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AGREEMENT FOR THERAPY SERVICES/ INFORMED CONSENT

Welcome to Link Therapy and Mediation. We understand it can take a lot of courage to enter into therapy, particularly if you are unfamiliar with the process. This document is intended to help answer your practical questions about the therapy process, and we are more than happy to discuss any remaining concerns in person when we meet to hear your story and the reasons why you are currently seeking therapy.

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. This Notice, which is included in this Agreement, explains HIPAA and its application to your personal health information. The law requires that we obtain your signature acknowledging that we have provided you with this information by the end of the first session. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us (and our clinic) unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

CONSENT FOR SERVICES

I understand my rights under HIPAA and the Minnesota Client Bill of Rights. I believe I understand the basic goals and methods of psychotherapy and that my therapist may use different methods of helping me and my family based on the unique factors associated with our needs. I have no important questions or concerns that the therapist has not discussed with me. I understand that reaching the agreed upon therapeutic goal(s) is not guaranteed and that therapy has varying levels of effectiveness for different individuals. I also understand that my therapeutic goal(s) may evolve and change based on new insights and/or changes to my life situation.

I am agreeing to participate in the following types of services, while acknowledging that the course of therapy may change, and the participants may change, by agreement of both parties.

_____ Individual Therapy
_____ Couples Therapy
_____ Family Therapy
_____ Group Therapy

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I also agree that the following individuals will be part of the therapy process:

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With enough knowledge, and without being forced, I enter into therapy with this therapist. I will keep my therapist fully up to date about any changes in my feelings, thoughts, and behaviors. When difficulties arise I will let my therapist know so that we can address them in an honest and direct manor.

I further understand that this agreement will become part of my record of therapy.

Risks and Benefits: I further understand that the initial symptoms or problems presented may initially become more intense because confronting important questions about who I am and who I want to be may at times cause internal conflict. I understand the therapy requires an active investment of various resources (emotional, time, money, and others) that may lead to uncomfortable feelings like sadness, anger, or frustration. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you as an individual will experience.

Couple and/or Family Therapy: I understand that couple and family therapy can be beneficial in maintaining healthy family relationships that can positively impact the physical and mental health of individual family members. However, family therapy can also pose unique challenges because more than one person is involved in the process. I agree to the following regarding couple and family therapy:

- Information discussed is for therapeutic purposes and is not intended for legal purposes
- Signing this agreement means that couples will not subpoena information from marriage therapy and try to use it against each other later in legal proceedings
- Phone calls, texts, or emails between sessions should be used primarily for scheduling purposes only
- Sometimes in the course of couple of family therapy, the therapist will have sessions that do not include all family members. In such cases, the therapist will not report back to other family members what was discussed without the permission of the family member who shared the information. However, anytime the therapist believes that the couple or family cannot make progress toward their stated goals, he or she reserves the right to terminate therapy. While the therapist will not pass information between family members when specifically asked not to, if the unwillingness to engage in open communication will hinder goals, therapy will not continue. Therapists are not secret-keepers in family systems.
- If a couple or family breaks up and a family member contacts the family therapist for individual services, the family therapist reserves the right to proceed according to his or her clinical judgment. Referrals for some family members may be provided when the therapist anticipates a potential conflict of interest. The decision of which family member(s) continue in therapy with the family therapist is at the therapist's discretion.

There may be times when the therapist appears to take someone's side or be against someone else. The therapist is on the side of the family or couple *relationship* and will do what he/she deems necessary to improve it.

Experiential Group Therapy: I understand that if I participate in experiential group therapy, my identity may be disclosed to other group members, family members of other group members (ex. parent night in DBT group), or facilitators of experiential activities (ex. yoga instructor, high ropes course facilitator, etc.). I understand that my attendance at such events will be taken as my consent to participate. I also understand I can leave at any time if I don't feel comfortable. I also understand the therapist will make every effort to let all other group participants, their family members, and other experiential facilitators know that the strictest confidentiality is expected of them.

TERMINATION OF SERVICES

I understand that I can terminate therapeutic services at any time. When doing so I agree to notify my therapist and schedule a final session. I understand that if I miss three appointments in a row without informing my therapist, they will begin the process of terminating my therapy. If my therapist believes there to be a conflict of interest, he or she may terminate services with me but will not do so without providing me with viable alternatives to seek treatment from another qualified professional.

THERAPY FEES

Services	Intern	Mental Health Practitioner	Licensed Mental Health Professional
90791 Intake (60 min)	$100	$120	$200
90832 Individual/ Family Therapy (30 min)	$40	$50	$85
90834 Individual/ Family Therapy (45 min)	$55	$70	$110
90837 Individual/ Family Therapy (60 min)	$80	$100	$160
90846, 90847 Family Therapy (45-50 min)	$70	$90	$140
90853 Group therapy session	$50	$50	$50
90853, S9480, H2019 DBT Intensive Outpatient Group (90 minutes)	$165	$165	$165
90785 Interactive Complexity (added on to codes above in appropriate circumstances	$5	$8	$10
90839 Crisis Therapy (60 min)	$110	$135	$225

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90840 Crisis Therapy (30 min add on to 90839 above)	$55	$70	$115

*Sliding fee scale available upon request for all cash clients seeing intern, mental health practitioner, or licensed mental health professional. Fees are as of January 1, 2013 and are adjusted periodically.

FINANCIAL AGREEMENT

I understand that if I am a parent seeking therapy for a minor child, I am the financial guarantor of my client's account. If I am an adult seeking services for myself, I am the financial guarantor of my own account. By signing below I agree to the above fee schedule and understand payment (cash, check, Visa, MasterCard, or Discover) is due in full (including copays) at the beginning of each counseling session. I also agree to pay a fee of $10 plus the amount of the check for any returned checks.

I understand the following regarding use of insurance or the sliding fee scale:

In-network Insurance: If I have insurance coverage with a company that Link Therapy and Mediation is with, I have the following options:
____ Bill my insurance using an approved diagnostic code at the fees listed above
____ Pay the fee listed above in full (or on the sliding fee scale if my income is less than $90,000 annually)

Out-of-network Insurance: If I have insurance coverage with a company that Link Therapy and Mediation is **out-of-network** with, I have the following options:
____ Bill my insurance using an approved diagnostic code (in which case I could be responsible for the difference between what my insurance covers and the *full* amount listed above, regardless of what the allowed amount would be for an in-network provider)
____ Decide not to use my insurance and pay in cash, using the sliding fee scale above, which is an objective fee scale based on my income and other factors

No Insurance Coverage: If I do not have insurance coverage, I have the following option:
____ Pay the fee listed above in full if my income exceeds $90,000 annually
____ Pay the appropriate amount based on the sliding fee scale if my income is less than $90,000 annually

The agreed upon fee per 50-minute session is _____.

Comments or notes about fees or fee arrangements:

_____

_____

Note: Should you become involved in any legal action in which you or someone else require the therapist's participation, the psychotherapist's regular hourly fee, plus $100 per hour, is charged per hour for personal preparation, professional consultation, travel to and/or attendance at any legal proceeding. The extra fee is due to the sometimes complex nature of preparation and the extra costs that can be incurred for a therapist while preparing. Clients will need to pay in advance of any legal preparation.

CANCELLATION POLICY

I understand I am welcome to come to any part of my scheduled session, even if I have to be late. If I am running late, I will call my therapist to let him/her know. If I need to cancel or reschedule an appointment, I will give my therapist twenty-four (24) hours notice**. I understand failure to attend a session without giving notice will result in a fee equal to the full amount for the session and that this fee cannot be billed to my insurance meaning I will be responsible to pay it in full**. I also understand that canceling a session with less than twenty-four (24) hours notice will result in a $40 fee for mental health practitioners and a $60 fee for mental health professionals, or the cost of my full session if my agreed upon fee per session is less than the late cancel fee. I understand that exceptions for unforeseen or unavoidable situations are at the discretion of the psychotherapist. I understand that I will not be charged if I have a death in my immediate family or an emergency hospitalization for myself or an immediate family member. I also understand that insurance will not cover the payment for a missed appointment or a late cancel fee.

CONFIDENTIALITY

You should be aware that we practice with other mental health professionals and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

Under the rules governing Marriage and Family Therapists and Licensed Professional Clinical Counselors in the state of Minnesota, a therapist or counselor, and employees and professional associates of the therapist, must not disclose any private information that the therapist, employee, or associate may have acquired in rendering services except as follows:

- When state law mandates the report of suspected abuse or neglect of a child or vulnerable adult or prenatal exposure to drugs and alcohol.

- When failure to disclose the information presents a clear and present danger to the health or safety of an individual (including but not limited to threat of suicide or homicide).

- If you are involved in a court proceeding and a request is made for information concerning the professional services we provided for you, such information is protected by the privilege law. We cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should

- consult with your attorney to determine whether a court would be likely to order me to disclose information.

- When records are subpoenaed by the courts.
    - When the person, employee, or associate is a defendant in a civil, criminal, or disciplinary action arising from the therapy.

    - When the patient is a defendant in a criminal proceeding and the use of the privilege would violate the defendant's right to a compulsory process or the right to present testimony and witnesses in that person's behalf.

I understand the therapist is required to participate in legal proceedings when court-ordered, and I understand the therapist's fee for involvement in legal proceedings.

- If a government agency, pursuant to their lawful authority, is requesting the information for health oversight activities, we may be required to provide it for them. Also, if a client identifies a health professional and discloses that the health professional has violated his or her ethical code when treating a client/patient, including but not limited to initiating sexual contact with a client/patient throughout the term of treatment or within two years of the termination of treatment, the appropriate board must be notified.

- If a client files a complaint or lawsuit against us, we may disclose relevant information regarding that client in order to defend ourselves.

- If a client files a workers' compensation claim, we must, upon appropriate request, disclose information related to the claim to appropriate individuals, which may include that client's employer, the insurer or the Department of Labor and Industry.

- When a patient agrees to a waiver of the privilege accorded by this section, and in circumstances where more than one person in a family is receiving therapy, each such family member agrees to the waiver. Absent a waiver from each family member, a marital and family therapist cannot disclose information received by a family member.

Based on the AGREEMENT FOR THERAPY SERVICES/INFORMED CONSENT, the therapist will release confidential information for the following reasons:

- When a client is a minor, parents have access to records. Minor clients can request, in writing, that particular information not be disclosed to parents. Such a request should be discussed with the therapist. All minor clients under the age of eighteen (except when the minor is married or has born a child) must have the consent of their parents or guardians to receive on-going therapeutic services. Parents who share joint legal custody BOTH need to consent for ongoing mental health services for their child(ren). **I understand that when a client is a minor, parents have access to records.**

- When the therapist presents the case in consultation with other professionals, supervisors, or consultants, who are bound by the legal framework of privacy and confidentiality, for professional development and guidance purposes. Similarly, we may use examples from your case, without revealing personal details that could identify you, when training other students and therapists. **I give permission to this therapist to present my case in consultation with other professionals, supervisors, or consultants, who are bound by the legal framework of privacy and confidentiality, for professional development and guidance purposes and to use examples from my case that would not identify me when training other students and professionals in the field of mental health.**

- Client authorizes this provider (Link Therapy and Mediation LLC) to release any information necessary to process insurance claims. By doing so the client authorizes payment of medical benefits to this provider (Link Therapy and Mediation LLC) for mental health services. Link Therapy and Mediation LLC cannot guarantee confidentiality of records held by insurance companies**.** You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we can provide requested information to your carrier. **I give permission to this therapist to release any information necessary to process insurance claims.**

All other private information must be disclosed only with the informed consent of the client.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

Cell phone/Email/Fax Communication - If I choose to use email or a cell phone for communication I agree that I understand it may compromise the confidentiality of my information in ways my therapist cannot control. I also understand my therapist may share a fax machine with other therapists and that those therapists will work together to ensure my privacy to the best of their ability.

PROFESSIONAL RECORDS

The laws and standards of our profession require that we keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself and/or

others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.

PATIENT RIGHTS

HIPAA provides you with several rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record 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 disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement and the Notice of Privacy Practices (privacy policies and procedures). We are happy to discuss any of these rights with you.

EMERGENCY PROCEDURE

In the event of a life-threatening emergency, call 911. If I have another crisis that can not wait I am aware I can call the Crisis Connection at 612-379-6363.

My signature on this AGREEMENT FOR THERAPY SERVICIES/INFORMED CONSENT means I have reviewed, understand, and consent to the points above and indicates my consent to participate in therapy at Link Therapy & Mediation, LLC.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____