Michael Noll, LPC

1488 Kenwood Dr, Suite 101
Menasha, WI 54952

(920) 215-1553 Phone/Text
(920) 731-8606 Fax

Client Rights

As a client of Michael Noll, LPC, you have the right:

1. To be treated with dignity and respect, free from abuse.
2. Receive prompt and adequate treatment.
3. To participate in the planning of your treatment.
4. To have access to your treatment records after discharge/termination (or during treatment with the approval of your treating provider).
5. To refuse treatment.
6. To file a grievance.

Patient Privacy Consent of Personal Health Information (PHI)

The Department of Health and Human Services has established a "Privacy Rule" to help insure that PHI is protected for privacy. The Privacy Rules was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about a patient to carry out treatment, payment or health care operations (PTO).

As our patient, we want you to know that we respect the privacy of your personal medical records, and will do all we can to secure and protect privacy. We strive to always take reasonable precautions to protect your privacy. When it is necessary, we provide the least amount of information possible to those entities that require us to do so. This information may include your treatment, payment or health care operations and will always be in your best interest. As a matter of clinic property, PHI will not be released without obtaining written client consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose not to allow disclosure of your PHI. If you choose to give consent by signing this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have objects to this form, please ask to speak to our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Grievance

If you have a concern about the services you are receiving, please discuss it with your provider. You will not be penalized or threatened in any way for presenting your concerns.

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Signature Date

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Consent for Treatment form Mental Health Evaluation and/or Treatment

1. **Consent to Evaluate/Treat:** I am voluntarily consenting to a mental health evaluation and/or treatment by Michael Noll, LPC. Evaluation and/or treatment may be administered via interview, psychological assessment or testing, psychotherapy or medication management. The length and frequency of treatment will vary according to my individual needs. I understand that following the evaluation, I will receive complete and accurate information regarding:
    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

    Treatment will be conducted within the boundaries of Wisconsin Law for Psychological, Psychiatric, Social Work, Professional Counseling, or Marriage and Family Therapy.

2. **Benefits to Evaluation/Treatment:** Possible benefits to treatment include improved cognitive and/or academic/job performance, health status, quality of life, and awareness of strengths and limitations. Risks associated with psychotherapy may include:
    a. Disruptions to your daily life that occur because of therapeutic changes
    b. Emotional pain due to recalling and exploring past personal issues and family history
    c. Emotional pain due to discussing and exploring current relational issues
    d. Although one anticipates improvement of symptoms through therapy, we cannot guarantee positive results.

3. **Charges:** Fees are based on the length or type of evaluation and/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. Fee schedules are available to me upon request.

4. **Confidentiality, Harm and Inquiry:** Information from my evaluation and/or treatment is contained in confidential records at the office. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or other; 2) if concerns about possible abuse or neglect arise or domestic violence; 3) if a court order is issued to obtain my records; 4) there is reportable child abuse.

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

6. **Expiration of Consent:** This consent to treat will expire 18 months from the date of signature, unless otherwise specifies.

I have read and understand the above, and I consent to the evaluation and treatment. I understand that I have the right to discuss this information with my provider at any time.

_____	_____
Client Name (print)	Date of Birth
_____	_____
Client Signature	Date
_____	_____
Parent/Guardian Signature	Date