

Info for Clients

- Two copies of this form are to be signed by the client or the client's parent/guardian (if client is a minor) at the first session.
- A third copy may also be signed by a foster parent or other caretaker that has physical care of a client. However, this signature does not supplant the need for the parent/guardian signature.
- One copy stays in the file and the client keeps the other copy.

This form serves the following purposes:

- It gives clients important information in such topics as confidentiality, eligibility for services, consultants, etc.
- It gives clients information about the fee policy.
- It tells clients under what circumstances we may discontinue service, including repeated no-shows and failure to pay bills
- It gives clients a format for signing off on their receipt of other documents, such as the client grievance procedure, etc.

This form must be discussed with the client, and details explained as necessary.

****This may require that this form be mailed prior to the first session.****

INFORMATION FOR CLIENTS

The mission of Children's Service Society of Wisconsin is to build, sustain and enhance a nurturing environment for Wisconsin children. CSSW is a private, not-for-profit, non-sectarian child welfare agency providing counseling and psychotherapy to strengthen families. This sheet contains important information about our policies and procedures. Please read it carefully. Ask your therapist to answer any questions you may have.

Eligibility: Eligibility for CSSW counseling programs is based on the existence of a presenting problem. No one will be denied services because of an inability to pay. You may be referred to another community resource if you (1) do not meet the eligibility criteria; (2) there is not enough staff time available to help you; or (3) there is a more appropriate service provider elsewhere in the community or your insurance company has another counseling resource for you.

After you begin working with CSSW, services may continue: (1) so long as there are identified treatment goals which have not yet been met; and (2) there is evidence that you are interested in pursuing these goals.

The agency may discontinue services if: (1) all treatment goals have been met; (2) you fail to demonstrate an interest in actively pursuing treatment goals, for example, by showing a pattern of regularly missing appointments; (3) you fail to pay for services as agreed upon in your Fee Agreement; or (4) upon the professional recommendation of your therapist.

Appointments: Appointments are scheduled with individual therapists. A counseling or psychotherapy hour consists of a one 45-60 minute interview with your therapist. If you need to cancel an appointment, please do so at least 24 hours in advance. You, not your insurance, will be billed for missed appointments.

Hours: The agency is open Monday through Friday 8:30 a.m. to 5:00 p.m. Evening hours are available by appointment.

Consultants: Your therapist collaborates with other licensed therapists in his/her clinical work. Your therapist also has a supervisor who may be contacted if you have questions or concerns. The supervisor will meet with you when necessary or at your request. The agency consultant(s) are _____ and _____.

Confidentiality: All contacts between staff and clients are strictly confidential and will not be revealed to any person or agency outside of Children's Service Society, without your written consent. The primary exception to this rule is those situations in which reporting is mandatory under Wisconsin law (e.g., child abuse, child neglect, sexual abuse, etc.) In addition, please note that your signature on the fee agreement gives the agency permission to release information necessary for the processing of claims for payment.

Emergencies: In an emergency, you may call the office 24 hours, 7 days a week at (insert office's phone number) to speak to your/a therapist. During non-working hours our answering service takes messages for non-emergencies and at your request, will have your/a therapist return your call immediately for emergencies. Following are a list of additional numbers to call in the event of an emergency:

Informed

Consent:

It is the policy of Children's Service Society that each patient, or individual acting on behalf of the patient, will receive specific, complete and accurate information regarding the psychotherapy or other treatment they receive through the agency. You will be asked to read and sign the Informed Consent Policy form prior to beginning work with your therapist. Those patients receiving medication from an agency consultant will be asked to sign an Informed Consent specific to the medication being used.

**Grievance
Procedure:**

Children’s Service Society of Wisconsin shall, as part of the intake process, share information with clients concerning informal methods for resolving client concerns and formal procedures by which clients may seek resolution of a grievance. At any time a complaint occurs, the client or other complainant shall be provided with a copy of the agency’s Client Grievance and Requests for Administrative Review Policies and Procedures. Program staff shall be familiar with client rights and with these agency procedures. The program staff and their supervisor will forward the complaint to the local Client Rights Specialist. If a client or parent wishes to contact a Specialist directly, they can be reached at:

The Northern & Western Area

Marnie Hersrud
2004 Highland Avenue Ste N
Eau Claire, WI 54701

Contact for the following offices:

- Barron
- Eau Claire
- Fox Valley
- Marshfield
- Oshkosh
- Sheboygan
- Stevens Point
- Wausau

The Southeastern Area

Langston Verdin
620 S. 76th Street Ste 120
Milwaukee, WI 53214

Contact for the following offices:

- Kenosha
- Madison
- Sun Prairie
- Milwaukee
- Racine
- Waukesha

No sanctions will be threatened or imposed against any client who files a grievance, or any person including an employee of the agency, the department, or a county department or a service provider, who assists a client in filing a grievance or participates in or testifies in a grievance procedure or in any action for any remedy authorized by law.

If you have a concern about the services you are receiving, you are encouraged to discuss it with your therapist. If this does not resolve the issue, you may present a written complaint to the Program Supervisor or the Regional Director. If you are still not satisfied, please request a written copy of the Grievance Procedure.

**Client Access
To Records:**

Under Wisconsin law, you have a right to review your treatment record. Ask your therapist for the procedures used in sharing your file with you. If you feel that it contains incorrect information, ask your therapist for the procedure used to request a change in record information.

Fee Policy:

A fee is charged for professional services provided by the therapists at Children’s Service Society of Wisconsin (please refer to the Fee Policy & Fee Agreement). If you have private insurance or medical assistance, we will bill for services at the established rate. If you do not have insurance, or if your insurance does not pay in full, you will be responsible for paying the rate established on your Fee Agreement. You are also responsible for continued payment at the agreed upon rate once your maximum insurance benefits have been used.

If you are receiving services under managed care, health insurance, medical assistance, or an EAP, the agency will need to obtain information about covered services, co-payments and deductibles, etc. The agency will either obtain the specific information required or ask you to obtain the information. Your signature on this form authorizes Children’s Service Society of Wisconsin to release any information necessary to process insurance claims.

My signature below indicates that I have been given a copy of this information sheet, the “Client Rights and the Grievance Procedure for Community Services” brochure and the “CSSW Joint Notice of Privacy Practices”. For clients age 12-17, I have been given a copy of the “Rights of Children and Adolescents in Outpatient Mental Health Treatment”.

Signature (adult or minor age 12 or older): _____ **Date:** _____

Signature of Guardian if signer is under the age of 18: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____