Choices Psychotherapy, Ltd.

office: 952.544.6806 • facsimile: 952.545.0098
715 Florida Ave. S., Suite 307 • St. Louis Park, MN 55426

INFORMED CONSENT

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

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 invoices to them for payment on your behalf.

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. Therapy fees are $175.00 for an initial assessment and $150 for each additional 50 minute session. Psychiatry fees vary according to services provided. 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. **Choices Psychotherapy requires a credit card on file for all clients with a deductible and/or co-insurance. Your credit card, encrypted and stored securely, will be charged at the end of the month for any unpaid balance in that account billing cycle.** ***Clients are requested to and always have the opportunity to pay on-line, by mail or in person, prior to their card being charged on mxmerchant.com.***
6. Statements will be provided to clients the first week of the month and for clients with balances due, **payment is required upon receipt**. A 10% surcharge is added to accounts overdue 30 days and an additional 1.5% per month is added thereafter. Service(s) may 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 30 days.
8. **A client may leave therapy at any time, and by signing this document client 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.**

Part Two: 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 Ltd 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 Ltd 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 Three: Cancellation/No Show Policies

- **CANCELLATION OF SCHEDULED APPOINTMENTS must be done with a 24 hour notice (48 hours for Psychiatry)**
- 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 a client is able to reschedule the missed appointment within the same week, fees will not be assessed. Insurance companies do not pay for missed appointments. Other instances of this fee being waived require a therapist's recommendation due to client extenuating circumstances and administrative approval.
- If **two 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 therapist, and to present a plan to reestablish services, which initially may be done on a "same-day" appointment basis, per the availability of the therapist and clinical necessity. Termination of services may also be considered by the therapist.

Part Four: Limits of Confidentiality

All diagnostic, psychiatric, 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/ psychiatrists/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/psychiatrist/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/psychiatrist/professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances: Health care practitioner/psychiatrist/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 medical examiner, 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/psychiatrist/professionals must report professional misconduct by a health care practitioner/psychiatrist/professional. In cases in which a practitioner/psychiatrist/professional or legal disciplinary meeting is being held regarding the health care practitioner/psychiatrist/professional's actions, related records may be released in order to substantiate disciplinary concerns.

Court Orders: Health care practitioner/psychiatrist/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, Ltd. 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: Bill of Rights

Minnesota Board of Medical Practice	Minnesota Board of Nursing	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 500 Minneapolis, MN 55414 Phone: 612-617-2130 Fax: 612-617-2166	2829 University Avenue SE Suite 200. Minneapolis, MN 55414. Phone 612-317-3000. Fax 612-617-2190.	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/psychiatrist/professional's name and credentials (degrees, licenses): _____.
2. You, the client, have the right to privacy as defined by rule and law; Your records and transactions with the practitioner/psychiatrist/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/psychiatrist's/professional's theoretical approach in working with clients; and have a right to complete and current information concerning the practitioner/psychiatrist/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/ and or medication treatment planning;
5. If you find you are unable to work with the practitioner/psychiatrist/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 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 Choices' Executive Director: Susan Davis, LICSW, 715 Florida Ave. S., Suite 307, St. Louis Park, MN 55426. 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 Seven: 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/psychiatrist/professional are designed with the client's best interest in mind, and will be reviewed periodically.
- I understand there are **benefits** to therapy and/or medication treatment 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 and/or medication management. 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/

psychiatrist/professional if legally mandated. I may temporarily appear to worsen after the beginning of therapy and/or medication treatment. 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 and/or some medication may not work for me.

- I understand that there are no guarantees made about the outcome of therapy and/or the medications that may be prescribed. 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/psychiatrist/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 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 Eight: 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 and/or medication management, 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/psychiatrist/professional to administer services and to treat myself or a person or persons for who I am guardian.

Check One Box For Payment For Services

I hereby authorize Choices Psychotherapy, Ltd. to release all billing and medical information regarding my diagnosis and therapy and/or medication 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.

Reminder Notifications For Services

I understand that reminder notifications for ongoing sessions are a courtesy of Choices and will be made via email or text messaging. I understand that I am fully responsible to remember and attend my scheduled appointments even if this service fails.

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: (Note: Disregard for Psychiatry Services)

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 willing consent for therapy of themselves and/or a minor child.

_____ _____ _____

Practitioner/Psychiatrist/Nurse/Professional Signature Date Printed Name