ALTERNATIVES IN PSYCHOLOGICAL CONSULTATION, S.C.
FACE SHEET

CLIENT INFORMATION: (To be Completed by Client)

Today's Date:_____ ☐ Ck here if Update

Name: Last: _____First: _____

SS#:_____-_____-_____ Sex: ☐M ☐F DOB:_____/_____/_____

Address:_____ City: _____ Zip:_____

Phone:(home)_____ (work):_____ (Cell):_____

Marital Status: ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated*

Race: ☐*Caucasian* ☐*African American* ☐*Hispanic* ☐*Asian* ☐*Other*: _____

Limited English Speaking? ☐ Yes ☐ No If yes, what is primary language: _____

Disabilities: ☐*None* ☐*Hearing* ☐*Visual* ☐*Orthopedic* ☐*Cognitive* ☐*Medical* ☐*Psychiatric* ☐*Other*: _____

Emergency Contact Name: _____ Phone Number: _____

COMPLETE THIS SECTION ONLY IF CLIENT IS A MINOR ☒Not Applicable

Are you currently enrolled in school? ☐Yes ☐No Name of School: _____Highest Grade Completed: _____

Primary Care Provider (if child): _____ Relationship: _____

LEGAL GAURDIAN (if applicable)

Legal Guardian's Name: _____ Occupation: _____
Relationship to client _____SS#:_____DOB:_____
Address: _____ City:_____ Zip: _____
Phone: (home)_____(work)_____(other)_____

Insurance Information

What Insurance, if any do you have? _____

Primary Insurance Holder's Name: _____ **Insurance Holder's Date of Birth:** _____

Policy/Member Number: _____ **Group No. if applicable:** _____

Appointment Reminders

Would you like to receive a reminder for your appointments? ☐Yes ☐No If yes, choose the preferred method: ☐Call ☐Text

Preferred cell phone number for reminders to be sent to (if different from above): _____

To be completed by Therapist: **Therapist Name:** _____

Service to be provided: ☐ Indiv TX ☐Family TX ☐AODA Ind ☐AODA Gp ☐Couples ☐Other: _____

Location: ☐ North Side Office ☐ South Side Office ☐ In Home ☐Ct Has Co-Occurring Diagnosis

Service code primarily billing:_____ Primary Diagnosis: _____ (no.) Secondary Diagnosis: _____ (no.)

Alternatives in Psychological Consultation
10045 W. Lisbon Avenue
Wauwatosa, WI 53222
Phone 414-358-7144
Fax 414-358-7158
www.altlig.com

Consent for Treatment

I, the undersigned, have been informed of the following on the date indicated below:

1. Type of treatment to be provided.
2. The way the treatment is to be given and services provided.
3. The expected treatment side effects or risk of side effects which are possible.
4. Goals or benefits expected.
5. The name of the person providing the treatments and his/her credentials.
6. Estimated length of treatment.
7. Estimated cost of treatment and my ultimate responsibility for those costs.
8. Other available treatment.
9. Steps to follow in case of an emergency.
10. Probable consequences of not receiving treatment suggested.
11. Possible risks, if any, associated with treatment suggested.
12. If I disagree with any part or the entire treatment plan suggested, I can request a second opinion and will be assisted in obtaining that second opinion.
13. The name of my provider's supervisor and that he/she is available at any time to me should I have a question, concern or complaint about my treatment.
14. My rights as a client. I understand that information given within a therapeutic relationship shall remain confidential, except for those circumstances outlined in Wisconsin Statutes which require a provider to report the occurrence or likely occurrence of homicide, suicide, physical assault, or child abuse.
15. Grievance procedures should I believe my rights were violated.
16. My consent to treatment does not include consent for participation in any research or educational programs in which this agency is involved or may become involved in during my treatment.
17. At times, your provider(s) may seek information on the internet about you for risk management or other clinical purposes. If this happens, you will be told about any Internet searches and have an opportunity to correct any incorrect information.
18. Providers will not accept Facebook requests from clients. Please don't contact your provider via any social network sites.
19. Texting and taking messages while in treatment should be avoided. You may use email/texting to communicate with your provider about administrative details, such as appointment times and cancellations, but no other types of correspondence shall take place via this method. E-mail is not secure or confidential.

My signature below indicates my consent to the treatment plan described to me today. **I understand my consent automatically expires 12 months from the date in which my consent was given.** I do, however, have the right to withdraw this consent at any time I choose.

_____ _____
Client Signature Date

_____ _____
Parent/Legal Guardian Signature (if applicable) Date

_____ _____
Therapist Signature Date

This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail.
The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Meetings

Evaluation meetings usually last from 1 to 3 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your goals. If psychotherapy is begun, sessions are usually 50 minutes (50 min. hour). Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. If it is possible, I will try to find another time to reschedule the appointment.

Limits on Confidentiality

The law protects the privacy of all communications between a patient and a clinician. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by state law and HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I will make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record.
- You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member. D*isclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement*.
- If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected. I cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
- If a client files a worker's compensation claim and I have treated him/her for any condition reasonably related to the condition for which the claimant claims compensation, I may be required to disclose information, upon appropriate request, to the client's employer.
- There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a client's treatment. These situations are unusual in my practice.
- If I have reason to believe that a child I have seen has been abused or neglected, or has been threatened with abuse or neglect that I believe is likely to occur, the law requires that I file a report with the appropriate governmental agency, usually the appropriate county department or child welfare agency. Once such a report is filed, I may be required to provide additional information.
- If I have reason to believe or suspect that abuse, material abuse or neglect of an elder adult has occurred, the law allows me to file a report with the appropriate government agency, usually the appropriate county agency or the long-term care ombudsman's office. Once such a report is filed, I may be required to provide additional information.
- If I believe that a client presents a foreseeable risk of harm to another, I may have to take protective actions including notifying the potential victim, contacting the police, or seeking hospitalization for the client.
- If such a situation arises, I will make every effort to fully discuss it with you before taking any action, and I will limit my disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

Professional Fees

My hourly fee is $160. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. For legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party.

Contacting Me

Due to my work schedule, I am often not immediately available by telephone. You may contact me through my voicemail at 414-358-7999 **ext. _____.** I'll make every effort to return your call on the same day, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If immediate response is required, you may call the emergency on-call therapist at (414) 303-8698.

If you are unable to reach me or the emergency on-call therapist and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if

Client Rights

HIPAA provides you with several rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location in which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

Billing and Payments

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. [In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.]

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. [If such legal action is necessary, its costs will be included in the claim.]

Insurance Reimbursement

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf. You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis.

Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

By signing this Agreement, you agree that I can provide requested information to your carrier. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by contract].

Minors & Parents

Clients under 18 who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records unless I decide that such access is likely to injure the child, or we agree otherwise. Because privacy in psychotherapy is crucial to successful progress, particularly with teenagers, it is my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Client Signature:_____ Date: _____

Alternatives in Psychological Consultation
Request for Confidential Handling of Health Information

We may receive requests to release your personal health information. Your information WILL NOT be released without your permission or unless ordered by law. However, if such a request should arise, you have the right to indicate the method in which you would like your health information shared.

I, _____ request that
(Print First and Last Name of client)

Alternatives in Psychological Consultation, S.C. handle my confidential
(name of practice)
health information in the following way(s):

A. All reasonable requests to receive communication of your health information by alternative means will be granted. **Please initial** the means by which you prefer to receive your health information.

____ ***Initial*** -Mail

____ ***Initial*** - Fax

____ ***Initial*** - Telephone

____ ***Initial*** - Other: _____

____ ***Initial*** - No Preference

B. All reasonable requests to receive communication of your health information at alternative locations will be granted. **Please complete the following section ONLY if you want communications regarding your health care information sent to an alternate address other than your residence.**

_____
(Street Address)

_____ _____ _____
(City) (State) (Zip Code)

X_____ _____
Client or Guardian Signature Date

Alternatives in Psychological Consultation, S.C.
Fees and Service Policy (Rev. 5/2016)

Providing Services

It is the policy of Alternatives in Psychological Consultation, S.C. (APC) to provide psychotherapy to any client requiring treatment, or to refer the client to another resource that could provide appropriate services. All clients will be assessed for appropriateness of treatment and continuation of treatment is contingent upon client cooperation. Lack of motivation, including but not limited to, two or more missed sessions without appropriate notice may result in termination.

Fees

The following are APC's fees for services. Please note our fees are usual and customary fees for therapeutic services.

Master's Level Therapist	Psychologist	Substance Use Counseling
Initial Evaluation--$225	Initial Evaluation--$225	Initial Evaluation--$225
1 hour session-- $160	1 hour session--$180	1 hour session-- $160
45 min Session--$140	45 Min Session--$160	45 min Session--$140
30 Min Session--$100	30 Min Session--$120	30 Min Session--$100

Group Therapy	Urinalysis Testing
Per hour Session--$55	$12 per Test

Note: Clients who are receiving services through Milwaukee County or State of Wisconsin funding are not subject to these fees, as they are covered through a Voucher Program. If you have questions regarding our fees, please discuss them with your provider prior to the beginning of any professional service.

Co-Payments

Any co-payment is due at the time of service. While we will bill your insurance and obtain authorization for treatment as a courtesy to you, it is always the client's responsibility to know the limitations of his/her insurance and to know what services have been authorized. Please notify us promptly of changes to your insurance. Any unpaid claims will be the client's responsibility. If an account becomes overdue in an amount over $50, your provider cannot continue providing services. You would then have to seek services outside of the clinic. APC is able to provide you with a list of other agencies who may serve you.

Sliding Fee Policy

APC offers a sliding fee for individuals who have family incomes 100% to 200% of the Federal Poverty Guidelines. Clients may complete an application to see if they would qualify for discounted fee. Copies of the application and income/discount schedule can be found in the outpatient waiting areas, our website (altlig.com), or can be obtained from your therapist.

Cancellation

A notice of at least 24 hours must be given before cancellation of any appointment. If cancellation is not made in compliance with this policy, or an appointment is missed, the client may be billed a $25.00 fee for the session. If a client misses two or more sessions without proper notification, services may be terminated.

File Copies

As a client, you have right to a copy of your medical file. Upon written request and payment for administrative copying costs, we will furnish you with a copy of your file. Alternatives charges the following rate for this service: $.45 per copy for the first 50 pages; $.25 per copy for each page over 50, with a minimum charge of $8.40.

Emergencies

APC has a 24-hour emergency phone available to all clients. There is no charge for this service. However, this number should be used only for emergency purposes and not to convey messages to providers regarding cancellations or other non-emergency issues. **The emergency phone number is 414-303-8698**.

***I have received a copy of this agreement*.**

_____ _____

Signature Client/Guardian Date

WISCONSIN NOTICE FORM—Updated 9/23/13

Notice of Health Care Service Provider Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW HEALTH CARE, PSYCHOLOGICAL, AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

APC may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*

--*Treatment* is when APC provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when APC consults with another health care provider, such as your family physician or another psychologist.

--*Payment* is when APC obtains reimbursement for your healthcare. Examples of payment are when APC discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

– *Health Care Operations* are activities that relate to the performance and operation of APC's practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- "*Use*" applies only to activities within APC [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of APC [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

APC may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances, when APC is asked for information for purposes outside of treatment, payment and health care operations, APC will obtain an authorization from you before releasing this information.

APC will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes APC clinicians have made about conversations during a private, group, joint, or family counseling session, which have been kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. ****Please note that APC Care Coordinators do not conduct psychotherapy or counseling sessions. Notes generated by Care Coordinators are for the purpose of coordination of care, not treatment. Therefore, these notes are not considered "psychotherapy notes."**

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) APC has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

APC may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If APC has reasonable cause to suspect that a child seen in the course of professional duties has been abused or neglected, or have reason to believe that a child seen in the course of professional duties has been threatened with abuse or neglect, and that abuse or neglect of the child will occur, APC must report this to the relevant county department, child welfare agency, police, or sheriff's department.
- **Adult and Domestic Abuse:** If APC believes that an elder person has been abused, or neglected, APC may report such information to the relevant county department or state official of the long-term care ombudsman.
- **Health Oversight:** If the Wisconsin Department of Regulation and Licensing requests that APC release records to them in order for the Psychology Examining Board to investigate a complaint, APC must comply with such a request.
- **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and APC will not release the information without written authorization from you or your personal or legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance, if this is the case**.**

- **Serious Threat to Health or Safety:** If APC has reason to believe, exercising professional care and skill, that you may cause harm to yourself or another, APC must warn the third party and/or take steps to protect you, which may include instituting commitment proceedings.
- **Worker's Compensation:** If you file a worker's compensation claim, APC may be required to release records relevant to that claim to your employer or its insurer and may be required to testify.

IV. Client's Rights and Health Care Provider's Duties

Client's Rights:

1. *Right to Request Restrictions*--You have the right to request restrictions on certain uses and disclosures of protected health information about you. You have the right to restrict disclosure of PHI to a health plan with respect to health care for which you have paid out-of-pocket and in full. However, APC is not required to agree to all restrictions you request.
2. *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, APC will send your bills to another address.)
3. *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, APC will discuss with you the details of the request process.
4. *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. APC may deny your request. On your request, APC will discuss with you the details of the amendment process.
5. *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, APC will discuss with you the details of the accounting process.
6. *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.
7. *Right to Electronic Copy*—You have the right to request and receive a copy of your PHI if stored electronically in a designated record set.
8. *Right to Timely Response*—You have the right to receive your PHI in 30 or fewer days after we receive your request, whether in a paper or electronic format. APC may request one 30-day extension to provide your PHI, but will give you notice if this occurs.
9. *Right to Prohibit Sale of PHI*—You have the right to prohibit the sale of your PHI without your express written authorization.
10. *Right to Opt Out*—You have the right to opt out of receiving any fundraising communications from APC.

(Please note: APC currently does not sell your PHI or use your PHI for fundraising communications).

11. *Right to Notification of Breach*—You have a right to be notified if there is a breach of unsecured PHI.
12. *Right to Reasonable Fee*—You have a right to receive your PHI information, but may be charged a reasonable, cost-based fee to cover costs of copying or labor to compile, scan, etc. records. See APC Fee and Service Policy for rates.

Health Care Provider's Duties:

- APC is required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.
- APC reserves the right to change the privacy policies and practices described in this notice. Unless APC notifies you of such changes, however, APC is required to abide by the terms currently in effect.
- If APC revises its policies and procedures, APC will provide individuals with a revised notice.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision APC makes about access to your records, or have other concerns about your privacy rights, you may contact Karen T. Drexler (414) 358-7146. If you believe that your privacy rights have been violated and wish to file a complaint with APC, you may send your written complaint Karen T. Drexler, 10045 W. Lisbon Ave. Wauwatosa, Wisconsin 53222.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. APC will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on September 23, 2013. APC reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that it maintains. APC will provide you with a revised notice.

Signing below acknowledges I have read and received a copy of this notice.

_____	_____	_____
Client Name (print)	Client Signature	Date

Alternatives in Psychological Consultation
Authorization for Release of Information

Client Name: _____ Client Date of Birth: _____

This form, when completed and signed by you, authorizes me to release or obtain protected information from your clinical record to the person you designate.

I authorize Alternatives in Psychological Consultation staff to ☐release or ☐obtain (check one or both) information with the following agency or person.

Name of agency: _____
Name of contact person: _____
Address:_____
_____
Phone:_____

Specific information to be released **by** Alternatives in Psychological Consultation:

☐ History/Physical Exam ☐ Psychological Evaluation ☐ Psychiatric Evaluation ☐Social Assessment ☐Aftercare Plan
☐Discharge Summary ☐General/Verbal Information on case progress ☐ Urine Screen Results ☐Case Notes
☐Other: _____

Specific information to be released **to** Alternatives in Psychological Consultation:

☐History/Physical Exam ☐ Psychological Evaluation ☐ Psychiatric Evaluation ☐Social Assessment ☐Aftercare Plan
☐Discharge Summary ☐Genera/Verbal Information on case progress ☐Urine Screen Results ☐Case Notes
☐Other: _____

I am allowing Alternatives in Psychological Consultation to release or obtain this information for the following reasons: ("at the request of the individual" is all that is required if you do not state or check a specific purpose): _____
_____

☐Transfer of Care ☐Continued Care ☐Legal ☐Insurance ☐Personal Use ☐Other: _____

This authorization expires 365 days from the date this authorization is signed unless otherwise noted: **Exp. Date: _____.**

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the Alternatives in Psychological Consultation (APC) office address at 10045 W. Lisbon Ave. Wauwatosa, WI 53222. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Notification of your withdrawn release will be sent via mail by Alternatives in Psychological Consultation to all applicable entities immediately upon your withdrawal.

I understand that Alternatives in Psychological Consultation generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I further understand that I have a right to receive a copy of any mental health treatment record to be disclosed.

I understand that if a recipient of the health information is not governed by federal and state confidentiality laws, the health information disclosed as a result of this authorization may be re-disclosed by the recipient and no longer be protected by such laws.

_____ _____
Signature of Client Date

_____ _____
Signature of Legal Guardian Date

If the authorization is signed by a personal representative of the client, a description of such representative's authority to act for the client must be provided.

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	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 asleep, 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're 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 in some way	0	1	2	3

Column Totals _____ + _____ + _____

Add Totals Together _____

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Alternatives in Psychological Consultation, S.C.

Client Questionnaire

In your own words, what areas of your life would you like to work on? (Why did you come to Alternatives today?)

Please check which areas you may want assistance with or more information about.

☐	Parenting /Family/Children	☐	Physical Complaints
☐	Work/School/Financial	☐	Impulse Control
☐	Intimacy	☐	Anger
☐	Sexuality	☐	Concentration
☐	Social/Personal Interactions/Peers/Friendship	☐	Someone hurting you (physically or emotionally)
☐	Legal Issues	☐	Thoughts of hurting self/others
☐	Drug or Alcohol use	☐	Sleeping Problems
☐	Worry/Stress	☐	Loss of Interest in things
☐	Eating/Weight Concerns	☐	Other _____

Comments: _____

_____

ABOUT YOU:

Who do you live with?	**What are your Spiritual/Cultural Affiliations:**
Describe Your Living Arrangements:	**Do you have any Legal History? Explain:**
What are some of your Strengths?	**Who are some Supports in your life?**
What is your Highest Level of Education?	**What school do you attend (if child) or where do you work?**
Are you aware of any birth complications you (or your child if he/she is client) had or exposure to drugs prenatally?	**Are you or have you been in the Military? If yes, which area and dates.**

Please tell me about your Family:

Parents & Siblings: **(Use Back of page if you need More Room)**

Parent/Caregiver Name: _____ ☐ *Deceased* ☐ *Living*	*Age:* ____	*Describe Relationship/Concerns:*
Parent/Caregiver Name: _____ ☐ *Deceased* ☐ *Living*	*Age:* ____	*Describe Relationship/Concerns:*
Sibling: ☐ *Deceased* ☐ *Living* *Name:* _____	*Age:* ____	*Describe Relationship/Concerns:*
Sibling: ☐ *Deceased* ☐ *Living* *Name:* _____	*Age:* ____	*Describe Relationship/Concerns:*
Sibling: ☐ *Deceased* ☐ *Living* *Name:* _____	*Age:* ____	*Describe Relationship/Concerns:*

Children: ☐ Not Applicable **Use Back of page if you need More Room)**

Name	Age	Problems/issues	Relationship w/Child

MEDICAL INFORMATION

Who is your Primary Doctor? _____

Location/Phone: _____

Approximate Date of your last physical/exam:_____

Are you pregnant or do you think you are pregnant? ☐*Yes* ☐*No* ☐ *NA*

Please List any Physical Complaints and their Duration: ☐None

1.	4.
2.	5.
3.	6.

Note: _____

Did you have any past surgeries? If yes, what and when? ☐None

_____

Please list any Allergies: ☐None

_____

Have you ever had in-patient or out-patient services for mental health or Drug use? ☐**Yes** ☐**No** **If yes, where & when:**

_____

Medications

List past and current medication use:

Medication Name	Dosage	Frequency	Prescribed by:	What was the medication Prescribed to Help with?:	Currently Taking	Took in Past
1.					☐	☐
2.					☐	☐
3.					☐	☐
4.					☐	☐
5.					☐	☐
6.					☐	☐
7.					☐	☐

Is there any history of mental illness or drug/alcohol use in your family? If yes, please list: ☐ Not applicable

I. SUBSTANCE USE/ABUSE (Please check 'yes' or 'no' to the following questions.)

UNCOPE: ☐ Not applicable ☐ Applicable

Yes= 1	No=2	
		1. Have you used drugs other than those required for medical reasons?
		2. Do you use more than one drug at a time?
		3. Are you always able to stop using drugs and/or alcohol when you want to?
		4. Do you ever feel bad or guilty about your drug and/or alcohol use?
		5. Do people in your life ever complain about your involvement with drugs and/or alcohol?
		6. Have you engaged in illegal activities in order to obtain drugs and/or alcohol?
		7. Have you neglected your family because of your use of drugs and/or alcohol?
		8. Have you engaged in illegal activities in order to obtain drugs and/or alcohol?
		9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs and/or alcohol?
		10. Have you had medical problems as a result of your drug and/or alcohol use (e.g. memory loss, hepatitis, etc.)?

Are you, or do you think you may be pregnant? ☐Yes ☐No ☐NA

Have you ever attended a Support Group (like AA/NA/GA?) ☐Yes ☐No

If yes, where/when: _____

II. OTHER CONCERNS

Have you ever had financial problems due to gambling? ☐Yes ☐No

Has anyone else expressed concern about them amount of time/money spent on gambling? ☐Yes ☐No

Do you look at pornography? ☐Yes ☐No

Do you think you have any sexual concerns? ☐Yes ☐No

Communicable Diseases Statement:

State law requires our agency to give information regarding the prevention and treatment of communicable diseases to all clients.

Please indicate if you currently have or have had any of the following:

Tested positive for tuberculosis? ☐Yes ☐ No Tested positive for HIV? ☐Yes ☐ No

Tested positive for Hepatitis? ☐Yes ☐No Ever had a sexually transmitted disease? ☐Yes ☐ No

Note: _____

Please answer a Few Questions about how it was Growing Up

1. What memories do you have before age 5, or if can't remember, what have you been told things were like?

2. What was life like for you through about age 12 (or what things stand out for you)?

3. What was it like for you though middle and high school (or what things stand out for you)?

4. What was it like for you when you first began living on your own (if applicable)?

5. Describe any history of abuse, neglect, and/or any traumas (e.g. accidents, etc.) inflicted on you or by you.

6. Describe your legal history (name of any arrests, imprisonments, etc.)

7. What is your financial history (e.g. poverty in childhood) as well as current financial concerns (e.g. bankruptcy)?

8. Tell me about your past and present personal relationships (history of date frequency, separation and divorce of current relationship(s).

9. Who are the people in your life that are your biggest supporters?

10. What causes you the most distress in your life right now? Please rate on a scale of 1-10 (10=highest)

11. What is the main thing you want to change?

12. What are some goals you would like to accomplish through therapy?

    a)

    b)

    c)

    d)

Client's Copy

Alternatives in Psychological Consultation, S.C.
Fees and Service Policy (Rev. 5/2016)

Providing Services

It is the policy of Alternatives in Psychological Consultation, S.C. (APC) to provide psychotherapy to any client requiring treatment, or to refer the client to another resource that could provide appropriate services. All clients will be assessed for appropriateness of treatment and continuation of treatment is contingent upon client cooperation. Lack of motivation, including but not limited to, two or more missed sessions without appropriate notice may result in termination.

Fees

The following are APC's fees for services. Please note our fees are usual and customary fees for therapeutic services.

Master's Level Therapist	Psychologist	Substance Use Counseling
Initial Evaluation--$225	Initial Evaluation--$225	Initial Evaluation--$225
1 hour session-- $160	1 hour session--$180	1 hour session-- $160
45 min Session--$140	45 Min Session--$160	45 min Session--$140
30 Min Session--$100	30 Min Session--$120	30 Min Session--$100

Group Therapy	Urinalysis Testing
Per hour Session--$55	$12 per Test

Note: Clients who are receiving services through Milwaukee County or State of Wisconsin funding are not subject to these fees, as they are covered through a Voucher Program. If you have questions regarding our fees, please discuss them with your provider prior to the beginning of any professional service.

Co-Payments

Any co-payment is due at the time of service. While we will bill your insurance and obtain authorization for treatment as a courtesy to you, it is always the client's responsibility to know the limitations of his/her insurance and to know what services have been authorized. Please notify us promptly of changes to your insurance. Any unpaid claims will be the client's responsibility. If an account becomes overdue in an amount over $50, your provider cannot continue providing services. You would then have to seek services outside of the clinic. APC is able to provide you with a list of other agencies who may serve you.

Sliding Fee Policy

APC offers a sliding fee for individuals who have family incomes 100% to 200% of the Federal Poverty Guidelines. Clients may complete an application to see if they would qualify for discounted fee. Copies of the application and income/discount schedule can be found in the outpatient waiting areas, our website (altlig.com), or can be obtained from your therapist.

Cancellation

A notice of at least 24 hours must be given before cancellation of any appointment. If cancellation is not made in compliance with this policy, or an appointment is missed, the client may be billed a $25.00 fee for the session. If a client misses two or more sessions without proper notification, services may be terminated.

File Copies

As a client, you have right to a copy of your medical file. Upon written request and payment for administrative copying costs, we will furnish you with a copy of your file. Alternatives charges the following rate for this service: $.45 per copy for the first 50 pages; $.25 per copy for each page over 50, with a minimum charge of $8.40.

Emergencies

APC has a 24-hour emergency phone available to all clients. There is no charge for this service. However, this number should be used only for emergency purposes and not to convey messages to providers regarding cancellations or other non-emergency issues. **The emergency phone number is 414-303-8698**.

Alternatives In Psychological Consultation, S.C
10045 W. Lisbon Ave. Suite 221
Wauwatosa, WI 53222
Phone: 414-358-7144 - Fax: 414-358-7158
www.altlig.com

Grievance Procedure and Form

If you have a grievance or a problem:

1. Discuss it with your therapist
2. Call the office to talk to the Compliance Officer, Karen Drexler at 414-358-7146
3. Write your complaint below and mail it to:

   10045 W. Lisbon Avenue
   Wauwatosa, WI 53222

Complaint:

Name of Provider you work with:

Your name:_____Date:_____

Where and how we can contact you:_____

_____

Your recommendations:_____

_____

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 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 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 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 sec. 51.30, Wis. Stats. and/or HSS 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.
- 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, DSL
  P.O. 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:
  DSL 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: **Karen T. Drexler** **Phone: 414-358-7146**
10045 W. Lisbon Ave.
Wauwatosa, WI 53222

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.

WISCONSIN NOTICE FORM—Updated 9/23/13 (Client Copy)

Notice of Health Care Service Provider Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW HEALTH CARE, PSYCHOLOGICAL, AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

APC may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*

--*Treatment* is when APC provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when APC consults with another health care provider, such as your family physician or another psychologist.

--*Payment* is when APC obtains reimbursement for your healthcare. Examples of payment are when APC discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

– *Health Care Operations* are activities that relate to the performance and operation of APC's practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- "*Use*" applies only to activities within APC [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of APC [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

APC may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances, when APC is asked for information for purposes outside of treatment, payment and health care operations, APC will obtain an authorization from you before releasing this information.

APC will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes APC clinicians have made about conversations during a private, group, joint, or family counseling session, which have been kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. ****Please note that APC Care Coordinators do not conduct psychotherapy or counseling sessions. Notes generated by Care Coordinators are for the purpose of coordination of care, not treatment. Therefore, these notes are not considered "psychotherapy notes."**

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) APC has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

APC may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If APC has reasonable cause to suspect that a child seen in the course of professional duties has been abused or neglected, or have reason to believe that a child seen in the course of professional duties has been threatened with abuse or neglect, and that abuse or neglect of the child will occur, APC must report this to the relevant county department, child welfare agency, police, or sheriff's department.
- **Adult and Domestic Abuse:** If APC believes that an elder person has been abused, or neglected, APC may report such information to the relevant county department or state official of the long-term care ombudsman.
- **Health Oversight:** If the Wisconsin Department of Regulation and Licensing requests that APC release records to them in order for the Psychology Examining Board to investigate a complaint, APC must comply with such a request.
- **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and APC will not release the information without written authorization from you or your personal or legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance, if this is the case**.**

- **Serious Threat to Health or Safety:** If APC has reason to believe, exercising professional care and skill, that you may cause harm to yourself or another, APC must warn the third party and/or take steps to protect you, which may include instituting commitment proceedings.
- **Worker's Compensation:** If you file a worker's compensation claim, APC may be required to release records relevant to that claim to your employer or its insurer and may be required to testify.

IV. Client's Rights and Health Care Provider's Duties

Client's Rights:

13. *Right to Request Restrictions*--You have the right to request restrictions on certain uses and disclosures of protected health information about you. You have the right to restrict disclosure of PHI to a health plan with respect to health care for which you have paid out-of-pocket and in full. However, APC is not required to agree to all restrictions you request.
14. *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, APC will send your bills to another address.)
15. *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, APC will discuss with you the details of the request process.
16. *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. APC may deny your request. On your request, APC will discuss with you the details of the amendment process.
17. *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, APC will discuss with you the details of the accounting process.
18. *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.
19. *Right to Electronic Copy*—You have the right to request and receive a copy of your PHI if stored electronically in a designated record set.
20. *Right to Timely Response*—You have the right to receive your PHI in 30 or fewer days after we receive your request, whether in a paper or electronic format. APC may request one 30-day extension to provide your PHI, but will give you notice if this occurs.
21. *Right to Prohibit Sale of PHI*—You have the right to prohibit the sale of your PHI without your express written authorization.
22. *Right to Opt Out*—You have the right to opt out of receiving any fundraising communications from APC.

(Please note: APC currently does not sell your PHI or use your PHI for fundraising communications).

23. *Right to Notification of Breach*—You have a right to be notified if there is a breach of unsecured PHI.
24. *Right to Reasonable Fee*—You have a right to receive your PHI information, but may be charged a reasonable, cost-based fee to cover costs of copying or labor to compile, scan, etc. records. See APC Fee and Service Policy for rates.

Health Care Provider's Duties:

- APC is required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.
- APC reserves the right to change the privacy policies and practices described in this notice. Unless APC notifies you of such changes, however, APC is required to abide by the terms currently in effect.
- If APC revises its policies and procedures, APC will provide individuals with a revised notice.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision APC makes about access to your records, or have other concerns about your privacy rights, you may contact Karen T. Drexler (414) 358-7146. If you believe that your privacy rights have been violated and wish to file a complaint with APC, you may send your written complaint Karen T. Drexler, 10045 W. Lisbon Ave. Wauwatosa, Wisconsin 53222.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. APC will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on September 23, 2013. APC reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that it maintains. APC will provide you with a revised notice.

Signing below acknowledges I have read and received a copy of this notice.

_____	_____	_____
Client Name (print)	Client Signature	Date