

Family Options Counseling, LLC

Client Service Agreement and Financial Responsibility

Clients Name: _____

Informed Consent:

- Voluntary:
 - I am voluntarily consenting to treatment or assessment for the named client and have the option to withdraw from services at any time.
 - I understand that this consent to treatment / assessment will be in effect for the duration of one year, unless I withdraw my informed consent in writing.
- Risks and Benefits:
 - I understand that no guarantees are made to me about the results of treatment or assessments.
 - I understand the plan for treatment / assessment and understand the potential risk and benefits of the treatment / assessments.
 - I understand the alternative treatment options.
 - I understand that I have the option to withdraw from services at any time.
- My Responsibility:
 - I understand that it is my responsibility to inform the assigned clinician if there are any changes in my condition (or the minor receiving services).
 - I acknowledge that I have received a copy of the Privacy Practices and Grievance Procedure for Family Options Counseling.
 - I understand that if the client is a minor, I will participate in treatment / assessment services as agreed upon with the assigned clinician.
 - I understand that it is my responsibility to attend scheduled therapy appointments. It is also my responsibility to cancel any appointments 48 hours prior to the session so that time can be used by someone else in need. I understand that I may lose my therapy time if I do not show up for my appointments.

Confidentiality and Its Limits:

- Our Responsibility Regarding Your Information:
 - I understand the Privacy Practices that was provided to me to begin services at Family Options Counseling. I am comfortable asking my clinician further questions about my confidential information.
- Mandated Reporting:
 - I understand that the clinician's at Family Options Counseling are mandated reporters for suspected abuse of children or vulnerable adults. I understand that if I report abuse to a child or a vulnerable adult, that the clinician(s) will have to report it to the appropriate social service agency and / or legal authorities.

- Duty to Warn / Protect:
 - I understand that if I disclose intentions or a plan to harm another person and have the ability to carry out that plan, my clinician(s) are required to warn the intended victim and inform the legal authorities. I also understand that if I disclose intentions to harm myself (or minor child discloses intentions), my clinician(s) are required to report this to the appropriate authorities or family members.

Phone Sessions / Electronic Communication:

- I understand that I can not participate in phone sessions at Family Options Counseling. Phone communication is appropriate for scheduling purposes and providing brief updates typically when the client is a minor.
- I understand that I will contact my clinician directly if I need to cancel / reschedule an appointment and I will not rely on third parties.
- I understand that text messaging and emailing is not an appropriate mode of therapeutic communication and that my therapist will be unable to respond through text messages. Text messaging and email communication may be an appropriate mode to schedule appointments if agreed upon by myself and my clinician.

Insurance Companies or Contracted Third Party Payors:

- I understand that I am providing permission for Family Options Counseling, for the purpose of payment for services, to disclose information to insurance companies or contract agencies that may be responsible for the payment of my services.
- I understand that it is my responsibility to inform Family Options Counseling of any changes to my insurance or enrollment in third party contracts. It is ultimately my responsibility to pay for any services that are not paid for by my insurance company or contracts.
- I understand that I have the right to review my history of services and payments by requesting this information from my clinician.
- I understand that if I do not provide payments or agree to a payment plan in a timely manner, my outstanding invoice may be turned over to a collections agency.

Financial Agreement:

- I agree to the following financial agreement between myself and Family Options Counseling.
- My insurance information:
 - Primary Insurance: _____
 - Secondary Insurance: _____
 - Tertiary Insurance: _____

- My preference is to utilize the sliding fee scale that Family Options Counseling offers. In order to utilize this scale, I understand that Family Options Counseling will not process any claims through insurance.
 - Based on my annual income of _____, and the number of people supported by this income, I agree to pay _____ per session. I have provided a copy of my most recent pay stub.

Following is a list of the fees for services at Family Options Counseling. If a contract exists with a third party payor, those agreed upon fees will be billed. If a third party payor authorizes the services through a contract agreement, Family Options Counseling will not send an invoice to the client.

Type of Service	Masters Licensed Training Level	Therapist / Master's Level	Psychologist / Doctoral Level
Intake Evaluation	\$150.00	\$200.00	\$300.00
Individual / Family Therapy	\$100.00 per hour	\$150.00 per hour	\$200.00 per hour
Group Therapy	\$60.00 per hour \$90.00 per 1.5 hour	\$60.00 per hour \$90.00 per 1.5 hour	\$60.00 per hour \$90.00 per 1.5 hour
Testimony	\$100.00 per hour	\$100 per hour	\$200.00 per hour

By signing this agreement, I agree to the terms of this contract and agree to the financial responsibility outlined in this contract.

Guardian/Client Printed Name

Date

Guardian/Client Signature

Date

Client Signature (14 years and older)

Date

Therapist

Date

Family Options Counseling, LLC
Insurance Information Form

Financial Payer Information - Primary Insurance	Financial Payer Information - Secondary Insurance
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Policy Holder Phone Number:	Policy Holder Phone Number:
Relationship to Client:	Relationship to Client:
Address of Policy Holder:	Address of Policy Holder:
Policy Holder Date of Birth:	Policy Holder Date of Birth:
Policy Holder SSN#:	Policy Holder SSN#:
Policy Holder's Employer:	Policy Holder's Employer:
Insurance Group #:	Insurance Group #:
Insurance ID Number:	Insurance ID Number:
Insurance Mailing Address	Insurance Mailing Address
Insurance Phone Number on card for Verification of Coverage:	Insurance Phone Number on card for Verification of Coverage:

Family Options Counseling, LLC

Release of Information

Client ID#: _____

Client Name: _____

Client's Guardian: _____

DOB: _____

I understand that my treatment information is confidential. I authorize Family Options Counseling to do the following with my treatment information:

Exchange my treatment information to the following individuals or agencies:

I do not wish to exchange my treatment information.
(If you wish to include an individual or agency in the future a new release of information document will be completed at that time.)

I understand that this authorization will expire in one year unless a different date is indicated.

Adjusted date: _____

I understand that the treatment information being disclosed includes any information from birth to the end of my treatment unless otherwise specified below.

Time period: _____

I understand that I am authorizing any of my treatment information to be disclosed unless otherwise specified below:

Specific information disclosed: _____

Client's Signature (if 14 years old)

Date

Guardian's signature (if client is under 18)

Date

Therapist's signature

Date



Family Options Counseling, LLC

3505 N. 124th Street ■ Brookfield, WI 53005
Phone: 414.431.4444 ■ Fax: 414.431.0858
www.familyoptions.com

Family Options Counseling Standards

Family Options Counseling is committed to maintaining a welcoming, safe environment. Our mission is to provide outpatient therapeutic services to children, adolescents and families within a healing environment. These standards are designed so that everyone visiting Family Options Counseling feels welcomed and comfortable. We are committed to maintaining a family friendly environment.

- Family therapy is an expected component of services. For example, family sessions may be every other week alternating with individual sessions.
- For individual and family therapy, children under 10 years old must be accompanied by an adult.
- For group therapy, an adult caregiver who leaves Family Options Counseling will provide contact information to the receptionist and be available if needed to pick the children up within 15 minutes.
- Children under 10 must be supervised by a caregiver when using the bathrooms.
- Please have youth use the bathroom prior to checking in for therapy.
- Clients must sign in at the front desk upon arrival when checking in with the receptionist.
- Clients must sign out at the front desk when done with their session and provide transportation information.
- Cancellations require a 24 hour notice. Please contact your therapist directly to cancel or reschedule any appointments.
- Youth are to remain in the waiting room while waiting for their session as well as while waiting for a ride.
- Family Options Counseling is a non-smoking agency. Please do not smoke outside the building.
- While in the waiting room, please respect others by using appropriate language and a quiet tone of voice. Keep headphones at a low volume so others can not hear your music.
- Family Options Counseling has games and activities for youth while they are waiting in the waiting room. Using kind manners, please ask the receptionist for access and assistance with the supplies.

My signature reflects an understanding of the above standards of behavior. By agreeing to therapeutic services at Family Options Counseling, I will work with my children to be able to maintain these standards. I understand my therapist can be used as a support.

Guardian

Date

As a client attending therapy at Family Options Counseling, I understand that the above standards are important. I will work on supporting the standards when I come to Family Options Counseling and will talk with my therapist when I need additional support.

Client

Date

As the therapist, I understand these standards of behavior and will check in with Family about their experience while attending therapy.

Therapist

Date

Family Options Counseling, LLC **Client Rights / Privacy Notice**

The purpose of this form is to provide our clients with specific information regarding the treatment they will receive at Family Options Counseling. This agency offers both verbal and written information to our clients. Please ask your therapist for any clarification regarding your treatment.

My signature on this form indicates that the therapist provided complete information regarding the following areas:

- The benefits of treatment
- Potential risks of treatment
- How treatment will be delivered
- Alternative treatment options
- Assessment and evaluation

My signature on this form also indicates that I have received a copy of the privacy practices and grievance procedures of Family Options Counseling. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Family Options Counseling, of my rights with respect to my health information, and how to use the grievance process.

I have been provided with the opportunity to discuss any concerns I may have regarding my treatment and the privacy of my health information.

Client

Date

Legal Guardian / relationship to client
(necessary if client is under age 18)

Date

Family Options Counseling, LLC

Privacy Notice

The purpose of this privacy 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.

Protected Health Information (PHI) includes personal information relating to your past, present and future medical or mental health condition. In accordance with the Privacy Rule and Health Insurance Portability and Accountability Act of 1996 (HIPAA), Family Options Counseling has established a policy to guard against unnecessary disclosure of your health information. This notice is effective April 14, 2003.

Family Options Counseling may use and disclose health information about you in the following ways:

- **To Provide Treatment:**
Family Options Counseling may use your PHI to provide care to you and disclose your health information to others who provide care to you. This may include consultation or supervision with other therapists or treatment team members. This consultation or supervision would occur to assist in determining the best treatment options for you.
- **To Obtain Payment:**
Family Options Counseling may include your PHI in invoices to collect payment from third parties for the services you receive. Family Options Counseling may be required by your health insurer to provide information regarding your health care status to determine eligibility of benefits, receive prior authorization, and reimbursement for services.
- **To Conduct Health Care Operations:**
Family Options Counseling may use and disclose your PHI for its own operations in order to facilitate business activities including, but limited to, quality assessment, employee review, program development, case management, professional review, training programs, licensing and certification, business planning and development, business management, general administrative duties, treatment outcome research, and marketing.
- **When Legally Required:**
Family Options Counseling may have to make disclosures of your PHI when required by state or federal law without your authorization. Information is disclosed to legal authorities for the purposes of maintaining compliance with the Privacy Rule. Family Options Counseling also has to report to legal authorities suspected child abuse or neglect, domestic violence, possible attempts or thoughts of endangering self or others, or a response to a court order. Additionally, Family Options Counseling is required to disclose your PHI if you are a victim of a crime or in order to report a crime.
- **With Authorization:**
Family Options Counseling will not use or disclose your PHI not specifically permitted by law unless given your authorization.

Client's right in regards to PHI:

- **Right to Request Restrictions:**
Family Options Counseling privacy policy provides our clients with the right to request restrictions on certain uses and disclosures of your PHI. Our clients have the right to request a limit on Family Options Counseling's disclosure of client's PHI to someone who is involved in client care or payment. However, Family Options Counseling is not required to agree to the client's request. Clients who wish to make a request for restrictions should contact Family Options Counseling at 414-431-4444.

- **Right to Receive Confidential Communications:**

Family Options Counseling privacy policy provides our clients with the right to request their therapist to communicate with them in a certain way to protect confidentiality. For example, the client may ask that Family Options Counseling only conduct communications pertaining to clients PHI with them privately with no other family members present.

- **Right to Inspect and Copy Your PHI:**

Family Options Counseling privacy policy provides our clients with the right to inspect and copy your PHI, including billing. However, this right does not necessarily apply to psychotherapy notes or information gathered for judicial procedures. In the event that the client would like to inspect their PHI, they should arrange a meeting with their therapist to review their records in our offices. Family Options Counseling may charge a reasonable fee for copying and assembling costs associated with this request.

- **Right to Amend Your PHI:**

Family Options Counseling privacy policy provides our clients with the right to amend their PHI if they believe that information is incorrect or incomplete. This request may be made as long as this information is maintained by Family Options Counseling. Family Options Counseling may deny the request if it is not in writing, does not include a reason for the amendment, if the records were not created by Family Options Counseling, if the records are not part of Family Options Counseling's records, if the request includes a part of the record that client is not permitted to inspect or copy, or if in the opinion of Family Options Counseling the records containing your PHI are accurate and complete.

- **Right to an Accounting of Your PHI:**

Family Options Counseling privacy policy provides our clients with the right to request an accounting of disclosures of client's PHI made by Family Options Counseling for certain purposes which may include disclosures required by law and disclosures made for research. This request for an accounting must be made in writing and should specify the time period for the accounting which cannot include dates prior to April 14, 2003. Family Options Counseling will provide the first accounting of a request during any 12 month period without charge. Subsequent accounting requests may be subject to a reasonable fee.

- **Right to a Paper Copy of this Notice**

Family Options Counseling privacy policy provides our clients with the right to receive a paper copy of this notice at any time, even if you have received this notice previously.

Responsibilities of Family Options Counseling:

Family Options Counseling is required by law to maintain the privacy of client's PHI and to provide clients with this notice of our duties and privacy practices. Family Options Counseling is required to abide by the terms of this notice reserve the right to change the terms of this notice at any time. If Family Options Counseling makes any changes to this notice, we will provide a copy of the revised notice to our clients.

Grievance Procedures:

Family Options Counseling clients have the right to express complaints to Family Options Counseling or to legal authorities if they believe that their rights have been violated. Family Options Counseling encourages our clients to express any concerns they may have regarding the privacy of their PHI. Our clients will not be retaliated against in any way for filing a complaint.

Family Options Counseling encourages clients to express their concerns to their therapist an initial stage of resolution. In the event that the client's concerns are not resolved, the client should express their concerns in writing to the owners of Family Options Counseling.

Contact Person:

Family Options Counseling has designated Kimberly Young as its contact person for all issues regarding client privacy and your rights under the Federal privacy standards. Kimberly Young can be contacted at Family Options Counseling at 414-431-4444.

Rights of Minors: Outpatient Behavioral Health Treatment

Consent for Mental Health Treatment

If you are younger than 14-years-old, a parent or guardian must agree, in writing, to you receiving outpatient mental health treatment.

If you are 14 years or older, you and your parent or guardian must agree to you receiving outpatient mental health treatment.

If you want treatment but your parent or guardian is unable to agree to it or won't agree to it, you (or someone on your behalf) can petition the county mental health review officer for a review.

If you do not want treatment but your parent/guardian does, the treatment director for the clinic where you are receiving services must petition the mental health review officer for a review.

Regardless of your age, in an emergency, the treatment director for the clinic may allow you to receive outpatient mental health treatment, but no medication, for up to 30 days.

During the 30 days, the treatment director must get informed written consent of your parent or guardian, or file a petition for review for admission with the mental health review officer.

Consent for Substance Use Treatment

Any minor can consent to substance use treatment at a public facility as long as it is for prevention, intervention, or follow-up.

If you are younger than 12-years-old, you may only get limited substance use treatment (such as detox) without a parent or guardian's consent.

If you are 12 years or older, you can be provided some limited treatment (assessment, counseling, and detox less than 72 hours) without your parent or guardian's consent or knowledge.

If your parent or guardian agrees to it, you can be required to participate in substance use treatment, including assessment and testing.

Review by Mental Health Review Officer and/or Court

Each juvenile court appoints a mental health review officer for that county. www.dhs.wisconsin.gov/clientrights/mhro

The juvenile court must ensure assistance is provided in the petition for review.

If you request it and the mental health review officer believes it is in your best interests, review by the mental health review officer can be skipped and the review will be done by the court.

If the mental health officer does the review, a hearing must be held within 21 days of the filing of the petition for review. Everyone must get at least a 96-hour notice of the hearing.

To approve your treatment (against your will or despite the refusal of your parent/guardian), the mental health review officer must find that:

- The refusal of consent is unreasonable.
- You are in need of treatment.
- The treatment is appropriate and least restrictive for you.
- The treatment is in your best interests.

If you disagree with the decision of the mental health review officer, you and your parent/guardian will be informed of the right to a judicial review.

If the court does the review, within 21 days of the mental health review officer's ruling, you (or someone acting on your behalf) can petition the juvenile court for a judicial review.

A court hearing must be held within 21 days of the petition. Everyone must get at least a 96-hour notice of the hearing.

If you do not want the treatment, the court must appoint you an attorney at least 7 days prior to the hearing.

If it is your parent/guardian who does not want the treatment and you do not already have a lawyer, the court must appoint you one.

To approve your treatment (against your will or despite the refusal of your parent/guardian), the judge must find that:

- The refusal of consent is unreasonable.
- You are in need of treatment.
- The treatment is appropriate and least restrictive for you.
- The treatment is in your best interests.

A court ruling does not mean that you have a mental illness. The court's ruling can be appealed to the Wisconsin Court of Appeals.

Treatment Rights

You must be provided prompt and adequate treatment.

If you are 14 years or older, you can refuse mental health treatment until a court orders it.

You must be told about your treatment and care.

You have the right to and are encouraged to participate in the planning of your treatment and care.

You and your relatives must be informed of any costs they may have to pay for your treatment.

Personal Rights

You must be informed of your rights.

Reasonable decisions must be made about your treatment and care.

You cannot be treated unfairly because of your race, national origin, sex, gender expression, religion, disability, or sexual orientation.

Record Access and Privacy Rights

Staff must keep your treatment information private (confidential). However, it is possible that your parents may see your records.

If you are younger than 14-years-old, you must view your records in the presence of a parent/guardian, attorney, judge, or staff member. You may always see your records on any medications you take. Regardless of your age, staff may limit how much you may see of your records. They must give you reasons for any limits.

If you are at least 14-years-old, you can consent to releasing your own mental health treatment records to others.

If you are at least 12-years-old, you can consent to releasing your substance use treatment records to others.

Patient Rights Help

- Contact the client rights staff at your treatment provider.
- File a complaint. Client rights staff will look into your complaint.
- Contact Disability Rights Wisconsin at 800-928-8778. Their advocates and attorneys can help you with patient rights questions.

For More Information

Visit the DHS client rights website at: www.dhs.wisconsin.gov/clientrights/minors

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 HFS 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, DDES 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 Disability and Elder Services or designee. Send your request to the DDES 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:

Name: Kimberly Young

Phone: 414-431-4444

Address: 3505 N. 124th St

Brookfield, WI 53066

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.

Printed by:
Department of Health and Family Services
Division of Disability and Elder Services
April 2006

PDE-3112

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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.

Family Options Counseling, LLC

Authorization to Email Invoices

Clients Name: _____

To help provide a more effective method of delivery for your invoices and/or statements, Family Options Counseling offers the option to email our clients their invoices and statements. If you wish to activate this delivery method on your account, please complete this Authorization to Email Invoices and/or Statements form. Make sure to note the exact address(es) where you would like us to send your invoices and/or statements.

I would like to receive invoices at the following email address:

Email Address

Email Address

I would like to receive paper invoices and not receive them via email.

I may revoke this consent in writing at any time.

By signing this agreement, I agree to receive invoices from Family Options Counseling electronically.

Guardian/Client Printed Name

Date

Guardian/Client Signature

Date

Therapist

Date

Please fax this completed form to 414-431-0858.

Completed forms may also be mailed to:
Family Options Counseling
3505 N. 124th St.
Brookfield, WI 53005

Family Options Counseling, LLC

Recurring Payment Authorization Form

Schedule your payment to be automatically deducted from your bank account, or charged to your Visa, MasterCard, American Express or Discover Card. Just complete and sign this form to get started!

Here's How Recurring Payments Work:

You authorize regularly scheduled charges to your credit card. You will be charged the amount indicated below for each session. A receipt for each payment will be emailed to you and the charge will appear on your bank statement as "Family Options Counsel." You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

I would like to have a credit card on file for recurring payments.

I do not wish to have a credit card on file at this time.

Please complete the information below:

I _____ authorize Family Options Counseling to charge my credit card
(full name)

account indicated below for _____ on or after the date of service. This payment is for
(amount)

(Client Name)

Billing Address _____

Phone# _____

City, State, Zip _____

Email _____

Account Type: Visa MasterCard AMEX Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

SIGNATURE _____

DATE _____

I understand that this authorization will remain in effect until I cancel it in writing to Family Options Counseling, LLC at 3505 N. 124th St, Brookfield, WI 53005. Changes in my account information or termination of this authorization must be made at least 15 days prior to the next billing date. I understand that the payments may be executed up to one week after the date of service. I acknowledge that the origination of all transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my credit card company; so long as the transactions correspond to the terms indicated in this authorization form.