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**Informed Consent & Agreement for Psychotherapy Service**

**Introduction.** This document is intended to provide important information to you regarding your, or your child’s, treatment. Please read the entire document carefully and be sure to ask me any questions that you may have regarding its contents before signing. You may have questions about me, my qualifications, my therapeutic approach, or other therapeutic issues not addressed here. It is your right to have a complete explanation for any questions you may have, now, or in the future. Please feel free to ask questions or share any concerns that may arise. Although I know this may be uncomfortable at times, your openness and honesty will allow me to better serve you.

**Information About Your Therapist.** Whenever you wish, I will discuss my professional background with you and provide you with information regarding my experience, education, special interests, and professional orientation. You are free to ask questions at any time about the above, and anything else related to your therapy or other concerns.

**Fees.** The fees for service are $140 per 60-minute session. I reserve the right to periodically adjust the fee. You will be notified of any fee adjustment in advance. Fees are payable at the time that services are rendered. Please ask me if you wish to discuss a written agreement that specifies an alternative payment procedure.

If there is need for telephone contact, with you or a third-party, other than for scheduling purposes, you understand that you are responsible for payment of the agreed-upon fee (on a pro-rated basis) for any calls lasting longer than 10 minutes.

**Appointment Scheduling and Cancellation Policies.** Sessions are typically scheduled to occur one time per week at the same time and day if possible. I may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful therapeutic outcome. If an appointment is missed, or cancelled with less than 24-hour notice, you, not your insurance company, may be charged the full fee for that missed session. Exceptions may be made if you are sick or if there is an unavoidable emergency**.**

**Delinquent Accounts.** You understand that you are responsible for all charges incurred and that services must be paid in full at the time of each visit, unless other arrangements have been made.

**Psychological Services.** Psychology is not easily described in general statements. It varies depending on the personalities of the counselor and client, and the particular problems a client is experiencing. There are many different methods including cognitive behavioral therapy, EMDR, and other methods of treatment I may use to deal with the problems that you hope to address. In order for therapy to be most successful, you may be asked to complete homework assignments between sessions to support the work done in session.

As with any treatment, psychotherapy can leave benefits and risks. Since therapy often involves discussing unpleasant aspects of life, clients may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, positive solutions to specific problems, and significant reductions in feelings of distress. But, there is no guarantee of what clients will experience.

Our first session will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow. Please evaluate this information, along with the comfort level you feel towards me as your therapist. Therapy involves a large commitment of money and energy, so you should select your therapist after careful consideration. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up an appointment with another mental health professional for a second opinion. It is best to discuss this in a planned termination session if possible.

**Confidentiality and Privacy Information.**  The law protects the privacy of all communications between a client and a psychotherapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require that you provide written, advance consent. Your signature on this agreement provides consent for other activities as follows:

* On occasion I may consult with other health and mental professionals about your case. The other professional(s) are professionally bound to keep information confidential.
* I may have contact(s) with an accountant and billing services. These business associates are required to maintain the confidentiality of this data unless otherwise required by law.
* Disclosures required by health insurance to collect overdue fees are discussed elsewhere in this agreement.

There are some situations in which I am permitted, or required, to disclose information without either your consent or authorization.

* If you are involved in a court proceeding and a request is made concerning the professional services I have provided to you, such information is protected by the psychotherapist/patient privilege law. I cannot provide any information without your written authorization or a court order.
* If a government agency, pursuant to their lawful authority, requests information for health oversight activities, I may be required to provide such information.
* If a client files a complaint or lawsuit against me, I may disclose relevant information regarding the client in order to defend myself.
* If a client files a worker’s compensation claim, I must, upon appropriate request, disclose information related to the claim to the appropriate individuals, which may include the client’s employer, the insurer, or the Department of Labor & Industry.

In some situations, I am obligated by law to take action to protect others from harm. In such situations, I may have to reveal information about a client’s treatment. These situations are unusual in my practice.

* If I know or have reason to believe a child has been neglected, physically abused, or sexually abused, within the preceding three years, the law mandates that I file a report immediately with the appropriate governmental agency.
* If I have reason to believe that a vulnerable adult is being maltreated, or if I have knowledge that a vulnerable adult sustained a physical injury that is not reasonably explained, the law mandates that I file a report immediately with the appropriate government agency.
* If I believe that a client presents a serious and specific threat of physical violence to another, I may be required to disclose information necessary to take protective actions. These actions may include notifying the potential victim, contacting their family or others who can help provide protection, contacting the police, or seeking the client’s hospitalization.

If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. **You must understand that I utilize “no secret” policy when conducting family or marital/couple therapy.** What this means is that I do not keep secret information gathered in individual conversations (by phone, e-mail, or individual session) if the information revealed in some way violates the integrity of the couples/family therapy (for example; revealing an affair, substance problem, or intent to leave the relationship). Such information will need to be revealed to the other partner for therapy to effectively continue. Please feel free to ask me about the “no secret” policy and how it may apply to you.

**Professional Records.** The laws and standards of my profession require that I keep protected information (PHI) about you in your professional record, except in unusual circumstances that involve a danger to yourself or others. You may examine or receive a copy of your clinical records, if you make a request in writing. These records will be provided to you in the form of a diagnosis and treatment plan. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence or have them forwarded to another mental health professional so you can discuss the contents.

**Patient Litigation.** I will not voluntarily participate in any litigation or custody dispute in which you and another individual, or entity, are parties. I have a policy of not communicating with patients’ attorneys and will generally not write or sign letters, reports, declarations, or affidavits to be used in any patient’s legal matters. I generally will not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving you, you agree to reimburse me for any usual and customary hourly rate for such services at $140 per hour.

**Client Rights.** HIPAA provides you with rights with regard to your clinical records and disclosure of protected health information. These rights include requesting that I amend your records; requesting restrictions on what information from your clinical records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information and procedures are recorded in your records; and the right to request a paper copy of this agreement, the attached notice form, and my privacy policies and procedures.

**Minors & Parents.** Clients under 18 years of age who are not emancipated, and their parents, should be aware that the law might allow parents to examine their child’s treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up access to their child’s records. If they agree, during treatment, I will provide them only with general information about the progress of the child’s treatment, and his/her attendance at scheduled sessions. Any other communication will require the child’s authorization, unless I feel that the child is in danger to himself/herself or someone else, in which case I will notify the parents of my concern.

**Therapist Availability/Emergencies.** You may leave a message for me at any time on my confidential voicemail at 952-451-3161. If you wish me to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are generally returned within 24 hours during traditional workday hours. Please understand that as a solo, outpatient practitioner, I am unable to provide continuous 24-hour crisis services. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request for emergency services, go to the nearest emergency room, and/or call the crises county hotline in your area.

**Your Initials and Signature below indicates that you have received, read, and agreed to the terms of the HIPAA Notice Form Psychotherapist-Client Services Agreement**

Please initial

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_24 hour cancellation policy. You also realize that Insurance Companies do not provide

 reimbursement for cancelled sessions, so you will be responsible for the full amount

 $ 140 or contracted rate of your insurance company.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Co-pays are due at the time of service.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If there is an outstanding balance of 60 days and arrangements haven’t been made

 for payment than I have the option of using legal means to secure payment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone calls longer than 10 minutes will be billed to you at $140 per hour (or

 $ 20 per each 10-minute interval).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_You understand the limits of confidentiality as listed in the agreement.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Release of information to the insurance company for the purpose of billing for

 services.

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Patient Name (Please Print) Signature of patient (or authorized representative) Date

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 Signature of patient (or authorized representative) Date

I understand I am financially responsible for payment for all services rendered and that I am obligated to pay all charges denied by my insurance carrier. Any assignment and authorization in no way releases me from responsibility and imposes no obligation on my therapist to collect money on my behalf.

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Name of Responsible Party (Please Print) Signature of Responsible Party Date

**Consent to Treatment of Minors**

The parent or legal guardian of each child who attends session must complete this section. Some custody agreements require the signatures of both parents for treatment. Because of this, it is generally my policy to require the signature of both parents in any divorce situation.

**Confidentiality with Minors**

The state of Minnesota provides significant confidentiality to minors seeking mental health treatment. My role as a therapist is to help minors learn to communicate openly and directly with their parents; therefore, I typically involve parents in the counseling process. When children are making poor and dangerous choices, parents will be brought into the conversation as soon as possible. Situations involving suicidal ideation, suicide attempts, or substance abuse are examples of concerns that would necessitate a conversation with a child’s parents.

I hereby consent to the treatment of my child(ren) per the terms outlined in the above pages of this document:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Parent/Guardian Name (please print) Parent/Guardian Signature Date

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Parent/Guardian Name (please print) Parent /Guardian Signature Date