

## SOAR SERVICES, INC.

### CONSUMER INFORMATION PACKET

Soar Services wants to assist you in a way that is as clear, practical, and simple as possible. As in many areas of modern life, there are many laws, rules, and requirements that must be discussed when treatment is begun. This pamphlet tries to explain the essential basics. Please do not hesitate to ask questions if something is unclear to you!

#### Rights All Clients Have in Wisconsin:

- a. The right to be informed of the Consumer Bill of Rights.
- b. The right to confidentiality of all conversations and records. However, there are specific situations, such as those involving child abuse, threat of harm or injury to self or another where SOAR would be required to make a report to appropriate authorities. Please discuss this with your therapist if you have a concern.
- c. The right to receive prompt and adequate treatment.
- d. The right to the least restrictive treatment conditions necessary.
- e. The right to be referred to other helping resources.
- f. The right to be free from unnecessary medications.
- g. The right not to participate in experimental research.
- h. The right to withdraw from treatment upon request.
- i. The right not to be filmed or taped.
- j. The right to suggest changes in treatment methods and procedures.
- k. The right to access treatment records with a 24-hour notice.
- l. The parent, guardian, or person in the place of parent of a developmentally disabled minor shall have access to the minor's court and treatment records at all times, except in the case of a minor aged 14 or older who files a written objection to such access with the custodian of the records.

#### Total Cost of Treatment:

Client fees for Mental Health services are set at \$130.00 per hour for individual, couple and family sessions.

Sliding fee scale is available for self-pay consumers.

EAP clients will use the approved amount of sessions and then must provide insurance information or self-pay.

#### Fees Are the Responsibility of the Consumer:

Health insurances vary tremendously and are based on a legal contract between you and your insurance carrier. We will do our very best to help you make legitimate claims, but please remember you are responsible for any portions of your bill that your policy does not or will not cover.

#### Assignment of Insurance Benefits:

While you may opt to pay us in full at the time of service and then receive insurance reimbursement, it is usually simpler, safer, and less expensive to authorize your insurance provider to pay us directly.

#### Payment Plans:

If it is not possible to pay in full at the time of service, our billing specialist or your therapist will discuss payment plans with you. A minimum monthly payment will be required and we appreciate your efforts to stay current with your bill.

**Missed Appointments or Late Cancellations:**

When you schedule an appointment, that time is set aside for you. We request a 24-hour notice for appointment cancellations. Since we cannot bill insurance for missed appointments or late cancellations, **we may bill you \$25.00 after the second no show.** This amount must be paid prior to scheduling further appointments. You may be exempt from this charge for emergencies (such as illness or car accidents) that physically prevent you from attending your session and if it is impossible to reschedule the session.

**Reaching Your Therapist:**

**Soar Services phone number is 715-468-2841.** Our general office hours are Monday through Thursday 9:00 a.m. to 4:00 p.m. You may leave a message or possibly reach your therapist between the hours of 9:00 a.m. to 4:00 p.m. and your therapist will get back to you usually within 24 hours. After 4:00 p.m. messages will be taken on an answering machine and calls returned as soon as possible. In cases of emergency, you can call the **Washburn County Crisis Line at 1-888-552-6642;** 24 hours a day, 7 days a week, and 365 days a year. Please be aware that your therapist may be unable to return your call as quickly as you may want or need. If there is serious danger, please contact your local hospital, this helpline, or dial 911.

**Grievance Procedure:**

If you are ever dissatisfied or concerned about your care, you are encouraged to request a meeting with the Director or her designee. Every reasonable and practical effort will be made to resolve the matter because we sincerely want you to be satisfied!

**INFORMED CONSENT FOR PSYCHOTHERAPY**

**All Consumers Must Give Their Informed Consent Prior to Treatment**

This means all clients understand the following general information:

The benefits of therapy are designed to help alleviate and/or cope with the problems and symptoms that you present. **Potential benefits of treatment and services** include increased self-understanding; progress toward your goals and objectives; improved control over your moods and behavior; improved self-esteem; improved assertiveness; improved interpersonal relationships; improved independence; and an opportunity to be totally open and honest in a nonjudgmental atmosphere with nearly complete confidentiality (see item “d” for the exceptions).

**Administration of treatment and services through therapy** is conducted in individual sessions or group sessions with a therapist for the purposes of defining and attempting to resolve problems or concerns and discuss any issues that are important to you. You may meet alone with your therapist or may bring a significant other (e.g., your spouse).

**Side effects or risks of treatment:** Progress may be slow; you may get worse before you get better; you may have a variety of feelings, e.g., sadness, anxiety, anger, depression, etc., when you talk or think about your problems; relationships may change in some ways; it may take a long time to work through some long-standing problems.

There are some limits to confidentiality (**see below**).

**Limits on confidentiality:** Discussions with your therapist are confidential under most circumstances. The most likely exceptions: (1) you are a child who has been abused, or you are an abuser of a child; (2) you make a direct, serious threat to harm yourself or another person; (3) a judge orders that confidentiality be lifted, in any kind of case.

**Alternatives to psychotherapy services:** you might continue to try to resolve matters on your own, you might talk with a friend or family member.; you might try exercise, taking a class, changing jobs, etc. Please also be aware that if at any time you don't feel your current therapist is helpful enough, we would be happy to recommend other therapists to whom we could refer you.

**Probable consequences of not receiving the proposed treatment and services:** You could stay the same or get worse; relationships may suffer; job performance may get worse; your ability to function day-to-day could get worse; anxiety and/or depression may interfere with sleep or other activities, etc.

**Clients may be involuntarily discharged for:** non-payment of services, unreasonable behavior, or behaviors resulting from mental health symptoms.

**This informed consent is effective for (12) months from date of signature.**

**YOU HAVE A RIGHT TO WITHDRAW THIS INFORMED CONSENT AT ANY TIME**