PRO

RECOVERY AND THERAPY

AGREEMENT FOR PSYCHOTHERAPY SERVICES/ INFORMED CONSENT

Welcome to PRO Recovery and Therapy. It can take a lot of courage to enter into psychotherapy, particularly if you are unfamiliar with the process. This document is intended to help answer your practical questions, and we are more than happy to discuss any remaining concerns in person at your initial appointment.

This document contains important information about our professional services and business policies. When you sign this document, it will also represent an agreement between us and become a part of your electronic medical record. You may revoke this Agreement in writing at any time. That revocation will be binding on us (and our clinic) unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

CONSENT FOR SERVICES

_____ I have received and understand the Notice of Privacy Policy regarding my privacy rights per federal HIPAA laws.

_____ I have received and understand the Minnesota Client Bill of Rights

_____ Consent for Services: With enough knowledge, and without being forced, I enter into psychotherapy with this provider. I will keep my provider fully up to date about any changes in my feelings, thoughts, and behaviors. When difficulties arise I will let my provider know so that we can address them in an honest and direct manner. I understand the basic goals and methods of psychotherapy and that my provider may use different methods of helping me based on the unique factors associated with the presented needs. I have no important questions or concerns that the provider has not discussed with me. I understand that reaching the agreed upon therapeutic goal(s) is not guaranteed and that psychotherapy has varying levels of effectiveness for different individuals. I also understand that my therapeutic goal(s) may evolve and change based on new insights and/or changes to my life situation.

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

Alternatives: I understand there are many viable alternatives to psychotherapy, such as, but not limited to, self-help books, support groups, medication and other medical interventions, and psychotherapy interventions other than what is offered at PRO Recovery and Therapy and that I am welcome to discuss any options with my provider at any time.

Differentiation from Other Services: Psychotherapy is a process by which concerns, symptoms, and behaviors are treated in the hopes of symptom reduction and increased overall functioning and satisfaction with life. Psychotherapy is not coaching (coaching is not reimbursable by insurance).

PROFESSIONAL BOUNDARIES

I understand that psychotherapy is a professional relationship. Though my provider cares deeply about my life, the relationship is different from a friendship. This means I will not be friends with my provider on social media or see my provider outside of sessions simply because the professional boundaries for mental health providers do not allow for it. In addition, I understand ethical boundaries prevent my provider from having both concurrent personal and professional relationships with me and/or my family members or from having a personal relationship with me following the termination of our work together in psychotherapy.

TERMINATION OF SERVICES

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

PSYCHOTHERAPY FEES

Intake – Diagnostic Assessment	$200
Individual Psychotherapy 30 min	$85
Individual Psychotherapy 45 min	$110
Individual Psychotherapy 60 min	$160
Crisis Psychotherapy 30 min add on	$115
Interactive Complexity add on	$16

The fees listed above represent the fees PRO Recovery and Therapy bills to your insurance company. The amount you are responsible for is the “allowed amount” on your explanation of benefits, which may be paid by the insurance company, owed by you, or a combination thereof. Total charges will not be known until your care is complete and your claims have been billed to and processed by the insurance company if you are using insurance to pay for your services.

I understand I am responsible for all charges not covered by my insurance company.
*Sliding fee scale available upon request

FINANCIAL AGREEMENT

I am an adult seeking services for myself, I am the financial guarantor of my own account. By signing below I agree to the above fee schedule and understand payment (cash, check, Visa, MasterCard, Discover, or American Express) is due in full (including copays) at the beginning of

each counseling session. I also agree to pay a fee of $30 plus the amount of the check for any returned checks.

I understand the following regarding use of insurance or the sliding fee scale. Please choose one:

In-network Insurance: If I have insurance coverage with a company that PRO Recovery and Therapy is in-network with, I have the following options:

_____ Bill my insurance using an approved diagnostic code at the fees listed above

_____ Pay the fee listed above in full (or on the sliding fee scale if my income is less than $90,000 annually)

The agreed upon fee per 50-minute session is _____ (Provider only)

Out-of-network Insurance: If I have insurance coverage with a company that PRO Recovery and Therapy is out-of-network with, I have the following options:

_____ Bill my insurance using an approved diagnostic code (in which case I could be responsible for the difference between what my insurance covers and the full amount listed above, regardless of what the allowed amount would be for an in-network provider)

_____ Decide not to use my insurance and pay in cash, using the sliding fee scale, which is an objective fee scale based on my income and other factors

No Insurance Coverage: If I do not have insurance coverage, I have the following options:

_____ Pay the fee listed above in full if my income exceeds $90,000

_____Pay the appropriate amount based on the sliding fee scale if my income is less than $90,000 annually

The agreed upon fee per 50-minute session is _____ (Provider only)

Comments or notes about fees or fee arrangements:

CREDIT CARD AUTHORIZATION

All services are required to be paid on a minimum of a monthly basis unless otherwise agreed upon. I understand I am welcome to pay for my services in cash or check, or use my Visa, MasterCard or Discover debit or credit card. I understand PRO Recovery and Therapy follows the Payment Card Industry Data Security Standard set of requirements designed to ensure that all companies that process, store, or transmit credit card information maintain a secure environment for financial data.

I am choosing to authorize PRO Recovery and Therapy to store my credit card information within their electronic record keeping system and will complete the credit card authorization form.

I understand that if I fail to make payments owed for attended sessions, if I do not attend a scheduled session, or if I cancel a session less than 24 hours from the start time of the session, and do not make the required payment(s) within 7 business days, PRO Recovery and Therapy has my permission to charge the card listed above according to the Cancellation Policy/No-Show Policy below. I understand that if I am having difficulty paying I can speak with my therapist about alternative arrangements.

CANCELLATION/NO SHOW POLICY

I understand I can be up to 20 minutes late for my scheduled session. If I am running late, I will call my provider to let her know. If I need to cancel or reschedule an appointment, I will give my provider twenty-four (24) hours' notice. I understand failure to attend a session without giving notice will result in a $50 no show fee and that this fee cannot be billed to my insurance meaning I will be responsible to pay it in full. I also understand that canceling a session with less than twenty- four (24) hours notice will result in a $50 fee. I understand that exceptions for unforeseen or unavoidable situations are at the discretion of the provider. I understand that I will not be charged if I have a death in my immediate family or an emergency hospitalization for myself or an immediate family member. I also understand that insurance will not cover the payment for a missed appointment or a late cancel fee. You may call 651.204.1944 ext. 102 to make any necessary changes to your appointment times and schedule.

Should a client have three no show/no cancellation occurrences, the client will no longer be allowed to schedule future appointments. However, should the client desire to continue therapeutic services, the client may call in the morning he or she wishes to have an appointment and request a same-day appointment. If the clinician has availability in his/her schedule, the client will be given the opportunity to obtain the appointment slot.

EMERGENCY PROCEDURE

In the event of a life-threatening emergency, call 911. If I have another crisis that cannot wait I am aware I can call the Crisis Connection at 612-379-6363. For after hours or emergency needs, please call 911, contact the Washington County Crisis Services at 651-275-7400 or call your local mobile crisis unit. While PRO Recovery and Therapy providers are not available 24/7, we will do our best to respond to any client needs in a timely manner. It is requested that any clients who are admitted to the hospital notify their provider as soon as possible This will assist in effective coordination of care.

CONFIDENTIALITY (AND EXCEPTIONS TO CONFIDENTIALITY)

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

Under the rules governing mental health professionals in Minnesota, a provider or counselor, and employees and professional associates of the provider, must not disclose any private information that the provider, employee, or associate may have acquired in rendering services except as follows:

-When state law mandates the report of suspected abuse or neglect of a child or vulnerable adult or prenatal exposure to drugs and alcohol.
-When failure to disclose the information presents a clear, present, and imminent danger to the health or safety of any individual (including but not limited to threat of suicide or homicide).

- -When records are subpoenaed by the courts or other regulatory agencies, including the following:
- When the person, employee, or associate is a defendant in a civil, criminal, or disciplinary action arising from the psychotherapy. If a client files a complaint or lawsuit against us, we may disclose relevant information regarding that client in order to defend ourselves.
- When the patient is a defendant in a criminal proceeding and the use of the privilege would violate the defendant's right to a compulsory process or the right to present testimony and witnesses in that person's behalf.
- If a government agency, pursuant to their lawful authority, is requesting the information for health oversight activities, we may be required to provide it for them. Also, if a client identifies a health professional and discloses that the health professional has violated his or her ethical code when treating a client/patient, including but not limited to initiating sexual contact with a client/patient throughout the term of treatment or within two years of the termination of treatment, the appropriate board must be notified.
- If a client files a workers' compensation claim, we must, upon appropriate request, disclose information related to the claim to appropriate individuals, which may include that client's employer, the insurer or the Department of Labor and Industry.

If you are involved in a court proceeding and a request is made for information concerning the professional services we provided for you, such information is protected by the privilege law. We cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order PRO Recovery and Therapy to disclose information.
I understand the provider is required to participate in legal proceedings when court-ordered, and I understand the provider's fee for involvement in legal proceedings.

- When the provider presents the case in consultation with other professionals, supervisors, or consultants, who are bound by the legal framework of privacy and confidentiality, for professional development and guidance purposes. Similarly, we may use examples from your case, without revealing personal details that could identify you, when training other students and providers. I give permission to this provider to present my case in consultation with other professionals, supervisors, or consultants, who are bound by the legal framework of privacy and confidentiality, for professional development and guidance purposes and to use examples from my case that would not identify me when training other students and professionals in the field of mental health. It is assumed that your provider may consult with other providers who work for PRO Recovery and Therapy, whether or not those other providers are also working on your case, to get feedback about how to best provide your care. Also, if your provider is unlicensed as a mental health professional in the state of Minnesota, he or she is under supervision, inside and/or outside PRO Recovery and Therapy, and will receive feedback about your care from his/her supervisors.

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

- All other private information must be disclosed only with the informed consent of the client. When a patient agrees to a waiver of the privilege accorded by this section, and in circumstances where more than one person in a family is receiving psychotherapy, each such family member agrees to the waiver. Absent a waiver from each family member, a marital and family provider cannot disclose information received by a family member.

COURT AND LEGAL PROCEEDINGS

Because a safe and trusting relationship with your provider is the cornerstone of an effective therapeutic experience, we do not willing engage in any court and other legal proceedings on behalf of a client. While the legal process may demand dissemination of information regarding your treatment or other health information, revealing personal details about a client in court can be particularly damaging to the client-provider relationship, which is built on trust and confidentiality, and may not provide helpful to the client's case. As such, we ask that you decline from involving your provider in any court or legal proceedings in which you engage. If you require a treatment progress summary letter form to use on your help in court proceeding, at least one week's notice is required, and applicable associated fees will be assessed as outlined below. With the exception Substance Use Disorder Assessments, we do not perform court evaluations. Should we be summoned to court under judge's order subpoena, we will charge the full amount applicable under law our services. Fees will also be assessed for copies of your records for court purposes. In the event that your provider is summoned to court to testify, appropriate hourly fees will be assessed, for which the client will be fully responsible for paying to PRO Recovery and Therapy in advance.

Treatment Progress Summary Letter	$35.00
Court document preparation (per hour)	$50.00
Court Appearances (per hour)	$250.00

ELECTRONIC HEALTH RECORDS DISCLOSURE

PRO Recovery and Therapy keeps and stores records for each client in a record-keeping system produced and maintained by Best Notes. PRO Recovery and Therapy uses Breezy Notes as a claims clearing house to store, process, and transmit claims to 3rd party payers.

While our record-keeping company and PRO Recovery and Therapy both use security measures to protect these records, their security cannot be guaranteed.

I understand PRO Recovery and Therapy stores my health record electronically in compliance with various state and federal laws and that I can opt out of having my record stored electronically but that doing so may prevent me from being able to use my health insurance to pay for services.

Lastly, at times, PRO Recovery and Therapy may need to store paper records that are part of your medical record or otherwise associated with your medical file that contain your PHI. In these situations, PRO Recovery and Therapy has file cabinets that are locked to store these kinds of paper records. The keys to these filing cabinets are stored inside a locked punch button key box that requires a staff member to enter a digital code to open.

ACCESS TO MEDICAL RECORDS

The laws and standards of our profession require that we keep Protected Health Information about you in your Clinical Record. Unless your provider believes viewing your record could be harmful to you or another person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.

My signature on this AGREEMENT FOR PSYCHOTHERAPY SERVICIES/INFORMED CONSENT means I have reviewed, understand, and consent to everything above and indicates my consent to participate in psychotherapy at PRO Recovery and Therapy.

CONTACT INFORMATION AND CHANGES TO PERSONAL INFORMATION

It is your responsibility to inform PRO Recovery and Therapy as soon as possible regarding any changes to your personal or contact information that would affect our ability to contact you, secure payment.

Client Name (Printed): _____

Client Signature: _____

Date: _____