

# **Easttown Psychotherapy, L.L.C.**

## **Information about Professional Services, Practices, Policies, and Patient's Bill of Rights**

Welcome to Easttown Psychotherapy, L.L.C. This is an outpatient counseling facility that provides individual therapy. Confidentiality is maintained in all services provided in accordance with Federal Regulations. Individuals are given information about professional services, practices, policies and patient's bill of rights for their reference. Your length of treatment will vary depending on the nature of the problems that bring you here for services, the pace that we work at during sessions, as well as your motivation and the resources available to you to get well. Each individual has a right to terminate treatment at anytime and for any reason. I am currently accepting new patients.

### **CANCELLATION AND NO SHOW POLICY:**

A full session fee will be charged for all appointments cancelled with less than 24 hours notice. Because insurance does not pay for missed sessions, you will be billed for missed sessions if you are using insurance to pay for therapy. This policy is in effect unless we determine that you were not able to make your appointment or give sufficient notice due to circumstances beyond your control.

No shows will be charged and billed to you at your regular session rate. Because counseling sessions are in high demand and waiting lists for appointments are long, and if there happens to be 2 consecutive appointment cancelations in a row your treatment will be terminated and a list of referral counselors will be provided for you.

### **FEES:**

You are expected to pay our agreed-upon fee or your insurance deductible/co-payment by cash, check or credit card at the time of each session, unless other arrangements have been made.

If you use your health insurance to help pay for your sessions, you are responsible for verifying and understanding the limits of your coverage, as well as any co-payments and deductibles. You are responsible for all service fees not covered by health insurance, all deductibles and co-payments. If, during the course of treatment, your insurance ceases to cover your sessions, you have the option of paying out-of-pocket to continue treatment with us. Counseling services will be placed on hold for any bills exceeding \$300.00. Counseling services will resume upon payment of outstanding bill.

We also offer a reduced fee scale that offers a reduced rate for therapy services based on income. Documentation of income must be provided to determine if you qualify for reduced rate sessions.

### **Fee schedule is as follows for the 2025 year:**

90837 Individual Counseling: 50 Minutes	\$145.00
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### **CONTACTING ME:**

If I am not immediately available by telephone, please leave a confidential voicemail. Calls are usually returned within 24 hours during normal business time, with the exception of weekends and holidays. If you are unable to reach me and feel that you can't wait for me to return your call, contact your primary care physician, psychiatrist or the nearest emergency room and ask for the behavioral health clinician on call. You may also contact Milwaukee County after hours crisis line at (414) 257-7222, of the Suicide and Crisis Hotline at 988. E-mail is not a secure form of communication and I cannot guarantee that the information you disclose in an e-mail will not be intercepted by a third party. Therefore, e-mail is not an appropriate means of communicating confidential or urgent information to us. E-mail is **NOT** a form of counseling and I kindly ask that you reserve all counseling related issues for your appointment. If you cannot wait until your scheduled appointment please call to reschedule for an earlier appointment. Social media like Facebook, linked-in and twitter are excellent ways to stay in touch, but that is not an acceptable form of connection for counseling services—we ask that you refrain from contacting/connecting with us via these mediums. In the event of illness or death of your counselor a case transfer will be made to another qualified counselor of your choosing.

### **HOURS OF OPERATION:**

The office is open Monday - Thursday 9 am – 5 pm.

## **BENEFITS, RISKS AND ALTERNATIVES TO COUNSELING:**

**Benefits of Counseling:** Improved well being, better relationships, solutions to specific problems, a better understanding of oneself and reduced or elimination of symptoms

**Alternatives to Counseling:** Medications, no services, inpatient treatment, and alternative holistic practices.

**Possible consequences of not receiving proper counseling:** Continuation of current problems, addressing unpleasant aspects of your life, you may experience uncomfortable feelings and painful emotions and symptoms and/or an exacerbation of problems and symptoms.

When you receive services for Mental Health, Alcoholism, Drug Abuse, or Developmental Disability as an inpatient or outpatient, you have the following rights under Wis. Statute Sec. HFS 75 and HFS 6.

## **TREATMENT AND RELATED RIGHTS:**

You have the right to be free from having unreasonable arbitrary decisions made about you, to receive prompt adequate treatment that is effective, to be informed and educated about your treatment as it relates to session duration, frequency of session and therapeutic procedures, to refuse any treatment, including medications, to refuse or to give informed consent to participate in drastic treatment or in experimental research, to a humane psychological and physical environment.

## **COMMUNICATION AND PRIVACY RIGHTS:**

It is my ethical obligation to safeguard information we obtain about you in the course of our work together, within the limits of, or exceptions to confidentiality as law determines it. You have the right to refuse to be filmed or taped without your consent, to have your conversation with staff and all medical and health care records kept confidential in accordance with WI law, Sec.51.30, Stats. To have your records released at your discretion with a properly signed and completed release of information. And to see your health care records after termination of treatment with proper notice. By law records are kept for 7 years after termination of therapy services. After 7 years the records are destroyed. If utilizing insurance to cover the cost of counseling services please be advised that most insurance carriers require disclosure of diagnosis, date of treatment and treatment plan goals in order to pay for services rendered. Be aware that a diagnosis becomes part of your permanent medical record. Please consult with your insurance carrier for more information about what is required. Additionally, to provide quality care there will be times when colleagues will be consulted for continuity of care—you will always be made privy to case consultations that occur.

## **COUNSELOR CREDENTIALS:**

All counselors at this facility are licensed by the State of Wisconsin and hold an advanced degree in the specialty area of Social work, Counseling or Psychology. Continuing education is a top priority so all providers attend classes, seminars, conference and the like on a regular basis. Additionally, all providers are active members of various professional organizations in their field. There are no providers on staff that prescribe medications. If medications are recommended a referral will be made to the appropriate provider of your choice.

## **YOUR RIGHT TO COMPLAIN AND HAVE ACCESS TO THE COURT SYSTEM:**

You may bring court action for damages against persons violating your rights or confidentiality. If you have a grievance, a grievance procedure is available to you and to have an advocate represent you during the grievance process. Please send all grievances in writing to: **Easttown Psychotherapy, LLC, 400 E. Wisconsin Ave, Suite 220A. Milwaukee WI 53202**

# Easttown Psychotherapy, L.L.C.

## Informed Consent to Treatment

I and/or members of my family will be receiving counseling beginning today. I hereby attest that the staff of Easttown Psychotherapy, L.L.C. has explained to me the policies, procedures, bills of rights, and possible alternative methods of treatment. In addition, I have been given documentation of the above as well as a copy of the fee schedule for my records.

In addition, I understand:

- If I have further questions I may request specific information in writing at anytime during the course of treatment.
- I had time to study this information and/or seek additional treatment options.
- This consent is effective throughout my treatment at Easttown Psychotherapy, L.L.C.
- I have the right to withdraw consent at anytime, in writing.
- The benefits and cons of the proposed counseling treatment.
- The way the counseling treatment will be administered to me and I acknowledge that I actively participated in the treatment plan development.
- Alternative treatment modalities available to me.
- Confidentiality of client information.
- Probable consequences of not receiving proper treatment.
- Payments for services rendered are my responsibility, including no show and cancelations that are less than 24 hours, which will be billed at full session fee, insurance co-payments and deductibles.
- I understand that I may be billed for phone consultations between myself and my provider that last longer than 15 minutes (a service that is not covered by insurance).
- I understand that e-mail is not a form of counseling and that counseling related issues should be saved for counseling sessions with my provider.
- Out of pocket payments for counseling services are due at the time of service.
- Counseling services will be placed on hold for any bills exceeding \$300.00 (unless a payment plan has been established). Counseling services will resume upon payment of said bill.

I authorize Easttown Psychotherapy, L.L.C. to determine the form of treatment necessary and agree to participate in the development and advancement of my treatment plan.

Once you have reviewed the relevant issues with your counselor, please sign below to indicate that you have obtained all information that you deem necessary and that you accept the policy and procedures outlined above. A copy of this form is available to you upon request.

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Client Signature

Date

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Agency Witness

Date