Collaborative Counseling, LLC
Clinic Information and Client Consent Policies

Overview of Therapy

Therapy varies depending on the therapist, the client, and the client's particular situations and goals. Your therapist may use many different methods to deal with your particular situations and goals. In order for therapy to have the best outcome**,** you will likely have to invest energy in the process and work actively on things we talk about both during and between our sessions.

Therapy can have benefits and risks. The risks may include experiencing uncomfortable feelings like sadness, guilt, anger, anxiety, or frustration when discussing aspects of your life or relationships. Research shows psychotherapy to have benefits that can include better relationships, solutions to specific problems, increased life satisfaction, improved physical health, and significant reductions in feelings of distress. However, it is impossible to predict or guarantee what you will experience.

Your first few sessions will involve an evaluation of your situation and needs, we will also discuss your goals. During this time, you and your therapist together will decide if your therapist is the best person to provide you with therapeutic services. Therapy can involve a significant investment of time, energy, and money so it is important you select a therapist you are comfortable working with. If at any time you have questions about any aspect of your work with your therapist, please discuss with your therapist or feel free to contact the Owner, Naomi Doriott Larson at 763.210.9966 or via email at naomi@collaborativemn.com. If you decide you do not want to continue in therapy, please inform your therapist. We do recommend a final session for closure. If you want help finding another therapist or other appropriate resources, we will happily assist you in doing so.

Confidentiality and Data Privacy Policy (HIPAA)

This notice describes how your health information may be used and disclosed and how you can access this information. Please review this and all other policies carefully. We are committed to protecting our clients' privacy and confidentiality. A state and federal law, the Health Insurance Portability and Accountability Act (HIPAA) went into effect on April 14, 2003 and requires us to inform you of this policy. HIPAA requires us to continue maintaining your privacy, to give you this notice, and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment; for example, a review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information to obtain payment of the services you receive (e.g. we can send information as requested by your health insurance plan). We may use or disclose your health information for our normal healthcare operations (e.g. staff who complete scheduling, training of staff who have signed confidentiality agreements, etc). We may share your medical information with our business associates, such as a billing service, administrative staff, etc… To protect your privacy and confidentiality we have a written contract with each business associate requiring them to protect your privacy. We may consult with other licensed professionals in counseling as necessary, protecting your confidential information, to gain guidance for your treatment. We may use your information to contact you (e.g. mailings). We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine, or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. Finally, we may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner(s). Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may

request in writing we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use the address or telephone number you have on file with us. You have the right to transfer copies of your health information to another practice. You have the right to see or receive a copy of any of your health information. You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W, Room 509F Washington, D.C. 20201. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact the Owner of Collaborative Counseling, Naomi Doriott Larson, via phone at 763.210.9966 or via email at naomi@collaborativemn.com.

The State of Minnesota and Wisconsin laws impose some limitations to your rights to confidentiality. The following is a list of situations in which you may lose your right to confidentiality:

- If you make a specific threat to harm yourself or someone else (and the risk of danger is deemed imminent), your therapist must take appropriate steps to protect you or warn the appropriate parties.
- If your therapist suspects you have physically or sexually abused or neglected a child or vulnerable adult, your therapist must make a report to the proper authorities. This includes some cases of domestic abuse when a child is exposed to weaponry or is physically threatened and/or used as a weapon.
- If you are pregnant and using a controlled substance such as heroin, cocaine, phencyclidine, methamphetamine, or their derivatives.
- When there is a court order to release your records to the legal authorities.
- If an investigation or disciplinary proceeding is mandated by the licensing board and your information is involved in those proceedings.

If you are a minor, you have a limited right to privacy in that your parents may have access to your records. However, if the therapist believes sharing this information will be harmful to you, confidentiality will be maintained to the limits of the law.

Group Therapy: The right to confidentiality is addressed in the group setting. However, Collaborative Counseling and group therapists are not responsible for any breaches of confidentiality by group members.

There are instances in which individuals associated with Collaborative Counseling have duties that require access to the information you may share for claim processing, scheduling, reports, consultations, etc…

Release of Records

The laws and standards of this profession require that we keep treatment records. You are entitled to examine and/or receive a copy of your records if you request it in writing. In order to see your records, you and your therapist will need to discuss the contents together. Because these are professional records, they can be misinterpreted and/or be upsetting to people who are not mental health professionals. If you prefer not to discuss them with your therapist and your therapist believes seeing them could be emotionally damaging, they will send them to a mental health professional of your choice.

All information regarding patients is considered strictly confidential and will not be given out to other entities or individuals without your written consent. In the event of a request for transfer of records, the records will be forwarded upon completion of a consent form and a payment fee based on the current legal maximums allowed by the Department of Health. Copies of records are available for a $17.21 processing fee, plus $1.30 per page for copying.

Crisis Response and Contacting Your Therapist
Your therapist is often not immediately available by phone because we do not answer the phone when in session with clients. Feel free to leave a voicemail and your therapist will get back to you within 5 business days (Monday through Friday). We will make every effort to return your call as soon as possible (usually within a few hours and almost always within 24 hours Monday through Friday). If you are difficult to reach, please leave times you will be available. If you want discretion used when calling you or leaving a message for you, please let us know in advance. At times when your therapist will be unavailable for an extended time, you will be provided with a backup therapist to contact if necessary.

Outpatient mental health services are consultative in nature; we are not equipped to handle emergencies. Please call the Crisis Connection 612.379.6363, 911 or go to the nearest hospital emergency room if you are in crisis. Phone consultations with clients, or parents of clients, during or after business hours, are not a part of the services we are able to offer at Collaborative Counseling. Please document any concerns you might have between appointments, and bring them to your next session so that we might discuss them. Phone consultations with prescribing physicians, school districts, and other collaborative services are always available free of charge for our clients, with your signed authorization for release of confidential information.

Emailing or Text Messaging Your Therapist
Electronic communication (email and texting) is a commonly used way of exchanging information, however, there is no guarantee that this form of communication is secure. Collaborative Counseling cannot ensure the security or privacy of the information exchanged. Email is not an appropriate means for communicating about your therapy or about a mental health emergency. If you want to email your therapist please confirm their policy and preference since each clinician's preference may vary.

Although they add convenience and expedite communication, it is very important to be aware that email and cell phone communication can be accessed relatively easily by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through them. Therapist emails and data on computers may not be encrypted, it is always possible that faxes can be sent erroneously to the wrong address, and computers, including laptops, may be stolen. Our computers are equipped with a firewall, virus protection and passwords, and we also password-protect and back up all confidential information from computers (stored off-site) on a regular basis.

You should also know that any email or text messages your therapist receives from you and any response sent back to you may become a part of your legal record and may be revealed if your records are summoned by a legal entity.

Please notify your therapist if you decide to avoid or limit, in any way, the use of emails, cell phones SMS (text), faxes, or storage of confidential information on computers. If you communicate confidential or private information via SMS (text) or email, we will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and your therapist and our clinic will honor your desire to communicate on such matters via email or text messaging.

Please do not use email or faxes for emergencies. Due to computer or network problems, emails may not be deliverable, and your therapist may not check my emails or faxes daily. We prefer to use email to arrange or modify appointments only. If you email me content related to your therapy sessions, please note that email is not completely secure or confidential. If email communication outside of therapy requires more than 5 minutes to read and respond to, I may charge for my professional services rendered in 15-minute increments. Please indicate if you intend to pay these charges, or I will save it for review during your appointment time.

Social Media Policy
Please note that Collaborative Counseling is on various social media websites as a way to market the services we offer. To protect your confidentiality Collaborative Counseling encourages you to consider the public nature of social media before liking, fanning or following our social media postings. Messaging on Social Networking sites such as Twitter, Facebook, Google+, or LinkedIn is not secure. It could compromise your confidentiality to use wall

postings, @replies, or other means of engaging with me online if we have an already established client/therapist relationship. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you have questions, please contact your therapist or our clinic administrator who can help clarify questions you may have.

Financial Responsibility
Most health insurance plans include behavioral health coverage, however, the exact coverage varies widely with the different health insurance plans. Clients are responsible for services received not covered by insurance; therefore, we strongly recommend you call your insurance company to verify your coverage. When you call your insurance company, ask to verify your coverage for outpatient mental health. It is also your responsibility to keep us up-to-date with any changes in your benefit plan and/or insurance coverage.

Cancellation Policy
Please give a 24-hour notice if you will not be able to keep an appointment. If you do not give a 24-hour notice, you will be charged one-half (1/2) of a regular session fee. This is not billable to most insurance companies. Kindly phone us with cancellations as soon as possible to avoid late cancellation fees, and out of respect to others who may need that appointment time.

Cases Involving the Legal System
Our services are not to be utilized for testimony, custody disputes, disability or any other form of court evaluations. We are happy to refer you to other providers in the area who provide these services should you require any court evaluation or testimony. Should we be subpoenaed or mandated by the courts to testify, you will be required to pay all fees associated with the writing of case summaries and/or other reports, consultation with attorneys, consultation with mental health professionals, review of other records, and any other preparation. The client will also need to pay for other fees incurred including travel time, meals, parking and all other costs associated with the court time. Therapist testimony will require that the client be billed directly, as insurance will not cover these charges. All fees must be paid prior to the date of testimony. Court appearances are significantly more expensive due to the complexity and difficulty of being involved in such matters.

Treatment of Minors
Treatment of children and adolescents is best done with the involvement of their caregivers and parents. Children with unmarried or divorced parents typically benefit from regular contact with both parents, unless it can be shown that this contact threatens the child's safety or mental health. Therapy is confidential, but not secret. Parents are entitled to understand the nature of their child's problem as well as the method and course of treatment. Both parents have right of access to medical or mental health treatment, regardless of custody unless the custodial parent provides us with a court order limiting access or communication.

Parents may have access to their child's medical records, however, often with mental health records it is often determined to not be in the best interest of the child or adolescent. Minnesota and Wisconsin State Law entitles parents with legal custody to information regarding their child's treatment and generally entitles parents to copies of their child's health records. Minnesota and Wisconsin State Law allows for an exception to the release of copies of health records in the case of mental health. Mental health records are kept confidential to protect the child's ability to speak freely about their relationships and concerns regarding each parent. It is rarely in the child's best interest to have therapy records read by parents. Parents are encouraged to meet regularly with their child's therapist and to stay informed of what is occurring in therapy. Arrangements can be made to observe appointments, review records in the office, and freely share information regarding the child's health and treatment.

In cases where there is joint (split) legal custody between parents or guardians who are not married or cohabitating, we require both parents' authorization and signature for treatment of their minor child/children. We believe it is best to identify and resolve potential parental conflicts or disagreements before treatment begins. If one parent is unavailable or unwilling to consent and we have a note from the child's medical doctor determining that it is appropriate to proceed with the consent of only one parent, if needed.

Counseling with children is done with the goal of providing an emotionally neutral setting to process current concerns and emotions. The usefulness of such therapy is extremely limited when the therapy itself becomes

simply a matter of dispute between the parents or between parents and children. With this in mind, and in order to best help children in therapy we follow the following agreements in our therapy with minors:

- Counseling and therapy will not yield considerations about custody. Collaborative Counseling recommends that parties who are disputing custody consider participation in alternative forms of negotiation and conflict resolution, including mediation and custody evaluation, rather than settle a custody dispute in court.
- The therapist of your child has the primary responsibility, as your child's therapist, to respond to your child's emotional needs. This includes, but is not limited to, contact with your child and each of his or her caregivers, and gathering information relevant to understanding your child's welfare and circumstances as perceived by important others (e.g. pediatrician, teachers). In some cases, this may include a recommendation that you consult with a physician should matters of your child's physical health be relevant to this therapy.
- We ask that all caregivers remain in frequent communication regarding your child's welfare and emotional well-being. Open communication about his or her emotional state is critical. In this regard, we invite each of you to initiate frequent and open exchanges with your child's therapist.
- We ask that all parties recognize and as necessary, reaffirm to the child, that the therapist is the child's helper and not allied with any disputing party or familial side.
- Please be advised regarding the limits of confidentiality as it applies to psychotherapy with a child including but not limited to these considerations:
    - We keep records of all contacts relevant to your child's well being. These records are subject to court subpoena and may, under some circumstances, be solicited by parties (including attorneys) in divorce or other legal proceedings.
    - Any matter brought to your therapist's attention by either parent regarding the child, may be revealed to the other parent. Matters brought to our attention that are irrelevant to the child's welfare may be kept in confidence.
- We are not responsible for routine communication with parents who do not attend appointments and we cannot routinely contact the non-custodial parent after each appointment. We are unable to send a summary letter, note, or e-mail after each appointment, unless payment arrangements have been made for this service. Expectation is that parents will communicate with each other openly regarding treatment and that each parent will cultivate a healthy relationship and open communication with their co-parent and their child.

Rates

Billing Code	***Service***	***Length of Visit***	***Fee for Service***
90791	Intake	45-50 minutes	$275
90832	Psychotherapy 30 minutes	16-37 minutes	$100
90834	Psychotherapy 45 minutes	38-52 minutes	$175
90837	Psychotherapy 60 minutes	53 minutes plus	$225
90847/90846	Family/Couple Therapy	45-50 minutes	$175
90785	Interactive Complexity (add-on)	n/a	$100
90839/90840	Psychotherapy for Crisis	60 minutes/add 30 minutes	$200/$100
90853/90849	Group Therapy	60-90 minutes	$100/$250
96150-96154	Health/Behavior Assessment	15 minute units	$50/unit
H2019	DBT Group Therapy	15 minute units	$50/unit
96101-96120	Psychological and Neuropsychological Testing	60 minutes	$200
96116	Neurobehavioral Status Examination	60 minutes	$200
90887	Feedback Review of Assessment	60 minutes	$200
97532	Cognitive Rehabilitation	15 minute units	$50/unit
Billed to client	Phone Calls, Letters, Emails or Reports	15 minute units	$50/unit
Billed to client	Court Appearances	Varies	$300 per hour
Billed to client	Late Cancel or No Show	n/a	Half Session Fee

Collaborative Counseling

Client Information

Client's name: _____ Date of birth: _____

Address: _____
Street City State Zip Code

Home phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____
Do you consent for the use of your email by Collaborative Counseling? Please circle: YES or NO

Social Security Number of Client (or Parent/Guardian if applicable): _____

Employer (Note: if intake is for child, write employment for both parents.)

Name of Employer: _____ Address: _____

Primary Insurance Information

Carrier	***Provider Phone Number***	***Policy ID***
Group Number	***Policy Holder Name (if not client)***	***Policy Holder Date of Birth***

(If Applicable) Secondary Insurance Information

Carrier	***Provider Phone Number***	***Policy ID***
Group Number	***Policy Holder Name (if not client)***	***Policy Holder Date of Birth***

Collaborative Counseling, LLC, reserves the right to change the policies, practices, and procedures described in this document. We will notify you in writing of any significant changes. My signature below indicates I am consenting to treatment at Collaborative Counseling, LLC, and have received and understand the contents of the clinic's counseling Policies, including the Notice of Privacy Practices (HIPAA). If I have questions, the information has been explained and/or summarized for me.

_____ _____
Signature (Client or Legal Guardian if client is under 18) Date

My signature below certifies my consent to the billing and payment policy. All of my questions have been answered and the policy regarding billing is fully agreed to. I also, by signing below, consent to taking full responsibility for any outstanding bill for services rendered. I also agree that my signature authorizes Collaborative Counseling, LLC to pursue any outstanding balance due to them should I not follow the clinic policy.

_____ _____
Signature (Client or Legal Guardian if client is under 18) Date

Collaborative Counseling

Billing Information and Policy

Our billing policy for services, which are the client's responsibility, is as follows:
Please initial each item:

_____ All co-pay, co-insurance, sliding fee scale, payment plan, and deductible amounts are due on the date of service. If client payments are not made on the date of service, or if arrangements for an alternate payment plan have not been made, charges will be submitted to the client credit or debit card on file in our office.

_____ Clients will not receive a statement for services that are the responsibility of their insurance company. Nor will clients receive a statement if their balance has been paid in full on each date of service, and their account is current.

_____ Any counseling services that are not eligible for coverage through a client's insurance plan become the responsibility of the client. If not paid on the date of service, these charges will be submitted to the credit card on file either on the date of service, or on the date we receive notice that services have been denied. Receipts for all credit or debit card transactions will be mailed to clients along with their statement. Payments due that are not paid are subject to fees within the limitations of the law.

_____ A late cancel fee will be submitted to the credit or debit card on file for clients with private insurance coverage, a payment plan, or a sliding fee scale, which includes cash clients. This charge is submitted on the date of service only if clients misses an appointment without giving a 24-hour notice to cancel or do not show up to a scheduled appointment without notice.

_____ By signing you agree that: I understand that if I default on any payment obligations as called for in this agreement Collaborative Counseling, LLC will have the right to forward my information to collections, and in the event that it becomes necessary to utilize a collection agency to resolve a past due account, up to an additional 30% will be assessed to my account to cover the costs of this action. I agree to pay all costs of collection, including but not limited to collection agency fees, court costs, and attorney fees. I understand and give my consent for Collaborative Counseling, LLC, to forward my information to collections, should I default on this agreement and fail to pay my Balance Due.

Credit Card Information

We require all clients to keep a credit card on file in accordance to the above billing policy.

Name on Credit/Debit Card: _____ Billing Zip Code for Card: _____

Credit Card Type: Visa: _____ MasterCard: _____ Discover: _____ American Express:_____

Card #:_____ Exp Date: _____ 3 Digit # on Back of Card: _____

I acknowledge I have been informed and agree to the above billing policy. I understand that payments are due on the date of service. I agree that Collaborative Counseling, LLC may bill the credit card on file for any payments which are my responsibility, that have not been paid on the date of service. I hereby consent for Collaborative Counseling, LLC to utilize my credit card information for any outstanding balance.

_____ _____ _____

Signature of Credit Card Holder, Authorizing Payment | Date Signed | Initials of Witness