Pathway to Wellness
Community Clinic

560 4th Street, Prairie Du Sac, WI 53578
608.643.3663 • fax 608.370.8177 • pathwaytwcc.com

PROCEDURE FOR PSYCHIATRIC EMERGENCY

If you believe you are having a psychiatric emergency or having thoughts of harm to self or others, please call 911 for immediate assistance to assure the best clinical outcome possible. High risk individuals should receive immediate treatment.

If you need to reach your therapist for a non-life-threatening emergency, call Pathway to Wellness Community Clinic SC at 608-643-3663. If the clinic is closed, leave a message and we will return your call by the next business day Monday through Friday. If you feel you cannot wait to speak with someone, reference the numbers below, go to the nearest hospital or call 911.

If psychiatric hospitalization is required, you may be transferred to the appropriate hospital depending on your insurance. Please notify us ASAP if you are hospitalized, let the staff know you are a client of Pathway to Wellness Community Clinic so they can communicate with your therapist and coordinate any needed further care.

We appreciate your cooperation in allowing us to provide you with the best care possible.
Thank you,

Tammy Kirch
Owner - Pathway to Wellness Community Clinic SC

PATIENT COPY

Additional Helpline options:

988 Suicide Crisis and Lifeline: **CALL OR TEXT 988 or 988lifeline.org/chat**
1-800-273-8255 (TALK) remains available

National Hope Line Network: 1-800-442-HOPE (4673) Text “HOPELINE” to 741741

Sauk County Mental Health Crisis: 608-355-4200

Columbia County Mental Health Crisis: 518-828-9446

Dane County Mental Health Crisis: 608-280-2600

REVISED: 3.13.2024

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WELCOME TO PATHWAY TO WELLNESS COMMUNITY CLINIC

This informational packet is designed to help you understand our policies and procedures along with your rights as a client/patient of PTWCC. Please read through this packet and if you have questions, feel free to ask. Your signature is requested on the last page indicating your understanding and willingness to participate and abide by these policies. We appreciate your trust and confidence in us. We take pride in our training, knowledge, and capabilities, and we want you to know that we are dedicated to giving you quality health care.

OFFICE HOURS: To reach a provider during office hours, or to make or change an appointment, please call:

Pathway to Wellness Community Clinic SC
608.643.3663
Monday | Thursday | Friday 9am-5pm
Tuesday | Wednesday 9am-6:30pm

After hours, you can leave a message on our GENERAL voicemail and we will return it on the next business day. If your call is a medical emergency, please call "911" or go directly to your local Urgent Care or Emergency Room. See PTWCC's Psychiatric Emergency Policy to reach an on-call therapist after hours.

INSURANCE AND BILLING INFORMATION

VERIFICATION OF INSURANCE BENEFITS & PRECERTIFICATION: Your insurance carrier will be contacted to verify outpatient mental health benefits. Some managed care companies require pre-certification, pre-authorization, or a referral prior to treatment. It is your responsibility to obtain the necessary information for treatment at Pathway to Wellness Community Clinic. You will also be responsible for any deductibles or co-payments not covered by your insurance plan, due at the time of service. Call # on card for your benefits. Also refer to the Fee Agreement. Insurance claim forms are completed by this office as a courtesy to you. We do not accept responsibility for collecting your claim or negotiating a settlement on a disputed claim. The clinic also needs to be notified immediately of any changes with your insurance.

MONTHLY STATEMENTS: A statement of your account will be sent to you monthly. It is expected that you will make regular payments on any outstanding balance. Balances more than 30 days past due are subject to interest and penalty fees of 7% per month, more than 90 days past due balance will be sent to collections. If your balance goes over $100.00, we may not be able to see you until a payment is made to bring the balance below $100 or you set up and adhere to a written payment plan. If you wish to arrange a payment plan, you are encouraged to discuss this with PTWCC billing.

(Note to parents of a minor child: It is this clinic's policy to accept the parent signature on this form as an agreement to be responsible for payment of the minor child's services. If a divorce occurs during your child's treatment, it is still the responsibility of the signing parent to make sure payments are made in a timely manner on your account. It is not the responsibility of Pathway to Wellness Community Clinic to determine the financial responsibility of the minor child after the divorce has occurred. Therefore, the parent or guardian who signs the responsibility form will remain the responsible party until the bill is paid in full.)

APPOINTMENT POLICY: Scheduled appointments can be cancelled up to 24 business hours in advance without penalty. If you do not cancel outside of 24 hours or do not show up, you will be charged $75.00 for the first, $100.00 for the second, and $150.00 for the third occurrence and any others that may follow. Balance due must be paid before rescheduling. If appointments are repeatedly missed or there are multiple late cancellations, your clinician may discontinue services. Please note that insurance companies will not cover this expense. NOTE: Services will automatically be terminated after 90 days of no contact with client.

CLIENT ELIGIBILTY: Eligibility for Pathway to Wellness Community Clinic services are based on the existence of a presenting problem. You may be referred to another community resource if you (1) do not meet the eligibility criteria; or (2) there is a more appropriate service provider elsewhere in the community and/or your insurance company has another counseling resource for you.

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

PTWCC 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 provider.

CLIENT RIGHTS:	CLINIC RESPONSIBILITIES:
As a client at Pathway to Wellness Community Clinic you have the right to: • Be treated with dignity • Have confidentiality of all treatment records • Review your treatment records • Prompt and adequate treatment or rehabilitation • Share your information to others included in your medical care	As a health care clinic, our responsibilities are to: • Maintain privacy and security of your health information • Inform you of a breach that may compromise the privacy or security of your information • Follow the duties and privacy practices described • Not use or share your information, unless given your written permission, and knowing you can change your mind at any time.

GRIEVANCE PROCEDURE: If you feel that any of these rights have been abridged or have questions concerning any aspect of treatment, please talk with your therapist. If you are not satisfied, you have the right to submit, in writing, to Pathway to Wellness Community Clinic, a statement of your concerns or complaints. When received, your statement will be reviewed, and within thirty (30) days you will receive a response in writing.

You have the right to contact your client rights specialist to file a grievance or to learn more about the specific grievance process used by the agency for which you are receiving services; this information is posted in our entry way to the clinic and included in this packet.

To be signed by parent/guardian if client is UNDER 18 or an adult w/guardianship. Please PRINT LEGIBLY

PATIENT INTAKE INFORMATION

Name: Last: First: MI: Preferred:

Address: Apt/Box #: City: State: Zip:

Date of Birth: Age: Social Security #:

Gender: ☐ Bio Sex ☐ Male ☐ Female Gender Identity: Preferred Pronouns: Other:

Email Address: Preferred Email for Portal Access:

PTWCC has access to only 1 (ONE) email for your PORTAL ACCESS,
(if multiple households) consider one SHARED FAMILY email for all communications with Clinic.

Primary Phone: ☐ Text ☐ Voice Message | Other Phone: ☐ Text ☐ Voice Message

****Would you prefer email, text or call for appointment reminders? _____ (email preferred by Clinic)****

Work Phone: May we call or leave message at this #? ☐ Yes ☐ No

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other

Employment: ☐ Full-time ☐ Part-time ☐ Unemployed/looking for work ☐ Student ☐ Retired ☐ Disabled
☐ Other: _____
Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship to Client: _____ Phone: _____

I give consent to contact the above listed person in the event of an emergency: ☐ Yes ☐ No
I give consent to contact the above listed person to coordinate my appointments: ☐ Yes ☐ No
I give consent to contact the above listed person to discuss my care: ☐ Yes ☐ No (May need to complete ROI-Release of Information)

Briefly describe what brings you to Pathway to Wellness: _____

_____

_____

Referral for: ☐ Mental Health ☐ Substance Abuse ☐ OWI/Zero Tolerance ☐ Domestic Abuse
Referred by: ☐ Self ☐ Hospital ☐ Family/Friend ☐ School ☐ Court ☐ Physician ☐ DHS ☐ Probation Officer
Other: _____
Name of referral (If applicable, DHS contact, probation officer, doctor): _____

CONTACT INFORMATION FOR UNDER 18

PRIMARY CONTACT	SECONDARY CONTACT
Contact Name:	Contact Name:
(If different than above) Address: Apt/Box #:	(If different than above) Address: Apt/Box #:
City: State: Zip:	City: State: Zip:
Relationship to Patient:	Relationship to Patient:
Phone: ☐ Text ☐ Voice Message	Phone: ☐ Text ☐ Voice Message
Email Address:	Email Address:
Custody or Guardianship Status:	**Custody or Guardianship Status:**

FAMILY/HOME & SOCIAL INFORMATION

Confidential: For Professional Use Only

Mother's Name: _____ Age: _____ Occupation: _____

Father's Name: _____ Age: _____ Occupation: _____

Step-Mother(s) / Step-Father(s) Name(s): _____

How many siblings do you have? _____ Which number are you: _____

Spouse/Partner's Name: _____ Age: _____ Occupation: _____

My relationship with my spouse/partner is: ☐ Poor ☐ Fair ☐ Average ☐ Good ☐ Excellent

Do you have children? List below: (use back if additional space is needed)

Full Name	D.O.B.	Full Name	D.O.B.

Please provide the information about the child's siblings/other children or adults living in the home, not mentioned above:

Full Name	Age	Relationship (full, half, step, foster)	Lives with Child?	If no, where?
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

What is the highest level of education completed: _____

Do you have military history: ☐ Yes ☐ No

Have you been or are you currently in the legal system for any reason? _____

MEDICAL/HEALTH INFORMATION

Current Primary Care Physician: _____ Clinic: _____

Have you received mental health treatment before? ☐ Yes ☐ No Diagnosis if known: _____

If so, Where:_____ When: _____

Have you been hospitalized for psychiatric reasons? ☐ Yes ☐ No

If so, Where:_____ When: _____

Does anyone in your family have a history of addiction or behavioral health issues? If so, please list relationship and issue:

_____

_____

What medications do you take? (Include non-prescription, herbal medicines and supplements - Use back if needed)

Medicine	Dose	Frequency	Prescribed by:

Please list any allergies, including medication allergies/sensitivities: _____

_____

Do you have a history of alcohol use: ☐ Yes ☐ No
Do you currently drink: ☐ Yes ☐ No
If yes, please indicate the amount and frequency:
In a day _____ In a week _____ In a month _____

Do you have a history of drug use: ☐ Yes ☐ No
Do you currently use any drugs: ☐ Yes ☐ No
If yes, please indicate the amount and frequency:
In a day _____ In a week _____ In a month _____

SYMPTOM CHECKLIST

Please CHECK any of the following that have been bothering you lately:

☐ Abuse	☐ Agoraphobia	☐ Ambition
☐ Anger	☐ Anxiety	☐ Appetite
☐ Bowel Trouble	☐ Career Choices	☐ Children Issues
☐ Compulsive Behaviors	☐ Concentration	☐ Confidence
☐ Coping Skills	☐ Depression	☐ Distracted Easily
☐ Divorce	☐ Easily Startled	☐ Eating Problems
☐ Education	☐ Empty Feelings	☐ Energy (High/Low)
☐ Extreme Fatigue	☐ Family/Life Changes	☐ Fears
☐ Fetishes	☐ Finances	☐ Friends
☐ Grief/Loss	☐ Guilt	☐ Headaches
☐ Health Problems	☐ Hopelessness	☐ Inferiority Feelings
☐ Insomnia	☐ Irritability	☐ Isolate/Avoid Others
☐ Lack of Interest in Activities	☐ LGBTQ Issues	☐ Learning Disabilities
☐ Legal Issues	☐ Legal Issues due to Anger Management	☐ Loneliness
☐ Making Decisions	☐ Marital/Relationship Issues	☐ Memory Issues
☐ Mood Swings	☐ My Thoughts	☐ Nervousness
☐ Nightmares	☐ Obsessive Thinking	☐ Overweight/Underweight
☐ Painful Thoughts	☐ Panic Attacks	☐ Parental Responsibilities
☐ Phobias	☐ Relationship Issues	☐ Restless/Fidgety
☐ Ritual Behaviors (Nail Biting, Picking, etc.)	☐ Sadness	☐ Self-Esteem
☐ Self-Harm (Cutting, Burning, etc.)	☐ Separation	☐ Sexual Problems
☐ Sexuality Issues	☐ Short Temper	☐ Shyness
☐ Sleep Issues	☐ Stress	☐ Suicidal Thoughts
☐ Tobacco Use	☐ Trauma History	☐ Work Related Issues

Is there anything else important for your therapist to know or that you have not written about on any of these forms? Please list here and use the back of the paper if needed.

CONSENT FOR TREATMENT
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

COUNSELING is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. Through the course of (your) counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Your therapist is available to support you throughout the counseling process.

CONFIDENTIALITY:
All interactions with Pathway to Wellness Community Clinic (PTWCC) including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your records are confidential. No record of counseling is contained in any academic, educational, or job placement file. You may request in writing that the counseling staff release specific information about your counseling to persons you designate.

EXCEPTIONS TO CONFIDENTIALITY:
• The counseling staff works as a team. Your therapist may consult with other PTWCC counseling staff to provide the best possible care. These consultations are for professional and training purposes.

• If there is evidence of clear and imminent danger of harm to self and/or others, a therapist is legally required to report this information to the authorities responsible for ensuring safety.

• Wisconsin state law requires that staff of PTWCC who learn of, or strongly suspect, physical or sexual abuse or neglect of any person under 18 years of age, must report this information to county child protective services.

• A court order, issued by a judge, may require the Pathway to Wellness Community Clinic staff to release information contained in records and/or require a therapist to testify in a court hearing.

We appreciate prompt arrival for appointments. Please notify us at 608-643-3663 if you will be late, 24-hour notice of cancellation allows us to use the time for others and avoids you being charged a late cancellation or no-show fee. NOTE: Services will automatically be terminated after 90 days of no contact with client.

I have read and discussed the above information with my therapist and offered a copy of PTWCC's Notice of Privacy Practices. I understand the risks and benefits of counseling, the nature, and limits of confidentiality, and what is expected of me as a client of the Pathway to Wellness Community Clinic SC. Signature is required on the last page of the packet.

*The Notice of Privacy Practices is posted in the Clinic waiting room, on our website, and by request, a paper copy.

INSURANCE

☐ I am self-pay and not billing insurance.

Primary Insurance

Insurance Company Name:

Insurance Address:

Member Number:	Group Number:
Policy Holder Name:	Policy Holder DOB:
Customer Service Phone Number:	Effective Date:

Policy Holder Address (if different than patient):

Secondary Insurance

Insurance Company Name:

Insurance Address:

Member Number:	Group Number:
Policy Holder Name:	Policy Holder DOB:
Customer Service Phone Number:	Effective Date:

Policy Holder Address (if different than patient):

If you have any additional insurance coverage, please see reception for an additional form.

GUARANTOR: The person responsible for any unpaid balance.

Must be completed if patient is under 18 years old

Name:	DOB:	Social Security #:

Address (if different than patient):

Phone Number:	Guarantor Signature:

OBLIGATIONS OF RESPONSIBLE PARTY: Our clinic files for reimbursement with your insurance company. However, the ultimate responsibility for your account is yours. Insurance billing is a courtesy, and the clinic does not accept the responsibility for collection of your claim or of negotiating a settlement on a disputed claim. If the patient is responsible for a balance due, you will receive a monthly statement.

ASSIGNMENT OF BENEFITS: I hereby authorize Pathway to Wellness Community Clinic SC, to release the minimum medical information necessary to process my insurance claims. I further authorize the above insurance company(s) to make payment directly to the provider for the benefits herein and otherwise payable to me.

NOTIFY US WITH INSURANCE CHANGES: You must notify PTWCC at the time of any change in your insurance status, including but not limited to a change in your insurance provider, loss of insurance coverage, or Medicare or Medicaid eligibility. If you fail to notify PTWCC in a timely manner of a change and PTWCC is unable to bill for or collect fees from an insurer (including Medicaid or Medicare) due to your lack of notice, then PTWCC may require you to pay for all unbilled or uncollected fees to the extent allowed by law.

FEE AGREEMENT / RESPONSIBLE PARTY

PLEASE NOTIFY CLINIC IMMEDIATELY WITH ANY INSURANCE CHANGES

As part of receiving services offered at Pathway to Wellness Community Clinic SC, please be aware of the following responsibilities regarding payment for charges of services rendered:

• Client is responsible for knowing Insurance benefits. Check with your insurance carrier regarding your benefits, co-pays, co-insurance, and deductible in your plan. Call phone number on card for outpatient mental health coverage. Be sure to ask if Prior Authorization is needed.

• Psychological Testing: See separate letter. Some insurances do not cover Psychological Testing or prior authorization may be required, if yours does not please discuss cash rate options with us.

• Unless other arrangements are made, full payment is due at the time services are provided. For clients who have insurance, co-payments are due at time of service and the deductible will be determined after we receive the insurance Explanation of Benefits (EOB).

• **Your signature on the last page authorizes PWTCC to bill your insurance and makes you responsible for all charges,** whether paid by insurance including any charges for denied services not prior authorized, or not covered by the applicable insurance company.

• To cancel a scheduled appointment, you must provide 24 hours' notice. Late cancellations/No Shows will be billed $75 for the 1st missed appointment, $100 for the 2nd, and $150 for the 3rd occurrence and any others that may follow. (If your appointment is on a Monday, you must cancel the Friday prior.) If appointments are repeatedly missed or there are late cancellations, your clinician may discontinue services. Please note that insurance companies will not cover this expense.

• Outstanding balances over $100 require payment or have a signed payment plan in place prior to scheduling future appts.

• You are responsible for prompt payment of bills for your account. Balances more than 30 days old are subject to 7% interest (minimum 50¢) and penalty fees. If you fail to make a payment within three months of when the charges come due, your balance will be turned over for collections to a collection agency.

• If you have any questions/concerns about billing, please raise these questions with Tammy Kirch as soon as possible, we are happy to assist you.

MASTER LEVEL THERAPIST SERVICES & CODES		**PhD LEVEL SERVICES & CODES**	
$250.00/ Initial Evaluation	90791	$350.00/ Initial Evaluation	90791 PhD
$200.00/ 60 Minutes	90837	$250.00/ 60 Minutes	90837 PhD
$190.00/ 45 Minutes	90834	$240.00/ 45 Minutes	90834 PhD
$180.00/ 30 Minutes	90832	$230.00/ 30 Minutes	90832 PhD
$265.00/ 60 Min. Family w/o Patient	90846	$315.00/ 60 Min. Family w/o Patient	90846 PhD
$265.00/ 60 Min. Family w/ Patient	90847	$315.00/ 60 Min. Family w/ Patient	90847 PhD
$250.00/ 60 Minutes Crisis Therapy	90839	$300.00/ 60 Minutes Crisis Therapy	90839 PhD
$125.00/ 30 Minutes Crisis Add-On	90840	$150.00/ 30 Minutes Crisis Add-On	90840 PhD
CASH RATE:		CASH RATE:	
$160.00/ Initial Evaluation		$200.00/ Initial Evaluation	
$140.00/ Session		$170.00/ Session	
		Psychological Testing: $150.00 Per Unit / Minimum $700 (Multiple Units Apply) Discuss codes with Reception	
Other FEES:			
Patient Forms/Letters: Requiring less than 15 minutes of time for completion, $50.00 fee.			
Requiring more than 15 minutes of time for completion, $100.00 fee.			
Subpoena I Administrative I Court Order billed at $200.00 an hour			
Returned Checks: A $30.00 fee will be applied for any returned checks.			

Client Rights and the Grievance Procedure for Community Services*

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.

CLIENT RIGHTS

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 DHS 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 made to work except for personal housekeeping chores. If you agree to do other work, you must be paid.
• You may make your own decisions about things like getting married, voting, and writing a will, if you are over the age of 18, and have not been found legally incompetent.
• You may use your own money as you choose.
• You may not be filmed, taped, or photographed unless you agree to it.

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, including medications.
• No treatment or medication 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 and medications on your behalf.]
• You may not be given unnecessary or excessive medication.
• You may not be subject to electroconvulsive therapy or any drastic treatment measures such as psychosurgery or experimental research without your written informed consent.
• 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.

RECORD PRIVACY AND ACCESS

Under Wisconsin Statute sec. 51.30 and DHS 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 sec. 51.30, Wis. Stats., and/or DHS 92, Wisconsin Administrative Code, is available upon request.

GRIEVANCE PROCEDURE AND RIGHT OF ACCESS TO COURTS

• Before treatment is begun, the service provider must inform you of your rights and how to use the grievance process. A copy of the Program's Grievance Procedure is available upon request.
• If you feel your rights have been violated, you may file a grievance.

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• 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 manager for good cause may grant an extension beyond the 45-day time limit.
• The program'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 manager 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 MANAGER'S DECISION

If the grievance is not resolved by the CRS's report, the program manager or 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 manager's decision to the County Agency Director. You must make this appeal within 14 days of the day you receive the program manager's decision. You may ask the program manager 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 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 manager'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 manager to forward your grievance to the State Grievance Examiner or you may send it yourself. The address is: State Grievance Examiner, Division of Care and Treatment Services (DCTS), 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 Care and Treatment Services or designee. Send your request to the DCTS Administrator, P.O. Box 7851, Madison, WI 53707-7851.

You may talk with staff or contact your Client Rights Specialist, whose name is shown below, if you would like to file a grievance or learn more about the grievance procedure used by the program from which you are receiving services.

Your Client Rights Specialist is:
Dolores Kluppel Vetter - PhD
(Dee Vetter) DKVetter@charter.net
6402 Odana Road, Madison, WI 53719
608.204.6076 x 2

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

WISCONSIN DEPARTMENT of HEALTH SERVICES

STATE OF WISCONSIN DEPARTMENT OF HEALTH SERVICES Division of Care and Treatment Services
www.dhs.wisconsin.gov P-23112 (09/2016)

Pathway to Wellness
Community Clinic

560 4th Street, Prairie Du Sac, WI 53578
608.643.3663 • fax 608.370.8177 • pathwaytwcc.com

GOOD FAITH ESTIMATE

YOU HAVE THE RIGHT TO RECEIVE A "GOOD FAITH ESTIMATE" EXPLAINING HOW MUCH YOUR MEDICAL CARE WILL COST

Under the law, healthcare providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items or services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or a picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, please contact our Clinic at (608) 643-3663. You can also visit www.cms.gov/nosurprises or call 1-800-985-3059.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care-like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

EMERGENCY SERVICES

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

CERTAIN SERVICES AT AN IN-NETWORK HOSPITAL OR AMBULATORY SURGICAL CENTER

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protection from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THESE PROTECTIONS:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  • Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  • Cover emergency services by out-of-network providers.
  • Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  • Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, please contact Pathway to Wellness Community Clinic at (608) 643-3663. You may also call 1-800-985-3059 or visit the CMS website for more information about your rights under federal law. https://www.cms.gov/nosurprises/consumers

Pathway to Wellness
Community Clinic

560 4th Street, Prairie Du Sac, WI 53578
608.643.3663 • fax 608.370.8177 • pathwaytwcc.com

SIGNATURES FOR PATHWAY TO WELLNESS COMMUNITY CLINIC

This informational packet is designed to help you understand our policies and procedures along with your rights as a client/patient of PTWCC. Your signature is requested below indicating your understanding and willingness to participate and abide by these policies. We take pride in our training, knowledge, and capabilities, and we want you to know that we are dedicated to giving you quality health care.

By signing below, I verify I have reviewed the following documents and validate my signature.

Emergency Procedure

Welcome to PWTCC

Patient Information Form

Consent for Treatment / Privacy Notice

Insurance Form

Fee Agreement

State of WI Client Rights and Grievance Procedure

Good Faith Estimate

Please sign below indicating you have read and understand your rights as a Pathway to Wellness client:

Print Client Name:_____Date: _____

Signature of client or parent/guardian:_____

If signed by other than client, indicate relationship:_____

Clinic Witness:_____

You can have the opportunity to ask questions about this information or request copies and can reference the PTWCC website to review all forms.

CLIENT EMAIL/TEXTING CONSENT FORM

1. **RISK OF USING EMAIL/TEXTING**
   The transmission of client information by email and/or text has risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following:

   • Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
   • Email and text senders can misaddress an email or text and send the information to an unintended recipient.
   • Backup copies of emails and texts may exist even after the sender and/or recipient has deleted his or her copy.
   • Employers and online services have a right to inspect emails sent through their company systems.
   • Emails and texts can be intercepted, altered, forwarded, or used without authorization or detection.
   • Email and texts can be used as evidence in court.
   • Emails and texts may not be secure and therefore it is possible that the confidentiality of communications may be breached by a third party.

2. **CONDITIONS OF THE USE OF EMAIL AND TEXT**
   Therapists cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Therapist is not liable for improper disclosure of confidential information that is not caused by therapist's intentional misconduct.

   Client/parent/legal guardian must acknowledge and consent to the following conditions:

   • Email and texting are not appropriate for urgent or emergency situations. Providers cannot guarantee any particular email and/or text will be read and responded to within a certain period of time.
   • Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
   • All email will usually be printed and filed into the client's medical record. Texts may be printed and filed as well.
   • Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.
   • Client/parent/legal guardian should not use email or texts for communication of sensitive medical information.
   • Provider is not liable for breaches of confidentiality caused by the client or any third party.
   • It is the client's/parent's/legal guardian's responsibility to follow up and schedule an appointment.

3. **CLIENT ACKNOWLEDGEMENT AND AGREEMENT**
   I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts with my therapist. I consent to the conditions and instruction outlines, as well as any other instructions my therapist may impose for communicating with me via email or text.

   Print Client Name:_____ Date: _____

   Signature of client or parent/guardian:_____

   ☐ **CLIENT DECLINES AUTHORIZATION FOR CONSENT FOR EMAIL OR TEXTING**

   Client Signature:_____ Date: _____

   Staff Member Signature:_____