

**ELMARGREEN
ASSOCIATES, INC.**

114 GRAND AVE WAUSAU WI 54403 715-845-7175

DATE: _____

THERAPIST: _____

Name: _____ Home Address: _____ City: _____

State: _____ Zip: _____ Home phone: _____ Cell: _____ Employer: _____

May we contact you at work?: _____ yes _____ no Work# : _____ DOB: _____

Age: _____ Sex: _____ Soc. Sec#: _____ Marital Status: _____ Spouses Name: _____

Spouses DOB: _____ Spouses Soc Sec.#: _____ Employer: _____ Work# : _____

Referral: _____ Physician: _____

Children:	Name: _____	Age: _____
	_____	_____
	_____	_____
	_____	_____

Emergency Contact : _____

Telephone: _____

PRIMARY INSURANCE COVERAGE:

Subscriber Name: _____
 Subscriber Address: _____
 City: _____ State: _____ Zip: _____
 Subscriber Phone#: _____ DOB: _____
 Subscriber Soc. Sec.#: _____
 Subscriber GRP#: _____
 Employer: _____
 Insurance Co. Name: _____
 Insurance Co. Phone: _____
 Policy#: _____ Employee ID#: _____

SECONDARY INSURANCE:

Subscriber Name: _____
 Subscriber Address: _____
 City: _____ State: _____ Zip: _____
 Subscriber phone#: _____
 DOB: _____ Sub SS#: _____
 Subscriber GRP#: _____
 Employer: _____
 Insurance Co. Name: _____
 Insurance Co. Phone: _____
 policy#: _____ Employee ID#: _____

1. I hereby authorize payment directly to Elmergreen Associates from my insurance company for services performed at this at this clinic.
2. I hereby authorize Elmergreen Associates to release any medical information necessary to process insurance claims.
3. I may be charged for missing appointments cancelled less than 24 hours in advance. If any other payor source denies benefits, I will be held responsible for the amount due.
4. I recognize and accept personal responsibility for payment of the deductible amount and for any balance outstanding after payment of insurance benefits.
5. In the event any unpaid balance is placed for collections with any 3rd party collection agency, and/or placed with an attorney to obtain judgment or otherwise satisfy payment of this account, a fee determined by our collection agency will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly by Elmergreen Associates, Inc. to collect amounts owed under this agreement such costs include, but are not limited to court costs, service fees, filing fees and other incidentals associated with our collection efforts.
6. A late fee of \$3.00 will be added each month for any account more than 60 days over due.

Client/Guardian Signature: _____ Date: _____

Please make sure to read and sign the back of this form.

Hourly Therapist Fee: _____

CLIENT RIGHTS

I understand that the following is a summary of my rights as a client of Elmergreen Associates:

The right to prompt and adequate treatment environment.

The right to be treated with respect and dignity.

The right to refuse to be filmed or taped.

The right to participate in the development of my treatment plan, including benefits, effects and method of treatment.

The right, upon request, to receive information regarding alternative programs or methods of treatment.

The right to refuse any treatment, including medications.

The right to have access to your treatment record after discharge, or during treatment if facility director approve it, and to have access at all times to records of medications I take or any treatment I receive for physical health reasons.

The right to refuse, or to give informed consent, to participate in drastic treatment or in experimental research. Informed consent shall remain in effect until formal discharge from the treatment program, unless revoked by me in writing.

The right to file a grievance.

If you believe that one of your client rights may have been violated, the agency's complaint investigator will investigate the matter and attempt to find a resolution if the complaint is validated. If you wish to file a complaint, you may request a complaint form from any staff member of the agency.

I am encouraged to contact my therapist regarding any concerns or problems I may have during my treatment and after my discharge. I further understand that I may at any time, request resumption of services. I understand my therapist may be consulting with a supervising psychologist regarding my case. I may also request a meeting with the psychologist.

In signing this consent, I have been provided with the following information:

- a. The benefits of the proposed treatment and services;
- b. The way the treatment is to be administered and the services are to be provided;
- c. The expected treatment side effects or risks of side effects which are a reasonable possibility, including side effects or risks of side effects from medications;
- d. Alternative treatment modes and services;
- e. The probable consequences of not receiving the proposed treatment and services;
- f. The time period for which the informed consent is effective, which shall be no longer than 15 months from the time the consent is given; and
- g. The right to withdraw informed consent at any time, in writing.

Client Name (print): _____ Date: _____

Client/Guardian Signature: _____

(copy available upon request)

Elmergreen Associates, Inc. cannot be responsible for children left unsupervised in the waiting room. Please make prior arrangements for childcare.