

### Treatment Contract/Registration

**WELCOME!** The most important goal of therapy is to help you feel and do better in your life. 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 and supportive friends during a crisis and that you assume responsibilities for helping yourself. Treatment will be provided in the least restrictive environment possible.

We understand at times you may be in a psychological or life threatening crisis. Since our counselors are frequently in session 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 practitioner.

In a crisis situation please do the following:

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

If you are in urgent need to talk to your therapist, please call or text your therapist. Include a phone number in any message you leave AND indicate that it is an urgent matter

Signatures indicate that you have read, understand and agree to the above.

_____	_____
Client Signature	Date
_____	_____
Parent Signature	Date
_____	_____
Therapist Signature	Date

CLIENT INFORMATION

Client name \_\_\_\_\_ Email \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship Status \_\_\_\_\_  
Social Security # \_\_\_\_\_ Employer \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

INSURANCE

Primary Insurance Co: \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
ID# \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Co-pay amt per visit \_\_\_\_\_ Deductible \_\_\_\_\_ Yes: \_\_\_\_\_ No: Amount \_\_\_\_\_ : Effective date \_\_\_\_\_ :  
Prior Authorization or Referral Name and phone \_\_\_\_\_

POLICY HOLDER INFORMATION

Insured Person \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Relation to Client \_\_\_\_\_ Employer \_\_\_\_\_

SECONDARY INSURANCE

Insurance Co: \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
ID# \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

RESPONSIBLE PARTY

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

I assign all benefits from insurance or other third-party coverage to be paid. I understand that by signing this form I acknowledge that if my insurance carrier or HMO/PPO does not cover certain service, I will pay for them in full. I authorize the release of any medical information necessary to process any claim for services provided. A photocopy of this authorization may be honored.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

### Consent, Disclaimers, Fees, Waivers, and Other Conditions for Service

\_\_\_\_\_: I/we, the undersigned, understand that these sessions are for individual, family and/or couple therapy. If more in-depth treatment, including possible use of medications, is needed in the opinion of ACTS Therapy LLC, I/we understand that the appropriate referrals for me/us will be made according to professional standards of practice.

\_\_\_\_\_: I/we understand that a confidential file (the medical record) about my/our appointments and proceedings will be kept. I/we can examine this file in the therapist/counselor's presence at a time arranged in advance by the client(s). Client notes will not be provided to any lawyer's subpoena due to client confidentiality. If this is a divorce or custody case all parties must sign a release for client notes to be released including the minor child.

\_\_\_\_\_: I/we understand that release of the medical record requires my/our signature on a statement of consent. In addition, I/we understand that exceptions to confidentiality are:

- Indicators that a minor is being abused or neglected
- Indicators that an elder or vulnerable adult is being abused or neglected
- Indicators that a pregnant female is abusing alcohol and/or drugs
- Indicators that a family member or I present a risk for causing harm to self or others

Should ACTS Therapy LLC find or suspect that any of these conditions are present, I/we expect that a break of confidentiality will occur to protect me/us and/or others.

\_\_\_\_\_: I/we understand that ACTS Therapy LLC retains the professional privilege and right to, in an appropriate manner, confidentially consult with other professionals regarding my/our situation. Names will not be used unless serious danger in some form is believed to be imminent.

\_\_\_\_\_: I/we understand that there is a right to privacy in the individual, couple, and or family therapy process ACTS Therapy Therapists are not in a position to monitor me/us on a daily basis. Consequently, responsibilities that I/we agree to fulfill when receiving services are:

- To independently schedule and attend appointments with sufficient frequency to meet my/our needs
- To voluntarily notify the therapist/counselor about any dangers and risks, and discuss the circumstance
- To monitor my own phone, text, email or technology if choosing to contact a therapist in this manner.

\_\_\_\_\_: I/we understand ACTS Therapy LLC fee for service and notification guidelines: We will also fill out a credit card information sheet to be used for co-pays or deductibles as stated on that paperwork (please read that page carefully)

- If utilizing insurance:
  - Eligibility for services will be attempted if client(s) gave insurance information before first appointment. HOWEVER this does not guarantee payment for the services. Some situation that may fall into this category are as follows:
    - A diagnosis that your insurance company deems "not medically necessary"
    - Marriage/couple's counseling
    - A diagnosis that your insurance company has excluded from coverage

- A service rendered that is not covered under your Member Benefit Contract
- While we will attempt to obtain prior authorization your insurance company may deny continued sessions for a variety of reasons. If this happens and you decide you would like to continue in therapy, there is an appeals process with your insurance company.
- If your insurance no longer covers services and you wish to continue therapy, you may do so with the understanding that you are responsible for the total payment at the time service is rendered.
- You are responsible to find out if a deductible is required and to pay that until amount reached and to pay full amount of fee until deductible is met
- Co-pays and Deductibles are due at the beginning of each session or as agreed upon with therapist.
- Cancellations or changes must be arranged 24 hours in advance. A charge will be imposed if the client or clients “no show”.

\_\_\_\_\_: I/we understand that should ACTS Therapy LLC be requested to render any type of service on my/our behalf “between sessions” and/or “out of session”, I/we agree to ACTS Therapy at the rate of \$40 per 15minute increment (\$40 minimum). This includes consultations, phone calls, letters, emails and text. This does not include time to schedule appointment or notification of a change in appointments.

- Additional fees may be charged for assessments or testing or educational material utilized to reach your goals
- Court proceedings disrupt all client at ACTS Therapy as such time to attend court proceedings will be charged \$300 per hour. This will include all time for preparation, travel and wait time as well as the court time. Travel fees may also be charged for mileage and hotel if necessary. This is not billable to insurance.

\_\_\_\_\_: I/we understand that the internal office area of ACTS Therapy or satellite locations are covered under HIPPA. The commons area including receptionist area is not protected under HIPPA

\_\_\_\_\_: I /we understand that technology such as text messages, emails or other media are not protected by HIPPA. If you choose to text, email or contact your therapist utilizing technology the therapist is not responsible for breach of confidentiality. It is the policy of ACTS therapy to allow each therapist to determine policy regarding responding to text, email or other technology.

\_\_\_\_\_: I/we understand that a therapy dog is on site with some of our therapists. If allergic please request a dog free zone.

\_\_\_\_\_: I/we understand that if our therapist is not fully licensed they will follow the guidelines of their board and the state of Minnesota in regard to billing and supervision. This provides the client with the expertise of your therapist as well as the consultation of a supervisor licensed by the state of Minnesota.

\_\_\_\_\_: I/we have been provided with a copy of the Bill of Rights

\_\_\_\_\_: I/we understand that there is no guarantee that I/we will benefit from receiving individual, couple, and/or family therapy.

I/we am/are seeking services from ACTS Therapy LLC under my/our own free will and understand the content explained in this agreement. ACTS Therapy LLC has reviewed each item with me/us. I/we understand and accept the conditions outlined above and acknowledge that I/we am/are free to discontinue services at any time by providing appropriate notice. We need your signature giving your consent to these policies in order to proceed with providing therapy to you.

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Therapist Date

**Release of Information Consent Form**

I \_\_\_\_\_ authorize **ACTS Therapy LLC** to use and disclose the specific health information described below concerning:

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax: \_\_\_\_\_

**TO BE RELEASED TO:** Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax: \_\_\_\_\_

\_\_\_ Academic testing results

\_\_\_ Psychological testing results

\_\_\_ Behavior programs

\_\_\_ Service plans

\_\_\_ Case notes

\_\_\_ Summary reports

\_\_\_ Intelligence testing results

\_\_\_ Vocational testing results

\_\_\_ Medical reports

\_\_\_ Entire record

\_\_\_ Personality Profile

\_\_\_ Psychological reports

\_\_\_ Progress reports

\_\_\_ Other (specify) \_\_\_\_\_

The above information will be used for the following purposes

\_\_\_ Planning appropriate treatment or program

\_\_\_ Continuing appropriate treatment program

\_\_\_ Determining eligibility for benefits or program

\_\_\_ Case review

\_\_\_ Updating files

\_\_\_ Other (specify) \_\_\_\_\_

I understand that I may revoke this consent at any time by providing written notice and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive this information

Client's name (please print) \_\_\_\_\_

Client's signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse/Parent Signature: \_\_\_\_\_ Date \_\_\_\_\_

Witness (if client is unable to sign: \_\_\_\_\_ Date \_\_\_\_\_

Person informing of client of rights: \_\_\_\_\_ Date \_\_\_\_\_

## **Payment Contract for services**

Bill to: Person responsible for payment of account: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

### **Federal Truth in Lending Disclosure Statement for Professional Services**

#### **Fees for Professional Service**

I understand that the below fees are the reasonable and customary fees charged by ACTS Therapy LLC. If for any reason my insurance company or EAP refuses payment I agree to pay ACTS Therapy LLC the following rates per session.

A fee of \$220 for Intake/Assessment

A fee of \$150 for individual therapy (up to a 45-minute session)

A fee of \$180.00 for Individual Therapy (52 + minute session)

A fee of 175.00 for Family/Couples Therapy

Cash Fee is \$120 for up to a 45-minute session.

Late Cancellation Fee: \$80

Client/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

**Authorization and Consent to Treat Minors (Children and teens under age 18 years)**

As the parent/guardian of \_\_\_\_\_,  
DOB \_\_\_\_\_

I am authorizing and giving my consent for ACTS Therapy LLC to provide psychological services to my adolescent/child. I understand that I may revoke this consent at any time. My signature indicates that I am legally able to give such consent and that no other parties are required to be notified in order for their consent to also be given.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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### Special Confidentiality Agreement for Parents

Your child has the right to private, confidential communication with the therapist providing care. This means that some of the issues that they discuss will stay between them and that we will not disclose that information to anyone, including you, unless we have been given permission by your child to do so. We need your child to be open and honest with us in order to understand and treat the full range of issues your child is dealing with, and they may be too scared, angry, or ashamed right now to share those issues with you. We also recognize it is very important for you to know what your child is going through in order to do your job as a parent, which is why we will always encourage your child to be honest with you. We will encourage, prepare and support your child so that they feel safe enough to share those issues with you.

Consistent with ACTS Therapy policy, Minnesota law, and the federal patient privacy law known as HIPAA, your child will need to give his/her consent for us to disclose:

- All Mental Health records for children age 16 or older.
- All information concerning pregnancy, sexual activity, STD's and drug/alcohol use or abuse, regardless of the child's age
- Any information that your child's provider believes, if released, could cause harm to your child or to someone else, or that would significantly harm the treatment relationship with your child.

You should know that this confidentiality has limits. If there is any threat to your child's life, we have the duty to inform you and help to create a plan for safety. In addition, there are situations that we are mandated to report and cannot keep confidential. Those situations include: threats against another person, physical or sexual abuse, neglect, and pregnant women who report using drugs

We recognize how challenging it can be for a parent to raise a child, especially when the child has problems or a mental illness. We know how badly you might want to know everything your child has kept a secret from you, too. We want to be your partner in supporting your child's physical and mental wellbeing, and even when we can't discuss certain details about your child with you, we will always be there for you; guiding you and giving your child the best advice possible to protect him/her and encourage healthy decisions, including being open and honest with you.

I have read this from and I understand that I may not be able to receive all the information my child provides to ACTS Therapy LLC.

\_\_\_\_\_  
Parent /Guardian Signature

\_\_\_\_\_  
Parent/Guardian Signature

Date \_\_\_\_\_

Date \_\_\_\_\_

Adapted from Prairie Care notice

**Due to high deductibles and co-pays. We need to request this information for payment for services. If you have a HSA account use that card here. Thank you.**

### **Credit Card Authorization**

Authorization for ACTS Therapy to be good for one year:

Client Name:

Cardholder Name

Credit card Type (Please Circle One)

Visa or Master Card

Card Number:

Expiration Date

CSC (3 digit code on back)

Address of Cardholder:

Amount to be charged following these guidelines:

Late Cancel = \$80.00 to be charged at time of late cancel

Deductible: amount to be billed from EOB from your insurance company

Unpaid balance: If clients determine not to continue utilizing ACTS Therapy and have a balance.

Unpaid Co-pay's will be charged if not paid at next session

If you choose to have a monthly bill sent to you and not pay weekly. The balance of monthly bill is to be paid upon receipt of statement

Receipt will be sent to address of cardholder any time a charge is made to ACTS Therapy LLC

Signature of cardholder

Date:

## **Bill of Rights**

**Consumers of marriage and family therapy services offered by marriage and family therapists licensed by the State of Minnesota have the right:**

- 1. To expect that a therapist has met the minimal qualifications of training and experience required by state law;**
- 2. To examine public records maintained by the Board of Marriage and family Therapy which contain the credentials of therapist;**
- 3. To obtain a copy of the code of ethics from the Board of Marriage and Family Therapy, 2829 University Avenue SE, Suite 330, Minneapolis, MN 55414-3222;**
- 4. To report complaints to the Board of Marriage and Family Therapy by calling (612)617-2220;**
- 5. To be informed of the cost of professional services before receiving the services;**
- 6. To privacy as defined by rule and law;**
- 7. To be free from being the subject of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services;**
- 8. To have access to their records as provided in Minnesota Statutes, section 144.335, subdivision 2 and**
- 9. To be free from exploitation for the benefit or advantage of a therapist**