Renew Your Mind – Counseling Consulting and Supervision, LLC

1687 Woodlane Dr Suite 213 Woodbury MN 55125
651-347-1380

CLIENT INFORMATION - PLEASE READ CAREFULLY

The following information will help acquaint you with my office procedures, as well as provide information about your rights and responsibilities with regard to counseling. You will also find updated information about your rights pursuant to the Health Insurance Portability and Accountability Act (HIPAA). If you have any questions about this information, please discuss them with me at any time.

PROFESSIONAL RELATIONSHIP

Counseling is a way of helping people improve their lives and solve problems that are causing them distress by changing those aspects of themselves that are contributing to their problems. It involves looking at one's ways of coping with life, learning new ways to manage when current coping styles are not working. Counseling can have benefits and risks. Since counseling may involve discussing unpleasant experiences of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, counseling has also been shown to have many benefits. Successful counseling can lead to more satisfaction in relationships, new possibilities for addressing specific problems, and/or reductions in feelings of distress.

Our first few sessions will involve an evaluation of your needs and goals. By the end of the evaluation, we will be able to discuss your first impressions of what our work could include and a potential plan to follow, if you decide to continue with counseling. It is important to evaluate this information along with your own opinions of whether you feel comfortable working together. Since counseling involves a commitment of time, money, and energy, it is important to be selective about the psychotherapist you select. If you have questions about our work together, we can discuss these whenever they arise.

The most important aspect of counseling is the relationship between client and counselor. If this relationship is not working, please talk with me and we can either work toward a resolution or I will assist t in helping you find a new counselor transferring information to make the transition as smooth as possible.

CANCELLATIONS

Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. **All late cancellations /no-shows will incur a $90 charge and will be billed directly to you.**

CONTACTING ME

Due to the nature of my hours, I am often not immediately available by phone as I am usually with a client. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call as soon as I am available. If you are unable to reach me and feel that you are in a crisis, contact your family physician or the nearest emergency room and ask for the psychologist/psychiatrist/social worker on call or you can contact the Crisis Connection at (612) 379-6363, the St. Paul Ramsey Crisis Intervention Center at (651) 221-8922, or your local emergency services at 911. If I will be unavailable for an extended time, such as vacation, I will provide you with the name of a colleague to contact, if necessary.

BILLING, PAYMENTS, & INSURANCE

If paying privately, session fees are due at time of service. If you are billing insurance, co-pays are also due at time of service (unless your insurance requires another arrangement). **Clients are responsible for checking their coverage and knowing if there is a deductible that needs to be met at time of appointment, and how much it is, as well as the amount of their copay.**

If you need a receipt of payment please let me know and I will provide one. If your account is 60 days past due and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve using a collection agency or going through small claims court which will require me to disclose otherwise confidential information. If such legal action is necessary, the client will be responsible for all costs associated with it (collection agencies usually charge between 33-50% of the original amount.)

As part of the therapeutic process we do not believe it is helpful to participate in a legal process concerning any therapy that we might have given. If you ask that we do so we will decline. If it becomes necessary to participate in a legal process the hourly rate for preparation and testimony in a court hearing is $300/hr and will need to be paid in advance of services.

CLIENT BILL OF RIGHTS

1. You have the right to be treated with respect, dignity and consideration.
2. You have the right to confidentiality of information provided or obtained during the therapy process within the limits of the law.
3. You have the right to information about you therapist's credentials and training.
4. You have the right to information from your therapist about any assessments conducted.
5. You have the right to discuss with your therapist any concerns or questions you have about your therapy experience.
6. You have the right to review your file with your therapist.
7. You have the right to obtain an additional opinion about the problem which brought you to therapy and about preferences you might have for working with a different therapist.
8. You have the right to obtain a referral to other appropriate services.
9. You have the right to stop counseling at any point.
10. You have the right to report any grievances about a therapist to the therapist's supervisor and/or licensing board to which the therapist belongs. Grievances reportable include: sexual harassment, sexual advances, initiating or participating in social relationships and/or sexual behavior on the part of the therapist.

CONFIDENTIALITY AGREEMENT

Information about clients and their families is confidential with exception to the following:

1) Authorization by the client and/or family (valid authorization form).
2) Therapist's duty to warn another in the case of potential suicide, homicide or threat of imminent, serious harm to another individual.
3) Therapist's duty to report suspicion of abuse or neglect of children or vulnerable adults.
4) Therapist's duty to report prenatal exposure to cocaine, heroin, phencyclidine, methamphetamine, and amphetamine, THC (marijuana), excess & habitual use of alcohol or their derivatives.
5) Therapist's duty to report the misconduct of mental health or health care professionals.
6) Therapist's duty to provide a spouse or parent of a deceased client access to their child or spouse's records.
7) Therapist's duty to provide parents of minor children access to their child's records. Minor clients can request, in writing, that particular information not be disclosed to parents. Such a request should be discussed with the therapist.
8) Therapist's duty to release records if subpoenaed by the courts.
9) Therapist's obligations to contracts (e.g. to employer of client, to an insurance carrier or health plan).
10) In case of emergency – including serious injury or concern of serious injury to client, therapist will have the option of contacting client's emergency contact noted in the registration.
11) I undertake an extensive supervision and consulting process to insure clients are receiving the highest level of care. The purpose of supervision and consulting is to obtain additional insight, further my therapeutic skills, and insure the highest possible service to my clients. Every effort will be made to provide only those details necessary to gain feedback and maintain all confidentiality.

MINNESOTA NOTICE FORM: Policies and Practices to Protect the Privacy of Your Client's Health Information (HIPAA)

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND ASK IF YOU HAVE QUESTIONS. KEEP FOR YOUR RECORDS.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment, and Health Care Operations"*
  – *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or a psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my [office, clinic, practice group, etc.], such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

If I need to use or disclose your PHI for purposes outside of treatment, payment, or health care operations I will need an authorization from you. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures.

You may revoke an authorization at any time by notifying me in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained for insurance coverage, and the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I know or have reason to believe a child is being neglected or physically or sexually abused, or has been neglected or physically or sexually abused within the preceding three years, I must immediately report the information to the local welfare agency, police or sheriff's department.
- **Adult and Domestic Abuse:** If I have reason to believe that a vulnerable adult is being or has been maltreated, or if I have knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, I must
- immediately report the information to the appropriate agency in this county. I may also report the information to a law enforcement agency.
  "*Vulnerable adult*" means a person who, regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:
  (i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and
  (ii) because of the dysfunction or infirmity and the need for assistance, the individual has an impaired ability to protect the individual from maltreatment.
- **Health Oversight Activities:** A state licensing board may subpoena records from me if they are relevant to an investigation it is conducting.
- **Judicial and Administrative Proceedings**: If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law and I must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case.
- **Serious Threat to Health or Safety**: If you communicate a specific, serious threat of physical violence against a specific, clearly identified or identifiable potential victim, I must make reasonable efforts to communicate this threat to the potential victim or to a law enforcement agency. I must also do so if a member of your family or someone who knows you well has reason to believe you are capable of and will carry out the threat. I also may disclose information about you necessary to protect you from a threat to commit suicide.
- **Worker's Compensation**: If you file a worker's compensation claim, a release of information from me to your employer, insurer, the Department of Labor and Industry or you will not need your prior approval.

IV. Patient's Rights and Clinician's Duties

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI (and psychotherapy notes) in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may make a written complaint to me. You may also send a written complaint to the Secretary of the US Department of Health and Human Services.

IV. Effective Date, Restrictions and Changes to Privacy Policy

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain.

Signature _____ Date _____

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Client Information

Client Name (Print)_____ **Date of Birth** _____
Last Name First Name Initial

Street Address_____ Home Phone _____

City_____State_____ZIP_____ Work Phone _____

Email _____ Cell Phone _____

Is it OK to identify myself as a therapist if I call? YES NO

OK to communicate via email? YES NO

Sex: Female Male Age _____ Partner Status: Single Married Widowed Divorced Separated Other

Policy Holder Information: (if the client is not the policy holder)

Name_____Relationship _____
Last name First Name Initial

Address_____City_____State_____Zip_____**Date of Birth**_____

Employer_____

Employer Address _____Emplyer Phone:_____

Circle Your Relation to Insured: Self Spouse Child Other

Responsible Party (Where should the client's portion of the bill be sent, if not to the client?)

Name _____ Relationship _____

Address_____ Phone _____

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail client statements. I authorize the use of this signature on all insurance submissions.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature (if client is under 18 years old) Date

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Treatment Agreement

Clients Rights and Responsibilities

I affirm that I have received a copy, have read and understood the Client Rights and Responsibilities. _____(initial)

Notice of Privacy Policy

I affirm that I have received a copy, have read and understood the Privacy Practices (HIPAA). _____(initial)

Treatment Authorization

I request my therapist at RYMCCS plan and provide treatment to me (or my minor child) with my participation. I understand that I may withdraw this consent and terminate treatment at any time, for any reason.

Payment Responsibilities

I accept full responsibility for contacting my insurance company regarding benefits and coverage and agree to pay all deductibles, co-payments or co-insurance required by my health plan. _____(initial)

If services are NOT covered by a third party payor, subject to the provision of my third party contract, if any, I agree to pay for these services myself. _____(initial)

I agree that invoices can be sent to me via email. _____(initial)

I have been informed that billing will go through a 3rd party billing service. _____(initial)

I agree to give my therapist 24 hour prior notice of any appointment cancellation. I understand that if I do not give notice, I will be charged $90.00 for the cost of the office visit I missed. I am aware that insurance companies will not cover this cost. _____(initial)

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature (if client is under 18 years old) Date