Insurance/Fee Registration Form

Date_____ Diagnosis **(Therapist will Fill In)** _____

Therapist_____

Client Information

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

Street Address_____ Home Phone _____

City_____State_____ZIP_____ Cell Phone _____

Ok to Send Appointment Reminder Messages? ☐ Yes ☐ No

E-Mail Address_____ Ok to Leave/Send Messages? ☐ Yes ☐ No Work Phone _____

Gender: ☐ Female ☐ Male ☐ Other Age _____ Relationship Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Partnered

Employer _____

Referred by _____ May we acknowledge this referral? ☐ Yes ☐ No

Primary Insurance

Primary Insurance Company_____ Phone _____

Ins Claims Address_____City_____State_____Zip_____

Policy / Member ID_____Group/Account #_____

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

Name_____ **Date of Birth** _____
Last name First Name Initial

Address_____City_____State_____Zip_____Relationship_____

Employer_____

Secondary Insurance

Secondary Insurance Company_____Phone _____

Ins Claims Address_____City_____State_____Zip_____

Policy / Member ID_____Group/Account #_____

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

Name_____ **Date of Birth** _____
Last name First Name Initial

Address_____City_____State_____Zip_____Relationship_____

Employer_____

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.

_____ _____ _____

Responsible Party Signature (Required) Relationship Date

ACH/Credit Card Authorization

Our Top Priority at the Relationship Therapy Center is to provide you with the most effective and efficient therapy possible. In an effort to increase our efficiency and decrease the amount of time you and your therapist spend on the financial aspects of therapy – we require all clients of the Relationship Therapy Center have a valid payment method on file.

Our Automated Payment Program is intended as both an advantage to you and to our office. You won't need to spend valuable session time dealing with payment nor will you need to spend time outside of therapy writing out checks and making payments. The program eliminates monthly statements and therefore helps us to keep the cost of health care down. In this intake process, please provide valid payment information below. The information will be held securely. You will always have the option to pay fees using another payment method at the time of service. Charges to your bank account or credit card 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. This includes any other services not covered by insurance such as phone sessions. 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 charged.***

Coinsurance and/or Deductibles* – These amounts are determined after your insurance company has completed processing your claim. The time frame for claims to be processed ranges from 7-28 days. ***At that time, if a balance remains on your account the method of payment authorized below will be charged.*** You can always check the status of your claims on your insurer's website.

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 charged.***

Client Portal – In order to provide you with quick and accurate access to the financials of your therapy – you will be given access to our secure online Client Portal. The Client Portal will allow you to look at your bill at any time. You will also be able to securely message your therapist or our billing team on the Client Portal.

Method of Payment – ***If possible – we ask that you utilize our ACH Option***. This process will debit charges from your checking account and saves us approximately 3% in transaction fees. This savings allows us to keep the cost of health care down. If ACH is not a viable option – please choose our credit card option. If you are providing us with an HSA or HRA account – we ask that you provide a backup credit card. The backup card will only be charged if the HSA/HRA comes back with insufficient funds. If the HSA/HRA comes back with insufficient funds and we charge the backup card, we are unable to reverse the charge and apply the charge to your HSA/HRA at a future date. We can provide you with a receipt for your payment which you can submit to your HSA/HRA.

Client Name (printed) _____ **Card/Account Holder Name** _____

Billing Address _____ **City, State, Zip** _____

ACH Option - Checking Account – Check Here ☐

9 Digit Routing Number _____ Account Number _____

Credit Card Option - Check Here ☐ ☐ **Check here if this is an HSA card**

Account Number _____ Exp Date _____ Security Code _____

If the above credit card information is from an HSA or HRA account, please also furnish a backup credit card. This card will only be charged if the above card is declined.

Backup CC Account Number _____ Exp Date _____ Security Code _____

SIGNATURE _____ DATE _____

☐ **Please check this box to authorize RTC to charge the same payment method for your partner's sessions. If choosing this option – write your partner's name here:** _____

By signing above I authorize the Relationship Therapy Center Inc. 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.

THE RELATIONSHIP THERAPY CENTER, INC. (RTC)

RTC ST LOUIS PARK
5407 EXCELSIOR BLVD, SUITE A, B, D, & E
ST LOUIS PARK, MN 55416
PHONE: 612-787-2832

CLIENT INFORMATION BOOKLET

This booklet will help acquaint you with our office procedures, as well as provide information about your rights and responsibilities with regard to therapy. 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 your therapist at any time. Some of the forms you are filling out ask for similar information. This is due to the forms being for different purposes (eg insurance). We apologize for the redundancy and thank you for taking the time to fill out the forms.

PLEASE READ CAREFULLY

DIRECTIONS TO THE RELATIONSHIP THERAPY CENTER – 5407 Excelsior Blvd, Suites A, B & E, St Louis Park:

1. Take Highway 100 to Excelsior Blvd Exit
2. Take a Right (East) on Excelsior Blvd
3. Take a Right into the Miracle Mile Parking Lot
4. Take another Right in the Parking lot and go all the way to the West end of the Parking lot – next to Hoigaards.
5. As you face Hoigaards to the Right of their entrance is a door with a green awning that **says 'Wooddale Offices.'** Enter that door and go up the stairs. We have 4 suites on that floor, A, B, D, & E (Suites A and B are at the top of the stairs and Suites D & E are most of the way down the hall on the right).
6. Please have a seat in the waiting room and your therapist will be with you at the appointed time.

PROFESSIONAL RELATIONSHIP

Professional therapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular concerns you are experiencing. 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 a very active effort on your part. It might even include other important people in your life. Therapy can be more successful as you work on goals and strategies at home that you have talked about during sessions.

Therapy can have benefits and risks. Since therapy may involve discussing unpleasant experiences of your life, you may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy has also been shown to have many benefits. Successful therapy can lead to more satisfaction in relationships, new possibilities for addressing specific problems, and/or reductions in feelings of distress. But there are no guarantees of what you may experience.

The first few sessions will involve an evaluation of your needs and goals. By the end of the evaluation, you and your 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 this information along with your own opinions of whether you feel comfortable working together. Since therapy involves a commitment of time, money, and energy, it is important to make sure your therapist is a good fit. If you have questions about any procedures, please discuss these whenever they arise.

MEETINGS & PROFESSIONAL FEES

We conduct an intake session that ranges from 45-60 minutes at a cost of $225. Following the intake session is an evaluation period that will last from 2 to 3 sessions. During this time, you and your therapist will both decide if this is a good fit to help you reach your goals. Together you will work together to determine how often and for what length of time to meet. Depending on your particular situation – therapists most commonly suggest either weekly meetings or meeting in a more intensive format of 2-3 hour sessions. Our fees are as follows: 30 minutes- $110; 45 minutes - $165; 53-60 minutes - $200; 75 minutes - $260; family sessions – 50 minutes - $200. **Once an appointment is scheduled, WE NEED 48 HOURS ADVANCE NOTICE OF CANCELLATION. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. All cancellations or no shows without a 48 hour notification will incur a charge of $100**. If you are reserving a multiple hour session the cancellation fee is **$100 per hour and 5 days notice is required in order to cancel these sessions without a cancellation fee. All charges related to your therapy will be automatically charged to your credit card according to the ACH/Credit Card Authorization Form on the second page of this packet.** This includes charges noted in the next section "Connecting, Coaching, & Additional Professional Fees Outside of Session." All out-of-network and fee-for-service clients are entitled to a Good Faith Estimate for the costs of services.

CONNECTING, COACHING, & ADDITIONAL PROFESSIONAL FEES OUTSIDE OF SESSION

We strive to provide as much support as possible during your session. Sometimes individuals request extra help outside of session and want a prompt response. Some of these individuals want help using skills in the heat of the moment and others want a more objective opinion about a particular situation. Whatever the need – RTC therapists offer outside contacts of up to 10 minutes for $80 each (therapist availability varies). Clients can also choose to buy a package of 6 contacts at the rate of $295 – a 38% savings over the individual price. These contacts can include phone calls, texts, or e-mails. For other professional services you may require the rate is $220 per 60 minutes. These services include writing reports, some consulting with other professionals with your permission, and the time spent performing any other service you may request of your therapist. These services may not be covered by insurance. 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 at the rate of $325 per hour, including preparation and transportation costs, even if a 3rd party is the requestor.

CONTACTING YOUR THERAPIST

Due to the nature of therapy hours, your therapist may not be immediately available by phone due to being in session with clients. When unavailable, your therapist's telephone is answered by voice mail that is monitored frequently. Your therapist will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform your therapist of some times when you will be available. If you are unable to reach your therapist and feel that you can't wait for a return call, contact your family physician or the nearest emergency room and ask for the psychologist/psychiatrist/social worker on call. You can also contact one of the following**: the Crisis Connection** at (612) 379-6363, the **St. Paul Ramsey Crisis Intervention Center** at (651) 221-8922, **COPE** at (612) 596-1223 or your local emergency services at 911.

BILLING, PAYMENTS, & INSURANCE

If paying privately, session fees are due at time of service. If you have Blue Cross/Blue Shield, Preferred One, Aetna, Health Partners, or Cigna copays and deductible payments are also due at time of service (unless your insurance requires another arrangement). **If you are covered by an insurance policy other than the insurances listed above, please see our out of network policy on page 14 of this packet. Your portion of the payment is due at the time of the session.** If clients are behind more than two sessions, no appointments will be scheduled until payment for previous sessions are made. The only exception to this policy is when insurance coverage is unknown or insurance claims are delayed. If you need a receipt of payment please let us know and we will provide one. 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 costs associated with it (collection agencies usually charge between 33-50% of the original amount.) **ALL LATE BILLS WILL BE ASSESSED A 1.5% MONTHLY SERVICE CHARGE. All returned checks incur a $35 fee.**

INSURANCE REIMBURSEMENT & CONFIDENTIALITY (If Using Insurance)

You should be aware that your contract with your health insurance company requires that RTC provide them with information relevant to the services that provided to you. RTC is 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, RTC will make a reasonable 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 likely be stored in a computer. Although all insurance companies claim to keep such information confidential, RTC has 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. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above - unless prohibited by your insurer's contract. RTC will provide you with a copy of any report submitted, if you request it. By signing this Agreement, you agree that RTC can provide requested information to your carrier.

CONCERNS

We urge you to discuss with your therapist any questions or concerns you may have with the therapy you receive. If you are not satisfied with the results of that discussion and additional measures are necessary, a formal concern or complaint may be made with the Clinic Owner, Jeb Sawyer, at 612-483-4994.

SUPERVISION & CONSULTATION

At the Relationship Therapy Center we endeavor to provide the best therapy possible. Part of this process is regular consultation among therapists to ensure we are providing the best standard of care. Some of our therapists are also actively under supervision while working towards their licensure. These therapists include Rachel Nygaard, Erin Egertson, Lucreshia Grant, Sam Egertson, Camrie Trautman, Todd Faehner, Breana Foley, Nathan Miller, James Olson, Fiona McGovern, Rachel Klein, Kristi Murchie, Hailey, Sonstegard, and Trisha Witmer. If you have any need to reach out to a supervisor, please call Theresa Benoit at 612-850-8065.

TELEHEALTH CONSENT

I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.
By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined above in the 'Confidentiality' section of this document also apply to my Telehealth services.
2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.
3. I understand that miscommunication between myself and my therapist may occur via Telehealth.
4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.
5. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.
6. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.
7. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.
8. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

THE Relationship THERAPY CENTER

HEALTH HISTORY

On average, how many days per week do you currently drink alcohol? _____
On a typical day when you drink: (a) how many drinks do you typically have? _____
and (b) what type of alcohol (beer, wine, liquor, other)? _____
What is the maximum number of drinks you have had on any given day in the past month? _____

CAGE AID Questionnaire

Have you ever felt you ought to cut down on your drinking or drug use? **Yes or No (circle)**
Have you ever had people annoy you by criticizing your drinking or drug use? **Yes or No (circle)**
Have you ever felt bad or guilty about your drinking or drug use? **Yes or No (circle)**
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 or No (circle)**

IN THE PAST YEAR…

Do you use other illicit/street drugs? Yes or No (circle). If yes, which ones and how often? _____
_____
Do you use tobacco? Yes or No (circle). If so, what type? _____ How many times per day? _____
Do you gamble? Yes or No (circle). If so, how many times per week _____? Per month? _____
Have you ever thought you might have a gambling problem, or been told you might? _____
Have you had previous therapy? Yes or No (circle). If so, what was it for? _____
_____
What was helpful and not helpful about your past therapy experience(s)? _____
_____
Have you ever been hospitalized? _____ If yes, for what? _____
Have you ever attempted suicide? Yes or No (circle) If yes, please explain the conditions surrounding the attempt _____
_____
_____
Is Suicide a concern at this time? _____
What medications are you currently taking (esp. mental health medications)? _____
_____
Who prescribes the medications? _____
Any concerns about medications specific to mental health? _____
Do you currently have any medical conditions? _____
_____
Concerns you have about your health? _____
_____
Approximately how many hours of sleep do you get each night? _____
Estimate how much time you spend each day on "screen time" (including email, TV, internet, online shows, movies, social networking, etc.)? _____ Percentage that is: work? _____ school? _____ entertainment? _____ others? _____
Is there anything about how you think or feel that tends to bother you (i.e., unusual or troubling)? _____
_____
Any concerns your therapist should be aware of regarding your sexual interests or behaviors that have either bothered you or others, at some point? _____
Do you have any spiritual commitments that we should be aware of? _____
Has abuse ever been present in your current or past relationships including physical or emotional abuse? Yes or No (circle)
If you are in a relationship – do you believe your partner has jealousy issues? _____
Highest Level of Education Completed: ☐ Haven't Completed High School ☐ GED ☐ High School Graduate
☐ Some College ☐ College Grad ☐ Masters ☐ Doctorate ☐ Other – please fill in here _____
Occupation _____ Hours Worked Per Week _____ Length of Employment _____

ITEMS OF CONCERNS (CIRCLE ALL THAT APPLY):

Anxiety	Concentration	Social/Job functioning	Sex/Sexuality
Depression	Hopelessness	Family/Relationships	Spirituality/Faith
Self-Esteem	Worthlessness/Guilt	Eating Disorders	Obsessiveness
Appetite/Weight	Sleep	Abuse	Self-Harm
Energy/Fatigue	Mood	Internet Usage	Impulsive/Distractible

THE Relationship THERAPY CENTER

The Burns Anxiety Inventory*

Instructions : The following is a list of symptoms that people sometimes have. Put a check in the space to the right that best describes how much that symptom or problem has bothered you **during the past week**. Make sure you answer all the questions. If you feel unsure about any, put down your best guess

Symptom List

CATEGORY 1: ANXIOUS FEELINGS	0 – NOT AT ALL	1 - SOMEWHAT	2 - MODERATELY	3 – A LOT
1. Anxiety, nervousness, worry or fear				
2. Feeling that things around you are strange, unreal, foggy				
3. Feeling detached from all or part of your body				
4. Sudden unexpected panic spells				
5. Apprehension or a sense of impending doom				
6. Feeling tense, stressed, "uptight", or on edge				
CATEGORY II: ANXIOUS THOUGHTS				
7. Difficulty concentrating				
8. Racing thoughts or having your mind jump from one thing to the next				
9. Frightening fantasies or daydreams				
10. Feeling that you're on the verge of losing control				
11. Fears of cracking up or going crazy				
12. Fears of fainting or passing out				
13. Fears of physical illnesses or heart attacks or dying				
14. Concerns about looking foolish or inadequate in front of others				
15. Fears of being alone, isolated, abandoned				
16. Fears of criticism or disapproval				
17. Fears that something terrible is about to happen				

Symptom List (continued)

CATEGORY III: PHYSICAL SYMPTOMS	0 – NOT AT ALL	1 - SOMEWHAT	2 - MODERATELY	3 – A LOT
18. Skipping or racing or pounding of the heart (sometimes called "palpitations")				
19. Pain, pressure or tightness in the chest				
20. Tingling or numbness in the toes or fingers				
21. Butterflies or discomfort in the stomach				
22. Constipation or diarrhea				
23. Restlessness or jumpiness				
24. Tight, tense muscles				
25. Sweating not brought on by heat				
26. A lump in the throat				
27. Trembling or shaking				
28. Rubbery or "jelly" legs				
29. Feeling dizzy, lightheaded, or off balance				
30. Choking or smothering sensations or difficulty breathing				
31. Headaches or pains in the neck or back				
32. Hot flashes or cold chills				
33. Feeling tired, weak, or easily exhausted				

Add up your total score for the 33 symptoms and record it here: _____ Date _____

Scoring Key included on the next page. Please refer to this key to determine your degree (if any) of anxiety.

Scoring Key for Anxiety

Total Score	Degree of Anxiety
0-4	Minimal or no anxiety
5-10	Borderline anxiety
11-20	Mild anxiety
21-30	Moderate anxiety
31-50	Severe anxiety
51-99	Extreme anxiety or panic

The Burns Depression Checklist*

Instructions : Place a check in the box to the right of each of the 15 symptom clusters to indicate how much this type of feeling has been bothering you in the past several days. Make sure you answer all the questions. If you feel unsure about any, put down your best guess.

	0 – NOT AT ALL	1 - SOMEWHAT	2 - MODERATELY	3 – A LOT
1. Sadness: Have been feeling sad or down in the dumps?				
2. Discouragement: Does the future look hopeless?				
3. Low self-esteem: Do you feel worthless or think of yourself as a failure?				
4. Inferiority: Do you feel inadequate or inferior to others?				
5. Guilt: Do you get self-critical and blame yourself for everything?				
6. Indecisiveness: Do you have trouble making up your mind about things?				
7. Irritability and frustration: Have you been feeling resentful and angry a good deal of the time?				
8. Loss of interest in life: Have you lost interest in your career, your hobbies, your family, or your friends?				
9. Loss of Motivation: Do you feel overwhelmed and have to push yourself hard to do things?				
10. Poor self-image: Do you think you're looking old or unattractive?				
11. Appetite Changes: Have you lost your appetite? Or do you overeat or binge compulsively?				
12. Sleep changes: Do you suffer from insomnia and find it hard to get a good night's sleep? Or are you excessively tired and sleeping too much?				
13. Loss of libido: Have you lost your interest in sex?				
14. Hypochondriasis: Do you worry a great deal about your health?				
15. Suicidal impulses†: Do you have thoughts that life is not worth living or think that you might be better off dead?				

Add up your total score for the 15 symptom clusters and record it here: _____ Date:_____

Scoring Key is on the next page. Please refer to this key to determine your degree (if any) of depression.

† Anyone with suicidal urges should seek immediate consultation with a qualified mental health professional

Scoring Key for Depression

Total Score	Degree of Depression
0-4	Minimal or no depression
5-10	Borderline depression
11-20	Mild depression
21-30	Moderate depression
31-45	Severe depression

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 or a court order issued by a judge.
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 below.
11) If paying with a credit card – our credit card processor may require us to provide proof of service – which can include a signed receipt or a signed agreement. This is universally true if you decide to dispute the charge.
12) At times at the Relationship Therapy Center we will work collaboratively as team to provide the best care for clients by having you see multiple RTC therapists. During this process the therapists regularly share confidential information. If you prefer your information not be shared during this collaborative process, please notify your therapists in writing.
13) At The Relationship Therapy Center of Minnesota, Inc. we undertake an extensive consultation process to insure clients are receiving the highest level of care. Consultation members are available upon request and include supervisors and clinical members. The purpose of this consultation is to obtain additional insight, further therapeutic skills, and insure the highest possible service to our clients. Every effort will be made to provide only those details necessary to gain feedback and maintain all confidentiality. Therapist reserves the right to consult with other clinicians at the Relationship Therapy Center about any/all aspects of our work together, and reveal identifying information if necessary.

- **My signature below indicates I understand the above limits of confidentiality**
- **The Client Bill of Rights is posted in the waiting room. Please review this.**
- **In addition, your signature below indicates that you have read the pages 1-10 of this document and agree to abide by its terms during our professional relationship and agree to the financial obligations of therapy and consultation.**
- **Your signature also serves as an acknowledgement that you have received pages 1-10 of the AGREEMENT described above or have refused a copy of the information.**

_____ _____

Client Signature Date

_____ _____

Client Signature or Parent/Guardian for minor Date

EMERGENCY CONTACT:

_____ _____

Emergency Contact's Name Emergency Contact's Phone Number

MINNESOTA NOTICE FORM

Notice from the Relationship Therapy Center, Inc (RTC)
Policies and Practices to Protect the Privacy of Your Client's Health Information

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.

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

RTC 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 your therapist provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when your therapist consults with another health care provider, such as your family physician or a psychologist.
  - *Payment* is when RTC obtains reimbursement for your healthcare. Examples of payment are when RTC discloses 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 the clinic such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

RTC may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when RTC is asked for information for purposes outside of treatment, payment or health care operations, RTC will obtain an authorization from you before releasing this information. RTC will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes your therapist has made about your conversation during a private, group, joint, or family counseling session, which have been kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) RTC has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

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

- **Child Abuse:** If your therapist knows or has 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, your therapist must immediately report the information to the local welfare agency, police or sheriff's department.

- **Adult and Domestic Abuse:** If your therapist has reason to believe that a vulnerable adult is being or has been maltreated, or if your therapist has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, your therapist must immediately report the information to the appropriate agency in this county. Your therapist 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:** The Minnesota Board of Marriage & Family Therapy and the Minnesota Board of Behavioral Health and Therapy may subpoena records from RTC 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 RTC has provided you and/or the records thereof, such information is privileged under state law and RTC 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. Your therapist 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, your therapist must make reasonable efforts to communicate this threat to the potential victim or to a law enforcement agency. Your therapist 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. Your therapist may also 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 your therapist 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

Patient's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information. However, RTC is 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 being seen at RTC. On your request, RTC 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 RTC's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Your therapist may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, your therapist 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. Your therapist may deny your request. On your request, your therapist 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, your therapist 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 RTC upon request, even if you have agreed to receive the notice electronically.

Clinician's Duties:

- RTC is required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- RTC reserves the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will send you a copy by mail or give you a copy in session.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision your therapist makes about access to 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

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. Your therapist will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on 4/14/03

RTC reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that your therapist may maintain. RTC will provide you with a revised notice by mail or in session.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED OR REFUSED A COPY OF THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____

Signature of Client (Parent/Guardian for Minor) Date

_____ _____

Signature of Client (Parent/Guardian for Minor) Date

POLICY ON OUT OF NETWORK INSURANCE V3.0

APPLICABLE TO ALL INSURERS EXCEPT BLUE CROSS AND MOST PLANS THROUGH PREFERRED ONE, AETNA, HEALTH PARTNERS, AND CIGNA.

Increasingly over the past 9 years most Insurance Companies have saved money by decreasing benefits for out of network providers. The result has been a lot of confusion about benefits for these plans.

Therefore, at the Relationship Therapy Center we want to give you as much pertinent information up front so you can make informed decisions regarding your therapy experience. Please make sure you understand the following:

- If you do not have an insurance plan through Blue Cross, Preferred One, Aetna, Health Partners, or Cigna – your provider is going to be out of network (some Health Partners, Preferred One and Cigna plans are out of network also). Out of Network benefits are almost always different than in network benefits.

- When checking benefits the information we receive from some insurers has become either unreliable or impossible to attain. The result is that we need to pass this responsibility on to you as a client. We strongly recommend you contact your insurer and obtain your *Out of Network Benefits* directly from them. Because insurers are so unpredictable we no longer check out of network benefits for clients.

- You will be responsible for paying your portion of the bill. The estimated amount for the session is due at the time of session.

- If you have out of network coverage and obtain a code from your insurer – we can not use that code to bill insurance. Some insurers will say that it works – we have universally found that it never works.

- We do not accept EAP plans.

By signing below you agree to the above information and terms:

_____
Client Printed Name

_____ _____
Client Signature Date

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 the following procedures will not be covered by your insurance and will be your sole responsibility (fees for these services are in parentheses):

- **Intensive Couples Counseling (ICC) (Starts at $4,200 for 15 hours)**
- **Sessions longer than 1 hour (Some Blue Cross Policies do cover both a family and individual session in one day.) Each additional 53-60 minutes ($200). 45 minute sessions ($165). Family therapy – ($200).**
- **Sex Therapy is not covered by most insurers. 53-60 minutes ($200). 45 minutes ($165).**
- **Therapy services via phone calls, e-mails, and texts. Billed by the minute ($3/minute)**
- **Other professional time including writing reports, some consulting with other professionals with your permission, and the time spent performing any other service you may request of your therapist. 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 3rd party is the requestor ($325 for each 60 minutes).**
- **Personal & Couples Coaching Services – price determined by length (from $75-$200)**
- **Family Therapy (90846 & 90847) is not covered by all insurers ($200 for 45 Minutes)**
- **Telehealth is not covered by some insurers (from $95-$225)**
- **Psychoeducation classes ($50-$495)**
- **Individual Intensive Therapy Group – 3 Days ($999-$1,499)**
- **Fill in other services that will not be covered below:**

We are happy to provide a receipt for all services you receive and we encourage you to follow up with your insurer or health savings plan to see if you are eligible for reimbursement.

Please talk to us with any questions you may have.

By signing below I:

- Understand the specific services listed above are non-covered through my health insurer and
- Understand all charges will be my responsibility

_____ _____

Client Signature Date

AUTHORIZATION FORM

A therapeutic interchange of communication is a critical component of therapy. When completed and signed by you, the form below authorizes RTC to release and exchange confidential information with your partner. Although ethics of therapy require this release, it does not mean RTC will actively divulge information not considered therapeutic. This release is also limited to verbal communication and does not extend to client records (except where explicitly noted).

I __(**Your Name Here→**)_____ authorize:

_____

The Relationship Therapy Center, Inc.
5407 Excelsior Blvd, Suite B
St Louis Park, MN 55416
Phone 612-787-2832
Fax: 952-920-9323

and/or his or her administrative and clinical staff to release/exchange this information:

____Initial Assessment/History
____Past and Ongoing Case notes
____Summary of Treatment
____Medical/Lab Results
____Consultation Reports
____All of the above
____Treatment Plan
____Psychological Testing and Evaluation
____Neurological Testing
____Chemical Dependency Evaluation
____Educational Assessments
_**X**_Other (specify) ___**Ongoing Consultation for Therapy**_____

(Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.)

This information should only be released and/or exchanged with:

(Your Partner's Name Here→)_____(Individual's Name)

_____(Address)

_____ (Phone/Fax)

I am requesting my counselor to release/exchange this information for the following reasons: ("at the request of the individual" is all that is required if you are my client and you do not desire to state a specific purpose.)

_____At The Request Of The Individual_____

This authorization will expire:

____30 days after termination of treatment
_**X**_Upon my written request
____Immediately after requested information is received
____Other (Specify)_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the RTC office address. However, your revocation will not be effective to the extent that RTC has 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.

I understand that my counselor generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Client Date