The Therapy Place of La Crosse, LLC

Consent for Treatment

By signing this consent I acknowledge that I have carefully read the following information and understand it. I also acknowledge that it is my responsibility to ask any questions I have regarding treatment.

I understand that if therapy is to be helpful I must be an active participant both in session and in between sessions. I understand that I must attend sessions regularly in order to make progress with my treatment goals and that I will participate in the formulation of my treatment plan. I further understand that I have a right to information about alternate methods of treatment. I will ask my therapist any questions that I have about my treatment plan. I understand that I am free to seek alternate opinions from another therapist.

I understand that my therapist may refer me to another provider if my concerns do not fall within their area of expertise, if there is a conflict of interest, or if it has been decided that maximum benefit has been reached with this therapist.

I understand that my therapist may need to work with other treatment providers that I have. If that is the case I understand I need to sign a release of information for that to occur. In some cases your therapist may not work with you if you have additional treatment providers with whom you refuse to sign a release. This occurs in situations where your therapist feels it it detrimental to your mental health or treatment to work in isolation from your other providers.

I understand that the therapists at The Therapy Place of La Crosse, LLC participate in group consultation as required by the state of Wisconsin. By signing this release I give permission to my therapist to share information about my care to those in practice at The Therapy Place. If I have concerns or questions about this I will discuss those with my therapist.

I understand that my therapist will not provide therapy by text or e-mail. I may communicate by text or e-mail for administrative purposes (such as making/canceling appointments). I understand that I should not communicate by text or e-mail for an emergency.

I understand that my therapist will not accept Facebook friend requests from me. I further understand that I should not try to communicate with my therapist through any social media.

I understand that there are inherint risks and benefits to therapy and I will discuss this with my therapist if I have any questions.

_____I understand that The Therapy Place of La Crosse, LLC will bill my insurance as a courtesy to me. I understand that it is my responsibility to check my insurance benefits for coverage and that I am responsible for any charges not covered by my insurance. I further understand that I will be charged if I do not show up for a scheduled session or give 24 hour notice of cancellantion.

I acknowlege that I have received a copy of:

- My rights and responsibilities
- Emergency procedures
- Cost of services
- Greivance procedure

Confidentiality and Privacy

As required by HIPAA and the state of Wisconsin we keep your records confidential except in the following situations:

1. Clerical and billing staff will have access to your records in order to maintain files and perform billing functions.
2. Insurance companies require, at minimum, procedure codes and diagnostic codes. By signing this consent I give my permission to release the requested information to my insurance carrier.
3. In the event that you are in a therapy session with another individual you wave your right to confidentiality during that session with that individual. Also, if you request records they will not be released unless a release is signed by all individuals in the session.
4. If you sign a release form requesting the release of records to a third party.
5. If a court or regulatory board orders your records released.
6. If you threaten to harm yourself or someone else. In this case information will be released to those necessary to intervene including the individual(s) that is threatened. This will occur without your consent.
7. If your therapist hears about or suspects the abuse of a child or vulnerable adult. This information will be released to the proper authorities without your consent.

I understand that if I communicate with my therapist by text or e-mail my privacy cannot be guarnteed in those communications.

I have read and understand the above information. I understand that I can withdraw this consent at any time.

Client signature_____ Date_____

Parent/Legal Guardian_____ Date_____

Therapist_____ Date_____