

INFORMED CONSENT FOR THERAPY

Client Name:	Date of Birth:	Today's Date:
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Part One: Billing/Payment Policy

Choices Psychotherapy, Ltd. is dedicated to providing you with high quality mental health care. We are in-network providers with most insurance companies and will submit bills to them on your behalf for payment.

1. Clients wishing to use insurance benefits need to provide Choices Psychotherapy with their current insurance information when scheduling the first appointment. We will verify benefits and obtain necessary authorizations.
2. Verification of benefits is not a guarantee of payment and it is the clients' responsibility to call the customer service number on the back of their insurance card to have a full understanding of what services are covered. It is also the clients' responsibility to notify Choices Psychotherapy of any insurance changes. Failure to do so, which could result in a claim denial will then be the responsibility of the client to pay.
3. It is your responsibility to know your co-pay, deductible, and co-insurance prior to your initial appointment. Clients are required to pay for all sessions at the time of service, unless coverage through an insurance plan for which we are providers has been verified. Fees are \$175.00 for an initial assessment and \$150 for each additional 50 minute session. Payments are accepted by means of check, cash, or credit card. **A NSF fee of \$40.00** 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. **Failure to pay your copay will result in a \$5.00 fee.** We can not waive co-pays, co-insurance or deductibles.
5. If your insurance company requires a co-insurance and/or deductible to be paid by you, this amount is due when the claim is processed and an Explanation of Benefits (EOB) is sent to both the client and Choices Psychotherapy. **Choices Psychotherapy requires a credit card on file for those clients with a deductible and/or co-insurance and their credit card will be charged at the end of the month for any balance due.** Clients will have the opportunity to pay on-line, by mail or in person, prior to their card being charged.
6. Statements will be given to clients the middle of the month for those with balances due and payment is required upon receipt. A 10% surcharge is added on billed accounts and interest of 1.5% per month is added on accounts past 60 days. Service(s) will be temporarily interrupted for past due balances until arrangements for payment is made.
7. 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.
8. **A client may leave therapy at any time, and by signing this document agrees to pay all outstanding fees associated with their account immediately. Failure to do so will result in additional fees being assessed, including Court filing fees if applicable.**

INSURANCE INFORMATION	
Primary Ins:	Secondary Ins:
Co-pay Amount:	Co-pay Amount:
Co-ins Amount:	Co-ins Amount:
Deductible Amt:	Deductible Amt:

Visa/Mastercard/Discover	Card Number:	Exp Date:	CVV Code:
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My signature below authorizes Choices Psychotherapy to charge my credit card for any outstanding balances due by me at the end of each month, which may include co-pay, co-insurance, deductible, and/or late cancel no-show fees.

Card Holder Name

Card Holder Signature

Date

Initials: _____

Confidential

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Part Two: 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 therapists 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

Part Three: Limits of Confidentiality

Diagnostic and therapy sessions 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 have the right to access the minor records unless the therapist believes that sharing this information will be harmful to the client.

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

Part Four: 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: 1/1/2011.

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): _____

Initials: _____

Confidential

Part Five: Bill of Rights

Minnesota Board of Social Work	Minnesota Board of Marriage and Family Therapy	Minnesota Board of Psychology	Minnesota Board of Behavioral Health and Therapy
2829 University Ave. SE, Suite 340 Minneapolis, MN 55414 Phone: 612-617-2100 Fax: 612-617-2103	2829 University Ave. SE, Suite 330 Minneapolis, MN 55414 Phone: 612-617-2220 Fax: 612-617-2221	2829 University Ave. SE, Suite 320 Minneapolis, MN 55414 Phone: 612-617-2230 Fax: 612-617-2240	2829 University Ave. SE, Suite 210 Minneapolis, MN 55414 Phone: 612-617-2178 Fax: 612-617-2187

1. You, the client, have the right to know your practitioner/professional’s name and credentials (degrees, licenses): _____ working under Executive Director: Susan Davis, LICSW, 715 Florida Ave. S., Suite 307, St. Louis Park, MN 55426. Phone: 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; therapy 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 therapy, including the expected duration of therapy. You also have the right to participate in an informed way in the decision making process regarding your individualized therapy 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 therapy, 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.

Part Six: Statements of Understanding

- I understand that I will be responsible to take an active part in individual therapy planning, participating in homework outside of sessions, reporting my progress or any changes, as well as regularly reviewing the progress toward attainment of therapy goals. I understand that assessment, therapy 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 therapy. 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 therapy. 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 to insure therapy is medically necessary. I understand that I have the responsibility to give my provider and insurance carrier the information needed to receive appropriate care.

Part Seven: Written Acknowledgement of Consent for Therapy

I have read this “Informed Consent for Therapy” 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 therapy, either for myself and /or a minor child(ren) listed above. 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 therapy 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
Parent/Guardian Signature if client is a minor	Date	Print Name

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 therapy of themselves and/or a minor child.

Practitioner/Professional Signature	Date	Print Name
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