Evolve LLC

Wisconsin Mental Health Consent

Purpose: This form is to obtain an individual's written permission under Wisconsin law for our use of the individual's mental health treatment records to carry out treatment, payment activities, and health care operations, and our disclosure of the individual's mental health treatment records to family members or other persons involved in their care or payment for their care, and billing and assignment of benefits. This form should not be used to obtain written permission for the disclosure of mental health treatment records unless the name of the recipient is listed on this form.

Individual(s) Giving Consent:

Name of Client: _____ Preferred Name: _____
(Last) (First)

Other Participating Individuals: _____
(parent/significant other) (Last) (First)

Address: _____
(Street) (City) (State) (Zip)

Phone: _____

Client's Date of Birth: _____ Client's Gender Identity: _____

Marital Status: ( ) Married ( ) Single ( ) Other

How did you hear about us? ( ) Website ( ) Referral ( ) Family/Friends ( ) Other please specify: _____

How would you like to receive appointment reminders (Please choose one option)? ( ) Text ( ) Phone call
( ) Email: _____

To the Individual: Please read the following and complete the information requested.
Privacy Practices Notice: You have the right to read our Privacy Practices Notice before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

The uses and disclosures being authorized.
Our uses of mental health treatment records: By signing this form, you will consent to our use of your mental health treatment records to carry out treatment, payment activities, and health care operations as set forth in our privacy practices notice. This consent is effective until you revoke it in writing. Revocation of this consent will not affect any action we took in reliance on this authorization before we received your written notice of revocation. We may decline to treat you if you revoke this consent.

Our communication with you.
Please check the boxes below to indicate your consent to the following:

May we send correspondence to your home?	( ) Yes ( ) No
May we call you?	( ) Yes ( ) No
May we leave a message on you answering machine or voicemail?	( ) Yes ( ) No
May we send e-mail appointment reminders?	( ) Yes ( ) No
Would you like to sign up for our bi-monthly newsletter?	( ) Yes ( ) No

I had full opportunity to read and consider the contents of this consent. I understand that by signing this form, I am confirming mine or my minor child(ren) written permission for the use and disclosure of my mental health records as described in this form. I also confirm that I been provided accesses to the Privacy Practice Notice online via the website or by e-mail and that if I would like a hard copy of the Privacy Practice Notice I will be given one.

_____ _____
Client Signature **Date**
(14 years of age and older)

_____ _____
Parent/Guardian Signature **Date**
(Required if client is under 18 years of age)

Evolve LLC

Privacy Practices Notice

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. THIS PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Organizations Covered by this Notice

This notice applies to the privacy practices of Evolve LLC only.

Our Legal Duty

We are required by applicable law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect October 1, 2011 and will remain in effect unless we replace it.

We reserve that right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made changes. Before we make a significant change in our privacy practices, we will change this notice, post the revised notice at our service delivery site and make the new notice available to our patients and others upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information at the end of this notice.

Nothing contained in this privacy practices notice shall be deemed or construed as a waiver of Evolve LLC.

Uses and Disclosures of Medical Information

Treatment: We may use your medical information, without your permission to treat you. We may disclose your medical information, without your permission, to a physician or other health care provider for your treatment. These treatment activities include coordination of your care with other providers, health plans and other, consultation with other providers, and referral to other providers related to your care.

Payment: We may use and disclose your medical information, without your permission, to obtain or provide reimbursement for health care we provide to you, including submitting claims to health plans, insurers and others. These payment activities include justifying our charges for and demonstrating the medical necessity of the care we deliver to you, determining your eligibility for health plan benefits for the care we furnish to you, obtaining precertification or preauthorization for your treatment or referral to other health care providers, participating in utilization review of the services we provide to you and the like. We may disclose your medical information to another health care provider or plan to obtain payment or engage in other payment activities with respect to your health care.

We may need written permission to disclose information taken from your mental health treatment records for payment purposes.

Health Care Operations: We may use and disclose your medical information for our health care operations. Health care operations include: Health care quality assessment and improvement activities. Reviewing and evaluating health care provider and health plan performance, qualifications, and competence, health care training programs, health care provider and health plan accreditation, certification, licensing and credentialing activities. Conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention and business planning, development, management, and general administration, including customer service, de-identifying medical information, and creating limited data sets for health care operations, public health activities and research. With your written permission, we may disclose your medical information to a health plan or another health care provider who is subject to federal privacy protection laws, as long as the provider or plan has or had a relationship with you and the medical information is for that provider's or plan's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

We may need your written permission to disclose medical information or information taken from your mental health treatment records for certain health care operations.

Your authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice.

Family, friends and others involved in you care or payment for care: We may disclose you name and location in our facilities without your written permission to a family member, friend or any other person you involve in your health care or payment for your health care. Before we disclose you name and location without your written permission, we will provide you with an opportunity to object. If you are not present or are incapacitated or it is an emergency or disaster relief situation, we will use our professional judgment to determine whether disclosing you name and location is in your best interest under the circumstances. We may use or disclose your name and location to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your health care in the appropriate situations, such as a medical emergency or during disaster relief efforts. With your written permission, we may disclose your confidential medical information to a family member, friend or any other person you involve in your health care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

Health related products and services: We may use your medical information to contact you to provide appointment reminders, and to communicate with you about treatment alternatives and other health related benefits and services that may be of interest to you. These communications may describe health related products or services that we provide, payment for such products or services, and the health care providers in a provider or health plan network.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds or public health and interest activities, judicial and administrative proceedings, law enforcement, research, and other public benefit functions such as the following: for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence. To avert a serious and imminent threat to health or safety, for health care oversight, such as activities of state licensing and peer review authorities, and fraud prevention enforcement agencies, for research and in response to court and certain administrative orders and other lawful process. As well as to law enforcement officials with regards to crime victims, crimes on our premises, crime reporting in emergencies and identifying or locating suspects or other persons, to coroners, medical examiners, funeral directors. To military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding person in lawful custody and as authorized by worker's compensation laws. You may be able to opt out of use or disclosure of your medical information for research purposes or pursuant to be written request from a government agency, unless disclosure is required by law. We may not disclose HIV test results, certain confidential medical information or mental health treatment records for certain of these purposes without your written permission, unless required by law.

Individual rights

Access: You have the right to examine and to receive a copy of your medical information with limited exceptions. You must make a written request to obtain access to your medical information. You should submit you request to the contact at the end of this notice. We may charge you reasonable, cost-based fees for a copy of your medical information, for mailing the copy to you and for preparing any summary or explanation of your medical information you request. Contacting us using the information at the end of this notice for information about our fees.

Disclosure Accounting: You have the right to a list of instances after October 1, 2008 in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you and for certain other activities. You also have the right to a list of all written disclosures of your mental health treatment records. You should submit your request to the contact at the end of this notice. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more then 6 years before the date request. If you request this accounting more then once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to your additional requests.

Amendment: You have the right to request that we amend your medical information and mental health treatment records. Your request must be in writing, and it must explain why the information should be amended. You should submit you request to the contact at the end of this notice. We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform other of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restrictions: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends, or others you identify. We are not required to agree to your request. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit you request to the contact at the end of this notice. Any agreement we make to a request for restriction must be in writing signed by a person authorized to bind us to such an agreement.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by alternative means or to alternative locations that you specify. You must make your request in writing. You should submit your request to the contact at the end of this notice. We will accommodate your request if it is reasonable, specifies the alternative means or location for confidential communication, and explains how payment for our services will be handled under the alternative means or alternative location you request for confidential communication of your medical information. We will not ask you to explain the reason for your request.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information at the end of this notice.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information at the end of this notice. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, in response to a request you made to amend, restrict the use or disclosure of or communicate in confidence about your medical information, you may complain to us using the contact information at the end of this notice. You also may submit a written complaint to the:

State Grievance Examiner
Division of Mental Health and Substance Abuse Services
Department of Health Services
1 West Wilson Street, Room 850
P.O. Box 7851
Madison, WI 53707-7851
1-608-266-9369

Questions:
Evolve LLC
ATT: Brenda Velissaris MSE, LPC, NCC, CEDS
Owner and Clinical Director
3416 Association Drive
Appleton, WI 54914