RELATIONSHIP THERAPY CENTER

5407 Excelsior Blvd
Suite A, B, D, & E
St Louis Park, MN 55416
612-787-2832

2600 Eagan Woods Dr
Suite 200
Eagan, MN 55121
contact@mncouplescounseling.com

Client Registration Form

Patient Name: _____ **Date of Birth:** ___/___/_____
Last *First* *M. Initial*

Street Address: _____
City *State* *Zip*

Phone: _____ **Ok to call/leave a message?** □Yes □No **Ok to text?** □Yes □No
□Check this box to receive appointment reminder texts

Email: _____ □ Check this box to receive appointment reminder emails

Legal Sex: M / F / X **Pronouns:** □she/her/hers □he/him/his □they/them/their □other: _____

Race/Ethnicity: □ American Indian/Alaska Native (Tribe: _____) □ Asian □ Black/African American □ Native Hawaiian/Pacific Islander □ Multiracial □ White/Caucasian □ other: _____ □ Decline to answer

Relationship Status: □ Single □ Partnered □ Married □ Separated □ Divorced □ Widowed □ other: _____

How did you hear about us? _____

If you were referred: may we reach out to the person/entity that referred you to thank them? □Yes □No

Emergency Contact: _____ Phone: _____
Relationship To Client: _____ Email: _____

Insurance Registration

Are you planning to use insurance for your therapy? □Yes □No
If yes: please fill out the following information:

Insurance Company: _____ Phone: _____
Policy/Member ID: _____ Group #: _____ Payer ID #: _____

Do you have a secondary insurance policy? □Yes □No
If yes: please fill out the following information:

Insurance Company: _____ Phone: _____
Policy/Member ID: _____ Group #: _____ Payer ID #: _____

If the client is not the policy holder, please fill out the policy holder's information below:
Full Name: _____ Date of Birth: __/__/____ Relationship To Client: _____
Street Address: _____

Who is the person responsible for paying the bill? □ Client is responsible □ Someone else is responsible
If someone else is responsible: please fill out the following information:

Full Name: _____ Date of Birth: __/__/____ Relationship To Client: _____
Street Address: _____
Phone: _____ Email: _____

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.

_____ _____ _____
Responsible Party Signature (Required) Relationship Date

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Automated Payment Service Authorization

Our Automated Payment Service follows a similar process to leaving a credit card on file when you check in to a hotel. Securely storing your payment information on file saves valuable session time, as well as saving you time outside of therapy paying your bill. It also eliminates the need for monthly invoice statements, and therefore helps us keep the administrative cost of healthcare down.
Charges to your account will be determined as follows:

Copays/Self Pay Charges* – Copays are due on the date of service, per your contract with your insurance company. Self-pay charges are also due on the date of service. You may present another method of payment prior to, or at the time of service. *If another method of payment is not offered by the date of service, the method of payment you authorize below will be auto-charged within 1-3 business days after your session.*

Coinsurance and/or Deductibles* – These amounts are determined after your insurance company has finished processing your claim. The time frame for claims to be processed can range from 7-28 days. At that time, if a balance remains on your account, *the method of payment authorized below will be auto-charged within 1-3 business days after your claim is processed by your insurance company.* You can always check the status of your claims on your insurer's website. There may be instances when your insurance provider processes multiple claims at once, in which case you may be charged for multiple sessions at one time.

Late Cancellation or No-Show Charges – These charges are generated by your provider if you fail to show up for a scheduled appointment, or if you do not give adequate notice (48 hours) for canceling an appointment. *If you incur such a charge, the method of payment authorized below will be auto-charged within 1-3 business days after your originally scheduled appointment.*

Client Portal – You will be able to see any outstanding balance on your account using our secure online client portal, AdvancedMD, and you may pay any outstanding balance at any time. You are not able to access receipts through your AdvancedMD account, but you may contact the office to request payment records at contact@mncouplescounseling.com.

Method of Payment – Please provide a valid credit or debit card number in the space below. If you are providing an HSA/FSA/HRA card, we ask that you provide a backup credit or debit card as well. The backup card will only be charged if the HSA/FSA/HRA is declined for insufficient funds. If the backup card is charged, we are unable to reverse the charge and apply it to your HSA/FSA/HRA at a future date, but we can provide you with a receipt for your payment which you can submit to your HSA/FSA/HRA for reimbursement. We are able to accept all major credit cards, as well as CareCredit cards.

Client Name (printed) _____ **Card/Account Holder Name** _____
Billing Address_____**City, State, Zip** _____

☐ Check here if this is an HSA card ☐ Check here if this is a CareCredit card

Account Number _____Exp Date _____Security Code ____

If the above payment information is for an HSA/FSA/HRA account, please also provide a backup:

Backup CC Number _____ Exp Date _____Security Code ____

SIGNATURE _____ DATE _____

☐ **IF COUPLES/FAMILY COUNSELING: Please check this box if you would like us to store this method of payment on your partner/family member's account in addition to your own. If choosing this option – write your partner/family member's name here:** _____

By signing above I authorize the Relationship Therapy Center, PC to charge the payment method indicated in this authorization form according to the terms outlined above. I certify that I am an authorized user of the bank account or credit card and that I will not dispute the payment with my credit card company or banking institution, so long as the transaction corresponds to the terms indicated in this form.
*If cost is prohibitive – please talk with your therapist about possible options.

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Informed Consent for Psychotherapy

The therapeutic relationship is unique in that it is highly personal, and at the same time, a contractual agreement. It is important for you and the therapist to reach a clear understanding about how your relationship will work, and what each of you can expect. **This consent form will provide a clear framework for your work together.** Feel free to discuss any of this information with your therapist.

The Therapeutic Process

There are many different methods your therapist may use to deal with the concerns you hope to address. Therapy is **not like a medical doctor visit**; instead, it calls for an **active effort on your part**, and the outcome of treatment depends largely on your willingness or ability to engage in the process. Therapy is often more successful when you commit to practicing the strategies you are learning in therapy outside of your sessions.

Therapy can have **risks along with the substantial benefits**. Since the sessions may involve discussing unpleasant experiences, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, or helplessness. On the other hand, successful therapy can lead to more satisfaction in family relationships, new possibilities for addressing specific problems, or reductions in feelings of distress. There are no guarantees to what you will experience, and we cannot promise that your behavior or circumstances will change as a result of therapy, but we can promise to support you and do our very best to understand you and your repeating patterns, and provide you with skills and strategies to address them.

The first few sessions will involve an **evaluation of your needs and goals**. By the end of the evaluation, you and the therapist will be able to discuss your first impressions of what therapy could include, and a potential plan to follow. It is important to evaluate the information alongside your opinions regarding whether it makes sense for you and the therapist to work together. Since therapy involves a commitment of time, money, and energy, **it is important to ensure that the therapist is a good fit**. If you have any questions about any procedures, please discuss them with the therapist.

Although therapy may involve discussing personal or intimate details about your life, your relationship with the therapist must remain limited to a **mutually respectful therapeutic framework**. You have the right to refuse any therapeutic suggestions offered to you, and you may suspend or cease treatment at any time without penalty. If you decide to cease treatment, please notify your therapist so that your file can be closed and/or you can be referred to another resource. **If you cease treatment without notice, your file will be automatically closed 30 days after your last session.**

Contacting Your Therapist

Your therapist may not be immediately available by phone due to being in session with other clients. When unavailable, the therapist's phone is answered by a secure and confidential voicemail that is monitored frequently. The therapist will make every effort to return your call within 24 business hours. If you are unable to reach the therapist and feel you can't wait for a return call, please contact your physician or the nearest emergency room and ask for the psychologist/psychiatrist/social worker on call. You can also contact **Hennepin County COPE Crisis Care (612-596-1223)**; **St. Paul Ramsey Crisis Intervention Center (651-266-7900); or your local emergency services at 911.**

Although you are able to contact your therapist via text message and email as well as via phone call or through your client portal, please be aware that **text and email communication is not completely private or secure**, and may be intercepted, misdirected, or accessed by others (for example, if your therapist's phone is lost or stolen.) Text and email communications are also not covered by HIPAA privacy laws. We cannot guarantee confidentiality of any information that you choose to share with your therapist through these methods, although we value your privacy and take all reasonable steps to safeguard your health information.

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Confidentiality & Client Bill of Rights

The session content and all relevant materials to your treatment will be held confidential unless you request in writing to have all or portions of such content released to a specifically named person or entity. **Limitations of such client held privilege of confidentiality exist, and are itemized below**:

(1) Therapist's duty to warn another in the case of **potential suicide, homicide, or threat of imminent, serious harm** to another individual;

(2) Therapist's duty to report suspicion of **abuse or neglect of children or vulnerable adults**;

(3) Therapist's duty to report **prenatal exposure** to cocaine, heroin, phencyclidine, methamphetamine, amphetamine, THC/marijuana, excess & habitual use of alcohol or their derivatives;

(4) Therapist's duty to report the **misconduct of other mental health or healthcare professionals**;

(5) Therapist's duty to provide a **spouse or parent of a deceased client** access to the client's records;

(6) Therapist's duty to provide **parents of children aged 15* or younger** access to the client's records;

*__Minor clients who are 16 years old or older may consent to outpatient mental health care__ without the consent of a parent or guardian, per Minnesota Statute 144.3431. Clients under the age of 16 can request, in writing, that particular information not be disclosed to parents. Such a request should be discussed with the therapist.

(7) Therapist's duty to release records if **subpoenaed by the courts** or a court order issued by a judge;

(8) Therapist's obligations to **legal contracts** (e.g. to a credit card company, insurance carrier, or health plan);

(9) In case of emergency – including in case or concern of serious injury to client – therapist has the option to **contacting the client's emergency contact**, or others who may help ensure the client's safety;

(10) If you are paying with a credit card, **RTC's credit card processor may require the clinic to provide proof of service**, which can include a signed receipt or signed agreement. This is universally true even if you dispute the charge;

(11) If your account is 60 days past due, **RTC may choose to pursue collecting the balance using a collection agency**. The collection agency may require proof of service, such as a signed receipt or agreement;

(12) At times, therapists at RTC will work collaboratively as a team to provide the best care for clients by **recommending that you see multiple therapists at the practice**. During this process, the therapists involved in your care may share confidential information with one another for the purpose of coordinating such care. If you prefer that your information not be shared during this collaborative process, you may notify your therapist in writing;

(13) Therapists at RTC undertake an **extensive consultation process** to ensure clients are receiving the highest level of care. Consultation members are available upon request and may include supervisors and clinical members. The purpose of this consultation is to obtain additional insight, further therapeutic skills, and ensure the highest possible service to our clients. Every effort will be made to provide only those details which are necessary to gain feedback and maintain all privacy. RTC therapists reserve the right to consult with other RTC clinicians about any/all aspects of your work together, and reveal identifying information if necessary.

The Client Bill of Rights is posted in the waiting room at our offices. Please review it at your convenience.

[*Continued on next page]*

Insurance Reimbursement & Confidentiality

You should be aware that your contract with your health insurance company likely requires your therapist to provide them with information relevant to the services that are provided to you. **RTC is required to provide a mental health diagnosis in order to bill insurance.** Sometimes, we may be required to provide additional clinical information such as treatment plans or summaries, or partial or full copies of your clinical record.

In such situations, RTC will make a reasonable effort to release only the minimum information about you that is necessary for the purpose requested. The information will become part of the insurance company's files and will likely be stored in an electronic database. Although all insurance companies claim to keep such information confidential, **RTC has no control over what happens to the information once it is sent**. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above, unless expressly prohibited by your insurer's contract. RTC will provide you a copy of any report submitted, if you request it and if it is permissible by law. By signing this agreement, you agree that RTC may provide requested information to your insurance carrier.

Rates, Insurance, and Billing Procedures

Your therapist will consult a diagnostic intake session that ranges from 45-60 minutes at a cost of $225. Following the intake session is an evaluation period that lasts from 2-3 sessions. During this time, you and the therapist will both decide if this is a good fit to help you reach your goals. You will decide together on the length and frequency of your sessions. **The standard for adult individual or couples therapy is one 53-60 minute session per week**, but your therapist may recommend or you may request a different frequency or session length depending on your circumstances. The therapist may have other recommendations for clients under the age of 16.

Our fees are:
30-minute psychotherapy session - $110
45-minute psychotherapy session - $165
53-60 minute psychotherapy session - $200*
75-minute psychotherapy session - $260

*Clients seeing Theresa Benoit, Jeb Sawyer, or Nancy Carlson are billed at $300 for a 53-60 minute session.

Once an appointment is scheduled, we kindly ask 48 hours advance notice of cancellation. **All cancellation notices received within 48 hours of a scheduled session will incur a cancellation fee of $100.** If you have reserved a multiple-hour session, the cancellation fee is $100 per hour. It is important to note that insurance companies do not reimburse for cancelled sessions.

If paying privately, **session fees are due at time of service per the terms of our Automated Payment Service form**. If you are insured through an in-network insurance policy, **copays and deductible payments are due at time of service per the terms of our Automated Payment Service form**, unless your insurance provider requires another arrangement. If you are insured through an out-of-network insurance policy, please refer to our Out-Of-Network Policy form later in this intake packet. Your portion of payment is also due at time of session. All out-of-network, private pay, and uninsured clients are entitled to a Good Faith Estimate prior to the start of their care.

If your account is 60 days past due and arrangements for payment have not been agreed upon, **RTC has the option of using legal means to secure payment**. This may involve hiring a collection agency or going through small claims court, which will require RTC to disclose otherwise confidential information. In most collection situations, the only information released regarding a client's treatment is their name, the nature of services provided, and the amount due. If such legal action is necessary, the client will be responsible for all associated costs. **All returned checks will incur a $35 fee.** By signing this document you also authorize RTC to send you billing statements and payment confirmations via email.

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Supervision and Consultation

At the Relationship Therapy Center, we endeavor to provide the best therapy possible. Part of this process includes **regular consultation between our therapists** to ensure that we are providing the best standard of care. If your therapist must consult on your case, they will avoid offering any identifying information.

Some of our therapists are also **practicing under clinical supervision** while working towards independent licensure, which includes regular consultation with another fully licensed practitioner. The therapist's supervisor will not be in sessions with you, nor will your session be recorded in any way without your explicit permission. The therapist's supervisor is bound to the same ethical standards of confidentiality. Supervised therapists include: Kyra Anderle, Christopher Benjamin, Isabelle Bond, Anna Boyes, Chelsea Bohmer, Phillip Buganski, Krysta Clipp, Erin Egertson, Sam Egertson, Sharon Ganivet Hernandez, Bethany Hartzell, Christian Ann Larson, Dana Le Duc, Trevor Limberg, Kiera McGinness, Sidney Miller, Fernanda Quevedo, Josh Sampson, Julia Schultz, Holly Severson, Ellie Siedow, Jennie Stein, Vicky Thao, Charlie Walker, Yuqing Wang, Anna Ward, and Ashley Young.

If you have any need to reach out to a supervisor, please contact clinic owner and clinical supervisor Theresa Benoit at 612-850-8065 or mncouplescounseling@gmail.com.

Consent for Psychotherapy Services

By signing below, you agree that you have read and do understand the contents of this document, and agree to the policies of pursuing psychotherapy services with your clinician.

_____

Client Printed Name

_____ _____

Client Signature Date

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Health History

Items of Concern (Check all that apply):

- ☐ Abuse
- ☐ Anxiety
- ☐ Appetite/Weight Issues
- ☐ Concentration Issues
- ☐ Depression
- ☐ Disordered Eating
- ☐ Energy/Fatigue
- ☐ Family/Relationships
- ☐ Gender Identity/Issues
- ☐ Hallucinations
- ☐ Hopelessness
- ☐ Impulsivity/Distractibility
- ☐ Internet Usage
- ☐ Libido Changes
- ☐ Mood Changes
- ☐ Obsessiveness
- ☐ Panic Attacks
- ☐ Racial/Cultural Identity Issues
- ☐ Self-Esteem
- ☐ Self-Harm
- ☐ Sex/Sexuality
- ☐ Sleep Changes
- ☐ Social/Job Functioning
- ☐ Trauma

How long have you been experiencing these concerns? ☐< 1 month ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months ☐ 1-2 years ☐ 2+ years

Mental Health History

Have you ever been to therapy before? ☐Yes ☐No
If so, when, and for what purpose? _____

What was or was not helpful about your previous therapy experience? _____

Is there anything about how you feel/think that bothers you? _____

Have you ever been hospitalized for psychological or psychiatric reasons? ☐Yes ☐No If so, please explain:

Is suicide a concern at this time? ☐Yes ☐No
Have you ever attempted suicide? ☐Yes ☐No If so, what were the circumstances surrounding the attempt?

Have you been diagnosed with any psychiatric conditions? _____

Do you take any psychiatric medications? ☐Yes ☐No If so, please list them: _____

Who prescribes the medications? _____

Physical Health History

Have you been diagnosed with any non-psychiatric health conditions? _____

Do you take any non-psychiatric medications? ☐Yes ☐No
If so, please list them: _____

Who prescribes the medications? _____

Any health concerns that are distressing to you? _____

Habits

Do you drink alcohol? ☐Yes ☐No **If so:**
On average, how many days/week do you drink? _____
On average, how many drinks per day do you have? _____
What type(s) of alcohol? _____
What is the largest number of drinks you have had in a single day in the past month? _____
Do you use recreational drugs? ☐Yes ☐No If so, which ones and how often? _____

CAGE-AID ASSESSMENT:

Have you ever felt you ought to cut down on your drinking or drug use? ☐Yes ☐No
Have you ever had people annoy you by criticizing your drinking or drug use? ☐Yes ☐No
Have you ever felt bad or guilty about your drinking or drug use? ☐Yes ☐No
Have you ever had a drink or used drugs as an "eye opener" first thing in the morning to steady your nerves or to get rid of a hangover, or to get the day started? ☐Yes ☐No

Do you use tobacco? ☐Yes ☐No If so, what kind and how often? _____
Do you gamble? ☐Yes ☐No If so, how many times per week? _____ Per month? _____
Have you ever been told you have a gambling problem, or thought you might? ☐Yes ☐No
How many hours of sleep do you get each night? _____
How much "screen time" do you get each day? _____
How does your screen time relate to:
Work/School? _____
TV/video games/social media/etc? _____
Other? _____
On average, how often do you exercise? _____
Any concerns regarding food/appetite? _____

Any concerns regarding your sexual habits or behaviors?

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Personal/Social History

What is the highest level of education you have completed?

☐ Some high school ☐ High school graduate ☐ GED ☐ Some college ☐ Associates ☐ Bachelors ☐ Masters
☐ Doctorate ☐ Other: _____

What is your occupation?

☐ Employed full-time – Employer: _____ Title: _____ Hours/week worked: _____
☐ Employed part-time – Employer: _____ Title: _____ Hours/week worked: _____
☐ Student
☐ Currently unemployed
☐ Retired
☐ Other: _____

Please describe your current living situation:

☐ Alone ☐ With spouse/partner(s) ☐ With parent(s)/family ☐ With roommate(s) ☐ Other: _____
Are you experiencing any housing/financial stressors? _____

Are you experiencing distress related to your racial/ethnic/social/cultural identity? If so, please describe: _____

_____

Any concerns your therapist should be aware of regarding your racial/ethnic/social/cultural identity, racial trauma, etc? _____

_____

Do you have any spiritual commitments you would like your therapist to be aware of? _____

_____

Please describe your relationships with the following people, if applicable:

Biological mother: _____
Biological father: _____
Adoptive or Step-parent(s): _____

_____
Sibling(s): _____
Extended family: _____
Spouse/partner(s): _____
Ex-partner(s): _____
Child(ren): _____
Friend(s): _____
Other significant relationship(s): _____

Total number of close, supportive relationships in your life: _____

Has physical or emotional abuse ever been present in your relationships?

☐ No ☐ Yes – current partner ☐ Yes – previous partner(s) ☐ Yes – family member ☐ Yes – other: _____

Do you believe your spouse/partner has jealousy issues? ☐ Yes ☐ No

Please describe any significant or stressful life events that you have been experiencing:

_____

_____

_____

_____

Anything else you want your therapist to know?

_____

_____

_____

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Anxiety / Depression Assessments

Anxiety (GAD-7)

In the past 2 weeks, how often have you been bothered by the following problems?

1. Feeling nervous, anxious, or on edge:

0	1	2	3
Not at all	Several days	More than half the days	Nearly every day

2. Not being able to stop or control worrying:

0	1	2	3
Not at all	Several days	More than half the days	Nearly every day

3. Worrying too much about different things:

0	1	2	3
Not at all	Several days	More than half the days	Nearly every day

4. Trouble relaxing:

0	1	2	3
Not at all	Several days	More than half the days	Nearly every day

5. Being so restless it is hard to sit still:

0	1	2	3
Not at all	Several days	More than half the days	Nearly every day

6. Becoming easily annoyed or irritable:

0	1	2	3
Not at all	Several days	More than half the days	Nearly every day

7. Feeling afraid as if something awful might happen:

0	1	2	3
Not at all	Several days	More than half the days	Nearly every day

Total Score: _____

Depression (PHQ-9)

In the past 2 weeks, how often have you been bothered by the following problems?

1. Little interest or pleasure in doing things:

0	1	2	3
Not at all	Several days	More than half the days	Nearly every day

2. Feeling down, depressed, or hopeless:

0	1	2	3
Not at all	Several days	More than half the days	Nearly every day

3. Trouble falling or staying asleep, or sleeping too much:

0	1	2	3
Not at all	Several days	More than half the days	Nearly every day

4. Feeling tired or having little energy:

0	1	2	3
Not at all	Several days	More than half the days	Nearly every day

5. Poor appetite or overeating:

0	1	2	3
Not at all	Several days	More than half the days	Nearly every day

6. Feeling bad about yourself or that you are a failure or have let yourself or your family down:

0	1	2	3
Not at all	Several days	More than half the days	Nearly every day

7. Trouble concentrating on things, such as reading the newspaper or watching television:

0	1	2	3
Not at all	Several days	More than half the days	Nearly every day

8. Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual:

0	1	2	3
Not at all	Several days	More than half the days	Nearly every day

9. Thoughts that you would be better off dead or of hurting yourself in some way:

0	1	2	3
Not at all	Several days	More than half the days	Nearly every day

Total Score: _____

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Internal Release of Information for Relationship/Family Therapy

A therapeutic interchange of communication between all participants is a critical component of relationship/family therapy. When completed and signed by you, **this form authorizes the Relationship Therapy Center and its members to release and exchange confidential information from your client file with your partner or other designee(s) involved in your care.** Examples of such information may be:

- details about previous sessions during which the designee was present;
- notices about upcoming joint appointments;
- Information regarding billing or payment.

Although the ethics of relationship/family therapy require this release to be signed, it does not mean that RTC or its members will actively divulge information that is not considered therapeutic. This release is also limited to verbal communication and does not extend to client records unless explicitly noted.

You have the right to revoke this authorization in writing at any time by sending such written notification to the Relationship Therapy Center's office address. However, your revocation will not be effective to the extent that RTC's administrative or clinical staff have taken action in reliance on the authorization, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Furthermore, any information disclosed to the person(s) authorized may be subject to redisclosure by the recipient of the information, and will no longer be protected by the HIPAA privacy rules outlined in the Notice of Privacy Practices later in this packet.

Your therapist generally may not refuse to provide psychotherapy services on the basis of your refusal to sign this authorization, unless the psychotherapy services are provided to you for the purpose of creating health information for a third party. You should be aware that your therapist's effectiveness may be limited if they are not able to share relevant clinical and/or administrative information with your partner/other designee(s) who are participating in your care.

I authorize the Relationship Therapy Center and/or its clinical and administrative staff to release and exchange information with:

Your partner/other designee(s)'s name	***Phone number***	***Relationship to client***

I am requesting my counselor to release/exchange this information for the following reasons:

At the request of the individual for the purposes of communicating clinical and/or administrative information with the person(s) identified above.

Assignment and Release

By signing this document, you are agreeing to the above authorization and stipulations noted therein.

_____
Client Printed Name

_____ _____
Client Signature Date

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Informed Consent for Telehealth

This Informed Consent for Telehealth contains important information focusing on doing psychotherapy using a HIPAA-compliant internet video conferencing platform. Please read this carefully, and let your therapist know if you have any questions.

Benefits and Risks of Telehealth

Telehealth allows you to meet with your therapist remotely using a secure video conferencing service rather than meeting in-person in the therapist's office. Many clients and therapists find Telehealth convenient, as it allows therapy to continue without interruption when traveling, after relocating, or if meeting in-person isn't possible due to unforeseen circumstances like bad weather or illness. Though it is convenient, there are several risks to Telehealth therapy, such as:

- Risks to confidentiality. Although your therapist will take reasonable steps to ensure your privacy on their end, it is important for you to make sure you find a private place for your session where you will not be interrupted or overheard. It is also important for you to protect the privacy of your session on your device.

- Technology issues. Technology doesn't always work perfectly. Occasionally, internet connections may fail, audio or visual quality may be poor, or the session may be interrupted. Although very unlikely, there is also a small risk that someone could gain unauthorized access to your electronic communications. To help protect your privacy, we use a HIPAA-compliant video platform with end-to-end encryption, which means only you, your therapist, and anyone you invite to the session can access the meeting.

- Crisis response and management. If you are experiencing a mental health crisis or need immediate intervention, Telehealth may not be the safest or most effective option. Before beginning telehealth, you and your therapist will develop an emergency plan in the event that a crisis arrives.

- Efficacy. Research shows that telehealth is generally as effective as meeting in person for most mental health concerns. However, some therapists and clients feel that meeting face-to-face allows for better observation of body language and other nonverbal communication.

Confidentiality

The Relationship Therapy Center has a legal and ethical responsibility to make our best efforts to protect all Telehealth communications. We use a secure, HIPAA-compliant Telehealth platform, and have agreements in place with our technology providers to help safeguard your information.

While we take reasonable steps to protect your privacy, no electronic communication can be guaranteed to be completely secure. Although the risk is very small, unauthorized access to electronic communications is always a possibility.

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Appropriateness of Telehealth

If a situation arises where your therapist recommends or suggests a Telehealth session rather than an in-person session, such as in the case of inclement weather, therapist or client illness, or an unforeseen scheduling conflict, your therapist will assign a unique, secure Telehealth meeting link to your session, which you will receive by email (and text, with your consent).

If a situation arises where an in-person session is indicated, your therapist will arrange to see you at the practice office, or ask that an in-person colleague have a consultative session with you. If Telehealth services are no longer in your best interest, you and your therapist will discuss options for engaging in in-person counseling.

Because responding to emergencies can be more difficult during Telehealth sessions, you'll work with your therapist to create an emergency plan before beginning services. This plan includes identifying an emergency contact that is close to your location who can be reached if there is a serious safety concern. Your therapist may ask you to complete a separate authorization allowing them to contact this person if necessary.

If technology fails and your session is interrupted:

- If you are experiencing an emergency, call 911 or go to your nearest emergency room. After you have contacted emergency services, you may contact your therapist.
- If it is not an emergency, disconnect and wait while your therapist attempts to reconnect through the telehealth platform within two (2) minutes. If you have not reconnected after two minutes, please call your therapist using their direct phone number.

Fees

The state of Minnesota mandates Telehealth parity, which means that your rates and insurance reimbursement remain the same for Telehealth sessions as they would for in-person sessions. In order to access our secure Telehealth platform, we require a valid payment method to be placed on file.

Consent for Treatment via Telehealth Services

☐ Check this box to indicate that you agree that you have read and do understand the contents of this notice, and agree to the policies of pursuing Telehealth psychotherapy services with your clinician, and that you authorize your clinician to use a HIPAA-compliant internet video conferencing platform to provide services to you if it is in your best interest therapeutically.

or:

☐ Check this box to indicate that you do not consent to Telehealth psychotherapy services of any kind, even in the event of illness, bad weather, scheduling conflicts, or any other circumstance in which you may otherwise have the option to meet virtually rather than cancel or reschedule a previously-scheduled psychotherapy session.

_____

Client Printed Name

_____ _____

Client Signature Date

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.
This notice uses "I" and "me" to refer to your RTC therapist(s).
This notice goes into effect beginning 04/14/2003.

My Pledge Regarding Health Information

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information.

I am required by law to:

- Make sure that **protected health information ("PHI")** that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.

I may change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

How I May Use And Disclose Health Information About You

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures, I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment, Payment, or Health Care Operations. Federal privacy rules and regulations allow health care providers who have a direct treatment relationship with the client to use or disclose the client's PHI, without the client's written authorization, to carry out the health care provider's own treatment, payment, or health care operations. I may also disclose your PHI for the treatment activities of any health care provider. This too can be done without the client's written authorization. For example, if I were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your PHI, which is otherwise confidential, in order to assist me in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers, and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes. If you are involved in a lawsuit, I may disclose information in response to a court or administrative order. I may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request, or to obtain an order protecting the information requested.

[Continued on next page]

Certain uses and disclosures require your authorization.

Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR §164.501, and any use or disclosure of such notes requires your written authorization unless the use or disclosure is as follows:

- For my use in treating you.
- For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
- For my use in defending myself in legal proceedings against you.
- For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
- Required by law and the use or disclosure is limited to the requirements of such law.
- Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
- Required by a coroner who is performing duties authorized by law.
- Required to help avert a serious threat to the health or safety of others.

Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes without your written authorization.

Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

Certain uses and disclosures do not require your authorization.

Subject to certain limitations in the law, I can use and disclose your PHI without your authorization for the following reasons:

- When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
- For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
- For health oversight activities, including audits and investigations.
- For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain a written authorization from you before doing so.
- For law enforcement purposes, including reporting crimes occurring on my premises.
- To coroners and medical examiners, when such individuals are performing duties authorized by law.
- For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
- Specialized government functions, including ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or helping ensure the safety of those working within or housed in correctional institutions.
- For compliance with workers' compensation laws, although my preference is to obtain a written authorization from you before doing so.
- Appointment reminders and health related benefits or services. I may use and disclose your PHI to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

Certain uses and disclosures require that you have an opportunity to object.

Disclosures to friends, family, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment of your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

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You Have The Following Rights With Respect To Your PHI

1. *The Right to Request Limits on Uses and Disclosures of your PHI*. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it will negatively affect your health care.
2. *The Right to Request Restrictions on Out-of-Pocket Expenses Paid For In Full*. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. *The Right to Choose How I Send PHI to You*. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. *The Right to See and Get Copies of Your PHI*. Other than "psychotherapy notes", you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide a copy of your record, or a summary of it if you agree to receive a summary, within 30 days of receiving your written request. I may charge a reasonable cost-based fee for doing so.
5. *The Right to Get a List of the Disclosures I Have Made*. You have a right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with a written authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. *The Right to Correct or Update Your PHI*. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but if I do so, I will tell you why in writing within 60 days of receiving your request.
7. *The Right to Get a Paper or Electronic Copy of this Notice*. You have the right to get a paper copy of this notice, and you have the right to get a copy of this notice by email. And, even if you have agreed to receive this notice by email, you also have the right to request a paper copy of it.

Questions or Complaints

If you have any questions about this notice, disagree with a decision your therapist makes about your records, or have other concerns about your privacy rights, you may contact the clinic owner, Jeb Sawyer, at 612-483-4994.

If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint to:

Jeb Sawyer, MA, LMFT
5407 Excelsior Blvd, Suite B.
St. Louis Park, MN 55416

Acknowledgement of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing this document, you are acknowledging that you have received a copy of our HIPAA Notice of Privacy Practices, and that you have read, understand, and agree to the terms of this Notice.

_____

Client Printed Name

_____ _____

Client Signature Date

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Release of Information Authorization

Client Name: _____ DOB: ____/____/_____

By signing this form, I authorize _____
Your therapist's first and last name

and/or their administrative and/or clinical staff to release/exchange the following Personal Health Information (PHI):

- ☐ **Any and all information**
- ☐ Assessment results
- ☐ Billing / insurance information
- ☐ Continuation Of Care plan
- ☐ Current treatment update
- ☐ Demographic information
- ☐ Diagnosis / Diagnoses
- ☐ Discharge / transfer summary
- ☐ Educational information
- ☐ Medication management
- ☐ Nursing / medical information
- ☐ Presence/participation in treatment
- ☐ Progress Notes
- ☐ Psychological evaluation
- ☐ Relevant treatment records
- ☐Treatment plan / summary
- ☐ Other: _____

This information should only be released with the following individual/agency:

Individual/Agency's Name: _____
Address/City/State/Zip: _____
Phone: _____ Fax: _____
Email: _____

The date range of information to be released is:

☐ From Start Date (_____) to End Date (_____)
☐ For all dates of treatment

The purpose for this release is:

- ☐ At the request of the individual / Personal use
- ☐ Attorney or judicial request
- ☐ Other: _____
- ☐ Client care and treatment
- ☐ Disability

This authorization is considered ongoing, and does not expire unless I specify an expiration condition:

- ☐ 30 days after termination of treatment
- ☐ Upon my written request
- ☐ Immediately after requested information is received
- ☐Other: _____

I understand that any personal health information or other information released to the above entity becomes part of a designated record set and may be subject to re-disclosure by said entity, and then may no longer be protected by applicable federal and state privacy laws.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice to the Relationship Therapy Center. However, this authorization may not be revoked if the Relationship Therapy Center has taken action on this authorization prior to receiving my written notice.

Assignment and Release

By signing this form, I acknowledge that I understand and agree to the terms of this release.

_____
Client Printed Name

_____ _____
Client Signature Date

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Notice of Non-Covered Services

At the Relationship Therapy Center, we strive to provide the most cutting-edge treatments. Unfortunately, not all of these services are covered by healthcare insurers. Please understand that the following procedures will not or may not be covered by your insurance, and will be your sole responsibility. Fees for these services are listed in parentheses.

- Intensive Couples Counseling (starts at $2495 for 8 hours)
- Sessions longer than 60 minutes. Each additional 53-60 minutes ($200); Each additional 45 minutes ($165); Each additional 30 minutes ($110).
- Family Therapy (CPT codes 90846 & 90847) may not be covered by some insurers. (53-60 minutes: $200)
- Sex Therapy may not be covered by some insurers. (53-60 minutes: $200)
- Therapy services via phone call, email, or text messages ($3/minute)
- Other professional time, including writing reports, consulting with other professionals, time spent performing any other service requested by you or recommended by your therapist. (starts at $200 per 60 minutes)
- If you become involved in legal proceedings that require therapist participation, you will be responsible to pay for all of your therapist's professional time, including preparation and transportation costs, even if a third party is the requestor. (starts at $325 per 60 minutes)
- Personal or Couples Coaching Services (price determined by length; starts at $75)
- Telehealth may not be covered by some insurers. (53-60 minutes: $95-$225)
- Psychoeducation classes or support groups (starts at $50)
- Individual intensive therapy groups (starts at $999)

The Relationship Therapy Center is happy to provide a receipt for all services, as we encourage you to follow up with your insurer or health savings plan to see if you are eligible for reimbursement. Please let us know if you have any questions about this.

Acknowledgement of Non-Covered Services Notice

By signing this form, you acknowledge that the specific services listed above may not be covered through your health insurer, and you understand that payment for all such charges is the responsibility of the Responsible Party listed on the Client Registration form.

_____

Client Printed Name

_____ _____

Client Signature Date

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Notice of Out-of-Network Insurance Policies

Increasingly over the past decade, insurance companies have saved money by decreasing coverage benefits for out-of-network health care providers. This result has been a lot of confusion over benefits for these plans. At the Relationship Therapy Center, we want to give you as much advanced notice as possible so that you can make informed decisions regarding your therapy experience. Please make sure that you understand the following:

- The Relationship Therapy Center is contracted with the following insurance companies: Blue Cross Blue Shield; HealthPartners; Cigna; Aetna; Optum (UnitedHealthcare, Medica, UMR, UHSS, Surest). We are also often (but not always) considered in-network for smaller benefits companies that use the networks of the above insurance companies.

- We are considered out-of-network for certain specific Blue Cross Blue Shield and Aetna plans, primarily the Allina Elevate Premier Network.

- We are not directly contracted with Minnesota state Medical Assistance/Medicaid, though we are considered in-network for Medical Assistance plans that are through Blue Cross Blue Shield (group number: MNCAID01) or HealthPartners (group number: 4183 or 4190).

- Only certain therapists at the Relationship Therapy Center are credentialed Medicare providers. Only these therapists may bill in-network for Medicare or Medicare supplement plans. All other therapists are considered out-of-network with Medicare plans or supplements, even supplements that are administered through a company that we are otherwise contracted with.

- We strongly recommend that you contact your insurance carrier to obtain information about your coverage, including benefits estimates. It has become increasingly difficult to obtain correct information from insurance carriers prior to the processing of claims, and therefore our administrative staff no longer offers benefits estimates at time of booking.

- You, or the Responsible Party designated in your registration form, are responsible for paying your portion of the bill for any out-of-network services. The estimated amount of the session will be due at time of session. Out-of-network and private-pay clients are entitled to a Good Faith Estimate of their service costs.

- EAP benefits do not apply to our services.

Acknowledgement of Out-of-Network Policies Notice

By signing this form, you agree to the above information and terms.

_____

Client Printed Name

_____ _____

Client Signature Date