

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:** _____



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, 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: _____



Discounted/Sliding Fee Application and 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																						
	6,245	12,490	15,613	18,735	21,858	24,980	31,225	37,470	43,715	49,960	56,205	10,665	21,330	26,663	31,995	37,328	42,660	53,325	63,990	74,655	85,320	95,985	
1	6,245	12,490	15,613	18,735	21,858	24,980	31,225	37,470	43,715	49,960	56,205	10,665	21,330	26,663	31,995	37,328	42,660	53,325	63,990	74,655	85,320	95,985	
2	8,455	16,910	21,138	25,365	29,593	33,820	42,275	50,730	59,185	67,640	76,095	12,875	25,750	32,188	38,625	45,063	51,500	64,375	77,250	90,125	103,000	115,875	
3	10,665	21,330	26,663	31,995	37,328	42,660	53,325	63,990	74,655	85,320	95,985	15,085	30,170	37,713	45,255	52,798	60,340	75,425	90,510	105,595	120,680	135,765	
4	12,875	25,750	32,188	38,625	45,063	51,500	64,375	77,250	90,125	103,000	115,875	17,295	34,590	43,238	51,885	60,533	69,180	86,475	103,770	121,065	138,360	155,655	
5	15,085	30,170	37,713	45,255	52,798	60,340	75,425	90,510	105,595	120,680	135,765	19,505	39,010	48,763	58,515	68,268	78,020	97,525	117,030	136,535	156,040	175,545	
6	17,295	34,590	43,238	51,885	60,533	69,180	86,475	103,770	121,065	138,360	155,655	21,715	43,430	54,288	65,145	76,003	86,860	108,575	130,290	152,005	173,720	195,435	
7	19,505	39,010	48,763	58,515	68,268	78,020	97,525	117,030	136,535	156,040	175,545	Discount	95%	90%	85%	80%	75%	70%	60%	50%	40%	30%	20%
8	21,715	43,430	54,288	65,145	76,003	86,860	108,575	130,290	152,005	173,720	195,435	Adj Fee	\$ 8.25	\$ 16.50	\$ 24.75	\$ 33.00	\$ 41.25	\$ 49.50	\$ 66.00	\$ 82.50	\$ 99.00	\$ 115.50	\$ 132.00

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

Client Demographics Form

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

6. Annual Household Income:

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

7. How many people reside in your household?

1 5
 2 6
 3 7
 4 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 fidgety 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 + +

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

<p>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?</p>	<p>Not difficult at all _____</p> <p>Somewhat difficult _____</p> <p>Very difficult _____</p> <p>Extremely difficult _____</p>
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INTAKE QUESTIONNAIRE – CHILD

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. What is the primary issue for which you are seeking help?

	Length of time for issue	Received treatment in the past from:
<input type="checkbox"/> Parent/Child issues	_____	_____
<input type="checkbox"/> Over-activity	_____	_____
<input type="checkbox"/> Grieving	_____	_____
<input type="checkbox"/> Sibling issues	_____	_____
<input type="checkbox"/> Peer problems	_____	_____
<input type="checkbox"/> Abuse or trauma	_____	_____
<input type="checkbox"/> Behavior problem at home	_____	_____
<input type="checkbox"/> Eating issues	_____	_____
<input type="checkbox"/> Anger issues	_____	_____
<input type="checkbox"/> Depression/Sadness	_____	_____
<input type="checkbox"/> Sleep Issues	_____	_____
<input type="checkbox"/> Divorce/Custody issues	_____	_____
<input type="checkbox"/> Mood swings	_____	_____
<input type="checkbox"/> Alcohol/drug use	_____	_____
<input type="checkbox"/> LBGT	_____	_____
<input type="checkbox"/> Behavior problem at school	_____	_____
<input type="checkbox"/> Physical Problems	_____	_____
<input type="checkbox"/> Anxiety or worry	_____	_____
<input type="checkbox"/> Self-confidence issues	_____	_____
<input type="checkbox"/> Academic Performance	_____	_____
<input type="checkbox"/> Harming self (ex: cutting)	_____	_____
<input type="checkbox"/> Sexual Acting Out	_____	_____
<input type="checkbox"/> Suicidal Thoughts/Attempts	_____	_____
<input type="checkbox"/> Other: _____	_____	_____

Additional comments:

2. Is your child currently being seen by another mental health therapist or substance abuse therapist?

Yes No If yes, who? _____

It is often advantageous for all your behavioral health clinicians to have the ability to collaborate/communicate.

Do you consent to allow this collaboration? Yes No

3. **Has your child ever been a victim of a crime ? (whether reported or not) (Some examples might include: Sexual or physical abuse, bullying, etc.)** Yes No

CURRENT FAMILY INFORMATION

1. Does the child live with parent(s)? Yes No

2. If no, where does the child live and with whom? (Names/relationship): _____

3. Has the child lived with anyone else in the past? Yes No

4. If yes, with whom and where? _____

5. Who has legal guardianship of the child? _____

6. Parent Information

Father's Name		Phone			
Address		DOB		Age	
Occupation		Education			
Mother's Name		Phone			
Address		DOB		Age	
Occupation		Education			

Step-Father's Name		Phone			
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Address		DOB		Age	
Occupation		Education			
Step-Mother's Name		Phone			
Address		DOB		Age	
Occupation		Education			

Foster Father's Name		Phone			
Address		DOB		Age	
Occupation		Education			
Foster Mother's Name		Phone			
Address		DOB		Age	
Occupation		Education			

Guardian/Other Name		Phone			
Address		DOB		Age	
Occupation		Education			

List all other adults living in the home (i.e. aunts, uncles, grandparents, significant others, friends, etc.):

6. Please provide information about the child's brothers and sisters and any other children living in the home:

Name	Gender	DOB	Relationship (full, half, step, foster)	Lives with child?	If no, lives where?
	M F			Yes No	
	M F			Yes No	
	M F			Yes No	
	M F			Yes No	

7. 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

If checked, please explain:

8. The family's strengths are:

9. The family's weaknesses are:

10. The primary disciplinarian in the home is: _____

11. The kind of discipline used with the child is:

12. Are there any family circumstances you would like us to be aware of?

SOCIAL DEVELOPMENT

1. My child gets along with peers:

Poorly Sometimes Most of the time Almost Always

2. My child gets along with adults:

Poorly Sometimes Most of the time Almost Always

3. My child spends the most time with (check closest answer)

Younger children Same age children Older children Adults Self

4. My child's hobbies and interests are: _____

WORK AND ACADEMIC INFORMATION

1. What school does the child currently attend? _____

2. What grade is the child in? _____

3. School Contact Person/Role: _____

4. Number of schools the child has attended: _____

5. Locations of the schools the child has attended: _____

6. Does the child have a written IEP? Yes No

7. Is the child in special education classes? Yes No

8. If yes, what type? _____

9. The child is a Good Student Average Student Poor Student

10. Attitudes towards School

Truancy Argumentative Fighting with Peers Poor Effort

Disruptive Attentive Repeated Grades Expulsions

Suspensions Detentions Difficulty keeping Friends Noncompliant

Cooperative Motivated Complies with expectations Interested

11. Is your child currently employed? Yes No

12. If yes, where and number of hours per week: _____

ALCOHOL & DRUG HISTORY

Do you suspect/know your child has used drugs or alcohol before or during school? Yes No

Do you suspect/know if your child has missed school because of use or just to use? Yes No

My child avoids non-users. Yes No

Do you suspect/know if your child uses more than one drug to get intoxicated or high? Yes No

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

If checked yes, please explain: _____

My child is using the following:	How much each time?	How often?
Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Tobacco <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Marijuana <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Cocaine/Crack <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Heroin <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Meth <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Tobacco <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Hallucinogens: <input type="checkbox"/> Yes <input type="checkbox"/> No (MDMA, LSD, Psilocybin, Mushrooms, Ecstasy, Ketamine)	_____	_____
Opioids: <input type="checkbox"/> Yes <input type="checkbox"/> No (Oxycontin, Morphine, Codeine, Vicodin, Tramadol)	_____	_____
Amphetamines: <input type="checkbox"/> Yes <input type="checkbox"/> No (Adderall, Ritalin, Concerta)	_____	_____
Benzo's: <input type="checkbox"/> Yes <input type="checkbox"/> No (Xanax, Clonazepam, Ativan)	_____	_____
Party Drugs: <input type="checkbox"/> Yes <input type="checkbox"/> No (GHB, Rohypnol)	_____	_____
Synthetics: <input type="checkbox"/> Yes <input type="checkbox"/> No (Bath Salts, K2, Spice, 2-C-T-I)	_____	_____
Other (Specify) _____	_____	_____

Interventions:

- A. My child has been involved in a 12 step/AA program? Yes, currently Yes, but not currently No
- B. My child has received outpatient AODA treatment? Yes, currently Yes, but not currently No
- C. My child has received inpatient AODA treatment? Yes, currently Yes, but not currently No

LEGAL HISTORY

Has your child ever:	When?	For what?
Been arrested <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Been convicted <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Been on probation <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
My child is currently:	For what?	For how long?
On probation <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
	When?	For how long?

Registered as a sexual offender Yes No _____

Complete if applicable:

Name of child's social worker _____ Phone number: _____

Name of child's PO _____ Phone number: _____

DEVELOPMENTAL HISTORY

1. Pregnancy

Smoking during pregnancy Never Rarely Sometimes Frequently

Alcohol during pregnancy Never Rarely Sometimes Frequently

Drugs during pregnancy Never Rarely Sometimes Frequently

Medication during pregnancy Yes No (If yes, list all medications)

2. Labor

Spontaneous Induced Duration in hours: _____

Complications during pregnancy _____

Birth weight: _____ Infant days in hospital: _____

3. Did the child reach developmental milestones at a normal age?

MEDICAL HISTORY

1. Please check the appropriate box if your child has experienced any of these problems:

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

Please explain anything checked above: _____

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

Medication	Dosage/Frequency	Prescribing Physician	For what condition?

3. Does your child have a pediatrician or primary care physician? Yes No

If yes, who? _____

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 the child's strengths? _____

2. What are the child's 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 of 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 shall 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

Custody Agreement/Court Order

In order to comply with Wisconsin state law, it is our policy at Peaceful Solutions Counseling that any child who is mentioned in a court order or custody agreement cannot begin counseling until a copy of that order is given to and reviewed by the clinician. Please answer the following questions regarding the custody of and legal right to consent to mental health treatment for this child.

1. Are you the biological/adoptive parent of this child with full legal rights? Yes No

If YES: Do you have medical rights to seek treatment for this child? Yes No

If NO: Please bring the document stating your rights to make medical decisions to the first counseling appointment (a copy of the most recent custody agreement or divorce decree). If you do not bring these documents or do not have legal rights to consent, we will be unable to provide counseling services to the child.

2. Is this child named in any kind of court order or custody agreement? Yes No

If YES: Please bring a copy of these documents to the first counseling appointment.

* If you do not bring these documents, we will be unable to provide counseling services to the child.

I, _____, parent/guardian of _____,

hereby confirm that the above answers are both true and correct concerning custody and court orders involving this child. I also agree that the orders provided are current as filed with either the county or state authorities. Lastly, I agree that if any new orders or custody agreements are made during the time that this child is in services, I will present these papers to the clinician at Peaceful Solutions Counseling upon my receipt of the orders or custody agreements.

Parent/Guardian

Date

Witness

Date

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.

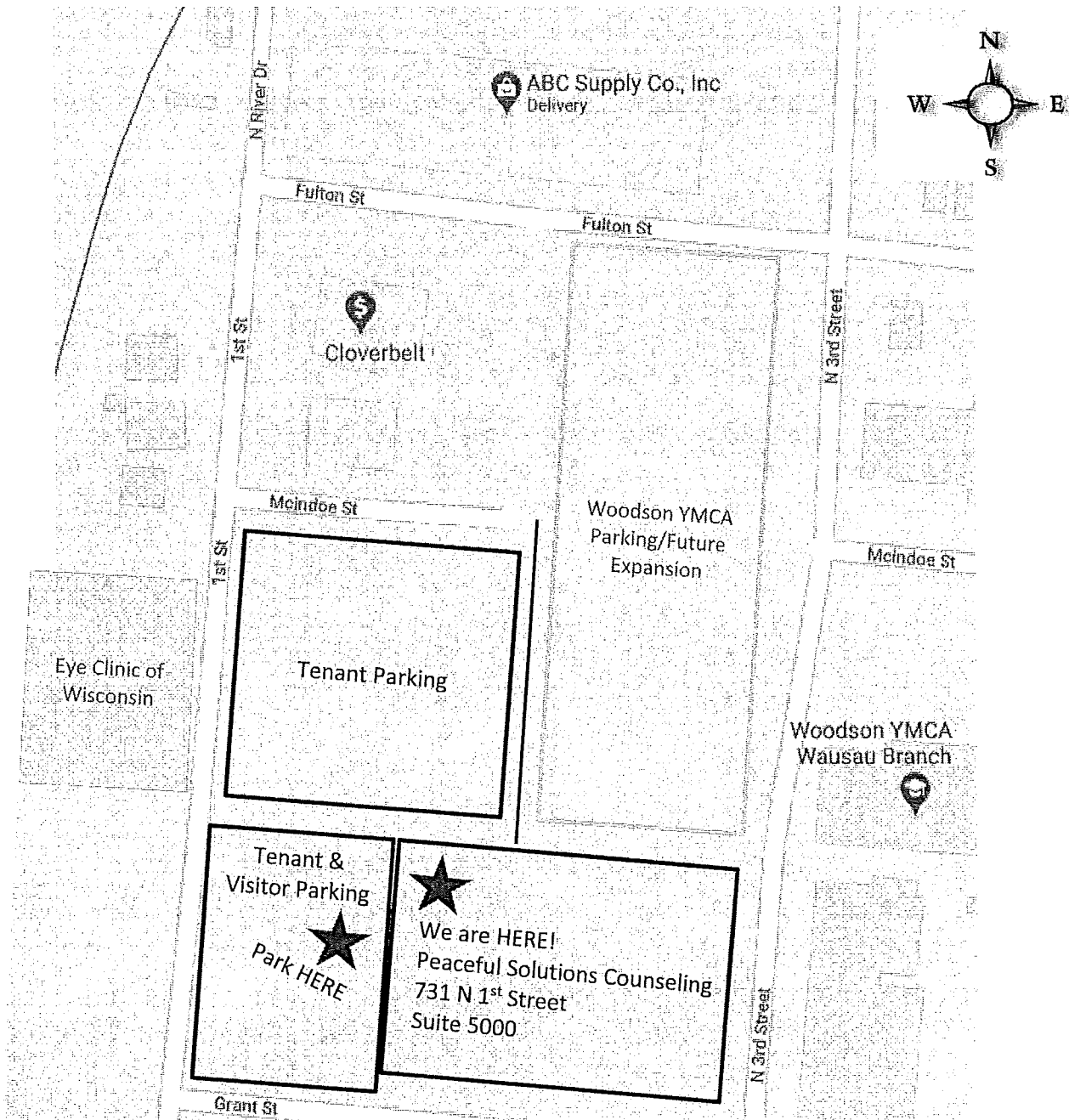
We reserve the right to revise or change this Notice. Each time you sign a consent for treatment at a site covered by this Notice we will provide a copy of this Notice in effect at that time.

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



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.