FamilyPath
AUTISM SERVICES

Registration

Today's Date:	

Client Information

Client Full Name (First, MI, Last)				
Date of Birth	Age (Years, Mos)	Gender	Home Phone Number	Other Phone Number
Street address:				
City	State	ZIP Code	County of Residence	

Client's Physician Information

Physician Name	Physician Phone Number
Physician or Clinic Address	Physician Fax Number

Parent/Guardian Information

Full Name of Parent/Guardian Completing this Form	
Mailing Address (if same as client, you may leave the address blank)	
Email Address	Home/Cell Phone Number
Employer	Work Phone Number
Relationship to Client	Parent/Guardian Date of Birth

Parent/Guardian Full Name	
Mailing Address (if same as client, you may leave the address blank)	
Email Address	Home/Cell Phone Number
Employer	Work Phone Number
Relationship to Client	Parent/Guardian Date of Birth

Parent/Guardian Signature*	Date

*The signature above acknowledges that I have received a copy of the Privacy Practice Notice

575 D'Onofrio Drive | Suite 101 | Madison, WI 53719
1017 W. Glen Oaks Lane | Suite 110 | Mequon, WI 53092
intake@familypathautism.com Phone: 866.912.2919 Fax: 608.841.1059 www.familypathautism.com

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Insurance Information

(Please provide a copy of both sides of your insurance card)

Primary Insurance Carrier		Phone Number
Address		
Policy Holder (Full Name)		
Group Number	Policy or Member Number	Person Code

Secondary Insurance Carrier (i.e. Medicaid/CLTS Waiver, Katie Beckett Program)		Phone Number
Address		
Policy Holder (Full Name)		
Group Number	Policy or Member Number	Person Code

Authorized Use of Signature on File

- I authorize the release of any medical or other information by FamilyPath Autism Services, LLC necessary to process and/or approve insurance claims.
- I authorize payment of medical benefits directly to FamilyPath Autism Services, LLC.
- I authorize the use of this form as my signature for all insurance claims and submissions.
- I permit a copy of this authorization to be used in place of the original.
- I have been advised and I understand the cost of treatment.
- If it is determined that treatment is **not** a covered benefit, I understand that I will be responsible for my bill.
- I authorize the use of this form on all insurance submissions made on my behalf.

Client Name	Date of Birth
Printed Name of Parent/Guardian	
Signature of Parent/Guardian	Date

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Client Rights, Responsibilities and Consent

When you receive any type of outpatient mental health service for you have the following rights under Wisconsin Statute sec. 51.61 (1) and DHS 94, Wisconsin Administrative Code:

Treatment Rights: You have the right to receive prompt and adequate treatment and to participate in treatment planning. You will be informed of your treatment and care including alternative and possible side effects. You have the right to refuse treatment and mediations (unless court ordered) and to be free from unnecessary or excessive medications and drastic treatment measures. You will be informed of any costs of your care and treatment. You will be treated in the least restrictive manner and setting (within limits of available funding) and to not be restrained or placed in seclusion unless in an emergency to prevent physical harm to you or others. You will not be discriminated against in the delivery of services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment. You have the right to be treated with courtesy, respect and dignity at all times by all employees of this agency.

Records Privacy and Access: Your treatment information will be kept confidential. Your records will not be released without your consent, unless the law specifically allows for this. You have the right to see your records of medications and health treatments. During treatment access may be limited if the risks outweigh the benefits. If access to records is limit you must be informed of the reason and you can challenge the reason by filing a grievance. After discharge you may see your entire record if requested. You may challenge the accuracy, completeness, timeliness or relevance of entries in your record. If the staff will not change part the record you challenged, you may file a grievance. A copy of sect 51.30 Wis Stats and/or DHS 92 is available upon request.

Privacy Rights: You have the right not to be filmed or taped without your consent.

Right of Access to Court: You have the right to bring legal action for damages or other court relief if they violate your rights.

Your responsibilities: To get the best treatment in the shortest amount of time possible, you have some responsibilities as a client. You should participate in your treatment planning, communicate and cooperate with staff who assist you with implementing your plan. You should provide staff with information about your past medical, social and psychiatric history to help staff best meet your needs. You should treat other staff, clients and property with respect and meet your financial obligations promptly, once you are aware of them.

Grievance and Resolution Process: If you feel your rights have been violated, you may file a grievance. You have the right to file a grievance without being penalized. The agency has a grievance process through which you may file a complaint and you may request a copy of the program's grievance procedure. You may file a grievance as you want and the process may end at any time if you feel the matter has been resolved. You do not have to use the grievance process and you may take your grievance directly to court if you believe your rights have been violated.

Access to Emergency Services: You have the right to access emergency services. In a therapeutic emergency, you may call the office 24 hours a day, 7 days a week. During non-business hours our answering service at your request will contact an on call therapist to return your call for emergencies. If you are experiencing a life threatening emergency, please call 911 or go to the nearest emergency room.

Discharge Policy: There are circumstances under which my child may be involuntarily discharged. I have read and understand the discharge policy of the clinic. FamilyPath Autism Services may discontinue services if (1) all treatment goals have been met, (2) you fail to demonstrate interest in actively pursuing treatment goals, (3) you fail to pay for services as agreed upon in your fee agreement, (4) upon the professional recommendation of your therapist.

I acknowledge that I have read the above Client Right and privacy notices and have had the opportunity to receive a copy of each.

Client Name	Date of Birth
Printed Name of Parent/Guardian	
Signature of Parent/Guardian	Date

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AUTISM SERVICES

Consent for Autism Treatment

Client Name	Date of Birth

Consent to Evaluate/Treat: I voluntarily consent that my child will participate in a mental health (e.g. autism services) evaluation and/or treatment by staff from FamilyPath Autism Services, LLC. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:

a. The benefits of the proposed treatment
b. Alternative treatment modes and services
c. The manner in which treatment will be administered
d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
e. Probable consequences of not receiving treatment

The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Wisconsin Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Counseling.

Benefits to Evaluation/Treatment: Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, as well as expectations regarding the length and frequency of treatment. It may be beneficial to my child, as well as the referring professional, to understand the nature and cause of any difficulties affecting my child's daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.

Charges: Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.

Confidentiality, Harm, and Inquiry: Information from my child's evaluation and/or treatment is contained in a confidential record at FamilyPath Autism Services LLC, and I consent to disclosure for use by FamilyPath Autism Services, LLC staff for the purpose of continuity of my child's care. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: 1) if my child is deemed to present a danger to himself/herself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

Discharge Policy: There are circumstances under which my child may be involuntarily discharged. I have read and understand the discharge policy of the clinic. FamilyPath Autism Services, LLC may discontinue services if (1) all treatment goals have been met, (2) you fail to demonstrate interest in actively pursuing treatment goals, (3) you fail to pay for services as agreed upon in your fee agreement, (4) upon the professional recommendation of your therapist.

Right to Withdraw Consent: I have the right to withdraw my consent for evaluation and/or treatment of my child at any time by providing a written request to the treating clinician.

Expiration of Consent: This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of my child. I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

Printed Name of Parent/Guardian	Signature of Parent/Guardian
Signature of Lead Therapist	Date

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Consent to Release of Information

Client Name	Date of Birth
Address	
City, State	Zip Code

- ☑ Release information to:
- ☑ Exchange information with:
- ☑ Obtain information from:
- ☑ Phone contact on with:

School or Service Agency/Organization (i.e. Birth to Three, School District, Preschool/Daycare)		
Address		
City	State	Zip Code

Purpose or need for disclosure (check all that apply):

- ☑ Evaluation / Assessment
- ☐ Further psychological care
- ☐ Other (specify):
- ☑ Treatment Coordination
- ☐ To process insurance claim

Specific information to be disclosed (check all that apply):

- ☑ Complete record
- ☑ Initial Assessment / Evaluation
- ☑ Medical diagnosis / Treatment records
- ☑ School records
- ☑ Progress reports
- ☑ Other (specify):
- ☑ Therapy Notes / Treatment Summary
- ☑ Diagnostic Evaluation / Assessment
- ☑ Psychological testing / evaluation
- ☑ Recommendations
- ☑ Discharge Summary

This consent will remain in effect for one (1) year from the date of signing unless revoked in writing by me at an earlier date. I have read, understood and accepted the additional information affecting release of records printed on the back of this form. I have had full opportunity to read and consider the contents of this Authorization, and I confirm that the contents are consistent with my direction to the health care provider. I understand that, by signing this form, I am confirming my authorization that the health care provider may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Printed Name of Parent/Guardian	
Signature of Parent/Guardian	Date

FamilyPath
AUTISM SERVICES

Consent to Release of Information

Client Name	Date of Birth
Address	
City, State	Zip Code

- ☑ Release information to:
- ☑ Exchange information with:
- ☑ Obtain information from:
- ☑ Phone contact on with:

Physician Name		
Address		
City	State	Zip Code

Purpose or need for disclosure (check all that apply):

- ☑ Evaluation / Assessment
- ☐ Further psychological care
- ☐ Other (specify):
- ☑ Treatment Coordination
- ☐ To process insurance claim

Specific information to be disclosed (check all that apply):

- ☑ Complete record
- ☑ Initial Assessment / Evaluation
- ☑ Medical diagnosis / Treatment records
- ☐ School records
- ☑ Progress reports
- ☐ Other (specify):
- ☑ Therapy Notes / Treatment Summary
- ☑ Diagnostic Evaluation / Assessment
- ☑ Psychological testing / evaluation
- ☑ Recommendations
- ☑ Discharge Summary

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Printed Name of Parent/Guardian	
Signature of Parent/Guardian	Date

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Consent to Release of Information

Client Name	Date of Birth
Address	
City, State	Zip Code

- [x] Release information to:
- [x] Exchange information with:
- [x] Obtain information from:
- [x] Phone contact on with:

Other		
Address		
City	State	Zip Code

Purpose or need for disclosure (check all that apply):

- [x] Evaluation / Assessment
- [ ] Further psychological care
- [ ] Other (specify):
- [x] Treatment Coordination
- [ ] To process insurance claim

Specific information to be disclosed (check all that apply):

- [ ] Complete record
- [ ] Initial Assessment / Evaluation
- [ ] Medical diagnosis / Treatment records
- [ ] School records
- [ ] Progress reports
- [ ] Other (specify):
- [ ] Therapy Notes / Treatment Summary
- [ ] Diagnostic Evaluation / Assessment
- [ ] Psychological testing / evaluation
- [ ] Recommendations
- [ ] Discharge Summary

This consent will remain in effect for one (1) year from the date of signing unless revoked in writing by me at an earlier date. I have read, understood and accepted the additional information affecting release of records printed on the back of this form. I have had full opportunity to read and consider the contents of this Authorization, and I confirm that the contents are consistent with my direction to the health care provider. I understand that, by signing this form, I am confirming my authorization that the health care provider may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Printed Name of Parent/Guardian	
Signature of Parent/Guardian	Date

Additional information regarding disclosure of patient medical information

FamilyPath Autism Services, LLC honors a patient's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

Right to refuse to sign this authorization: A client or parent / legal representative is under no obligation to sign this form, and may refuse to do so. Except as permitted under applicable law, FamilyPath Autism Services, LLC. may not refuse to provide treatment or other health care services if client or parent / legal representative refuse to sign this form. However, if client or parent / legal representative / parent / legal representative refuse to release this information by signing the form, it could result in a failure, for example, to properly coordinate treatment with other health care providers such as psychiatrist or primary physician, thus making treatment less effective. Depending on the specific situation, other potentially harmful effects could occur.

Right to receive copy of this authorization: If a client or parent / legal representative agrees to sign this form, they have the right to receive a signed copy of this form.

Revocation: A client or parent / legal representative has the right to revoke this authorization, in writing, at any time before it expires. However, written revocation will NOT affect any disclosures of your medical information that the person(s) and/or organization listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, revocation may not be effective in certain circumstances where the insurer is contesting a claim. Revocation must be made in writing and addressed to: FamilyPath Autism Services, LLC

Right to inspect or copy the health information to be used or disclosed: A client or parent / legal representative have the right to inspect or copy the medical information whose disclosure authorized to disclose, with certain exceptions provided under state and federal law. If the client or parent / legal representative would like to inspect records, contact your clinician or the office of FamilyPath Autism Services, LLC. In accordance with Wisconsin Stature 51.30 [Patient Access s.51.30(4)(d)3], inspection of a record shall be done with a clinician present.

Federal HIPAA Privacy Rules: These federal rules indicate when your protected health information may be used or disclosed without your authorization. Please see our Notice of Privacy Practices for additional information.

Multiple release of information: A client or parent / legal representative may request multiple releases of the information stated on the Authorization form. However, all releases based on this form are limited to records dated up to and including the date of the client or parent / legal representative's signature. A new authorization is 'necessary for release of information for care provided after that date of the client or parent / legal representative s signature, unless the Authorization specifically states that specific records that will be generated in the future may be released, for example " future records of a specific test" or "future records of a specific clinic appointment."

Copying Fees: If client or parent / legal representative are requesting disclosure/release of medical information to other hospitals, clinics, or physicians for further medical care, no copying fees will be charged. A fee may be charged for copies requested for other purposes.

Signatures: Generally, if the client is 18 years of age or older, the client is the only person who is permitted to sign a form to authorize the disclosure of medical information. If the client is under the age of 18, parent or guardian must sign this form. There are, however, many situations in which this general rule does not apply. For more information regarding who is authorized to sign this form, contact FamilyPath Autism Services, LLC.

Financial Agreement

You are responsible for the costs of services provided by FamilyPath Autism Services, LLC. We ask that you pay any expected co-pay/personal fee in full each month. You will be billed monthly, and we ask that you make payment in full within 30 days. Should you ever over pay; any payment will be promptly refunded. As a service to our clients insurance claims will be submitted to your insurance carrier(s).

If you have insurance coverage, please be sure to check with your carrier regarding your benefits, co-pays, co-insurance, and deductibles so you have a full understanding of your plan and what personal costs you may incur while receiving services from our office. You are responsible for any prior authorizations/referrals that may be needed. You are also personally responsible for any costs that exceed the benefit limits of your insurance policy or are not covered by your policy.

If you or your child has a Wisconsin ForwardHealth Medicaid plan you are responsible for keeping your ForwardHealth Medicaid coverage current. If you have a lapse in Wisconsin ForwardHealth Medicaid coverage, or coverage is cancelled, you will be responsible for payment of services. We will always bill your private insurance first for services provided. If your insurance will not cover services, we will then bill your Wisconsin ForwardHealth Medicaid plan.

The fee for services is as follows:

Diagnostic Evaluations/Testing	Individual Mental Health Treatment	Individual ABA Behavioral Treatment	Social Skills Group
$150.00/hour	$120.00/hour	$60.00/hour/therapist	$50.00/hour

Accounts must be kept current and monthly statements must be paid upon receipt unless written arrangements have been made. If your account balance goes above $300, and you have not made payment arrangements with our office, we may ask that you temporarily stop services until your account is brought up to date. For your convenience our office does accept MasterCard and Visa. If you have any questions regarding your account, please ask our account manager.

FamilyPath Autism Services, LLC reserves the right to seek legal means to secure reimbursement.

I have read, understand, and agree to the policies described above. I understand that I am responsible for my bill with FamilyPath Autism Services, LLC regardless if I have insurance coverage or not.

Client Name	Date of Birth
Printed Name of Parent/Guardian	
Signature of Parent/Guardian	Date

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