Peaceful Solutions Counseling

BILL OF RIGHTS FOR MENTAL HEALTH/AODA SERVICES
At Peaceful Solutions Counseling

1. You have the right to prompt and adequate treatment.
2. You have the right to be informed in writing about the costs of treatment.
3. You have the right to confidentiality of conversations and records.
4. You have the right to participate in the development of your treatment plan, including benefits, effects and method of treatment.
5. You have the right to be informed about alternatives to treatment.
6. You have the right to refuse any treatment unless a court orders you to receive treatment.
7. You may not be given any medication at our clinic as none of our staff are licensed physicians.
8. You may not be subjected to any drastic treatment measure without your express written, informed consent.
9. You have the right to be treated with dignity and respect, free from verbal or physical abuse.
10. You may not be videotaped, photographed or audio taped without your written consent.
11. You must be treated in the least restrictive manner.
12. You may not be discriminated against because of your race, gender, faith, age disability, sexual orientation or ethnicity.
13. You have the right to complain about your services. A copy of the state's laws about this is available upon request.
14. You have the right to be informed of the expected duration of treatment.

If you believe that one of your rights may have been violated, the agency's clients rights specialist will investigate that matter and attempt to find a resolution if the complaint is validated.

I am encouraged to contact my therapist regarding any concerns I may have during my treatment. I understand that my therapist may be consulting with a supervising mental health practitioner regarding my case and that I may request a meeting with the mental health practitioner.

My signature below indicates that I have been given a copy of the "Information for Clients" sheet, the "Client Rights and the Grievance Procedure for Community Services" brochure and the "Peaceful Solutions Counseling Privacy Notice".

Client Signature: _____ **Date:** _____

Guardian/Parent Signature (if applicable): _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

Peaceful Solutions Counseling

INFORMED CONSENT FOR TREATMENT

I. Treatment method:

Treatment services will be provided through individual, couple, group and family therapy sessions as deemed appropriate and mutually agreed upon by you and your therapist. Collateral contacts with significant others and other involved health care providers may also occur with mutual agreement, as deemed appropriate.

II. Alternative treatment approaches:

Mental Health/AODA therapy incorporates a broad array of theories and techniques for assisting in the resolution of psychological, emotional, and behavioral problems. You always have the option of seeking information from other health care providers regarding their approach or style of therapy.

III. Potential benefits of proposed treatment:

a. Reduction or alleviation of emotional pain related to presenting problem
b. Modification or elimination of self-defeating behaviors
c. Strengthening of self esteem
d. Enhancement of coping, communication, and problem-solving skills
e. Increased satisfaction with interpersonal relationships
f. Improved quality of life

IV. Potential side effects of proposed treatment:

a. Increased awareness of own role in the presenting problem with possible accompanying temporary dip in mood
b. Disruption in one or more key relationships or termination of such relationship(s)
c. Some degree of increased stress and frustration associated with changing long-standing beliefs and behaviors

V. Potential consequences for not receiving proposed treatment:

a. Continuation or worsening of emotional pain related to presenting problem
b. Continuation or further entrenchment of self-defeating behaviors
c. Weakening of self-esteem
d. Continued or increased dissatisfaction with interpersonal relationships
e. Diminished quality of life

VI. Duration of consent validity

a. Your consent to treatment, as indicated by your signature, is considered to be valid and in effect for 12 months from the date signed
b. You have the right to withdraw your consent, in writing at any time

I hereby give my consent to treatment at Peaceful Solutions Counseling according to the agreed upon treatment plan.

Consumer/Guardian Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

Peaceful Solutions Counseling

Peaceful Solutions Counseling, Inc.
731 N 1st Street, Suite 5000
Wausau, WI 54403
Phone: (715) 675-3458
Fax: (715) 675-7238

Billing Information

Date: _____

Client Name: _____ Age: _____ Date of Birth: _____

Sex: _____ Social Security Number: _____

Phone: _____ Alternative Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Payment Method: _____ Insurance _____ Medical Assistance _____ Self Pay
Fee Amount $_____.00

Insurance Name: _____

Phone Number on Card: _____

Subscriber's Name: _____

Subscriber's Address: _____

Date of Birth (for subscriber): _____ Relationship to Client: _____

Identification Number: _____ Group Number: _____

Address to Mail Claims: _____

Person Responsible for Billing (if different from client):

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Relationship to Client: _____

Dr. Name and Location: _____

Peaceful Solutions Counseling

Billing Agreement

It is the policy of Peaceful Solutions Counseling to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon family/household size and annual income. Please complete the following information and bring to your first appointment to determine if you are eligible for a discount. The discount will apply to all services received at this clinic. This form must be completed every 6 months or if your financial situation changes.

If you have private insurance you will be responsible for satisfying any amount left on your deductible. If your insurance does not pay in full once the deductible has been met, you will be responsible for the amount not paid by your insurance company **or** the amount established at the bottom of this fee agreement, whichever is the lesser amount. Provisions exist for reducing or waiving fees below the amount listed on the sliding fee scale, if you request a special waiver. Please note that a request does not change your fee until the Clinic Director approves the waiver.

A mental health or substance abuse initial assessment is $190.00 and ongoing services are billed at the rate of $165.00 per session. If you have Medicaid, Medicare or private insurance we will bill your insurance company for services at the established rate. Please note that a sliding fee scale cannot be used for court related alcohol/drug assessments.

MISSED APPOINTMENTS: With the exception of MA clients, if appointments are not canceled 24 hours in advance, you will personally be billed for the reserved time, for the amount established as your fee. Also note, after 3 no show/no call appointments, services will be terminated. If you arrive for your appointment 15 minutes or more past the scheduled time you will be asked to reschedule your appointment.

Please complete chart below. *Note: Include income from all sources including gross wages, tips, social security, disability, annuities, veteran's payments, alimony, child support, military, and public aid.*

Patient Name:	
Number Living in Household: _____	Household Income
Self (Income)	_____ Yearly/Monthly/Bi-Weekly *(Circle which one)*
Other Adult (s) (Income)	_____ Yearly/Monthly/Bi-Weekly *(Circle which one)*
Dependent children under age 18 (Income)	_____ Yearly/Monthly/Bi-Weekly *(Circle which one)*
Total:	_____ Yearly/Monthly/Bi-Weekly *(Circle which one)*

OFFICE USE ONLY

Based on this information the sliding fee will be: $_____per session

Current primary method of payment:
Insurance ____ MA ____ FEE____

I certify that the family size and income information above is correct, and that I agree to pay the established fee based on my co-insurance, co-pays and deductibles (if applicable). I also authorize Peaceful Solutions Counseling to release any information necessary to process insurance claims to: _____.

If requested, I am entitled to a list of entities to which my information has been disclosed. This agreement will remain in place for one year of signing this document unless revoked prior to that. I further acknowledge that this information has been reviewed with me and that I have received a copy.

Client or Parent/Guardian's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____

Peaceful Solutions Counseling Sliding Fee Scale

For services provided by therapists: Initial Session $190.00, Ongoing $165.00

Household Size	Gross Annual Income Levels - Not To Exceed										
1	6,245	12,490	15,613	18,735	21,858	24,980	31,225	37,470	43,715	49,960	56,205
2	8,455	16,910	21,138	25,365	29,593	33,820	42,275	50,730	59,185	67,640	76,095
3	10,665	21,330	26,663	31,995	37,328	42,660	53,325	63,990	74,655	85,320	95,985
4	12,875	25,750	32,188	38,625	45,063	51,500	64,375	77,250	90,125	103,000	115,875
5	15,085	30,170	37,713	45,255	52,798	60,340	75,425	90,510	105,595	120,680	135,765
6	17,295	34,590	43,238	51,885	60,533	69,180	86,475	103,770	121,065	138,360	155,655
7	19,505	39,010	48,763	58,515	68,268	78,020	97,525	117,030	136,535	156,040	175,545
8	21,715	43,430	54,288	65,145	76,003	86,860	108,575	130,290	152,005	173,720	195,435
Discount	95%	90%	85%	80%	75%	70%	60%	50%	40%	30%	20%
Adj Fee	**$ 8.25**	**$ 16.50**	**$ 24.75**	**$ 33.00**	**$ 41.25**	**$ 49.50**	**$ 66.00**	**$ 82.50**	**$ 99.00**	**$ 115.50**	**$ 132.00**

Client Demographics Form

THIS SECTION FOR OFFICE USE ONLY:

Intake date: _____

Marathon County Lincoln County

Other:

SAFE, AODA, Trauma, Mental Health,

CHOICES/County Social Worker

Ins Self Pay MA EAP

1. **Client Name:** _____

2. **Client Gender:**

( ) Female ( ) Male

3. **Client Age:**

( ) 0 - 6 years ( ) 18 – 24 years

( ) 7 –12 years ( ) 25 – 54 years

( ) 13 – 17 years ( ) 55 – 64 years ( ) 65+ years

4. **Client Zip Code:** _____

5. **Client's Race/Ethnicity:**

( ) White/Caucasian
( ) American Indian/ Alaska Native
( ) Native Hawaiian/Pacific Islander
( ) Hispanic or Latino
( ) Asian
( ) Black/African American
( ) Other race/two or more races
( ) Unknown

6. **Annual Household Income:**

( ) Less than $9,500
( ) $9,501 - $12,500
( ) $12,501 - $15,000
( ) $15,001 - $20,000
( ) $20,001 - $25,000
( ) $25,001 - $30,000
( ) $30,001 - $35,000
( ) $35,001 - $40,000
( ) $40,001 - $45,000
( ) $45,001 - $50,000
( ) $50,001 - $55,000
( ) $55,001 - $60,000
( ) $60,001 – more

7. **How many people reside in your household?**

( ) 1
( ) 2
( ) 3
( ) 4
( ) 5
( ) 6
( ) 7
( ) 8

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last 2 *weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	
TOTAL:				

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

Peaceful Solutions Counseling

INTAKE QUESTIONNAIRE – ADULT

Your responses to the following questions will help your therapist better understand you and your situation in order to provide the best possible service. Please answer all questions as completely as possible.

Name of person completing form: _____ Date: _____

IDENTIFYING INFORMATION (for individual receiving services)

Name: _____ Date of Birth: _____ Age: _____

Address: _____ Gender: _____

_____ Relationship Status: _____

Home Phone: (____) _____ Work Phone: (____) _____

Social Security Number: _____ Household Income: $_____

Emergency contact: Name: _____ **Phone:** _____

Relationship: _____

How did you hear about Peaceful Solutions Counseling (PSC)?

- ☐ Church/Religious Affiliation
- ☐ County Department of Social Services/Heath Services/Human Services
- ☐ Department of Corrections/Legal System/Court
- ☐ Employee Assistance Program (EAP)
- ☐ Employer/Co-worker
- ☐ Facebook/Twitter
- ☐ Friend/Relative
- ☐ Hospital/Doctor/Mental Health Provider
- ☐ School
- ☐ United Way's 2-1-1
- ☐ Insurance Company
- ☐ Internet Search
- ☐ PSC Client
- ☐ PSC Employee/PSC Program
- ☐ PSC Website/Brochure
- ☐ Other Social Service Agency
- ☐ Phone Book
- ☐ Self – Returning PSC Client
- ☐ Other: _____

Race:

- ☐ White/Caucasian
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Unknown
- ☐ Asian
- ☐ Black/African American
- ☐ Two or more races

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Non-Latino

Language of Choice:

- ☐ English
- ☐ Hmong
- ☐ Russian
- ☐ Laotian
- ☐ Spanish
- ☐ German
- ☐ French
- ☐ Other: _____

Religious Affiliation:

- ☐ Catholic
- ☐ Muslim
- ☐ Jewish
- ☐ Amish
- ☐ Mennonite
- ☐ Protestant (including Lutheran, Methodist, etc.)
- ☐ Non-Denominational
- ☐ No Affiliation
- ☐ Other: _____

Disability:
Do you have a disability? ☐ Yes ☐ No If yes, please specify: _____
If you have a disability, how can the office accommodate your needs?
_____

If you feel that the therapist should be aware of any special treatment considerations due to gender, age, sexual orientation or cultural, religious, national, racial or ethnic identity, please explain below:
_____
_____
_____

PRESENTING ISSUE (current situation and history)

1. **Have you ever been a victim of a crime? (whether reported or not)** ***(Some examples might include: Someone abusing you as an adult, abuse as a child, stalking/harassment, theft, etc.***

☐ **Yes** ☐ **No**

2. What is the primary issue for which you are seeking help? (please circle)

a. Marriage or relationship
b. Family problems
c. Depression
d. Mood swings
e. Behavior
f. Self-confidence
g. Problems with children
h. Peer problems
i. Eating disorder
j. Alcohol/drug use
k. Physical problems
l. Work related
m. Grieving
n. Abuse or trauma
o. Sexual functioning
p. Anger
q. Anxiety or worry
r. Harming self physically
s. LGBT issues
t. Custody issues
u. Other (explain)

_____
_____
_____

3. For each issue circled, how long have you had this/these issue(s)? _____
_____
_____
_____

4. Have you received treatment for this issue or any other issue in the past? ☐ Yes ☐ No
If yes when, where and with whom? _____
_____

5. Are you currently being seen by another mental health or substance abuse therapist? ☐ Yes ☐ No
If yes, who? _____
It is often advantageous for all of your behavioral health clinicians to have the ability to collaborate/communicate. Do you consent to allow this collaboration? ☐ Yes ☐ No

6. Have you recently had any thoughts of hurting yourself or others? ☐ Yes ☐ No

If yes, what thoughts and how frequent:

_____

_____

7. Have you ever attempted suicide or threatened to commit suicide? ☐ Yes ☐ No

If yes, what month/year and explain:

_____

_____

FAMILY HISTORY

1. Where did you grow up? _____

_____

2. Who did you live with? _____

_____

3. In the family you grew up in did you experience any of these issues? (Check all that apply)

☐ Eating disorders ☐ Mental illness ☐ Suicide (attempts or actual) ☐ Physical abuse

☐ Sexual abuse ☐ Emotional abuse ☐ Domestic violence ☐ Custody issues

☐ Incarceration ☐ Gambling ☐ Sexual Addiction ☐ Spending issues

☐ Substance Abuse

If checked, please explain: _____

_____

_____

CURRENT FAMILY INFORMATION

1. Household information:

Name:	Relationship	Date of Birth/Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. In your current family/household is there a history of: (check all that apply)

☐ Eating disorders ☐ Mental illness ☐ Suicide (attempts or actual) ☐ Physical abuse

☐ Sexual abuse ☐ Emotional abuse ☐ Domestic violence ☐ Custody issues

☐ Incarceration ☐ Gambling ☐ Sexual Addiction ☐ Spending issues

☐ Substance Abuse

If checked, please explain: _____

WORK AND ACADEMIC INFORMATION

1. Graduated from High School: ☐ Yes ☐ No
   If yes:
   Where? _____
   Year? _____
2. Other Education: ☐ Yes ☐ No
   If yes:
   Where? _____
   Year? _____
   Degrees earned _____
3. Military service: ☐ Yes ☐ No
   If yes:
   Which branch? _____
   Rank? _____
   Dates of Service: _____
   Type of Discharge: _____
4. Occupation: _____
5. Current employer: _____ Length of Employment: _____

ALCOHOL & DRUG HISTORY

Substance Type	Age of 1st Use	Any Use in the Last 30 Days Y/N	Frequency of Use (e.g., 3x/day, 1x/week, occasional, etc.)	Amount of Use	Rout of Use: Oral Smoke Snort/Huff IV/Injection
Alcohol					
Tobacco					
Marijuana					
Cocaine/Crack					
Opiates (OxyContin, Vicodin, Morphine, etc.)					
Heroin					
Amphetamines					
Methamphetamine					
Benzodiazepines (Valium, Xanax, Lorazepam, etc.)					
Sedatives (Ambien, Restoril, Lunesta, etc.)					
Hallucinogens (MDMA,					

LSD, Ecstasy, K-2, etc.)					
Barbiturates (Phenobarbital, etc.)					
Party Drugs (GHB, Rohypnol)					
Synthetics (Bath Salts, K-2, Spice, 2-C-T-1)					
Huffing					
Other:					

Have you ever felt like you should cut down on your alcohol or other drug use, including prescriptions? ☐ Yes ☐ No

Has anyone ever mentioned concerns about your alcohol or drug use? ☐ Yes ☐ No

Have you ever felt guilty about your drinking or drug use? ☐ Yes ☐ No

Are you in recovery from alcohol or drug addiction? ☐ Yes ☐ No

Is there a history of problems with alcohol or drugs in your family? ☐ Yes ☐ No

If checked yes, please explain: _____

_____

Interventions:

A. Have you ever been involved in a 12 step/AA program? ☐ Yes, currently ☐ Yes, but not currently ☐ No

B. Have you ever received outpatient AODA treatment? ☐ Yes, currently ☐ Yes, but not currently ☐ No

C. Have you ever received inpatient AODA treatment? ☐ Yes, currently ☐ Yes, but not currently ☐ No

LEGAL HISTORY

Are you now or have you ever:			When?	For what?
Had a "no contact" order	☐ Yes	☐ No	_____	_____
Had a restraining order	☐ Yes	☐ No	_____	_____
Been arrested	☐ Yes	☐ No	_____	_____
Been convicted	☐ Yes	☐ No	_____	_____
Been on probation	☐ Yes	☐ No	_____	_____
Been on parole	☐ Yes	☐ No	_____	_____
Registered as a sexual offender	☐ Yes	☐ No	_____	_____

MEDICAL HISTORY

1. Please check the appropriate box if you have experienced any of these problems:

☐ Eye disease, injury, poor vision
☐ Ear disease, injury, poor hearing
☐ Cancer
☐ Bowel problems

- ☐ Nose, sinus, mouth, throat problems
- ☐ Head injury
- ☐ Convulsions or seizures
- ☐ Suicide Attempt
- ☐ Memory problems
- ☐ Extreme tiredness or weakness
- ☐ Thyroid disease or goiter
- ☐ Skin disease
- ☐ Heart disease
- ☐ Back, arm, leg or joint problems
- ☐ Blood disease
- ☐ Stomach problems
- ☐ Premenstrual Syndrome (PMS)
- ☐ Eating disorder
- ☐ Liver, gallbladder disease
- ☐ Hemorrhoids, rectal bleeding
- ☐ Loss of consciousness
- ☐ Chest pain or angina pectoris
- ☐ Frequent or severe headaches
- ☐ Sleep disturbances
- ☐ Neck stiffness, pain, swelling
- ☐ Marked weight changes
- ☐ Circulatory problems
- ☐ Allergies or asthma
- ☐ Diabetes
- ☐ Encephalitis
- ☐ Meningitis
- ☐ Pregnancy not carried to term/stillbirths
- ☐ High blood pressure
- ☐ Other _____

Please explain anything checked above: _____

_____

_____

_____

_____

_____

2. Please provide information about medication(s), prescription or over-the-counter, which you take regularly:

Medication	Dosage/Frequency	Prescribing Physician	Date Prescribed	For what condition?

3. Do you have a primary care physician? ☐ Yes ☐ No

If yes, name of physician: _____

It is often advantageous for your treatment for your physician and your therapist to have the ability to collaborate/communicate. Do you consent to allow this collaboration? ☐ Yes ☐ No

4. Please list significant hospitalizations, operations, injuries (including broken bones): _____

_____

_____

COMMUNITY RESOURCES

1. Are you currently receiving any services from any community resources? (i.e., support groups, social services, church groups, school based services, food pantries, etc.)

_____

_____

GOALS

1. What are your strengths? _____

_____

2. What are your weaknesses? _____

_____

3. What goals would you like to see reached as a result of your involvement with Peaceful Solutions Counseling?

_____

_____

4. How will you know when these goals have been reached?

_____

_____

_____

decision, you may appeal it to the State Grievance Examiner.

- If you are paying for your services from a private agency, you may appeal the Program Supervisor's decision directly to the State Grievance Examiner.
- You must appeal to the State Grievance Examiner within 14 days of receiving the decision from the previous appeal level. You may ask the Program Supervisor to forward your grievance to the State Grievance Examiner or you may send it yourself. The address is: State Grievance Examiner, DSL, PO Box 7851, Madison, WI 53707-7851.

Final State Review

- Any party has 14 days of receipt of the written decision of the State Grievance Examiner to request a final state review by the Administrator of the Division of Supportive Living or designee. Send your request to the DSL Administrator, PO Box 7851, Madison, WI 53707-7851.

Your Rights

As a participant in Peaceful Solutions Counseling programs or as a client in our outpatient mental health programs, you should be aware of the rights afforded to you by law. Some of the rights this brochure describes are generic, that is they apply to anyone participating in any of our programs. Some of the rights apply only to specific services. Please check with your counselor/therapist to determine which rights apply to you. When you receive any type of service for mental illness, alcoholism, drug abuse or a developmental disability, you have the following rights under Wisconsin Statute sec. 51.61 (1) and HFS 94, Wisconsin Administrative Code.

Personal Rights

- You must be treated with dignity and respect, free from any verbal, physical, emotional or sexual abuse.
- You have the right to have staff make fair and reasonable decisions about your treatment and care.
- You may not be treated unfairly because of your race, national origin, sex, age, religion, disability or sexual orientation.
- You may not be filmed, taped or photographed unless you agree to it.

You may talk with staff or contact your Client Rights Specialist if you would like to file a grievance or learn more about the grievance procedure used by the Peaceful Solutions Counseling program from which you are receiving services.

Your Client Rights Specialist is:

Patti Gillette
Dix and Gillette Counseling
1720 Merrill Avenue Suite 401
Wausau WI 54401
(715)675-3888

NOTE: There are additional rights within sec. 51.61 (1) and HFS 94, Wisconsin Administrative Code. They are not mentioned here because they are more applicable to inpatient and residential treatment facilities. A copy of sec. 51.61. Wis. Stats. and/or HFS 94, Wisconsin Administrative Code is available upon request.

Information taken from:
Department of Health and Family Services
Division of Supportive Living
November 1998

Your Rights and the Grievance Procedure for Community Services*

for clients in programs offered by Peaceful Solutions Counseling and for clients receiving services in Wisconsin for mental illness, alcohol or other drug abuse or developmental disabilities.

* The term Community Services refers to all services provided in non-inpatient and non-residential settings.

Peaceful Solutions Counseling

Treatment and Related Rights

- You must be provided prompt and adequate treatment, rehabilitation, and educational services appropriate for you.
- You must be allowed to participate in the planning of your treatment and care.
- You must be informed of your treatment and care, including alternatives to and possible side effects of treatment.
- No treatment may be given to you without your written, informed consent, unless it is needed in an emergency to prevent serious physical harm to you or others, or a Court orders it. (If you have a guardian, however, your guardian may consent to treatment on your behalf).
- You must be informed in writing of any costs of your care and treatment for which you or your relatives may have to pay.
- You must be treated in the least restrictive manner and setting necessary to achieve the purposes of admission to the program, within the limits of available funding.

Record Privacy and Access

Under Wisconsin Statute sec. 51.30 and HFS 92, Wisconsin Administrative Code:

- Your treatment information must be kept private (confidential), unless the law permits disclosure.
- Your records may not be released without your consent, unless the law specifically allows for it.
- You may ask to see your records. You must be shown any records about your physical health or medications. Staff may limit how much you may see of the rest of your treatment records while you are receiving services. You must be informed of the reasons for any such limits. You may challenge those reasons through the grievance process.
- After discharge, you may see your entire treatment record if you ask to do so.
- If you believe something in your records is wrong, you may challenge its accuracy. If staff will not change the part of your record you have challenged, you may file a grievance and/or put your own version in your record.
- A copy of Wisconsin Statute sec. 51.30 and/or HFS 92, Wisconsin Administrative Code, is available upon request.

Grievance Procedure and Right of Access to Courts

- Before treatment has begun, the service provider must inform you or your rights and how to use the grievance process. A copy of the Agency's Grievance Procedure is available upon request.
- If you feel your rights have been violated, you may file a grievance.
- You may not be threatened or penalized in any way for presenting your concerns informally by talking with staff, or formally by filing a grievance.
- You may, instead of filing a grievance or at the end of the grievance process, or any time during it, choose to take the matter to Court to sue for damages or other Court relief if you believe your rights have been violated.

Grievance Resolution Stages

Informal Discussion (Optional)

- You are encouraged to first talk with staff about any concerns you have. However, you do not have to do this before filing a formal grievance with your service provider.

Grievance Investigation – Formal Inquiry

- If you want to file a grievance you should do so within 45 days of the time you become aware of the problem. The Program Supervisor for good cause may grant an extension beyond the 45 day time limit.
- The agency's Client Rights Specialist (CRS) will investigate your grievance and attempt to resolve it.
- Unless the grievance is resolved informally, the CRS will write a report within 30 days from the date you filed the formal grievance. You will get a copy of the report.
- If you and the Program Supervisor agree with the CRS's report and recommendations, the recommendations hall be put into effect within an agreed upon time frame.
- You may file as many grievances as you want. However, the CRS will usually only work on one at a time. The CRS may ask you to rank them in order of importance.

Program Supervisor's Decision

- If the grievance is not resolved by the CRS's report, the Program Supervisor or agency designee shall prepare a written decision within 10 days of receipt of the CRS's report. You will be given a copy of the decision.

County Level Review

- If you are receiving services from a County agency, or a private agency and a County agency is paying for your services, you may appeal the Program Supervisor's decision to the County Agency Director. You must make this appeal within 14 days of the day you receive the Program Supervisor's decision. You may ask the Program Supervisor to forward your grievance or you may send it yourself.
- The County Agency Director must issue his or her written decision within 30 days after you request this appeal.

State Grievance Examiner

- If your grievance went through the County level of review and you are dissatisfied with the

Peaceful Solutions Counseling

INFORMATION FOR CLIENTS FOR THE COUNSELING PROGRAM

Peaceful Solutions Counseling is a private, not-for-profit, non-sectarian agency, providing mental health and substance abuse counseling to strengthen individuals and families and promote non-violence and equality within intimate partner relationships. This sheet contains important information about our policies and procedures. Please read it carefully. Ask your counselor to answer any questions you may have.

Eligibility: Eligibility for Peaceful Solutions 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.

After you begin working with Peaceful Solutions Counseling, services may continue so long as there are identified treatment goals which have not yet been met.

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 8:00 a.m. to 5:00 p.m. Evening hours are available by appointment.

AODA Consultants: Supervision of your counselor by a medical doctor is a requirement if you receive substance abuse services.

Emergencies: Peaceful Solutions Counseling maintains regular office hours from 8:00 am to 5:00 pm Monday through Friday. Our therapists can be reached for emergencies during these hours and after hours and on weekends by calling (715) 675-3458. If any emergency occurs during a time when our office is not open, please use the following emergency numbers:

Peaceful Solutions Counseling Phone: (715) 675-3458 or 1-800-841-3346

North Central Health Care Facility Emergency Services Phone: (715) 845-4326

Confidentiality: All contacts between staff and clients are strictly confidential and will not be revealed to any person or agency outside of Peaceful Solutions Counseling, 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.

Informed Consent: It is the policy of Peaceful Solutions Counseling 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.

Grievance Procedure: Peaceful Solutions Counseling 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:

Dix and Gillette Counseling
Patti Gillette
1720 Merrill Avenue Suite 401
Wausau, WI 54401
(715) 675-3888

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 filling 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 Clinic 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 Peaceful Solutions Counseling (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 have private insurance you will be responsible for satisfying any amount left on your deductible. If your insurance does not pay in full once the deductible has been met, you will be responsible for the amount not paid by your insurance company or the amount established at the bottom of the fee agreement, whichever is the lesser amount. 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 the "Fee Policy and Fee Agreement" form authorizes Peaceful Solutions Counseling to release any information necessary to process insurance claims.

PEACEFUL SOLUTIONS COUNSELING
JOINT NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY.

When we refer to "you" or "your" in this Notice we refer to the person or persons receiving the services provided by Peaceful Solutions Counseling. When we refer to disclosures of information to "you", we mean disclosures to adults or children, the parent of the children, guardian or other person legally authorized to receive information about the person or persons receiving services from Peaceful Solutions Counseling.

Who follows this Notice:

This Notice applies to all **protected health information (PHI)** maintained by Peaceful Solutions Counseling for services provided at our office. If you have any questions after reading this Notice, please contact the Peaceful Solutions Counseling Privacy Officer.

Each time you receive services from Peaceful Solutions Counseling, a record of the services provided is created. Typically this record could contain information about the type of service you have received, the dates of service and the results of the service provided. At times this will include the reason you have come to Peaceful Solutions Counseling for service and the agreed upon goals of the service provided.

This Notice applies to all of the records containing PHI created as a result of services provided by Peaceful Solutions Counseling.

Our Pledge to Protect Your Health Information: We are required by law to maintain the privacy of your PHI and provide you with a description of our privacy practices. We will abide by the terms of this Notice.

How We May Use and Share Your Health Information With Others

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. For example, a counselor or therapist may use PHI about you or your child from a clinic record to determine which treatment option, such as family or individual therapy, best addresses your needs. Your worker or therapist may discuss information found in your record with our consultants, a colleague or their supervisor to assist in treatment planning for you or your child.

For Payment: We may use and disclose PHI to send bills and collect payment from you, your insurance company, or other payors, such as governmental agencies, for the treatment or other related services you receive from Peaceful Solutions Counseling, so Peaceful Solutions Counseling can receive payment for the treatment services provided to you. Examples of payment related activities are: making a determination of eligibility or coverage for insurance benefits, processing and sending claims to your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities.

For Health Care Operations: We may disclose PHI about you for business operations of Peaceful Solutions Counseling. These uses and disclosures are necessary for Peaceful Solutions Counseling to provide quality care and cost-effective services. The operations where we may need to disclose PHI includes, but is not limited to, quality assessment activities, employee review activities, and licensing activities. For example, we may share your PHI with third parties that perform various business activities (such as billing or typing services). We will require these third parties to have a contract with us that requires them to safeguard the privacy of your PHI. Quality assessment activities may include evaluating the performance of your therapist or examining the effectiveness of treatment provided to you when compared to patients in similar situations.

Appointments: We may use your PHI for the purpose of sending to you appointment reminders through the mail or by telephone. Messages left for you will not contain specific health information.

Required or Permitted by Law: Peaceful Solutions Counseling is required by law to disclose your PHI in certain circumstances:

- For public health oversight activities
- To facilitate the functions of federal or state governmental agencies
- To report suspected elder or child abuse to law enforcement agencies responsible to investigate or prosecute abuse
- In response to a valid court order
- To the Department of Health and Family Services, a protection or advocacy agency, or law enforcement authorities investigating abuse, neglect, physical injury, death or violent crimes
- To your court-appointed guardian or an agent appointed by you under a health care power of attorney
- Prison officials if you are in custody
- Worker's Compensation officials if your condition is work-related
- If necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public

When sharing PHI with others outside of Peaceful Solutions Counseling, we share only what is reasonably necessary unless we are sharing PHI to help treat you, in response to your written permission, or as the law requires. In these cases, we share all the PHI that you or the law requires.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights regarding your PHI we maintain. To exercise any of the rights discussed in the remainder of this section, please contact the Privacy Officer for Peaceful Solutions Counseling located at 1720 Merrill Avenue, Suite 300, Wausau, WI 54401

Right to Request Restrictions: You have the right to request certain restrictions of use and disclosure of your PHI by Peaceful Solutions Counseling for treatment, payment or health care operations. You also have the right to request a restriction on our disclosure of your PHI to someone who is involved in your care or the payment for your care. Peaceful Solutions Counseling is not required to agree to restrict the use and disclosure of your PHI. A request for restriction must be made in writing using the form available from the Privacy Officer.

Right to Inspect and Copy: With a few exceptions you have the right to inspect and receive a copy of your PHI. Should you wish to review or copy your PHI you should make a request using the form available from the Privacy Officer. We will arrange for your therapist or another health professional in our clinic to review the PHI with you in our office or to copy the information requested. We may charge you a reasonable fee if you want a copy of your PHI.

Right to Amend or Correct Your Record: If you feel the PHI we have about you is incorrect or incomplete, you may ask us to amend the information for as long as the information is maintained by Peaceful Solutions Counseling. Requests for amendment or correction should be made by submitting a form requesting amendment or correction available from the Privacy Officer. We will respond to your request within 60 days after you submit the form. We are not required to agree to the amendment.

Right to an Accounting of Disclosures: You have a right to request an accounting for disclosures. This is a list of those people with whom Peaceful Solutions Counseling may have shared your PHI, with the exception of information shared for purposes of treatment, payment or health care operations or when you have provided us with an authorization to do so. We may charge you a reasonable fee if you request more than one accounting for disclosures in any 12-month period. The request cannot include any disclosures made before March 7, 2007. Requests for an accounting of disclosures should be made by submitting a form requesting an accounting of disclosures to the Privacy Officer. This form is available from the Privacy Officer. We will respond to your request within 60 days after you submit the request.

Right to Request Confidential Communications: You have the right to ask that we communicate your PHI to you in a certain way or a certain location. For example, you can request that we contact you only at work or by mail. We will accommodate reasonable requests.

Right to Revoke Authorization: Uses and disclosures of PHI not covered by this Notice or the laws that apply to Peaceful Solutions Counseling will be made only with your authorization. If you authorize Peaceful Solutions Counseling to use or disclose your PHI, you may revoke that authorization in writing at any time. We are unable to reverse any disclosures we have made previously with your authorization. To revoke an authorization please contact your therapist or the clinic where you receive services.

Right to Complain: If you believe your privacy rights have been violated, you may file a complaint with Peaceful Solutions Counseling or with the Secretary of the Department of Health and Human Services. To file a complaint with Peaceful Solutions Counseling, contact the Privacy Officer. All complaints must be made in writing. The Privacy Officer will assist you in filing your complaint. Filing a complaint will not affect your care.

We reserve the right to revise or change this Notice. Each time you sign a consent for treatment at a site covered by this Notice we will provide a copy of this Notice in effect at that time.

Effective Date: March 7, 2007

How to Contact Us

Peaceful Solutions Counseling Privacy Officer:....(715) 675-3458

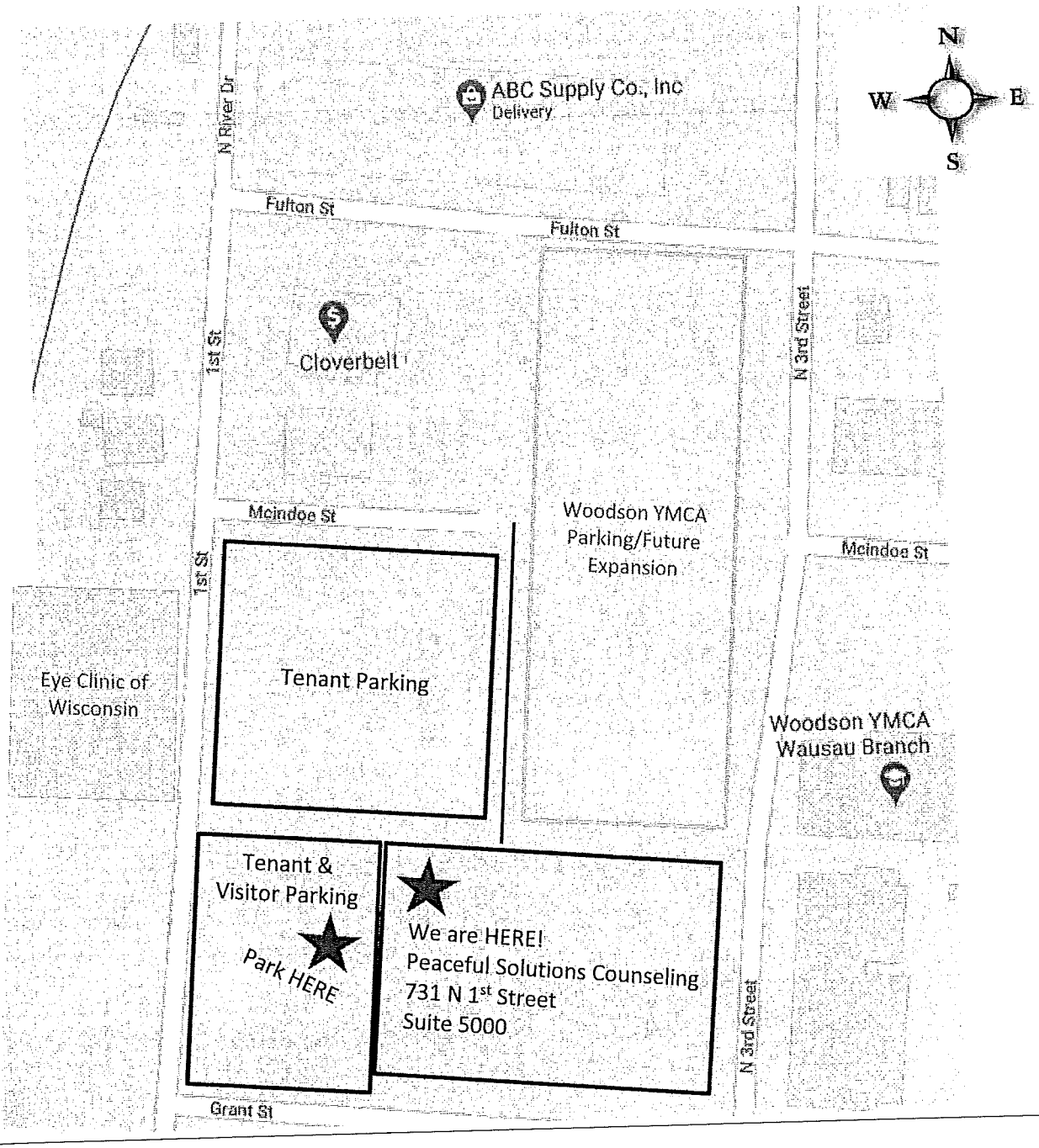
Secretary of Department of Health and Human Services:.....(877) 696-6775

Peaceful Solutions Counseling

731 North 1st Street, Ste 5000, Wausau WI 54403

Phone: 715-675-3458 Fax: 715-675-7238

www.peacefulsolutions.org



PLEASE NOTE

- Due to ongoing construction, parking lot entrances may change, but typically there are entries from McIndoe, 1st, and Grant Streets.
- With the Woodson YMCA Expansion, 1st Street is no longer accessible via McIndoe Street. Visitors should use either Grant St or Fulton St when arriving from the East.
- When facing the building from the parking lot (facing East), please use the LEFT entrance – there are stairs or a ramp – the entrance is handicap accessible.
- Upon entering the building, the agency suite is immediately to your LEFT.