Lutheran Counseling and Family Services of Wisconsin

Professional counseling services for
mental health, addiction, family issues and crisis management.

3800 N. Mayfair Road Wauwatosa, WI 53222

Phone: 414-536-8333
Fax: 414-536-8348
Toll free: 800-291-4513
E-mail: lcfs@lcfswi.org

STAFF DIRECTORY — Greater Milwaukee area

Deborah Rayburn, MS, LPC, CSAC, CSIT
Areas of expertise: family counseling, depression, anxiety, trauma, addiction, military veterans and families

Glenn Peters, LPC, SAC, AODA
Areas of expertise: alcohol and other drug addictions, family counseling, depression, anxiety, trauma,

Andrea Alfke, LPC
Areas of expertise: children and family therapy, adolescents, mood and thought disorders, women's issues, trauma

Dr. James Jensen, Ph.D.
Areas of expertise: depression, anxiety, stress, anger management, divorce, legal or workplace problems.

Rory Gaouette, MA, LPC
Areas of expertise: children and family therapy, adolescents, mood and thought disorders, women's issues, trauma

Tajuan Conway, MS, CSAC
Areas of expertise: substance abuse counseling, youth, adults and families, crisis management.

Deborah VanderKinter, MS, LPC, SAC-IT
Areas of expertise: substance abuse, depression, mood disorders, anxiety, stress management, PTSD, trauma, women's issues, life transitions

LCFS provides affordable and accessible mental health counseling, substance abuse treatment, family life education and adoption counseling and services to all who seek our care regardless of age, faith, culture or economic status. Most insurances accepted with a generous sliding fee scale for those uninsured or unable to afford payments.

WELCOME

Lutheran Counseling & Family Services of Wisconsin

Lutheran Counseling and Family Services of Wisconsin (LCFS) is a community, family, and faith-based organization that works to help individuals and families with mental health concerns, alcohol and drug addictions, as well as with adoption services and counseling. Our licensed staff of psychologists, counselors, therapists and social workers welcomes people of all ages, regardless of faith, culture or economic status.

LCFS provides individual, marital and family therapy, play therapy for children, counseling and treatment for addiction services (AODA) and adoption services for birthparents and couples wishing to adopt. Our goal is to provide professional help to individuals, couples and families so that they can become more loving and functional in their relationships.

FEE POLICY FOR THERAPY SERVICES

Plans for payment of counseling fees will be reviewed with staff before the first appointment using either health insurance or LCFS's sliding fee scale. As a licensed agency, many insurance companies will provide payment for services.

If your insurance covers outpatient psychotherapy or psychiatric services, please complete the included insurance form, providing all necessary information and required signatures.

Payment for therapy can be covered by the sliding fee schedule if no insurance is available. This fee is based on family size and income.

If you are covered by insurance, LCFS will call and verify benefits. Co-payments, deductibles or sliding scale payments are to be made at each visit. When an overpayment occurs, a refund is made to you when the counseling terminates. There is a $45.00 fee for all returned checks. Any account which becomes 60 days or more past due may be turned over to our collection agency.

Statements are sent periodically to your insurance company and/or client. Questions regarding the statement can be discussed with the LCFS Billing Service at 773-935-4700. A statement of your account is available upon request.

APPOINTMENT CANCELLATIONS

Appointment cancellations must be made at least 24 hours prior to the scheduled appointment or you will be billed $45.00 for the missed appointment.

PROBLEM SOLVING

If a client believes a right has been violated, the agency will investigate the matter and attempt to find a solution to the complaint. You may contact Lisa Huebner, Clients Rights Specialist, at 800-291-4513.

EMERGENCY RESOURCES

LCFS after hours: 877-521-5677

CLIENTS' BILL OF RIGHTS

Clients who receive mental health services have the following rights under Wisconsin Statute 51.61.

1. **To receive services in a safe and pleasant outpatient environment.**
2. **To receive prompt and adequate treatment.**
3. **As a voluntary client, have the right to refuse treatment or excessive medication.**
4. **To refuse to be filmed or taped during a therapy session unless consent has been given.**
5. **To have their treatment records and conversation about treatment kept confidential.**
6. **To have their treatment record at time of treatment or after the completion of services when giving therapist at least 24 hours notice.**
7. **To file a grievance procedure if concerned about service.**
8. **Each client shall have the right to be fully informed of his/her treatment and care.**
9. **Each client shall have the right to be treated with respect and recognition of the patient's dignity and individuality by all employees of the treatment facility or community mental health program and by licensed, certified, registered or permitted providers of health care with whom the patient comes in contact.**

STAFF

Deborah Rayburn, MS, LPC, CSAC, CSIT
Glenn Peters, LPC, SAC, AODA
Andrea Alfke, LPC
Dr. James Jensen, Ph.D.
Rory Gaouette, LPC
Tajuan Conway, CSAC, ICS
Deborah VanderKinter, LPC, CSAC
Kathryn Feiertag, MSW, CAPSW, Adoption Coordinator
Lisa Huebner, COO/Client Rights Specialist

LUTHERAN COUNSELING & FAMILY SERVICES OF WISCONSIN CLIENT INFORMATION

Note: All information requested is for Client

Name ______________________________________ Occupation____________________________________

Spouse Name _______________________________ Employer _____________________________________

Address ____________________________________ Business Phone ________________________________

____ Home Phone ___________________________________

Marriage Date _______________________________ Cell Phone/Text messages _________________________

Social Security Number _______________________ Race ____

Birth Date _______/ _______/ _________ Age ____ Email ____

Children/Others in Household	Relationship (daughter, stepson, grandparent)	Age

Do you have a religious preference? ________

Please provide name of church and location ____

Pastor's name ______________________________ How did you find out about us? _____________________

TO BE COMPLETED BY CLIENT:

Please read each item below and determine which statement is true for you OR your child. Then place an "X" in the appropriate box to indicate how often you feel the statement applies during the past month. Be sure to rate each item.

	None	Sometimes	Always		None	Sometimes	Always
Change in sleep				Very happy			
Episode of panic				Loss of concentration			
Change in energy				Change in sex drive			
Hallucinations				Losing self control			
Rapid heart beat				Unable to enjoy life			
Ready to explode				Shortness of breath			
Strange thoughts				Thoughts of suicide			
Angry				Change in appetite			
Tearful				Peculiar experiences			
Thoughts about harming people				Withdrawn from others			

Why are you here? ____

Do you use alcohol or drugs? __________ If yes, how often? ____

LUTHERAN COUNSELING AND FAMILY SERVICES FINANCIAL AGREEMENT

Client Name ____

Lutheran Counseling and Family Services (LCFS) is committed to providing you, the client, with the best possible care. In order to achieve this goal, we need your assistance and agreement with our payment policy. We must emphasize that as your provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to you, all charges are your responsibility. LCFS charges $175.00 per hour for our Master's Degree Counselors and $210.00 for our Psychologists.

****

SELF-PAY (SLIDING FEE) CLIENT (Copy of tax returns attached)

I, the client, understand that I am responsible for my therapy at the rate of $_____per hour.

****

INSURANCE CLIENT (Copy of insurance card(s) attached)

Primary Insurance Carrier ___________________________________

Secondary Insurance Carrier _________________________________

I, the client, understand that after my deductible of $_______is met, my co-pay per hour of therapy is $_____________. I also understand that verification of benefits does not guarantee payment for these services.

****

I, the client, understand that if cancellations are not made at least 24 hours before the scheduled appointment, I will be responsible for a $45.00 fee for that session. I understand that Lutheran Counseling and Family Services may waive this fee in certain circumstances. I, the client, understand that Lutheran Counseling and Family Services charges $45.00 for returned checks.

I, the client, understand that if my balance becomes 60 days past due, my account may be turned over to a collection agency.

_____ (please initial) I, the client, authorize the release of any medical information needed by my insurance company to process any claims.

Lutheran Counseling and Family Services reserves the right to raise therapy rates with a 30-day notice.

I, the client, understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account. I have read and understand this agreement and I will notify Lutheran Counseling and Family Services of any changes in my financial or insurance status.

Client ____ Date: ____________

Responsible Party ______________________________________ Date: ____________

NOTICE OF PRIVACY PRACTICES

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

Lutheran Counseling & Family Services of Wisconsin (LCFS) Responsibilities

LCFS is required to maintain privacy of your health information and to provide you with a notice of the legal duties and privacy practices regarding protected health information maintained about you. LCFS is required to abide by the terms of this notice.

Your Health Information Rights

Obtain a paper copy of the notice upon request. You are able to obtain a paper copy of the notice upon request. For example, you may request LCFS to provide a paper copy of notice if you normally receive electronically.
Request a restriction on certain uses and disclosures of your health information. You have the right to request restrictions on certain uses and disclosures of protected health information by sending a written request to LCFS; however, LCFS is not required to agree to your request restriction. We cannot agree to restrictions on use or disclosures that are legally required.
Receive Confidential Communications. You have the right to request LCFS communicate your information to you by alternate means. For example, you may request to be contacted at a phone number that is different from the phone number listed in your file.
Inspect and obtain a copy of your health information. In most cases, you have the right to inspect or have a copy of most of your mental health record. In order to receive this, you must sign a Consent for Release of Information form and a reasonable fee may be applied for a copy of your record.
Amend your record. If you believe your mental health information is incorrect or incomplete you may request we amend it. To request an amendment, you must send a written request to the Supervising Psychologist. You must include a reason that supports your request. In some cases, we may deny your request for amendment.
Obtain an accounting of disclosures of your health information. You have the right to an accounting of disclosures of your health information that LCFS has. Your request must specify a time period. The period may not be longer than 6 years and may not include dates before April 14, 2003.

LCFS may use or disclose your mental health information for treatment.
Your information may be disclosed with the Supervising Psychologist, in which they consult in relation to your care and treatment.

LCFS may use or disclose your health information for payment. LCFS may use or disclose your health information to obtain reimbursement for services. The bill may include information that identifies you, your diagnosis and your treatment. Example: LCFS may use or disclose your information to your insurer to obtain payment for mental health care services.
As Required by Law: Lutheran Counseling & Family Services of Wisconsin may use or disclose protected health information to the extent that the use or disclosure is required by law and the use or disclosure complies with and is

limited to the relevant requirements of the law. Uses or disclosures required by federal privacy rule and limited by the more protective requirements of state law include the following:

- Disclosures about victims of elderly or child abuse;
- Disclosures for judicial and administrative proceedings; or
- Disclosures for law enforcement purposes.

Patient Complaint Process

If you believe your rights have been violated, you may file a complaint with Lutheran Counseling & Family Services of Wisconsin or with the Secretary of the Department of Health and Human Services. To file a complaint with Lutheran Counseling & Family Services please contact Lutheran Counseling & Family Services of Wisconsin Clients Rights Specialist who will provide you with the necessary assistance.

Questions or Concerns

If you have any questions or concerns regarding your privacy rights or the information in this notice, please contact:

Lutheran Counseling & Family Services of Wisconsin
3800 N. Mayfair Rd.
Wauwatosa, WI 53222
(414) 536-8333
(800) 291-4513

Effective Date: This Notice of Privacy Practice is effective as of April 14, 2003.

LUTHERAN COUNSELING & FAMILY SERVICES OF WISCONSIN

WRITTEN ACKNOWLEDGEMENT OF HIPAA RECEIPT

I, ____, acknowledge that I have received the **HIPAA Notice of Privacy Practices** from Lutheran Counseling & Family Services of Wisconsin.

____ ___________________

Client or Personal Representative Signature Date

____

If Personal Representative, describe relationship

❑ Acknowledgment was unable to be obtained for the following reason:

____

____

____

________________________________ ________________________________

Employee Signature Date

CLIENTS RIGHTS AND INFORMED CONSENT ACKNOWLEDGEMENT

Please read and sign below

Lutheran Counseling & Family Services of WI, pursuant to DHS 94, Wisconsin Administrative Code wants you to be aware of your rights as a client, and asks for your informed consent to receive treatment. Included with this form is a pamphlet explaining your rights and the grievance procedure available to you. Please read it and keep it with your records.

The following are general points of information about the therapy process and treatment which will be reviewed orally and in writing. If you have specific questions, please ask your therapist

- The purpose of therapy is to help alleviate the problems and symptoms that you present.
- Therapy is conducted in sessions between you and your therapist talking about the problems and symptoms presented.
- Review the LCFS Welcome brochure and review emergency services how to contact provider or office outside of normal business hours.
- The provider shall inform the client or client's legal representative of the results of the assessment if client is appropriate for receiving outpatient mental health services.
- If there are any expected side effects, or risks of side effects from therapy, they will be discussed with you as well as possible outcomes.
- Treatment recommendations and benefits of the treatment recommendations will be discussed.
- Approximate duration and desired outcome of treatment recommended in the treatment plan will be discussed.
- A client receiving outpatient mental health services has the rights and responsibilities in the development and implementation of an individual treatment plan.
- LCFS has the right to involuntary discharge a client for refusal to pay as agreed upon or for behavioral disruption of the treatment.
- Your therapist will suggest alternative treatment modes and assist in referrals when appropriate and necessary.
- The probable consequences of not receiving therapy or of ending therapy can be discussed.
- The content of all sessions will be held confidential and can be disclosed outside this program only with your signed approval, unless a specific statutory exception applies or a duty to warn exists.
- Your signature below indicates you are giving consent to participate in therapy sessions and you understand your rights.
- You have the right to withdraw informed consent at any time in writing. Otherwise this consent will be valid for 12 months.

I have read the above information and have been notified of my rights and the grievance procedure available to me. I hereby give my informed consent to receive treatment.

______________________________	______________
Client Signature *(Initial Session)*	**Date**
______________________________	
Please Print Name *(Initial Session)*	
______________________________	______________
Parent or Guardian (if applicable) *(Initial Session)*	**Date**
______________________________	______________
Client Signature *(Annually* if applicable*)*	**Date**
______________________________	______________
Client Signature *(Annually* if applicable*)*	**Date**

CLIENT RIGHTS ACKNOWLEDGMENT

CLIENT NAME: ____________________________________(please print)

You received a brochure explaining your rights entitled "Client Rights and the Grievance Procedure." A complete copy of the Patient Bill of rights, Sec. 51.61(1), Wisconsin Statutes, and/or accompanying DHS 94, Wisconsin Administrative Code, is also available upon written request. In addition, a copy of Sec. 51.30, Wisconsin Statutes, and accompanying DHS 92, Wisconsin Administrative Code, relating to your right to confidentiality is available upon written request.

If you have any questions about your rights as a client of Lutheran Counseling & Family Services, please feel free to discuss such with your therapist or contact the Clients Rights Specialist named on the back of the brochure. If you believe any of your rights have been violated, you may discuss such informally with staff, or you may submit a formal grievance with the Clients Rights Specialist. The Client Rights Specialist will provide you with a form you may use to file a formal grievance.

SIGNATURES

With my signature below, I acknowledge that I read or had read to me the above information. I have been notified of my rights as an individual receiving mental health treatment at this clinic and the grievance procedure available to me. I understand this information and received a copy of the brochure entitled "Client Rights and the Grievance Procedure.

____
Client Date

____
Parent/Guardian, if applicable Date

____
Witness Date

LCFS
Lutheran Counseling & Family Services
...where Christian care makes the difference!

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby request and authorize Lutheran Counseling and Family Services of WI to disclose to Advanced Healthcare Solutions, Inc., P.O. Box 578220, Chicago, IL 60657.

From the file of ____
Client Name Date of Birth

The following information:

*Intake Information *Diagnosis *All Dates of Service

The purpose for such disclosure is for billing purposes.

I understand that I have the right to inspect and receive a copy of the material to be disclosed as required under SS. DHS 92.05 and 92.06. This consent is given voluntarily and I understand that treatment services are not contingent upon my decision concerning this release of information. I may revoke this authorization at any time except to the extent that information already released pursuant to this consent cannot be recalled. Authorization of disclosure to Criminal Justice Agencies will remain in effect and cannot be revoked by me until formal and effective treatment or revocation of my release from confinement, probation, parole or other proceedings under which I was mandated into treatment. (42 CFR Part 2.35)

____________________________________ ________________________
Signature of Client and/or Guardian Date

____________________________________ ________________________
Signature of Client and/or Guardian Date

____________________________________ ________________________
LCFS Witness/Notary Date

If an LCFS witness is not available for client's protection this form must be notarized.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules Prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse of patient/client.

Lutheran Counseling and Family Services of WI – OFFICE POLICIES

IF YOU HAVE BEHAVIORAL HEALTH/MEDICAL INSURANCE BENEFITS we will file claims for you. You must present your insurance card(s) at initial session and when insurance changes occur. Please allow sufficient time for claims to process. If claims are not processed in a timely fashion it is your responsibility to follow up with your insurance company to address the issue and make our billing company aware of the issue. The billing company's phone number is (773) 935-4700.

COPAYS/DEDUCTIBLES that are required by your insurance must be paid at the time of appointment. We accept cash, check, Visa and MasterCard. **IF YOU CANNOT MAKE YOUR REQUIRED COPAY/DEDUCTIBLE AMOUNT, YOUR APPOINTMENT WILL BE RESCHEDULED.**

REFERRALS that are required by your insurance company must be in our office before we can see you. It is your responsibility to verify that your required Primary Care Physician's referral is in our office before your scheduled appointment. **If we do not have the required referral, the provider CANNOT SEE YOU AND YOUR APPOINTMENT WILL BE RESCHEDULED.**

MINORS must be accompanied by a parent or legal guardian. If the parents are separated, whoever carries the insurance policy for the minor child will be responsible for payment of services for the child should dispute over payment arise. Lutheran Counseling and Family Services of WI will not enter a dispute of divorced or separated parents.

PROVIDE US WITH COMPLETE INFORMATION. We will ask you periodically if any of your information has changed. Lutheran Counseling and Family Services of WI will not be responsible for mistakes due to missing or incomplete information regarding your insurance. If your insurance changes it is your responsibility to inform us immediately, if you do not inform us of insurance changes you will be responsible for the entire bill forward.

MISSED APPOINTMENTS: As a courtesy to our clients, we do try to make reminder calls. However, we cannot guarantee a confirmation call; therefore, we consider your scheduled appointment a commitment your responsibility to honor. If you are unable to keep your scheduled appointment give us 24 hours notice, which will allow us to schedule another client. Appointments cancelled without 24 hours advance notice will be assessed a $45 fee that is not covered by insurance. If you cancel with less than 24 hours notice or no-show, the fee will be charged and you will not be able to be seen until the fee is paid. **Client cannot be seen until the fee is paid.** *We greatly appreciate your consideration.*

If you, client, no shows or cancel with less than 24 hours notice your treatment will be terminated after the second occurrence.

________________________________ ______________________________________
Signature **Date**

APPOINTMENT CONFIRMATION: I authorize Lutheran Counseling and Family Services of WI to confirm my appointments, if not available please handle the following way:

_________ Leave a message on my answering machine or voicemail.
_________ Leave a message with individual answering phone.
_________ Do not confirm my appointments.

Signature: ________________________________ Date: ______________________________
Print: ____________________________________

COMMUNICATION DISCLOSURE AND CONSENT

Lutheran Counseling and Family Services of Wisconsin (LCFS) requires a Guarantor to be connected to each medical service account. The Guarantor may or may not be the client receiving services but is the person who is financially responsible for payment of any charges/balances for the services received.

Lutheran Counseling and Family Services of Wisconsin communicates with its clients in various ways, using information the Guarantor provides, including email, land line phone, cellular phone, text messaging, fax and U.S. Mail.

By providing your **cell number** during the initial process, you

1. Consent and agree to receive text messages, telephone calls and other communications including, its affiliates and collection agency. These calls may be in respect to services received at LCFS and your financial obligations related to those services. I, client, understand this consent applies to all current and future services.
2. Understand you may be charged for text messages, calls or other communication by your wireless carrier.
3. I understand it is my responsibility to inform LCFS if I, client, choose to withdraw this permission. I can withdraw this consent at any time by contacting LCFS.

I have read, understand and agree to the above.

____
Client Name (PRINT)

____________________________ ________________
Client Signature Date

SERVICE FEE

Lutheran Counseling and Family Services of Wisconsin charges additional fees for our psychotherapists to correspond with your lawyer. There will be an upfront charge of $200. The fee should be paid upon request of the clinician's assessment of their client. Also, if a lawyer requests a copy of a patient's records, there is an additional fee of $25, plus postage cost.

____ ______________________

CLIENT DATE

____ ______________________

WITNESS DATE