbally or in writing at any time.

Client Signature: _____ Date: _____

Therapist Signature & Title: _____ Date: _____