Choices Psychotherapy

10201 Wayzata Boulevard, Ste 100, **Minnetonka**, MN 55305
7975 Stone Creek Drive, Ste 130, **Chanhassen**, MN 55317
7901 Xerxes Avenue South, Ste 225, **Bloomington**, MN 55431

INFORMED CONSENT

Client Name:	Date of Birth:	Today's Date:

Part One: 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 choose and know your practitioner/professional's name and credentials (degrees, licenses):

   ____.

   I'm under the supervision of: ____.
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; to receive therapy and/or medical 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's/professional's theoretical approach in working with clients; and have a right to complete and current information concerning the practitioner/ professional's assessment, diagnosis, and recommended course and nature of therapy/treatment, including the expected cost and duration of treatment. You have the right to know the risks and benefits of your treatment or alternative treatments. You have the right to know the risks or benefits of not receiving treatment. You also have the right to participate in an informed way in the decision making process regarding your individualized therapy;
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 or terminate psychiatry or therapy at any time, unless otherwise ordered by law (Court Order);
6. You, the client, have a right to reasonable notice of changes in services and/or to coordinated transfer of care when there will be a change in the provider of service;
7. You, the client, have the right to know emergency contacts in case you are unable to reach your provider, which includes; Suicide and Crisis Lifeline – dial 988, Poison Control Center 1-800-222-1222, Crisis Connection 1-900-245-4580, 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 Choices' Executive Director: Susan Davis, LICSW, 10201 Wayzata Blvd., Suite 100, Minnetonka, MN 55305. Phone: 952-544-6806. You may either call or submit a written complaint; you may also file a complaint with the mental health licensing boards listed above; you may assert your rights without retaliation.

Part Two: Statements of Understanding

- I understand that I will be responsible to take an active part in my individual treatment planning, participating in homework outside of sessions, reporting my progress or any changes, as well as regularly reviewing my progress toward attainment of therapy goals. I understand that assessment, diagnosis, 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 shown by scientists in well-designed research studies. If depressed, I may find my mood lifting. I may no longer feel afraid, angry, or anxious. In therapy, I will have opportunities to talk things out fully; to express my feelings and work toward finding my own ideas to address my problems. My relationships and coping skills may improve greatly. I may get more satisfaction out of social and family relationships. My personal goals and values may become clearer. I have the potential to grow in many directions, as a person, in my relationships, work or schooling, and in the ability to enjoy my life.
- I understand there are **risks** to participate in therapy. It is possible that for a time uncomfortable levels of negative feelings may be felt and I may recall some unpleasant and/or bothersome memories. It is also possible that as I participate in therapy I may have problems with people important to me. Family secrets may surface and may need to be reported by the practitioner/professional if legally mandated. I 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 my provider's best efforts, there is a risk that therapy may not work for me.
- I understand that there are no guarantees made about the outcome of therapy. 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 in order to bill my insurance company; a diagnosis will be made to ensure 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 Three: Electronic Communication Consent

______ As a client of Choices Psychotherapy, I understand that if I communicate with the clinic or my therapist via cell phone, email or text message there are inherent risks to limits of confidentiality and I release my therapist and Choices Psychotherapy from any liabilities should the communication be intercepted by third parties.

______ I agree to refrain from using email or text messaging as a form of communication with my therapist. I understand that if I do email or text my therapist, the communication will be viewed during my therapist's normal business hours, which have been provided to me. I acknowledge that an email/text response will not be returned, but a phone call will be made to me within 24-48 hours of the email/text and only if I have requested one and provided a phone number where I can be reached. I understand that email/text messaging will not be used for coaching, crisis response, or addressing therapeutic issues.

______ I agree that Email or Text messaging for the purpose of scheduling and rescheduling appointments must be pre-approved by each Individual therapist and/or Skills group facilitator. I also acknowledge that the preferred method of communication for making appointments is to phone the clinic or therapist during business hours to make an appointment.

Coaching Calls (FOR DBT CLIENTS ONLY)

_____ I understand that as a part of DBT protocol I may elect to use a phone coaching call as needed. When this occurs, I acknowledge that my therapist may communicate with me via cell phone (no text messages or emails) for the purpose of skills coaching, safety assessment or to schedule a follow-up appointment. I understand the inherent risks to limits of confidentiality with cell phone usage and release my therapist and /or the therapist on call if my therapist is on vacation or unavailable and Choices Psychotherapy from any liabilities should the communication be intercepted by third parties. I understand that my therapist may not be able to respond immediately and that my therapist will try to return the call within 1-2 hours. In emergencies, I agree to call 911, go to my local emergency room for care, call the Crisis Connection at 612-379-6363 or phone the individuals listed on my crisis plan.

Part Four: Limits of Confidentiality

All 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 clinic to not 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.

Client's Death: In the event of a client's death, medical records may be disclosed to the medical examiner, or parents of a deceased minor.

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 maybe required to release records of clients if ordered by a court.

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 Five: Receipt of Privacy Practices

This is to acknowledge receipt of a copy of the Choices Psychotherapy Notice of Privacy Practices with an effective date of: 9/23/2013.

Signature of client (or guardian if minor/or vulnerable adult)	Printed Name of client (or guardian if minor/or vulnerable adult)

Description of guardian's authority and relationship to client: ______________________________

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 Six: Written Acknowledgement of Informed Consent

I have read this "Informed Consent" and it has been fully explained to me. I am of sound mind and am fully competent to give informed and willing consent for therapy, either for myself and/or a minor child. 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.

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/minor.
- ☐ I am a single parent, with legal and physical custody of the child/minor.
- ☐ The child'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 wiling consent for therapy of themselves and/or a minor child.

____ ____

Practitioner/Professional Signature Date Printed Name