

INFORMED CONSENT FOR TREATMENT

Client Name:	Date of Birth:	Today's Date:
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Part One: Bill of Rights

Minnesota Board of Social Work
2829 University Ave. SE, Suite 340
Minneapolis, MN 55414
Phone: 612-617-2100
Fax: 612-617-2103

Minnesota Board of Marriage and Family Therapy
2829 University Ave. SE, Suite 330
Minneapolis, MN 55414
Phone: 612-617-2220
Fax: 612-617-2221

Minnesota Board of Psychology
2829 University Ave. SE, Suite 320
Minneapolis, MN 55414
Phone: 612-617-2230
Fax: 612-617-2240

1. You, the client, have the right to know your practitioner/professional's name and credentials (degrees, licenses):
_____ working under
Agency Supervisor: Susan Davis, LICSW, 715 Florida Ave. S., Suite 307, St. Louis Park, MN 55426 - 952-544-6806;
2. You, the client, have the right to privacy as defined by rule and law; Your records and transactions with the practitioner/professional are confidential, unless release of these records is authorized in writing by the client, or otherwise provided by law; You, the client, have a right to be allowed access to records and written information from records as provided in Minnesota Statutes, section 144.335, subdivision 2;
3. You, the client, have the right to be treated with personal dignity and respect; treatment free from verbal, physical, or sexual abuse; to be free from discrimination while receiving mental health services; and have the right to reasonable accommodations. If you are unable to read or have communication impairments, or do not read or speak English, to be informed of your rights in a language in which you understand;
4. You, the client, have a right to know your practitioner/professional's theoretical approach in working with clients; and have a right to complete and current information concerning the practitioner/professional's assessment and recommended course of treatment, including the expected duration of treatment. You also have the right to participate in an informed way in the decision making process regarding your individualized treatment planning;
5. If you find you are unable to work with the practitioner/professional provided, we will make every attempt to work with you to meet your needs and/or you may refuse services or treatment, unless otherwise provided by law (Court Order);
6. You, the client, have a right to reasonable notice of changes in services and/or to coordinated transfer when there will be a change in the provider of service;
7. You, the client, have the right to know of emergency contacts in case you are unable to reach your provider, which includes *United Way 211* dial 2-1-1 or 651-291-0211; Poison Control Center 1-800-222-1222 or 612-221-2113; call 911, or go to the nearest emergency room in case of a life-threatening emergency.
8. You, the client, have the right to file a complaint with the practitioner/professional's supervisor listed in (1). You may either call or put it in writing; you may also file a complaint with the mental health licensing boards listed above and you may assert your rights without retaliation.

Initial Here:

Part Two: Limits of Confidentiality

The contents of a counseling, intake, or assessment session are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of this agency not to release any information about a client without a signed release of information. State law mandates that mental health practitioners/professionals may need to report the following situations to the appropriate persons and/or agencies:

Duty to Warn and Protect: When a client discloses intentions or a plan to harm another person, the health care practitioner/professional is required to warn the intended victim and report this information to legal authorities. In cases in which

the client discloses or implies a plan for suicide, the health care practitioner/professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults: If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the health care practitioner/professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances: Health care practitioner/professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death: In the event of a client's death, medical records may be requested by the county coroner, as well as by the spouse or parents of a deceased client, as they have a right to access their child's or spouse's records.

Professional Misconduct: Other health care practitioner/professionals must report professional misconduct by a health care practitioner/professional. In cases in which a practitioner/professional or legal disciplinary meeting is being held regarding the health care practitioner/professional's actions, related records may be released in order to substantiate disciplinary concerns.

Court Orders: Health care practitioner/professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship: Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Other Provisions: Information about clients may be disclosed in consultations with other practitioners/professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed.

Initial Here:

Part Three: Receipt of Privacy Practices

This is to acknowledge receipt of a copy of the Choices Psychotherapy, Ltd. Notice of Privacy Practices with an effective date of 4/14/2003.

Signature of client (or guardian if minor)

Printed Name of client (or guardian if minor)

Description of guardian's authority: _____

Efforts to obtain written acknowledgement of receipt of the Notice of Privacy Practices were made; however acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify): _____

Part Four: Billing/Payment Policy

Choices Psychotherapy, Ltd. is dedicated to providing you with high quality mental health care. In order to maintain that commitment we must collect our billing in a timely manner. This policy is designed for that purpose.

1. It is required that clients wishing to use insurance benefits provide Choices Psychotherapy with their current insurance carrier information, as well as inform Choices Psychotherapy of any insurance changes. Choices Psychotherapy will verify eligibility.
2. In most cases and when clients choose to use their medical insurance, claims for service will be filed by Choices Psychotherapy, Ltd. with insurance carriers for which we are providers. This includes both Primary and Secondary CONTRACTED insurance plans.
3. Clients are required to pay for all treatment at the time of service, unless coverage through an insurance plan for which we are providers has been documented. Fees are \$150.00 for an initial assessment and \$125 for each additional session. Payments are accepted by means of check, cash, or credit card. A NSF fee of \$35.00 will be collected on all returned checks.
4. CO-PAYMENTS, in the form of check, cash, or credit card must be made at the time of service, per your insurance contract. **Failure in paying your co pay will result in a \$5.00 fee.** By law, we may not waive co-pays for either insurance or Medicare.

5. Service(s) may be temporarily interrupted for past due balances or until arrangements for payment are made.
6. If an insurance company does not pay for treatment OR requires client co-insurance or deductible amounts to be paid by the client, the client will be responsible for this amount, which may not be known at the outset of service.
7. Payment for services is required within 30 days of receipt of the itemized bill. A 10% surcharge is added on billed accounts and interest of 1.5% per month is added on accounts past 60 days. Services may be temporarily interrupted.
8. If financial difficulties or hardship arise, the client must call Choices Psychotherapy’s billing department to make acceptable payment arrangements. These arrangements will be determined on a case-by-case basis. A 1.5% per month finance charge will be assessed on all client balances over 60 days.
9. **A client may leave therapy at any time, and by signing this document agrees to pay all outstanding fees associated with their account.**

CANCELLATION/NO SHOW POLICIES

CANCELLATION OF SCHEDULED APPOINTMENTS must be done with a 24 hour notice.

- With regard to *commercial insurance and self pay clients*, if this 24-hour requirement is not met, a **\$25 late-cancel/no-show fee will be assessed. If there is a second occurrence, a \$50 fee will be assessed, and a third occurrence \$75.** If the client is able to reschedule the missed appointment within the same week, the fee will not be assessed. Commercial insurance companies do not pay for missed appointments. Other instances of this fee being waived requires a therapist’s recommendation due to client extenuating circumstances and administrative approval.
- If **three appointments are missed**, either by “late cancellation” or “no-show,” **all future appointments may be cancelled.** If recurring appointments are cancelled, it is the client’s responsibility to make contact with their provider, and to present a plan to reestablish services, which initially may be done on a “same-day” appointment basis, per the availability of the provider and clinical necessity. Termination of services may also be considered by the therapist.
- In the event you were referred for services by a social services case manager or probation officer, with proper release of information, they will be notified of your absences.

Initial Here:

Part Five: Statements of Understanding

- I understand that I will be responsible to take an active part in individual treatment planning, participating in homework outside of sessions, reporting my progress or any changes, as well as regularly reviewing the progress toward attainment of treatment goals. I understand that assessment, treatment planning and implementation with this practitioner/professional are designed with the client’s best interest in mind, and will be reviewed periodically.
- I understand there are benefits to therapy that have been shown by scientists in well-designed research studies. People who are depressed may find their mood lifting. Others may no longer feel afraid, angry, or anxious. In therapy, people have a chance to talk things out fully until their feelings are relieved or the problems are solved. Clients' relationships and coping skills may improve greatly. They may get more satisfaction out of social and family relationships. Their personal goals and values may become clearer. They may grow in many directions—as persons, in their close relationships, in their work or schooling, and in the ability to enjoy their lives.
- I understand there are also risks in participating in this treatment. It is possible that for a time uncomfortable levels of negative feelings may be felt and clients may recall some unpleasant and/or bothersome memories. It is also possible that clients in therapy may have problems with people important to them. Family secrets may be told by members of the family, or by the practitioner/professional if legally mandated. Clients may temporarily appear to worsen after the beginning of treatment. Most of these risks are to be expected when people are making important changes in their lives. Finally, even with our best efforts, there is a risk that therapy may not work for you.
- I understand that there are no guarantees made about the outcome of this therapy process. I understand and agree to the above stated limits of confidentiality, their meanings and ramifications. I understand that due to the laws of this state and the guidelines of the practitioner/professional’s profession, ethical rules concerning privacy will be honored. I understand that no reports or information will be released to other entities without my written authorization to release that information, excepting those mandated by court order to probation or other court ordered entities.

- I understand that in order to bill my insurance company, a diagnosis will be made that is accurate to insure treatment that is medically necessary. I understand that I have the responsibility to give my provider and insurance carrier the information needed to receive appropriate care.

Initial Here:

Part Six: Written Acknowledgement of Consent for Treatment

I have read this “Informed Consent for Treatment” and it has been fully explained to me. I am of sound mind and am fully competent to understand to give informed and willing consent for treatment, either for myself and /or a minor child(ren) listed below. Therefore, I hereby understand fully and agree to the terms laid out in this document. I authorize the assigned practitioner/professional to administer services and to treat myself or a person or persons for who I am guardian.

Check One Box

- I hereby authorize Choices Psychotherapy, Ltd. to release all billing and medical information regarding my diagnosis and treatment and substance abuse if applicable to any third party payer, when such information is requested for payment utilization review or coverage determination purposes.
- I am making payment for services directly; therefore I am not authorizing a release of information for billing purposes.

My signature below means that I understand and agree with all of the points above.

Client Signature	Date	Print Name
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Parent/Guardian Signature if client is a minor	Date	Print Name
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Check below to indicate custody status if client is a minor:

- Parents are married to each other and both are legal parents of the child/children.
- I am a single parent, with legal and physical custody of the child/children.
- The child/children’s other parent and I share legal custody. **Consent must be obtained from other parent to continue services beyond the initial appointment.**
- The child is in custody of the State of Minnesota. County: _____
- Printed name and capacity of person/s authorized to consent to services: _____
- Other _____

I, the practitioner/professional providing clinical services, have discussed the issues above with the client and/or parent or guardian of a minor client. My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent for treatment of themselves and/or a minor child.

Practitioner/Professional Signature	Date	Print Name
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AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name:	Date of Birth:
Address:	City, State, Zip: Phone:

I authorize the disclosure of information:

Between: To: From:

Name/Attention:	
Organization: Choices Psychotherapy, Ltd.	
Address: 715 Florida Ave S, Suite 307	
City, State, Zip: St. Louis Park, MN 55426	
Phone: 952.544.6806	Fax: 952.545.0098

Name/Attention:	Relationship: Primary Care Physician
Organization:	
Address:	
City, State, Zip:	
Phone:	Fax:

I authorize the disclosure of information: Written & verbal Written only Verbal only

The type of records that I authorize for disclosure are the following:

- | | |
|--|--|
| <input type="checkbox"/> Admission/intake information | <input type="checkbox"/> Treatment plan |
| <input type="checkbox"/> Psychological assessment/evaluation/testing | <input type="checkbox"/> Progress/case notes |
| <input type="checkbox"/> Psychiatric assessment/evaluation | <input type="checkbox"/> Progress reports/treatment plan reviews |
| <input type="checkbox"/> School records, IEP, assessment/evaluation | <input type="checkbox"/> Termination/discharge/treatment summary |
| <input type="checkbox"/> Chemical dependency assessment/evaluation | <input type="checkbox"/> Financial/health insurance information |
| <input type="checkbox"/> Medical history/assessment/evaluation | <input type="checkbox"/> Court/legal records |
| <input type="checkbox"/> Family/social history | <input type="checkbox"/> _____ |

Use of information is to assist Choices Psychotherapy, Ltd staff with clinical/coordination of services unless written below:

Other: _____

- I understand my records are protected by data practices laws and cannot be released without my consent unless allowed by law.
- I understand that alcohol and drug treatment records may be further protected by federal regulations (see 42 CFR part 2).
- I understand that only the information and records indicated above will be released or obtained.
- I understand that the information will only be released to or obtained from the persons or entities indicated above.
- I understand that this consent does not authorize the recipient of the information or records to redisclose the information or records to anyone else unless authorized by law.
- I understand that the information will only be used for the purposes indicated above and shared only within Choices Psychotherapy, Ltd.
- I understand that I may withdraw or modify this consent at any time, but that the revocation or modification will not affect any release or obtaining of information that occurred before the revocation or modification.
- I understand that this consent will expire and no longer be valid one year from the date I sign it.
- I understand my signature means that I have read this form or have had it read to me and explained in language that I can understand.

Client Signature	Date	Parent/Guardian Signature	Date
Client Signature	Date	Parent/Guardian Signature	Date
Witness Signature	Date	Special Conditions	