Brian T Ross LMFT

Welcome

6607 18th Ave. S. (Suite 101) Richfield, MN 55423
Telephone: 612-798-7373 x17

I am a highly skilled therapist dedicated to serving your special needs and concerns. In a setting that is caring, supportive and ethical, I work to empower individuals, couples and families to manage their own well-being.

Patient Satisfaction
Thank you for trusting my ability to provide you with appropriate, high quality care. I will make every effort to treat each client with respect and dignity regardless of race, beliefs, national origin, source of payment, age, religion, disability, or sexual preference.

If you experience a problem with any service, please discuss this with your therapist. If the situation is not resolved, or if the nature of the concern prohibits such discussion, please contact the professional licensing board.

Financial Responsibility
I request payment at the time of service. A.C.E. billing will submit your insurance claims. I am an out of network provider for most insurance companies, you will want to check with your insurance plan to find out what coverage you have for out-of-network benefits. Some insurance plans limit the number of sessions covered so you will want to understand the benefits available to you.

Initial Appointment
Your first appointment will take approximately one hour. During this appointment, you can discuss your situation and concerns with me. After this initial appointment, an assessment and recommendation for treatment will be made. We require a 24-hour notice to change or cancel an appointment Missed or cancelled appointments without the 24-hour notice will be charged at the regular rate.

Confidential Information
Information you furnish to me is confidential according to the Minnesota Access to Health Records Statute. This means that only you and restricted, authorized personnel have access to information in your medical chart. No treatment information will be released to persons, schools, or agencies without your consent, except by court order. If you choose to give your permission, be sure that you understand what information will be released and how it will be used.

If it appropriate to coordinate your care with your primary care physician, you will be asked for your written permission to do so. Your insurance company may require information about your care prior to providing payment of services.

There are some exceptions to confidentiality. For example:

- ❑ Health care providers are required by law to report cases of known or suspected abuse or neglect of children or vulnerable adults.
- ❑ In cases of threatened homicide or serious harm, the police and possible victim must be notified.
- ❑ In cases of threatened suicide, the police will be called.
- ❑ By law, information concerning dependent minors is accessible to the parents unless it is determined that such access would be harmful to the minor.

Clients under the age of 18:
All non-emancipated minor clients under the age of 18 years old must have the consent of their parents following an initial intake session to receive further services.

All minors have the right to request that their records be withheld from their parents. No information will be provided to parents of minors without the consent of the client.

As a client, you have the right to:
- ❑ Courteous and respectful treatment.
- ❑ A safe and comfortable environment
- ❑ Appropriate behavioral health care.
- ❑ A clear explanation of your diagnosis and treatment plan.
- ❑ Privacy and confidentiality.
- ❑ Participate in planning your care.
- ❑ Refuse behavioral health treatment.
- ❑ Be free from discrimination based on your religion, race, gender or culture.
- ❑ Register complaints.
- ❑ Access to your records as provided by law.

You are asked to:
- ❑ Treat staff with respect.
- ❑ Ask questions about your care.
- ❑ Tell your therapist everything you can about your condition, including all symptoms, medications, and past medical history.
- ❑ Pay your bills on time.
- ❑ Keep appointments, or give at least 24 hours notice if you need to cancel your appointment.
- ❑ Let the therapist know about any changes in your symptoms, medications or general condition.
- ❑ Treat clinic property with care.

Emergency Procedures:
For emergency situations you can call the Crisis Connection at 612-379-6363 or go to your nearest emergency room.

Business Services:
- ❑ Most therapeutic sessions will be 50 minutes in length. Longer sessions may be advisable based on the need and the therapeutic methods being used.
- ❑ Clients are asked to pay for each session at the time of service.
- ❑ For questions regarding scheduling, billing and payments, please talk with your therapist.
- ❑ Therapists will return calls within 24 hours with the exception of weekends. If an emergency arises and you are unable to reach your therapist, you can call the Crisis Connection or go to your nearest emergency room.
- ❑ Phone consultations with the therapist that exceed 10 minutes in length will be billed as a session and charge based on the time spent.
- ❑ You are expected to be here for each session that you schedule. The regular fee will be charged for sessions that are missed or cancelled without 24 hours notice.

Brian T Ross, LMFT

Informed Consent for Confidentiality

1. If anyone requests information about me, my therapist will not give it unless and until I have signed a separate written authorization for her to do so. My therapist will not discuss anything about me worth anyone without my written permission, except as noted here:

a. If I use insurance benefits, my therapist cannot guarantee confidentiality from the insurance company.
b. If my therapist learns that I have abused a child, a spouse or vulnerable adult (or if I am a child, spouse or vulnerable adult and report having been recently abused), she must report it to the proper authority.
c. If my therapist has good reason to believe that I intend to physically harm myself or someone else, she will discuss it with me and may be required to warn that person or persons (the Tarasoff duty), or to take steps to prevent such harm.
d. If my therapist has good reason to believe that I may be a danger to myself, she will contact at least one concerned person and/or take steps to prevent such harm.
e. If I give permission to release my records to a legal representative of my choice, these records could become discoverable by other legal representatives. If subpoenaed by the courts to release your records, we may have to do so.
f. My therapist may discuss my case with other clinicians. Identifying information (such as name) will not be shared without written permission.

2. All non-emancipated minor clients under the age of 18 years old must have the consent of their parents following an initial session to receive further treatment services. All minors have the right to request that their records be withheld from their parents. No information will be provided to parents of the minor without the knowledge of the client.

My signature indicates that I have read, discussed and understand this information.

_____ _____

Client/Parent/Legal Guardian Signature Date

Brian T Ross LMFT

Consent to use Disclosure of Healthcare Information for Treatment, Payment, or Healthcare Operations

This notice describes how Psychological and Medical information about you may be used and disclosed. Please review it carefully.

by signing this statement, I understand that as a part of my healthcare, Brian T Ross, LMFT originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. This information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that as a part of my treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I wish to have the following restrictions to the use or disclosure of my health information:

_____

(please list any restrictions)

I fully understand and accept the terms of this consent:

_____ _____

Client/ Parent/Legal Guardian Signature Date

I understand and have access to a *Notice of Information Practices* that provides a more complete description of all information uses and disclosures. I fully understand and accept the terms listed in that document including my rights and privileges as a client of Brian T Ross, LMFT:

_____ _____

Client/Parent/Legal Guardian Signature Date

Payment Agreement

I understand that I am responsible to pay for services received each time that I attend a session.

I further understand that cancelled appointments require at least 24 hour notice. In the case of a cancellation without 24 hour notice, a missed appointment or a late arrival, I may be charged for a full session. Insurance companies will not pay for appointments that are cancelled or missed.

The agreed upon fee for clinical services is as follows:

60 minute sessions: $165.00

75 minute sessions: $225.00

Group Sessions: $75.00

A service fee of $3.00/ transaction will be charged to all payments made by credit card.
A finance charge of 1.5% will accrue on accounts 90 days past due.
A $20.00 service charge will be added for returned checks.
A collections agency will be used for delinquent accounts.

I understand and agree to the above conditions:

_____

Client/Parent/Guardian Signature Date