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***CONSENT TO TREATMENT, BUSINESS POLICIES & AUTHORIZATION***

I would like to take this opportunity to welcome you to my practice. My goal as your therapist is to form a collaborative relationship with you to assist you in finding healthy solutions to your problems.

This document is designed to inform you of what you can expect from me regarding office policies, confidentiality, emergencies, and several other details regarding your treatment. Please read them and if you have any questions, please discuss them with me.

***Background Information***

I am a Licensed Professional Clinical Counselor in Minnesota with over 20 years of clinical experience, providing individual, couples and family therapy in mental health, social service, managed care, and in community-based settings. I have extensive experience working with diverse populations. My approach to therapy is based on developing an authentic relationship with you, built on self-acceptance, self-awareness, discovery and empowerment. My belief is that mental health is about finding a balance between the extremes of thinking, feeling, and behaviors. In my experience, when any of these are “off”, so will your life be “off” and in need of change and correction. So, being mentally healthy and happy are about finding a good balance with all areas of your life with all people. In counseling, we will work COLLABORATIVELY as a team, to examine areas of extreme in your life and explore new ways of resolving, improving, and correcting areas of distress and things that are simply not working for you. Counseling is about finding an improved direction and empowerment to continue on this new path. TOGETHER we will discover areas that keep you from reaching your full potential and destiny in life. If you’re looking for extra support and guidance through a challenging situation or you’re just ready to move in a new direction in your life, I look forward to working to with you to achieve your goals.

***The Therapeutic Relationship***

Psychotherapy is a professional service I will provide to you. Because of the nature of therapy, your relationship with me has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and I were to interact in any other ways (e.g., social, business, etc.) we would then have a “dual relationship.” Dual relationships may compromise our treatment and therefore, are discouraged in the mental health profession. In order to offer all my clients, the best care, my judgment needs to be unselfish and purely focused on your needs. Therefore, your relationship with me must remain professional in nature. Additionally, therapy with children and families, calls for a very active effort from both the parents and the child. I strongly encourage parent participation in all phases of their child’s treatment; therefore, it is very important that all appointments are kept and that practice of the newly acquired knowledge and skills are performed each week.

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**The Process of Therapy; Client Welfare, Safety and Risks**

***Informed Consent for Treatment***

The process of therapy services will include of range of services that are determined in discussions with each person seeking out therapy, following an initial therapeutic assessment. The ultimate goal of this initial assessment process is to determine the very best course of treatment, which usually is provided over the next several weeks. If, at any time, in the course of treatment, you have questions, feel free to ask them, whether they are about the direction or focus of therapy or the ultimate type of chosen treatment. Please do know that you do have a right to refuse any specific treatment and discontinue care at any time. You also have the right to seek alternative consultation and stop treatment at any time.

Know the that the expectation is that participation in therapy will result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits does require work on your part, in the office and out of the office visit. There can not however, be any promise or guarantee of outcome or results.

Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. As your therapist, I will ask for your feedback and views on your therapy, its progress and other aspects of the therapy process, and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with certain situations, so I may implement different strategies (which may include, but are not limited to cognitive behavioral, psychodynamic, existential, system/family, developmental, humanistic or psycho-educational) to help you achieve your therapy goals, and will address any questions you have about these strategies as needed.

**There are certain risks associated with psychotherapy**.

• During the evaluation or therapy process, remembering or talking about unpleasant events, feelings or thoughts can result in the experience of discomfort or strong feelings of anger, sadness, worry, fear, etc. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn’t sensitive unless it needs attention. Therefore, discovering the discomfort is most often, a success. On the other hand, therapy can often lead to significant reductions in feelings of distress, solutions to problems, and better relationships.

• As your therapist, I may challenge some of your assumptions or perceptions and propose different ways of looking at, thinking about or handling situations. This can also cause strong emotional reactions.

• Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in you making decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that you see as positive may not be viewed that same way by others in your life.

• Change will sometimes be easy and swift, but more often it will be slow and even frustrating.

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• There is no guarantee that psychotherapy will yield positive or intended results. While benefits are expected from the therapeutic process, specific results cannot be guaranteed, and there is no guarantee of what you or your child will experience.

As your therapist, I will check in with you on a regular basis to assess the benefits of therapy. I ask that you also share any concerns about the therapy process with me on an ongoing basis.

**There are times when it might be deemed necessary to terminate therapy**. These might include:

• Lack of progress in the treatment process or treatment is no longer beneficial

• Attendance issues (repeated no shows or late cancelations – less than 24 hours notice)

• Lack of payment for services

If it becomes necessary to terminate services, I will provide you with referrals to other qualified professionals for ongoing care.

By signing below, you acknowledge understanding of the risks and benefits of psychotherapy and agree to the terms stated above regarding your active participation, openness and honesty, and conditions for termination of therapy.

***Confidentiality of Records & Mandatory Reporting***

All communication shared with me both written and verbally will become part of a clinical record of treatment, and it is referred to as Protected Health-Information (PHI). I will always keep everything you say to me completely confidential, with the following exceptions:

**Exceptions to Confidentiality**: It is important that you understand the legal limitations to confidentiality which include, but are not limited to:

• If you make a serious threat to harm yourself or another person or are in imminent danger of harming yourself or someone else, the law requires me to take protective actions. These actions may include notifying the potential victim, contacting the police and appropriate state agencies, or seeking hospitalization for you.

• If I have reason to believe a child or any adult dependent has been or will be abused or neglected, I am legally mandated to report this to the proper authorities.

• If you are, or will be, involved in court proceedings, and there is a valid court order by a judge.

• If a guardian ad litem (GAL) is appointed in a custody case involving child clients I have seen for therapy services, and she/he is ordered by the court to have access to mental health practitioners and records therein, I am required to provide that information, as it is court ordered.

• The Patriot Act of 2001 requires me in certain circumstances to provide federal law agents with records, papers, and documents upon requests and prohibits me from disclosing to my client that federal agent sought or obtained the items under the Act.

• If you choose to communicate with me via email or texting, I cannot guarantee your confidentiality as sometimes an email remains on a server and may be accessible by others. Please do not bring up

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any therapeutic content to prevent compromising your confidentiality. You also need to know that we are required to keep a copy of all emails and texts as part of the clinical record

•Almost monthly, I participate in consultation with other local licensed therapist as well as occasionally seek out additional peer consultation. I share information about my cases and clients for the purpose of gaining further perspective and ideas for how to best serve my clients without revealing names or identity. All Peers I consult with as well as fellow therapists, are also bound by confidentiality so that any information shared does not leave the room in which it is shared and full names are not revealed.

Please note that in couples counseling, I do not agree to keep secrets. Information revealed in any context may be discussed with either partner if applicable or helpful. Please note that this does not apply if you reveal to me information that might put your life at risk. If I am put in a position of being asked to keep a secret, due to ethical reasons, I may have to terminate my work with you. If any person from any party wishes to release information found in the clinical record, I require that both parties sign the release.

In addition, it is important for you to know that children often do artwork and/or have pictures taken of therapeutic play materials. These items, or photos of these items, are kept in my file. Often it is therapeutically relevant to take a picture of their artwork, a specific item they may bring into therapy, or choose to share in the context of therapy. Sometimes children find a way to get into the picture or ask to be in the picture, and if it is deemed therapeutically important, then, that will be allowed.

While this written summary of exceptions to confidentiality and its limits, it is important that you read the **Notice of Privacy Practices** which provides more detailed explanations, and discuss with me, as your provider, any questions or concerns you may have. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality is quite complex, and I am not an attorney.

***Legal Issues***

\*\*I am not a custody evaluator and cannot make any recommendations on custody. \*\*

\*\*I do not do full therapeutic mental health testing or Chemical Dependency Evaluations or testing\*\*

Due to the sensitive nature of divorce and all potential issues that may arise in such cases, I have very specific policies to which you must agree before we enter a therapeutic relationship:

• If I am seeing a child whose parents are in the process of divorce or who are already divorced, I require a copy of the standing court order demonstrating the custodial rights of each parent and/or the parenting agreement that is signed by both parents and the judge at the first intake session. I will need to have contact with the parent who has legal custodial decision making for medical issues before I see the child for therapy, and will need to obtain written consent for the child to participate in therapy from the legal custodian(s), and prefer to have contact with both parents before seeing the child.

• If the custodial rights change during therapy, I must be notified by the parent who previously had the custodial rights, and I require an updated copy of the standing court order demonstrating the custodial rights. Failure to do so could lead to termination of the therapeutic relationship.

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• I will be available to provide an interview/ meeting with a guardian ad litem (GAL) assigned to investigate the best interest of any child that I am providing therapy to, upon production of court order demonstrating the GAL’s right to examine your clinical record or speak with me. Similarly, if a child or family is involved with CHIPS (Child In Need Of Protections), or Probation, I will need evidence of a case being open, and a copy of any Court Recommendations or County Case Plans and/ or legal authority given by a county judge. Alternatively, the adult client or parents of child client will need to sign a release for me to speak with the GAL, CHIPS County Staff, or Probation Officer. The client will be charged a full session fee for me to have such meeting with a GAL, CHIPS county staff, or Probation O.

• I will provide an identical summary of a child’s therapy progress, treatment plan information, and parent recommendations to both parents who share in the legal custody of the child I am providing therapy to, and will offer and encourage opportunities for both parents to participate in parent consultations along the way.

• When Family sessions are recommended, I will likely be very therapeutically helpful to see the child with each parent separately along with siblings and /or other significant family members who live in the home or homes where the child lives.

• I ask all my clients to waive right to subpoena me to court. This policy is set in order that I can preserve the efficacy and integrity of my therapeutic progress and relationship with you and/or your child. It is my ethical duty to make every reasonable effort to promote the welfare, autonomy and best interest of my clients. By signing this agreement, you are waiving right to have me subpoenaed, and agreeing in fact to not have me or my records subpoenaed.

In the event that I am deposed, subpoenaed, or otherwise compelled to give testimony even with this waiver – whether I testify or not- my fee for Court Related work is stated in the **Interaction With The Legal System** section below**.**

**Waive Right to Subpoena**: In order to protect and enhance our communication, you and the information you and/or your child provide to me during our sessions, I ask each client to waive his or her right to call me as a witness to court for any reason. The communication that you/your child provide during session is considered privileged. If you anticipate the need for a therapist’s involvement in court activity, I will be happy to refer you to someone who is more specialized to meet your needs, whenever possible.

**Legal Issues Regarding Minor Children:** It is extremely important to the therapeutic process that your child trust me implicitly, as the therapist. He/She must feel comfortable confiding issues of concern to me while knowing that he/she will never be betrayed. The relationship we establish is absolutely vital to the therapeutic benefit to be gained by your child.

Testifying in court may damage the relationship substantially: usually to the point where my effectiveness as a therapist is permanently destroyed. It is also quite likely that such an occurrence will do irrevocable damage to your child. This is because it often sabotages the progress already accomplished and leaves your child feeling betrayed...by me... and perhaps by you.

Therefore, if it is likely that your child will be involved with the court system for any reason, it is very important that you find another therapist to fulfill whatever legal requirements the child faces. As long

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as I am comfortable knowing that I will NOT be called to testify, I can be an effective therapist for your child and am willing to be your child’s therapist. If you know or expect a legal issue or the need for expert testimony, I can refer you to a specialist pertaining to your specific issues, whenever possible.

***Interaction With The Legal System***

I understand that I will not involve or engage my therapist in any legal issues or litigation in which I am a party to at any time either during my counseling or after counseling terminates. This would include any interaction with the Court system, attorneys, Guardian ad Litems, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system. In the event that I wish to have a copy of my file, and I execute a proper release, my therapist will provide me with a copy of my record, and I will be responsible for charges in producing that record. If I believe it necessary to subpoena my therapist to testify at a deposition or a hearing, I would be responsible for his or her expert witness fees in the amount of $1,500.00 for one-half (1/2) day to be paid five (5) days in advance of any court appearance or deposition. Any additional time I spend over one-half (1/2) day would be billed at the rate of $375.00 per hour including travel time. I understand that if I subpoena my therapist, he or she may elect not to speak with my attorney, and a subpoena may result in my therapist withdrawing as my counselor. Any summary documents prepared for court are also subject to the $375.00 per hour fee. See section **Professional Fees with and without Insurance.**

***Client Rights***

You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of therapy (if I can determine it), and my fee structure.

You may at any time and for any reason, seek a second opinion from another therapist or terminate therapy. In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate.

Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the therapist is a certified school psychologist, a licensed social worker, a licensed professional counselor, a licensed professional clinical counselor, a licensed psychologist, a licensed marriage and family therapist, or an unlicensed psychotherapist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client’s consent.

***Relationship Mandates, Conduct and Limitations***

I encourage open communication between family members, and I reserve the right to terminate our therapeutic relationship if I judge any secret to be detrimental to the therapeutic process. I will not be a “secret keeper” nor will I facilitate secret keeping.

If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first. If I should find myself in a social setting where you are present (e.g., shopping mall, restaurant, social event), I will respect your privacy by not initiating contact or seeking to engage you in a conversation unless initiated by you. Should a colleague, friend, or family member accompany me, I will not introduce them to you.

During the time we work together, we will meet weekly, or as scheduled, in sessions lasting

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approximately 45-50 minutes. Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. Our contact will be limited to the therapy sessions you arrange with me except when you may call or text me. Please do not invite me to social gatherings, offer me gifts, ask me to write references for you, or ask me to relate to you in any way other than in the professional context of therapy sessions. You will be best served if our sessions concentrate exclusively on your goals and concerns.

The length of therapy depends on the complexity and severity of problems. Some clients need only a few therapy sessions to achieve their goals, others may require months or years of therapy. As a client, you are in complete control and may end our therapeutic relationship at any time, although I do ask that you participate in a termination session, I also ask that you allow me the option of having a closing session with your child (my client) to appropriately end the therapeutic relationship. If you have any questions about my procedures, we should discuss them whenever they arise. You have the right to refuse or discuss modifications of any of my therapy techniques or suggestions that you believe might not be helpful. If, for a period of 1 month and a half, a client has stopped coming to sessions and has not returned the therapist’s phone calls, the therapeutic relationship is terminated, and the client’s case file is closed.

***Social Media Policy***

This section outlines my office policies related to use of social media. Please read it to understand how I conduct myself on the internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the internet.

If you have any questions about anything within this policy, I encourage you to bring them up when we meet. As new technology develops and the internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

**Friending**:

I **do not accept friend** or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

**Interacting**:

Please do not use SMS (mobile **phone text messaging**) or messaging on social networking sites such as Twitter, Facebook, or LinkedIn to contact me. EXCEPTION: Texting appointment dates and times. All other texting could be compromising your privacy and you do this at your own risk. These sites are not proven to be confidential modes of communication and are not secure. Do not email me, as any message will not be read in a timely manner and also may not be secure. Please call directly or text a message to have me call you. Do not use Wall postings, @replies, or other means of engaging with me in public online if we have an already established client/therapist relationship. Engaging with me this

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way could compromise your confidentiality. It may also create the possibility that these exchanges become part of your legal medical record and will need to be documented and archived in your chart.  **If you need to contact me between sessions, the best way to do so is by phone, at 320-249-7144**. Texting me at the same number is best for quick, administrative issues such as changing appointment times.

The use of **Search Engines** It is NOT a regular part of my practice to search for clients on Facebook or Google or other search engines. Extremely rare exceptions may be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

**Business Review Sites** You may find my counseling practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether thee business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client. Of course, you have a right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. I urge you to take your own privacy as seriously as I take my commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that I may never see it.

If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy with me wherever and with whomever you like. **Confidentiality means that I cannot tell people that you are my client and my Ethics Code prohibits me from requesting testimonials**. **But you are more than welcome to tell anyone you wish that I am your therapist or how you feel about the treatment I provided to you, in any forum of your choosing.**

If you do choose to write something on a business review site, I hope you will keep in mind that you may be sharing personally revealing information in a public forum. I urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection.

**Email**

I prefer NOT using email, and only when I get a text or phone call asking me to watch for something, will I be checking my email. Please do not email me content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my internet service providers. While it is unlikely

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that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record. You can leave me a copy at the office or mail me anything you think I should see.

In **Conclusion,** I want to thank you for taking the time to review my social media policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the internet, do bring them to my attention so that we can discuss them.

***In Case of Emergency; After Hour Support and Emergencies***

**Reflections Mental Health is NOT an emergency 24-hour services agency. I do not provide emergency services. My practice is an outpatient facility, and I am set up to accommodate individuals who are reasonably safe and resourceful. I often may not be immediately available by telephone, email, or text messages.**

While I am usually in my office between 9AM and 5PM M-TH and 4PM -7PM THUR, I will not answer the phone when I am with a client. You may call me or text me during business hours on my office number 320-249-7144 and leave me a confidential voicemail including your phone number (even if you know that I have it) along with a brief message. I will call you back, or text a reply when I have finished all the sessions and business with other clients or between sessions if possible; if not possible the same day that you leave the message, as soon as I can the next day. If I will be unavailable for an extended time, I provide with all my clients in advance my away-from-office dates, and a colleague to contact, if necessary.

If you are unable to reach me and feel that you can’t wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. To prevent compromising your confidentiality, please do not send me emails or text messages with any therapeutic content or confidential information.

***Professional Fees with and without Insurance***

**Financial responsibility for services rests with the client or family, regardless of any insurance coverage.**

* It is very important that you find out exactly what mental health services or behavioral health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services and /or behavioral health care services. If you have questions about the coverage, call your plan administrator. You are responsible for obtaining initial authorization for treatment from your insurance carrier. I will bill your primary insurance; however, you are responsible for co-payment amounts and deductibles as set by your specific benefit plan. *I will be happy to provide you with whatever information I can, based*

*on my experience, and I will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf after you have made the initial call.*

* Please understand that insurance companies require a diagnosed Mental Health Disorder from
* the DSM 5 to bill a therapy meeting to your mental health insurance. Sometimes, there is not an appropriate diagnosis code that is covered by your specific insurance, that is reimbursable,

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or no appropriate disorder that can be identified. At times, I may need to see you several times before determining if there is an appropriate code. If either of these happen, than it will be brought to your attention and discussed with you. Sometimes, an insurance company may also mandate I provide additional clinical information, beyond the diagnosis, to continue receiving mental health care service.

* If you have a primary and a secondary insurance, it is your responsibility and imperative that you inform us of both insurance policies. We need to know the information for both polices so that we can verify your benefits and ensure that you are properly covered.
* Also, if you recently changed insurance policies/plans (within 3 months of your visit), you need to make sure that your old policy has completely ended, as we are not responsible if your insurance company doesn’t pay. The financial responsibility for services still rests with you.

**Cancelations and Missed Appointments**

Please respect that there may be times when other clients are on a waiting list to be seen. If you must cancel, please notify the office as soon as possible. If an appointment is missed or it is cancelled with less than 24 hours’ notice, you may be charged a $50.00 cancellation fee. Please be aware that your insurance company cannot be billed for missed or cancelled appointment fees.

Charges for missed appointments are not covered by insurance. The charge will be billed directly to you, and you may be required to pay this fee prior to your next appointment. Recurrent no shows may result in a discharge from care**.**

Missed appointments, disability evaluations, court ordered evaluations, completion of forms for attorneys or employees, court appearances, copies of records, letters, or any other types of reports are not covered by your insurance and the charges associated with them are your responsibility.

**Payments and Fees**

There may be certain circumstance in which a client may not be covered by insurance or wish to pay privately for various reasons. For those cases, I do offer a variety of service packages that can be custom designed to fit your needs, if you choose to pay out of pocket. Please see the fee outline below. Lynette (Lyn) Imdieke-Struzyk reserves the right to announce fee increases; which upon effective date shall become current for all existing clients.

* Initial Intake session (including file set up and course of treatment; up to 80 minutes) $165.00
* Individual Session (Standard sessions length is 50 minute) $125.00
* Couples Session (up to a 60 minute session) $125. 00
* Disability evaluations/medical forms, Court-ordered evaluations, completion of $25.00

forms for attorneys or employers, EAP forms, or any other paperwork requests (per 15 minutes)

* Missed or canceled appointments-less than 24 hour notice $50.00
* Returned Check Fee $25.00
* Telephone consultations (over 10 minutes) are not covered by insurance $30.00 to $90.00
* Tele-mental Health Services Same as above
* Court related and /or Child Specialist Work for Collaborative Law cases (for any \*\*$800.00

and all time spent on the case; \*\**plus my out of pocket expenses* per ½ day

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As noted above; there is a $25 fee for any returned check, which is due at the time of your next session, along with the payment for that day’s session. Should you miss a payment for whatever reason, therapy sessions may be postponed until the full payment is rendered. If your account has not been paid for more than 60 days and arrangements have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is taken, its costs will be included in the claim.

**Please note that some charges are typically not covered by insurance and will be personally billed to the patient. These include but are not limited to:**

* Charges to completed medical forms and patient requested letters are not covered by insurance and are the responsibility of the patient. Fees vary according to the length and complexity of the form or patient requested letter. Payment is due prior to picking up or mailing the requested documents. Please allow 7-10 days for processing.
* Telephone Consultations beyond 10 minutes are subject to a $30-$90. A charge that insurance does not cover.
* Copy of records/ Disability evaluations/ Medical forms/ Missed or canceled appointments/ Returned check fees/ Court fees

**No Insurance**

Payment will be due at the time of service. If you are unable to pay your balance in full you will need to make prior arrangements with our billing office. Alternative payment plans can also be agreed upon as needed.

***Statement of Financial Responsibility***

**Assignment of Benefits and Release of Information:**

I hereby assign, transfer, and set over to provider, all of my rights, title, and interest to my reimbursement benefits under my insurance policy. I authorize the release of any information needed to determine benefits. I certify that the information given is correct. I understand that this order does not relieve me of my obligation to pay such bills if not paid by my insurance company, or of any balance due after payment by my insurance company.

Insurances vary in their coverage, and it is the patient's responsibility to understand his/her mental health benefits. There may be limitations and exclusions to coverage. The patient portion is set by the insurance company. Patients are responsible for any co-payments and deductibles at the time of service. We will submit insurance claims for our patients. However, the agreement of the insurance carrier to pay for care is a contract between you and the carrier. You should direct any questions and/or complaints regarding coverage to your insurance carrier, your employer, or your agent.

My biller and I are happy to help with insurance questions related to how a claim was filed, or regarding any additional information the carrier might need to process the claim. Specific coverage issues, however, can only be addressed by your insurance company. Please contact Customers Service at the number listed on your insurance card.

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*You will be responsible for notifying us with* ***any changes in address or insurance*** *while you are a client*. Please be sure to review your information, including demographics and insurance information, every 30 days, or whenever than is a significant change. Out of date information can cause unnecessary delays in the payment of your claim.

***Telemental Health Services***

*Please review this information if you are engaging in services at Reflections Mental Health through telemental health (remote video chat) services.*

***What is Telemental Healthcare?​ -*** *Telemental healthcare includes the practice of diagnosis, treatment, education, goal setting, accountability, referral to resources, problem-solving, skills training, and help with decision-making through the use of internet-based videoconferencing. Telehealth psychotherapy may include psychological health care delivery, consultation, coaching, and/or counseling. Telehealth psychotherapy will occur primarily through interactive audio, video, and telephone communications.*

***Possible Risks of Telemental Health***

*1. Technological failure, such as unclear video, loss of sound, poor connection, or loss of connection.*

*2. Nonverbal cues are less readily available (visible) to both the therapist and the client.*

***Expected Benefits of Telemental Health***

*1. Less limitations by geographical location.*

*2. Reduction of travel demand to a physical office, which includes decrease in travel time and expense.*

*3. Participation in therapy from your own home or the environment of your choosing.*

***Needs/ Expectations of client during each session***

*1. Internet access, with minimum bandwidth connection of 384 kb or higher.*

*2. Minimum resolution of 640x360 at 30 frames per second. (most smartphones/tablets over 4” and laptops are acceptable)*

*3. Operational web camera or computer (HD 1080p is recommended).*

*4. Proper lighting and seating to ensure a clear image of each party’s face.*

*5. Dress and environment appropriate to an in-office visit.*

*6. ​****Only agreed upon participants will be present******or within hearing range****.​ Any individual entering the room or disrupting the privacy of the therapy environment (including hearing or viewing the session) must be announced by the client. The presence of any individuals unapproved by both parties and not part of the treatment plan will be cause for termination of the session.*

*7. Valid ID must be presented by the client during the initial consultation, and a copy retained for the medical file.*

*8. The client must disclose the physical address of their location at the start of the session. Unknown*

*Please initial that you have read this page \_\_\_\_\_\_\_\_ 12*

*locations will be cause for termination of the session. ​****Your contact must take place at the address identified below.​*** *Any changes to your location requires the update to this document.*

*Location Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Address:​\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_​ State:​\_\_\_\_\_\_​ Zip:\_\_\_\_\_\_\_\_\_\_\_​ County:​\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*9. The client shall also* ***provide a phone number where they can be reached in the event of service disruption. Phone:*** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Telemental health delivery by Lynette (Lyn) Imdieke-Struzyk , M.S., L.P.C.C. may occur only with current residents of ​Minnesota​, who are currently within the state lines. The current laws that protect privacy and confidentiality also apply to telemental health.*

***Please Note :***

* *No permanent video or voice recordings are kept from telemental health sessions. Clients may not record or store videoconference sessions or face-to-face sessions.*
* *Telemental health may not be the most effective form of treatment for certain individuals or presenting problems. If it is believed the client would benefit from another form of service (e.g. face-to-face sessions) or another provider, an appropriate referral will be made.*

***Emergency protocol***

*Client is to provide the name and contact information for an additional person in case of emergency. In addition, in the event of a medical or mental crisis event, Lyn Imdieke-Struzyk, M.S., L.P.C.C. will contact the client’s local emergency services. The contact information for the client’s nearest hospital will be on record in the event an admission is necessary to address a client emergency. The information provided will include the nature of the crisis and immediate needs of the client.*

***Nearest Hospital for emergency services:*** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Response to technical difficulties***

*Should technical difficulties cause session disruption, Lyn Imdieke-Struzyk, M.S., L.P.C. C. will contact the client via preferred telephone contact. If the technical difficulties can be resolved quickly, the session will resume, and the client will not experience a shortened session length. If the technical issues cannot be resolved in a timely manner, the session will be rescheduled for a time when functionality is restored. The client will be contacted by telephone to develop a plan for session continuation.*

***Payment***

*Session costs are consistent with the normal billing practices of the office. Some insurance companies may not cover telemental health services, and the patient will remain responsible for the session fees and costs.*

***Contact between sessions***

*Telephone contact can be made in between sessions for the purposes of scheduling or other needs.*

Please initial that you have read this page \_\_\_\_\_\_\_\_ 13

*Videoconference technology is reserved for therapy sessions only. Additional costs may be associated with non-scheduling contact lasting longer than 5 minutes.*

***Consent to Treatment***

*I, voluntarily, agree to receive Telemental Healthcare assessment, care, treatment, or services and authorize Lyn Imdieke-Struzyk, M.S., L.P.C.C., to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services that I receive through Reflections Mental Health at any time, just I could with In office Mental Health Care. By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to ask questions and seek clarification of anything unclear to me.*

***Client Signature, Acknowledgement, Agreement, and Consent***

By signing and dating this document, you are indicating that you have read and understand the contents of this “***CONSENT TO TREATMENT, BUSINESS POLICIES & AUTHORIZATION*** ” form. You are also acknowledging you have read and signed the “**Health Insurance Portability and Accountability Act (HIPPA) Notice of Private Practices**” provided to you separately. Your signature also indicates that you agree to the policies of your relationship with your therapist, and you are authorizing your therapist to begin treatment with you, complete a behavioral assessment, receive care and the treatment that is considered necessary and advisable. I understand the practice of behavioral health treatment is not an exact science and acknowledge that no one has made guarantees or promises as to the results that I may receive. You also affirm, by signing this contract, that you are the legal guardian and/or custodial parent with legal right to consent to treatment for any minor child or children that you are requesting professional services from Lyn Imdieke-Struzyk. I have read or have had read to me all the information in this Information for Clients and Informed Consent paperwork and I have initialed all pages indicating that I have read them and understand them. I have had a chance to review and ask questions and have had all questions answered to my satisfaction. I agree to abide by all the policies outline herein. By signing this agreement, I am consenting to treatment and understand all the benefits and risks of therapy as outlined herein. I also hereby acknowledge that I have received the HIPAA notice form mentioned herein.

Please sign that you have read this Informed Consent form and understand that you do have a choice of receiving a copy of this form or simply saying you are aware of this packet of information and agree to follow its contents.

**Signature of Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Responsible Party, Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telemental Healthcare will be used: YES \_\_\_\_\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_**

***My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.***

**Signature of Therapist**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_ Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please initial that you have read this page \_\_\_\_\_\_\_\_ 14

***Complaints or Grievances***

If you feel that there is basis for a formal complaint or grievance about anything related to the professional services I am providing, I invite you to first communicate your concerns directly to me so that I will be informed and have an opportunity to respond and resolve any potential misunderstanding. You have a right to file a complaint about me with my licensing board and may do so by contacting the board at the following address and phone number:

Minnesota Board of Behavioral Health and Therapy

2829 University Ave SE, Suite 210

Minneapolis, MN 55414

[bbht.board@state.mn.us](mailto:bbht.board@state.mn.us)

Phone: (612)548-2177 Fax: (612)617-2187

**ADDITIONAL HELPFUL TIPS REGAURDING YOUR INSURANCE BENEFITS:**

* It is important to learn and understand the basics of your health insurance and how it works. Understanding and knowing your specific plan coverage is important prior to attending your first appointment. Please take a moment to read over the following information and become familiar with your personal insurance plan so that you can be prepared to make the appropriate payment on the date of your appointment.
* Your deductible is the amount that you are responsible for paying for before your health insurance plan will begin to pay out any expenses.
* Your coinsurance is the shared cost between you and your health insurance plan. For example, you pay 20 percent of the costs and your plan pays 80 percent of the costs. These percentages can vary from plan to plan. Some plans do not have a coinsurance.
* Your co-payment is a fixed dollar amount payment that you make each time you visit a provider. Co-payments do not accumulate and go towards meeting your plan deductible.
* Some high-deductible health insurance plans have a health savings account (HSA) that can be used to pay for certain medical expenses to bring down the cost of the deductible.
* If your recently changed insurance plans make sure that your old plan is showing cancelled. If it is not, it will cause issues with your current plan and you may be at risk of paying out of pocket.

**\*\*Always call your health insurance plan prior to your first appointment to verify your benefits and inquire about your deductible and any coinsurance and co-payment requirements\*\***

**Again, thank you for choosing Reflections Mental Health.**

Please initial that you have read this page \_\_\_\_\_\_\_\_ 15

**Reflections Mental Health**

**Initial Client Insurance Information**

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Intake date: \_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work)

**Person who carries the insurance**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Employer Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_ Secondary Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type(s) of service:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Source of referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary insurance company**: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Persons covered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M&F covered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer/Group: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Deductible: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Deductible met: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prior authorization needed: Yes No Effective date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy anniversary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Coverage for testing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Annual limit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other third-party coverage**: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Persons covered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M&F covered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( also make copies of Insurance Cards)

**Self Pay**: Personal payment amount: $ \_\_\_\_\_\_\_\_\_\_\_ Financial Terms signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Payment method (Insurance and cash clients; deductibles, co-payments, etc.)

\_\_\_\_\_Check \_\_\_\_\_ Cash \_\_\_\_\_ Charge card Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder's name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Completed procedures:

Entered system \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Confirmed insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Confirmed with client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please initial that you have read this page \_\_\_\_\_\_\_\_ 16