FaithWorks Counseling, LLC
10505 Wayzata Blvd, #101
Minnetonka, MN 55305
Ph: 952.451.3660
Fx: 952.746.8128

Anchor Counseling
110 First Ave. East
Jordan, MN 55352
Ph: 952.451.3660
Fx: 952.492.7885

Treatment Contract/Registration

WELCOME! The most important goal of therapy is to help you feel and do better in your life. As a client, you can help with your treatment by keeping the following information in mind throughout your therapy. This is a solution-focused, goal directed approach for a wide variety of problems, from crises in daily living to ongoing mental health issues. It is especially important that you keep in close contact with family or supportive friends during a crisis and that you assume responsibilities for helping yourself. Treatment will be provided in the least restrictive environment possible.

Standard therapy sessions are 45-50 minutes. While this can be somewhat flexible, the time frame will be maintained as much as possible to help all involved. Also, this is a courtesy to others that may be waiting. If you are dissatisfied with your progress in therapy, please discuss this openly. Your input and concerns are very important and talking about them often leads to beneficial results for all involved.

Confidentiality: Please understand that what you say is CONFIDENTIAL and will be discussed with other people only with your written permission (except in medical emergencies, under a court order, or as required by law, i.e. mandatory child abuse reporting, and vulnerable adult abuse reporting or for the purpose of consultation or supervision). If there is a clear intention to do serious harm to self or to another person, child abuse, or a pregnant woman using mood altering substances, Therapists are mandated by law to report such information to their respective boards to forward to appropriate authorities. Information regarding services provided to minor children can be given to parents on request as a matter of state law. If a minor child is seen, issues regarding confidentiality will be discussed with the parents. Insurance providers often require more detailed information of your situation prior to approval of continued treatment or payment for treatment. If you wish to know the informational requirements of your insurance company, please ask.

Office Hours and Cancellation Policy: Office hours vary. Therapy time is valuable to all involved. **Cancellations or changes of an appointment must be made at least 24 hours in advance or you will be charged for your session.** Please note that insurance companies do not pay for failed or canceled appointments. This is standard practice and is intended in part to preserve the time for those who may need it. See "Fees, Phone Calls and Reports" for specific fees. Please ask me about any questions you may have about this policy. You can make appointment changes by calling you're the office and leaving a message a message with your provider.

Consultation and Supervision: To provide you with the best possible service, *FaithWorks* Counseling providers engage in ongoing supervision and consultation with other mental health professionals. When discussing clients in these forums, confidentiality is protected.

Crisis Situations: Steps to take during a crisis will depend upon the nature of the crisis. You may call your individual therapist, but if not reached, you can call the Crisis Connection in the TC-Metro (612) 379-6363 or (866) 379-6363 after business hours, weekends and holidays; Carver/Scott Counties (952) 818-3702. When immediate service is required for life threatening situations, please call 911 or go to the emergency department at the closest hospital.

Fees, Phone Calls and Reports: Fees are as follows: $220 for the initial diagnostic session; $180 for extended (45-55 minutes) sessions, $165 for (30-45 minutes) individual and/or family sessions, for training and/or consultation (whether in the office or by phone), $80 per session for group therapy. **There is a 3% pass-through charge added for payment by credit card.**

Full payment (or co-payment if services are covered by insurance and any deductible has been satisfied) is due at the beginning of the therapy hour. There are not fees charged for phone calls, letters and reports to facilitate scheduling, information sharing, etc. and requiring up to 10 minutes of time. After 10 minutes, you are billed at a prorated $180 per hour rate. Scheduling paid telephone sessions is welcome when a situation is particularly urgent or because of travel or geographical difficulties. No-show individual/family appointments or cancellations made with less than 24-hour notice will be charged at $80 (Master level provider). No-shows or cancellations made with

less than 24 hour notice for group therapy will be billed at the rate of $80 per missed session. Please note: **All payment, including copays/co-insurance, late cancel/failed appointment fees and unpaid claims from your insurance company is due prior to or at the time of service or your appointment will be rescheduled for a time after payment is received.**

Insurance and Bookkeeping: FaithWorks Counseling, LLC retains the insurance billing and bookkeeping services of FaithWorks and Anchor billing. Please contact the phone number shown on the billing with any questions regarding billing or collections. There may be situations that our biller will be calling you directly regarding billing or collection issues. In many cases, insurance companies provide outpatient mental health benefits to their insured customers. **Please remember that services are provided for and charged to you, not to your insurance company. You are responsible for checking with your insurance company and/or your employer to be certain that they cover the services provided.** Because of the wide variety of insurance plans available guarantee cannot be made that any particular company will provide payment for services that you receive. **If your insurance company does not cover the services you receive; you are fully responsible for the amount due.** If you have any questions about obtaining coverage, please ask. However, your insurance carrier will make a decision about any reimbursement. In most cases, problems with insurance processing can be significantly reduced if the claims are filed through this office.

Collections*:* In case you do not pay your bill, FaithWorks Counseling, LLC reserves the right to seek payment through the use of a collection agency or through other legal means. The cost of collection, including attorney fees, may be added to your bill. Return check fee is $35 and will be billed to you. Unpaid balances may incur reasonable and customary interest charges.

Record-keeping, requests from Third Parties for Records, Testifying Regarding Records, and Related Costs. Our records are confidential and may not be used as evidence for litigation purposes. This includes all assessments, questionnaires, evaluations, and testing.

If you are involved in litigation, you or your non-health care advisors may not subpoena our documents or us as evidence in any proceeding, any communication, or documents related to the therapy process. Be advised that if we are somehow compelled to release documents, you as a client acknowledge and grant the right for us to file identical documents to the opposing party.

If we are forced to further document or respond to information requests, meet with your representatives, or testify in court, our fees are $400/hour, portal to portal, plus all expenses, half-day minimum, paid in advance. Agreement to this provision is required to receive therapy services from us, and is acknowledged by your signature at the end of this document.

Services NOT Offered:

We are **NOT Qualified** and we **do not offer** the following services:

1. Custody Evaluation
2. Visitation Recommendations
3. Disability Evaluation or Recommendation
4. Services requiring testimony in legal proceedings.

I **understand and agree to abide by the policies stated above.**

_____ _____

Client Signature Date

_____ _____

Parent Signature Date

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Client Responsibilities/Registration

Client Responsibilities

Each client has the responsibility to:

1. Refrain from physical (and other) abuse of self, others, and property. Clients are responsible for repair or replacement of any property they damage in the facility.

2. Devote reasonable energy and time to therapy work. Therapy is generally "hard (emotional) work." For progress to occur, we recommend making your therapy a high priority in your personal life. Your therapist may regularly assign homework that is intended to help you learn about yourself, and doing your homework is expected to expedite your therapy and decrease your costs.

3. Fulfill contracted behavior.

4. Be honest with your therapist concerning your thoughts and feelings about your therapy and treatment.

5. Keep appointments as made. Your appointment time is reserved for you. Therefore, you will be charged for the appointment unless you give at least 24hours advance notice. Exceptions may be made for emergencies and other extenuating circumstances.

6. Keep current in paying your fees (deductibles, co-payments, fee-for-service payments). You are required to pay your fee at the beginning of each session. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that occurred prior to the first visit to my office), session fees credited toward the deductible will be collected at the time of the session until the deductible payment is verified by the insurance company or third-party provider. Verification can be made through my billing coordinator, who will contact your insurance company to check your benefit status upon request.

7. Inform those involved in the treatment plan about any changes to physical health, insurance plan, or ability to pay for contracted services.

8. Parents or caregivers are responsible to supervise the activities of children with respect to use of facilities, material, etc.

I have read and understand my rights and responsibilities as noted above.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian Date

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Registration: Crisis Coverage

Providers at FaithWorks Counseling, LLC understand that at times you may be in a psychological or life threatening crisis. Since our therapists are frequently in sessions with other clients and thus may not be immediately available to assist you through your crisis we ask that you follow the crisis procedures outlined below. Please discuss any questions you have about these procedures with your therapist.

In **a crisis situation please do the following:**

1. If you are in a life-threatening crisis, please go the nearest emergency department or call 911 no matter what time of day it is.

2. If you are in urgent need to talk to your therapist, please call the therapist during normal business hours and listen closely to the voice mail directing you through steps for urgent calls. **Include a phone number in any message you leave AND indicate that it is an urgent matter.**

3. If you are in crisis after 5:00 pm Monday through Friday, on the weekends or on holidays, you may **call the Crisis Connection** at: Metro Area - (612) 379-6363 or (866) 379-6363; Carver/Scott Counties – (952) 818-3702. This is a free charge to you.

Signature indicates that you have read, understand and agree to the above.

_____ _____

Client Date

_____ _____

Therapist Date

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Provider Contact/Release of Information

Dear Client,

FaithWorks Counseling. LLC has a strong commitment to your holistic health. For that reason, it is important to have a close working relationship with your physician, psychiatrist. or other health care provider. I am asking for your permission to communicate with your health care providers. I find that I can serve you best if they are aware of mental health and substance abuse concerns which often impact health and well-being. Please complete the attached release to enable me to communicate with them about your care. If you have more than one provider. please let me know and I will provide you with additional forms. You will need to complete a separate release of information for each provider you wish me to communicate with during the course of your care at FaithWorks Counseling, LLC. I will be happy to answer any of your questions or respond to your concerns regarding this matter. If do not wish me to communicate with your other health care providers, please read and sign the bottom of this page.

Thank you.

Please check all that apply:

☐ Yes, please communicate information about my care with my primary care physician. I have completed the Consent for Release of Information (that follows this page) with the contact information.

☐ Yes, please communicate with providers other than my primary care physician. I have completed a Consent for Release of Information with the contact information.

☐ No, I do not want FaithWorks Counseling, LLC to communicate with my primary care physician.

☐ No, I do not want FaithWorks Counseling, LLC to communicate with other providers.

I understand that I may sign a release of information at any time for a specific provider and at that point FaithWorks Counseling, LLC will initiate communication with that provider.

Patient signature _____ Date _____

Parent/Guardian signature _____ Date_____

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Consent for Release of Information

This authorizes **FaithWorks Counseling, LLC/Anchor Counseling** to **use and disclose** the specific health information described below concerning: Client _____ Date of Birth::_____

This will authorize **FaithWorks Counseling, LLC/Anchor Counseling** to **release to** obtain from:

_____

Name:_____

Address:_____

Phone:_____ Email:_____

Dates_____(Information from the medical record maintained from (please list dates such as "all" or "2/04 to 2/05")

The information to be disclosed is: (please check all info that you are willing to have exchanged):

- ☐ History and intake information
- ☐ Consultation notes/ progress reports
- ☐ Treatment plan, goals. and results
- ☐ Court or probation records
- ☐ Social/ Psychological/ Medical reports
- ☐ Chemical dependency abuse or diagnosis, history and treatment (protected by Federal and State regulations 42 CFR Part 2 and ORS 430.399(5), 179 505)
- ☐ Medications used in treatment
- ☐ Other (specify)

The purpose of the information release is (please check all that apply):

- ☐ Diagnosis and evaluation
- ☐ Treatment planning
- ☐ To facilitate treatment
- ☐ Other:

If I am requesting the Authorization from you for my use and disclosure or to allow another health care professional or entity to disclose information to me: (1) You have the right to inspect a copy of the protected information to be used or disclosed; (2) You may refuse to sign this authorization: and (3) I must provide you with a copy of the signed authorization at your request. You may revoke this consent at any time and that upon fulfillment of the above stated purpose(s) or within one year, this consent will automatically expire without express revocation.

By signing this authorization, you may be directing me to disclose your health information to a person or organization that does not have the same obligations to protect privacy require of health care practitioners under state and federal law. The disclosure of the information specified above may carry with it the potential for unauthorized disclosure of your protected health information and loss of protection under state and federal law.

You may request that I require the recipient of your protected health information to sign a Confidentiality Agreement in which the recipient agrees to limit its use and disclosure of your information as specified by the confidentiality agreement. If the intended recipient refuses to sign the confidentiality agreement you request, I will not release the information.

I have reviewed the Authorization and I understand it. I understand that the information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy law.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent or Guardian or Witness Date

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Bill of Rights/Registration

BILL OF RIGHTS

Consumers of services offered by Marriage & Family Therapists licensed by the State of Minnesota have the right:

1. to expect that the practitioner has met the minimal qualifications of training and experience required by state law.
2. to examine the public records maintained by the Board of Marriage and Family which contain the credentials of the practitioner.
3. to obtain a copy of the rules of conduct from the Minnesota Board of Marriage & Family.
4. to report complaints to the practitioner, and if not satisfactorily resolved, to file a complaint with the Minnesota Board of Marriage & Family.
5. to be informed of the cost of professional services before receiving the services.
6. to privacy as defined by rule and law. This means that no information will be released from the facility in which the practitioner works without the client's informed, written consent, except for the following:
    a. The practitioner is required by law to report instances of abuse or neglect of a child or a vulnerable adult
    b. The practitioner is required by law and professional codes of ethics to notify proper persons and/or authorities if the practitioner believes there is a danger to a client or another identified person.
    c. The practitioner is required to report admitted prenatal exposure to harmful controlled substances.
    d. ln the event of a client's death, the spouse or parents of the deceased have a right to access the client's records.
    e. The practitioner must produce records or testimony in response to a Court Order and potentially to a subpoena.
    f. Parents or legal guardians of a non-emancipated minor client have the right to access their child's records.
    g. Case discussions with other staff through case management, consultation, testing, and treatment are confidential and are to be conducted as such by all staff.
7. to be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving psychological services.
8. to be respectful, considerate, appropriate, and professional treatment
9. to see information in his/her record upon request.
10. to be involved in the formulation of the treatment plan, the periodic review of plans and progress, and the formulation of the discharge plan.
11. to be informed of treatment options, expected outcome of treatment, expected length of treatment, and cost in language th.at he/she can understand.
12. to discuss needs, wants, concerns, and suggestions with the practitioner.
13. to be advised as quickly as possible if a scheduled appointment time cannot be kept due to illness or emergency.

Signature acknowledges receipt and understanding of these rights.

_____ _____

Signature of client **Date**

_____ _____

Signature of Parent/Guardian **Date**

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NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES/Registration

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

FaithWorks Counseling, LLC is committed to treating and using protected health information about you responsibly. This Notice of Health Information Privacy Practices describes the personal information I collect, and how and when I use or disclose that information. It also describes your rights as they relate to your protected health information.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Understanding Your Health Record/Information

Each time you visit FaithWorks Counseling, LLC/Anchor Counseling a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment. and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which I can assess and continually work to improve the services rendered and the outcomes achieved.

Your Health-Information Rights

Although your health record is the physical property of FaithWorks Counseling, LLC/Anchor Counseling, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and revoke your authorization to use or disclose health information except to the extent that action has already been taken

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES/Registration (2)

Responsibilities of My Practice
FaithWorks Counseling, LLC is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to my legal duties and privacy practices with respect to information I collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if I am unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

I reserve the right to change my practices and to make the new provisions effective for all protected health information I maintain. Should my information practices change, I will give you in person, or mail a revised notice to the address you've supplied to me.

I will not use or disclose your health information without your authorization, except as described in this notice. I will also discontinue using or disclosing your health information after I have received a written revocation of the authorization according to the procedures included in the authorization.

I have received the Health Information Privacy Practices notice and I have been provided an opportunity to review it.

Name_____ Birth Date_____

Signature_____

Date_____

Office or Client Copy