LAKEWOOD COUNSELING and Career Center

II 6607 18th Avenue South, Suite #101 Richfield, MN 55423 II lakewoodcounseling.com II (P) 612-798-7373 (F) 612-243-3615 II

Making Informed Consent/Agreement to Treatment

Therapy provides you a time and place to feel better, improve yourself, your life, and your relationships. I aim to provide specific intervention techniques and strategies to help you with issues during out sessions and during your everyday life. I will respect you, your values, your story, and your imperfections. I will put your best interests above all else and I will always respect the fact that, at the end of the day, YOU get to make your own decisions about your life.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness. Psychotherapy often requires discussing unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals and families who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress, and resolutions to specific problems. But, there are no guarantees about what will happen. **Psychotherapy requires a very active effort on your part**. **In order to be most successful, you will have to work on things that we discuss when you leave our sessions.**

Your first appointment will take approximately one hour. During this appointment, you can discuss your situation and concerns with me. After this initial appointment, a formal recommendation for treatment will be discussed. It is possible we will discuss referrals for other services that may be helpful in addition to or in place of therapy: e.g., psychological evaluation, psychiatric evaluation, chemical health evaluation/treatment, intensive outpatient program (IOP), hospitalization, etc.

FINANCIAL RESPONSIBILITY

I prefer payment at time of service. I will bill your insurance; however, **please note: I am an out-of-network provider. It is your responsibility to understand your insurance coverage, deductible, out-of-pocket-max, etc.** If insurance covers a portion of your fee, you will be responsible for the remaining balance. Typically, your insurance company will reimburse you directly. You will be notified if I am reimbursed from your insurance provider and you will see this amount deducted from your overall balance.

Business Services

- Most therapeutic sessions will be 50-60 minutes in length. Longer sessions may be advisable based on the need and therapeutic methods being used
- Clients are asked to pay for each session at the time of service if insurance is not being used
- For questions regarding scheduling, billing, and payment, please speak with your therapist
- Phone consultations with the therapist that exceed 20 minutes in length can be billed
- 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 hour notice, within reason.

Insurance companies typically require a formal diagnosis with their claims. Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (abbreviated as *DSM-5*) There is a copy in my office and I will be glad to let you see it to learn more about your diagnosis, if applicable/appropriate.

Clients are often unaware of the fact that, in order to submit therapy sessions to insurance, I am required to provide a clinical diagnosis for each session. You should be aware that a diagnosis can then follow a client in his/her health history. The client's insurance company can also have access to documents such as progress notes and assessments. Furthermore they can make decisions to extend or cut short the number of sessions based on perceived "compliance" with therapy. Finally, continued sessions are also based on the therapist's reports of enough progress to show the therapy is working, yet enough remaining problems to show that the therapy is still necessary.

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. You may revoke this permission in writing at any time. I will generally ask you to sign releases of information so I can ensure I am doing my due diligence in getting to know you. This may prompt me to communicate with your primary care physician, psychiatrist, a previous therapist or provider, hospitalization records, etc.

There are, however, several exceptions in which I am legally bound to take action even though that requires revealing some information about a client's treatment. If at all possible, I will make every attempt to inform you when these will have to be put into effect. The legal exceptions to confidentiality include, but are not limited, to the following:

1. If there is reason to believe you are threatening serious bodily harm to yourself or others. If I believe a client is threatening serious bodily harm to another, I may be required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens harm to him/herself or another, I may be required to seek hospitalization for the client, or to contact family members or others who can provide protection.
2. If there is good reason to suspect, or evidence of, abuse and/or neglect toward children, the elderly or disabled persons. In such a situation, I am required by law to file a report with the appropriate state agency.
3. In response to a court order or where otherwise required by law
4. To the extent necessary for emergency medical care to be rendered.

*In accordance with MN Statutes 144.294 RECORDS RELATING TO MENTAL HEALTH, a minor does have the right to refuse the release of their records to a parent/legal guardian. This refusal may or may not be granted, based what is deemed to be in the best interest of the client and/or family.

As a client, you have the right to:

- Courteous and respectful treatment
- A safe and comfortable environment
- Appropriate behavioral healthcare
- A clear explanation of your diagnosis and treatment plan
- Privacy and confidentiality
- Participate in the planning of your care
- Refuse behavioral health treatment
- Be free from discrimination based on of race, gender, class, religion, sexual orientation, disability, or other aspects of what we look like or where we come from
- Register complaints
- Access to your records as provided by law/policy

<u>You are asked to:</u>

- Ask questions about your care
- Tell your therapist everything you can about your condition, including all symptoms, medications, and past medical history
- Pay your balance in a timely manner
- Keep appointments, or give at least 24 hour notice if you need to cancel or reschedule your appointment
- Let your therapist know about any changes in your symptoms, medications, or general condition
- Treat clinic property with care

ENDING THERAPY

You have the right to take a break from your therapy at any time without permission or agreement. Therapists are ethically required to continue therapeutic relationships with clients only so long as it is reasonably clear that patients are benefiting from the relationship.

If you are unhappy with what is happening in therapy, I hope you'll talk with me so that I can respond to your concerns. Your feedback will be taken seriously and with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe, and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspect of the therapy and about my specific training and experience. You have the right to expect that I will not have any type of relationship with my client(s), outside of therapy.

CONTACTING ME

I am often not immediately available by telephone. While I am usually in the office during normal business hours, I do not answer the phone when I am with a client. If you need to contact me between sessions, please leave a message for me at **612-798-7373 ext. 11**. I check my messages each day unless I am out of town. If I am planning on being out of town, I will let you know in advance, if this seems appropriate. For emergency situations, call 911 or Crisis Connection at 612-379-6363 {toll free at 1-866-379-6363} or go to your nearest emergency room.

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

Client Signature ____ **Date** ___________________

Legal Guard Signature (if client is minor) _________________________ **Date** ____________________

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Consent to Use/Disclose 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, Lakewood originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, 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 for the various health professionals who may contribute to my care
- A source of information for applying my diagnosis to my bill
- A means by which third-party payers can verify that services were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that as part of Lakewood's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, *if* I consent to such disclosure for these permitted uses, including disclosures via fax.

I wish to have the following restrictions of the use or disclosure of my health information:

____

____

(please list any descriptions – use separate page if necessary)

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* (located in the lobby) 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 Lakewood Counseling.

____ ____________

Client/Parent/Legal Guardian Signature Date

ELECTRONIC COMMUNICATION POLICY

E-Mail Communications

Please be aware that e-mail is *not* a confidential means of communication. I cannot ensure that e-mail messages will be received or responded to immediately. E-mail is not the appropriate way to communicate confidential information or emergency issues. If you e-mail me you are accepting the risks inherent to this form of communication.

Please do not use e-mail for lengthy and complicated medical questions that should properly be addressed via consultation. I will try to reply to your e-mail in a timely manner, however my responses may be delayed over weekends, holidays, or due to technical difficulties. Please be aware that your e-mail communication may become part of your medical record. Please note that e-mail systems may be insecure or unprotected, other members of your household or your employer may have access to your communication via e-mail, therefore it should not be considered private.

Please be sure to include your full name in all communication. All information contained in e-mail messages is intended solely for the addressee unless otherwise explicitly stated and may contain information that is confidential, privileged, or otherwise protected from disclosure under applicable law. If you are an unintended recipient of any e-mail message originating from myself, you are hereby notified that you have received this document in error and that any review, distribution, or copying of this transmission is strictly prohibited. If you have received an e-mail communication in error, please notify me immediately by calling me and leaving a voicemail and destroy all copies on your system.

Text Communications

Text messaging is a very insecure and impersonal mode of communication. I use text communication only with your permission and only for setting and changing appointments unless we have made another agreement. Please do not text me about clinical matters. If you need to discuss a clinical matter with me, please call me so that we can discuss it over the phone or wait so that we can discuss it during your therapy session.

I have read the above information and understand the inherent risks involved if I decide to communicate electronically my therapist.

Signature of patient ____ Date ______________

Signature of parent/legal guardian (if necessary) ______________________________________ Date _____________

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Client Information Form

Date: __________________ Therapist: **Paul Lehrer, LICSW, LMFT**

Client's Legal Name: ____ Client's DOB: _______________________

Client's Primary Address: ____

City: ____ State: ___________ Zip Code: _____________________

Phone: (H) ____________________________ (C) ______________________________ (W) _________________________
please, only provide #'s if we have permission to use* *list 2nd address on backside, if applicable

How did you hear about Lakewood Counseling?: ____

Billing Information:

Responsible Person(s) (Guarantor): __________________________________ Relationship to Client: ______________

Guarantor's DOB: __________________________

Guarantor's Billing Address: ____

City: ________________________________ State: ___________ Zip Code: ____________________

Phone: (H) ________________________ (C) ___________________________ (W) ____________________________
please, only provide if we have permission to use

Insurance Information: *****Only Provide If You Wish For Your Sessions To Be Submitted To Insurance*****
***Please note that Lakewood Counseling and Career Center is an "Out of Network Provider". We will electronically bill the insurance company that you provide. Any insurance payments or denials are ultimately your responsibility to track. Any questions on insurance coverage, eligibility or payments should be directed to your insurance.**

Name of Insurance Company: ____

Client/ Insured's ID #: ________________________________ Group/Policy Number: _____________________

Mailing Address (on back of card): ____

Policyholder's Name: ______________________________ Relationship to Client: _______________________

Policyholder's DOB: _________________

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Payment Agreement

Cancelled appointments require at least 24 hour notice. In the case of a cancellation without at least 24 hour notice, a missed appointment, or a late arrival, you will generally be charged for the appointment. Insurance companies will not pay for appointments that are cancelled or missed.

The agreed upon for fee for clinical services is as follows:

50 Minute Session: **$175.00**
50 Minute Individual Clinical Supervision: **$75**
50 Minute Group Supervision: **$45**
Other: ___________________

***A $20.00 service charge will be added for returned checks. The clinic reserves the right to use a collection agency or conciliation court on accounts 60 days past due.

PLEASE PROVIDE THE REQUESTED CREDIT CARD INFORMATION BELOW. THIS WILL BE USED IF YOU HAVE NOT DISCUSSED A REASONABLE PAYMENT PLAN WITH YOUR THERAPIST AND YOUR ACCOUNT BALANCE GOES UNPAID FOR MORE THAN 60 DAYS.

Type of Credit Card ___________________________________(Visa, MasterCard, American Express, Discover)

Name(s) on Card ____

Billing Address ____

Credit Card Number ____

Card Security Code (CVV) ___________________________ Expiration Date _______________________

I understand and agree to the above conditions:

____ _______________

Signature - Client and/or Parent/Legal Guardian and/or Cardholder **Date**

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AUTO CREDIT CARD PAYMENTS (**optional*)

I hereby authorize Lakewood Counseling & Career Center to use the following credit card information for payment of future sessions (after the session is completed). I understand that I will be charged for missed appointments if I do not give Lakewood Counseling & Career Center twenty four (24) hour notice, within reason.

This method of payment is most helpful if insurance is not being used for therapy and/or if you have a large deductible that you need to reach before your insurance will reimburse you for therapy.

☐ *USE THE SAME INFORMATION I PROVIDED ON 'PAYMENT AGREEMENT' FORM

Type of Credit Card ___________________________________(Visa, MasterCard, American Express, Discover)

Name(s) on Card ____

Billing Address ____

Credit Card Number ____

Card Security Code (CVV) __________________________ Expiration Date _______________________

I understand and agree to the above conditions:

____ ____________________

Cardholder's Signature **Date**

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