

# LWCFC INFORMED CONSENT TO TREATMENT INFORMATION

Welcome to the Living Well Christian Family Clinic Counseling, LLC (LWCFC). Thank you for choosing LWCFC to assist you. We pray that the matters you bring are resolved to the glory of our loving Lord.

LWCFC, founded in 2008, is a state certified outpatient mental health clinic committed to providing quality counseling services by professionally trained therapists in a supportive, Christ-centered environment. It is our prayer that your relationship with your therapist will help you and/or your family members to gain better insight into your daily living and to grow towards a healthier more satisfying Christian life. This requires mutual effort by both you and your therapist, along with the strength of our gracious Lord. Living the Christian life is both a joy and a challenge for all of us.

**The following is important information about our services and your treatment. Please read it carefully and feel free to ask questions about anything that you do not understand.**

## **CONFIDENTIALITY**

The therapy relationship is confidential. Your therapist cannot release any information about the therapy process without your written permission. This includes even the fact that you are a client here. Confidentiality is governed by Federal and State law and LWCFC will abide by the law. When a couple seeks marital therapy, the therapy notes are “owned” by the couple. The signatures of both participants will be required to release information to third parties such as attorneys.

However, confidentiality does have its legal and ethical limitations. A therapist may break confidentiality if, in his/her clinical judgment, it is necessary to protect the safety or welfare of you (the client) or another person. If you threaten to hurt yourself or someone else, or raise suspicion of child abuse or neglect, your therapist is bound by law to report it to the proper authorities.

In addition, your therapist may discuss your case with other LWCFC professional staff and contracted consultants for purposes of effectively coordinating treatment and/or to meet state mandated requirements.

## **THE PROCESS OF THERAPY**

Depending on the personalities of the client and therapist and the issues that the client brings, therapy may vary. There are different approaches to address different problems. The currently acceptable treatment modes to help you with your specific situation will be discussed with you. Be assured that the specific approach agreed upon to help you will be a God pleasing one. Psychotherapy requires an active effort on your part. Together with the therapist you will choose how to approach your concerns. To be successful you will have to work toward goals both during sessions and at home.

Psychotherapy has both benefits and risks. Psychotherapy has been shown to reduce feelings of distress, create better relationships and resolve specific problems. Risks include experiencing increased uncomfortable feelings such as sadness, guilt, anxiety, anger, loneliness, and helplessness that may be part of the process of change. Relationships may also be affected. Side effects or risks of side effects from any psychotropic medications should be discussed with your physician.

### **Assessment and Treatment Planning**

There are two main steps in psychotherapy. The first step is assessment. You and your therapist will spend time evaluating your needs, goals, and gathering pertinent information. A treatment plan will be completed and will include an initial assessment, diagnosis (as appropriate), your treatment goals, and intervention techniques to accomplish these goals. You will then need to decide whether to continue the therapy process. If you choose not to work with your therapist, your therapist will refer you to another mental health professional in your area. Therapy involves a commitment of time, energy, and money, and any questions you have about the process should be discussed whenever they arise. Should you choose to not pursue therapy or discontinue prematurely against your therapist’s advice, your symptoms may return and/or worsen.

The second step is the actual therapy. While the first step usually takes 1 to 2 sessions, the actual number of sessions needed to accomplish goals for clients will vary greatly. Some matters are quite complex and considerable time is needed to accomplish the goals. Other situations take less time to resolve. Your therapist will make every effort to be as time and cost efficient as possible to help you resolve your concerns.

After the initial intake, psychotherapy typically occurs in 45 minutes blocks of time. A session usually occurs once per week to begin with and then, as progress toward your goals for therapy is being made, the time between your sessions is spread out. This is tailored to the needs/agreement between client and therapist.

Treatment goals will also be reviewed with you whenever requested, and after 90 days or 6 sessions (whichever covers the longer period). This allows you to discuss progress, approaches, and goals moving forward, or to determine successful completion of your goals.

### **SCHEDULING AND REMINDERS**

LWCFC business hours are 8:00 a.m. to 5:00 p.m. Monday through Friday. Please call during these hours especially when you are making or changing appointments, have questions regarding your bill, insurance, etc.

LWCFC uses an appointment reminder call service. Please be sure you have given staff your preferred phone number for this service. However, be aware the responsibility to attend or cancel appointments is the client's, even if a reminder call does not come.

### **CANCELLATION POLICY**

Due to the nature of therapy, your commitment to the therapy process is important and includes keeping your scheduled appointments. **Our cancellation policy requires a 24-hour notice of any cancellations (except for emergencies or other circumstances beyond your control). If such notice is not given, a \$75.00 fee will be charged to you and not to your insurance. Also, after 2 incidents of no show or late cancellation, any future appointments already scheduled will be cancelled. You will need to contact your therapist to discuss scheduling your next appointment.** It is also important for you to be prompt for your sessions; the charge will not be reduced if you are late.

### **E-MAIL**

Even when utilizing a HIPAA compliant email service, **there are risks associated with privacy when using e-mail communication.** LWCFC cannot guarantee that e-mail communication will be confidential; therefore clients are urged to be mindful of the information communicated with staff.

E-mail may be used to arrange administrative related tasks such as scheduling or cancelling appointments. **E-mail is NOT an appropriate form of communication for emergencies,** especially as staff cannot guarantee e-mails will be monitored or responded to in a timely fashion. Therapists will not conduct therapy via e-mail but may provide follow up information or resources for clients, or for other purposes as agreed upon in therapy sessions.

### **FEES AND INSURANCE**

Therapy is typically conducted in 45-minute sessions. However, there may be times when a 60-minute session is utilized (crisis stabilization, EMDR therapy, or other clinical reasons). The therapy is billed using CPT codes. The fees for a master level therapist in training are the same as that for a licensed therapist. A therapist in training works under the supervision of a qualified supervisor. The current fees for therapy at LWCFC (and the corresponding CPT Codes) are available upon request.

LWCFC billing is divided into two categories:

1. Non-insured services - Payment for services is due on the day of the scheduled appointment. Checks are to be made out to LWCFC.

2. Insured services - Your health insurance may cover all or a portion of the fee. We cannot guarantee payment from your insurance company. To avoid disappointment, we strongly suggest that clients contact their insurance company to make certain that their mental health insurance assumptions are correct. As you know, most insurance companies pay only a portion of the provided services. Further, clients must realize that professional services are rendered to a person, not to the insurance company. Hence, the insurance company is responsible to the client and the client is responsible to us. We cannot render services on the assumption that the charges will be paid by the insurance company. Should there be a dispute related to the service provided or the charge for that service, the settlement of that dispute is between you and your insurance carrier. Our office will not be involved in the settlement of such disputes. The final responsibility for the services provided to you is yours.

You will be asked to sign a form giving LWCFC your permission to release sufficient personal health care information to file the claim with your insurance company.

**It is our practice to receive payment for co-pays, co-insurance, and deductibles at the time of your visit.**

Payment methods include check, credit card, or cash. If the check is not cleared at the bank due to insufficient funds and LWCFC incurs a fee from the bank, you are responsible for paying \$25 in addition to what you may already owe.

You will receive monthly statements that will notify you of any balance on your account. Unless prior arrangements are made, past due balances may be submitted to a third party, such as a collection agency or attorney, for collection. Past due is defined as being 30 days delinquent from the date of billing. LWCFC reserves the right to determine when a past due account is referred to a third party for collection.

#### **EMERGENCY SERVICES**

When the Clinic is closed, an outgoing voice mail message will provide the consumer the options to call 911, contact their pastor, or go to the nearest hospital for help. For consumers currently being served by LWCFC and are at risk to hurt themselves, the consumer's provider will work with the consumer to develop a specific action plan to follow when emergency services are needed by consumer.

#### **LEGAL MATTERS**

In the event that a therapist is subpoenaed to testify in court and the consumer does not want their privileged and confidential information released to the court and will not sign a release of information form to allow this, all legal costs to prevent the release of information, including attorney's fees to represent the Clinic, will be the responsibility of the consumer. Also, all costs incurred for deposition and court testimony including travel time, cost for travel, preparation time including time spent with legal representation for the Clinic, time waiting to testify, and testifying time will be the responsibility of the consumer. Time spent in communicating with the consumer's attorney, either written (e.g. drafting a letter) or verbal, will be the responsibility of the consumer. Time will be billed at \$180 per hour. Mileage will be billed at fifty cents per mile. Paper copies of records will be billed at the following rates: \$1 per page for the first 25 pages; 75 cents per page for pages 26 to 50; 50 cents per page for pages 51 to 100; and 30 cents per page for pages 101 and above. A retainer of \$1200 is due in advance of giving testimony or communicating with an attorney regarding testimony. A Minimum non-refundable charge for a court appearance, including time waiting to testify, is \$1200. If the case is rescheduled without a minimum of 72-hour notice, the client will be charged an additional \$500 (in addition to the \$1200). Any payment owed above and beyond the retainer is due within 30 days of service.

#### **ALCOHOL / DRUGS**

If, in the judgment of the consumer's therapist, the consumer appears intoxicated due to alcohol and / or drugs, the therapist may choose to discontinue the session. The normal fee for the session will be billed to the client and not to insurance, if applicable.

### **INVOLUNTARY DISCHARGE**

A consumer may be involuntarily discharged by the Clinic because of the consumer's inability to pay for services or behavior that is a safety risk for staff or other consumers of the Clinic. Before the Clinic involuntarily discharges a consumer, the Clinic will do the following: notify the consumer in writing of the reasons for the discharge, the effective date of the discharge, sources for further treatment, and the consumer's right to have the discharge reviewed by the subunit of the Department that certifies Clinics.

### **CLIENT RIGHTS AND SATISFACTION**

If you consider the services you received are unsatisfactory or think your rights have been violated, you have the right to use a grievance procedure. Please contact the LWCFC office for an information packet on the procedures to follow. Include your name, address and phone number. Also, the State of Wisconsin has established a Patient Bill of Rights. (Statute Section 51.61). These rights are posted in our waiting room.

### **CLIENT ACKNOWLEDGMENT**

Your signature on this form indicates that:

1. you have received the **Informed Consent to Treatment Information** document and you agree to abide by its stated terms regarding the cost/charges for care and treatment services during your professional relationship with your therapist;
2. you have received the **Privacy Practice Notice**,
3. you consent to enable us to use and disclose your personal health information for purposes of treatment, payment and health care operations;
4. you have received a brochure describing your rights and the grievance procedure; and
5. you have received the handout describing the Mission of LWCFC and Statement of beliefs.

The time period for this informed consent shall be one year. At the end of this time frame this material will be shared with you again and your informed consent obtained. You have the right to withdraw informed consent at any time, in writing. This will, in effect, terminate therapy.

# LWCFC Fees and Insurance Information- Therapy

Therapy is typically conducted in 45-minute sessions. However, there may be times when a 60-minute session is utilized (crisis stabilization, EMDR therapy, or other clinical reasons). The therapy is billed using CPT codes. The fees for a master level therapist in training are the same as that for a licensed therapist. A therapist in training works under the supervision of a qualified supervisor.

The current fees for therapy at LWCFC (and the corresponding CPT Codes) are as follows:

<b>90791</b>	<b>Psychiatric Diagnostic Evaluation (Initial Intake Session)</b>	<b>\$225.00</b>
90832	Psychotherapy with patient or family member, 30 minutes ( <i>16-37 minutes</i> )	\$75.00
<b>90834</b>	<b>Psychotherapy with patient or family member, 45 minutes (<i>38-52 minutes</i>)</b>	<b>\$150.00</b>
90837	Psychotherapy with patient or family member, 60 minutes ( <i>53-60 minutes</i> )	\$200.00
90846	Family or couple psychotherapy, without patient present	\$175.00
<b>90847</b>	<b>Family or couple psychotherapy, with patient present</b>	<b>\$175.00</b>
90853	Group Psychotherapy ( <i>not family</i> )	\$50.00

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1. Non-insured services - Payment for services is due on the day of the scheduled appointment. Checks are to be made out to LWCFC.
2. Insured services - Your health insurance may cover all or a portion of the fee. We cannot guarantee payment from your insurance company. To avoid disappointment, we strongly suggest that clients contact their insurance company to make certain that their mental health insurance assumptions are correct. As you know, most insurance companies pay only a portion of the provided services. Further, clients must realize that professional services are rendered to a person, not to the insurance company. Hence, the insurance company is responsible to the client and the client is responsible to us. We cannot render services on the assumption that the charges will be paid by the insurance company. Should there be a dispute related to the service provided or the charge for that service, the settlement of that dispute is between you and your insurance carrier. Our office will not be involved in the settlement of such disputes. The final responsibility for the services provided to you is yours.

You will be asked to sign a form giving LWCFC your permission to release sufficient personal health care information to file the claim with your insurance company.

**It is our practice to receive payment for co-pays, co-insurance, and deductibles at the time of your visit.**

Payment methods include check, credit card, or cash. If the check is not cleared at the bank due to insufficient funds and LWCFC incurs a fee from the bank, you are responsible for paying \$25 in addition to what you may already owe.

You will receive monthly statements that will notify you of any balance on your account. Unless prior arrangements are made, past due balances may be submitted to a third party, such as a collection agency or attorney, for collection. Past due is defined as being 30 days delinquent from the date of billing. LWCFC reserves the right to determine when a past due account is referred to a third party for collection.

## **LIVING WELL CHRISTIAN FAMILY CLINIC PRIVACY PRACTICE NOTICE**

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

We respect the privacy of your personal health information. We are committed to maintaining the confidentiality of our clients' personal health information. This notice applies to all information and records related to your care that our Clinic has received or created. It extends to information received or created by our staff and counselors. This notice informs you about the possible uses and disclosures of your personal health information. It also describes your rights and our obligations regarding your personal health information.

We are required by law to do the following:

- Maintain the privacy of your protected health information;
- Provide to you this detailed notice of our legal duties and privacy practices relating to your personal health information;
- Abide by the terms of the notice that is currently in effect.

The Living Well Christian Family Clinic ("LWCFC" or "Clinic") participates in an organized health care arrangement. As such, we may share your health information and the health information of others we service with each other as needed for treatment, payment or health care operations relating to our organized health care arrangement.

### **I. WITH YOUR CONSENT WE MAY USE AND DISCLOSE YOUR PERSONAL HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS**

You will be asked, as part of the "Consent for Treatment", to consent to enabling us to use and disclose your personal health information for purposes of treatment, payment and health care operations. We have described these uses and disclosures below and provide examples of the types of uses and disclosures we may make in each of these categories.

**FOR TREATMENT:** We will use and disclose your personal health information in providing you with treatment and services. We may use and disclose your personal health information to other healthcare personnel in order to treat you or to assist in your treatment. For example, we may consult with the agency's supervising psychiatrist and/or psychologist regarding the course of your treatment

**FOR PAYMENT:** We may use and disclose your personal health information so that we can bill and receive payment for the treatment and services you receive at our clinic. Unless you object, we may use and disclose your personal health information in order to bill and receive payment for the treatment and services from your health insurance plan. For example, we may contact your health insurance plan to verify that you are eligible for benefits and for what range of benefits.

**FOR HEALTH CARE OPERATIONS:** We may use and disclose your personal health information in connection with our health care operations. These uses and disclosures are necessary to manage the clinic and to monitor our quality of care. Health care operations include:

- Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities; Medical review, legal services, and auditing, including fraud and abuse detection and compliance;
- Business planning and development; and
- Business management and general administrative activities, including management activities relating to privacy, customer services, and resolution of internal grievances.

For example, we may use personal health information to evaluate our clinic services, including the performance of our staff.

### **II. WE MAY USE AND DISCLOSE PERSONAL HEALTH INFORMATION ABOUT YOU FOR OTHER SPECIFIC PURPOSES**

**APPOINTMENT REMINDERS:** We may use or disclose personal health information to remind you of appointments.

**TREATMENT ALTERNATIVES:** We may use or disclose personal health information to inform you about treatment alternatives and health-related benefits and services that may be of interest to you.

**AS REQUIRED BY LAW:** We will disclose your personal health information when required by law to do so. Sometimes we must report some of your health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, certain physical injuries, or respond to a court order.

**FOR PUBLIC HEALTH ACTIVITIES:** We may be required to report your health information to authorities to help prevent injury. This may include using your health record to report information related to child abuse or neglect.

**FOR HEALTH OVERSIGHT ACTIVITIES:** We may disclose your health information to authorities so they can monitor, investigate, inspect, discipline or

license those who work in the health care system or for government benefit programs.

**FOR ACTIVITIES RELATED TO DEATH:** We may disclose your health information to the State Department of Health and Family Services so they can carry out their duties related to deaths associated with a psychotropic medication or suicide.

**TO AVOID A SERIOUS THREAT TO HEALTH OR SAFETY:** As required by law and standards of ethical conduct, we may release your health information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to you or the public's health or safety.

**FOR MILITARY, NATIONAL SECURITY, OR INCARCERATION/LAW ENFORCEMENT CUSTODY:** If you are involved with the military, national security, or intelligence activities, or you are in the custody of law enforcement officials or an inmate in a correctional institution, we may release your health information to the proper authorities so they may carry out their duties under the law.

**FOR WORKERS' COMPENSATION:** We may disclose your health information to the appropriate person(s) in order to comply with the laws related to workers' compensation or other similar programs. These programs may provide benefits for work-related injuries or illness.

### III. YOUR AUTHORIZATION IS REQUIRED FOR OTHER USES OR DISCLOSURES OF PERSONAL HEALTH INFORMATION

You may give us written authorization to use your personal health 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 disclosures permitted by your Authorization while it was in effect.

Unless you give us a written Authorization, we cannot use or disclose your personal health information for any reason except those described in this notice.

#### A NOTE ON OTHER RESTRICTIONS

Please be aware that state and federal law may have more requirements than HIPAA on how we use and disclose your health information. If there are more specific restrictive requirements, even for some of the purpose listed above, we may not disclose your health information without your written permission as required by such laws. We are also required by law to obtain your written permission to use and disclose your information related to treatment for a mental illness, developmental disability, or alcohol or drug abuse.

There may be other restrictions on how we use and disclose your health information than those listed above. We believe state and federal laws discussing such restrictions are Wisconsin Statutes Sections 146.82, 51.30, 895.50 and 905.04; Wisconsin Administrative Code HFS 92 and 124.14; and 42 C.F.R. Part 2 and 45 C.F.R. Parts 160 and 164. If you would like a copy of these laws, please contact the Clinic.

### IV. YOUR RIGHTS REGARDING YOUR PERSONAL HEALTH INFORMATION

While your health records are the physical property of the Clinic, the information contained in the health record ultimately belongs to you. You have the following rights regarding your personal health information that we maintain about you:

**CONFIDENTIAL COMMUNICATIONS:** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a confidential communication, submit a written request to the Clinic, specifying the requested method of contact or the location where you wish to be contacted. Our Clinic will accommodate reasonable requests. You do not need to give a reason for your request.

**REQUEST RESTRICTIONS:** You have the right to request a restriction in our use or disclosure of your personal health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we limit our disclosure of your personal health information to individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

You may verbally request that we restrict our disclosure of your personal health information, however, we may request you submit your request in writing to the Clinic. Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our Clinic's use, disclosure or both; and (c) to whom you want the limits to apply.

**ACCESS:** You have the right to inspect and obtain a copy of your personal health information that we use to make decisions about you, including medical records and billing records, except as excluded by law such as psychotherapy notes. Submit your request in writing to the Clinic in order to inspect or obtain a copy of your personal health information. We may charge a reasonable fee for our costs in copying and mailing your requested information. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to personal health information, in some cases you will have a right to request review of the denial. This review would be performed by a licensed health care professional designated by the Clinic who did not participate in the decision to deny.

AMENDMENT: You have the right to request that we amend your personal health information if you believe it is incorrect or incomplete as long as the information is kept by or for our Clinic. You may ask to amend your health information. You must make your request in writing, and it must explain why the information should be amended.

We may deny your request for amendment if the information:

- Was not created by our Clinic, unless the originator of the information is no longer available to act on your request;
- Is not part of the personal health information kept by or for the Clinic;
- Is not part of the information to which you have a right to access; or
- Is already accurate and complete, as determined by the Clinic.

If we deny your request for amendment, we will provide you with a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted to amend.

If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

ACCOUNTING OF DISCLOSURES: You have the right to request an "accounting" of our disclosures of your personal health information. This is a listing of certain disclosures of your personal health information made by the Clinic for purposes other than (a) treatment, payment and health care operations, (b) as consented and/or authorized by you, and (c) for certain other activities, as of April 14, 2003. To request an accounting of disclosures, you must submit a request in writing to the Clinic. An accounting will include, if requested: the disclosure date; the name of the person or entity that received the information; a brief description of the information disclosed; and a brief statement of the purpose of the disclosure or a copy of the request. The first accounting within a 12-month period will be free; for further requests, we may charge you a reasonable cost-based fee.

RIGHT TO A PAPER COPY OF THIS NOTICE: You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of the notice at any time. To obtain a paper copy of this notice, contact the Clinic.

#### V. COMPLAINTS

If you have concerns that we may have violated your privacy rights, or you disagree with a decision we made about access to your personal health information or in response to a request you made to amend or restrict the use or disclosure of your personal health information, you may file a complaint in writing with the Clinic. To file a complaint with the Clinic, contact Kim Stein, Client Rights Specialist, at 715-832-1678.

You may also submit a written complaint to the U.S. Department of Health and Human Services.

We support your right to privacy of your personal health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

#### VI. CHANGES TO THIS NOTICE

We will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your individual rights, our legal duties, or other privacy practices stated in the Notice. We reserve the right to change this Notice and to make the revised or new Notice provisions effective for all personal health information already received and maintained by the Clinic as well as for all personal health information we receive in the future. We will post a copy of the current Notice in the Clinic. We will provide a copy of the revised Notice to all Clients and/or their representatives.

#### VII. FOR FURTHER INFORMATION

This Notice takes effect April 14, 2003 and will remain in effect until we replace it. If you have any questions about this Notice of our Privacy Practices or would like further information concerning your privacy rights, please contact Joshua Lipps, Clinic Administrator, at 608-783-1452.



# **LIVING WELL CHRISTIAN FAMILY CLINIC**

## **Mission Statement**

The mission of Living Well Christian Family Clinic is to build and strengthen marriages and families and encourage individuals toward positive change and growth in their emotional, personal, and spiritual lives.

## **Statement of Beliefs**

We believe in the Triune God, one God eternally existent in three persons: Father, Son, and Holy Spirit (Matt. 28:19)

We believe that the Bible is the inspired (2 Pet. 1:21), inerrant (1 Cor. 2:13), infallible (Jn. 10:35), and completely authoritative (2 Tim. 3:16) Word of God.

We believe that all people are sinners by nature and activity (Ps. 51:5) and unable to reconcile themselves to God by any human efforts (Eph. 2:1, Rom. 3:9-18).

We believe that salvation is by God's grace and action alone (Eph. 2:8-9) accomplished through His Son, Jesus Christ (Jn. 3:16, Acts 4:12, Gal. 4:4-5).

We believe that Jesus Christ is the eternal Son of God, who became man, lived the perfect life that God requires, died a substitutionary death, and rose again from the dead to atone for the sins of the whole world (Col. 2:9, Acts 2:23-24, 1 Pet. 3:18).

We believe that it is by the working of the Holy Spirit through the Means of Grace that people receive faith in Jesus as their Lord and Savior (1 Cor. 12:3). The Holy Spirit gives believers the wisdom and strength to walk according to His will (Phil. 2:13, Gal. 5:16-25, Is. 41:10).

We believe that Jesus shall return visibly and bodily to judge all people. While unbelievers will be condemned to an eternity in hell, those who believe in Jesus will live with Him forever (Mk. 13:26, Jn. 5:27-29).