Informed Consent Signature Page

My signature on this Agreement for Therapy Services/Informed Consent means I have reviewed, understand and consent to services and I have read and understand the Privacy Practices, Mental Health Bill of Rights and Confidentiality rules and indicates my consent to participate in therapy at Conscious Healing Counseling. There is a copy of these forms for my review on the CHC website and my therapist reviewed a copy of these forms at the initial appointment.

I have read and had explained the following materials pertaining to therapy. A copy of this has been offered to me by the therapist.

\_\_\_\_\_ I have received and understand the Notice of Privacy Policy regarding my privacy rights per federal HIPAA laws and have access on the website.

\_\_\_\_\_ I have received and understand the Minnesota Client Bill of Rights. If you have a complaint, concern or issue with your care please speak with your therapist directly. If that is not possible you may contact the CEO by calling the main number: 612-900-0233. You may also contact the licensing board directly to file a complaint. All licensing board contact information is in the Minnesota Bill of Rights located on our website or waiting room wall.

\_\_\_\_ I have received and understand the Telehealth Informed Consent Form. I understand that there are risks and consequences from telehealth as outlined in the consent.

\_\_\_\_ I have received and understand COVID policies at CHC

\_\_\_\_ I have received and understand the Liability Wavier/Walk and Talk Consent (if applicable.)

\_\_\_\_I am agreeing to participate in the following types of services, while acknowledging that the course of therapy may change, and the participants my change of both parties.

\_\_\_\_\_\_ individual \_\_\_\_\_\_Couples \_\_\_\_\_\_Family \_\_\_\_\_\_Group Therapy

\_\_\_\_\_ I understand failure to attend a session without giving a forty-eight-hour notice will result in a fee of $75. A no-show/no call will result in a $100 fee.

\_\_\_\_\_ I understand I am responsible for any outstanding fees. A credit card is kept on file. I understand that insurance is billed with the following codes with the following rates:

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| --- | --- |
| **90791** Intake session/DA | $200.00 |
| **90834** 15-52 minutes individual therapy  | $130.00 |
| **90837** 53+ minutes individual therapy | $165.00 |
| **90847** Family session  | $165.00 |
| **90839** Crisis 30-74 minutes  | $165.00 |
| **90785** Interactive Complexity Code (add on)  examples: Play equipment, Physical device ,an interpreter | $100.00 |
| **98967** 11-20 minute phone call | $55 |
| **98969** 21-30 minute phone call | $75 |

\_\_\_\_\_ Divorced Parents bringing their child to therapy should communicate the status of legal custody and a method of communicating with each parent. CHC will consider the parent bringing the child to the intake appointment as the Financially Responsible person for billing/payment

\_\_\_\_ The security of client information is not guaranteed when information is left on a voicemail, texted or emailed. Therapists many share a fax machine with other therapists and those therapists will work together to ensure privacy of information.

\_\_\_\_\_ Legal action: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on your therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested . However, if CHC appearance at court is required by law and you signed a release form allowing this, CHC fee is $2,500 per day and must be paid in full 30 days prior to the expected court date.

\_\_\_\_ Therapy with minors: Parents have a right to their minor child’s file, however therapy works best if the parents allow the child some privacy in therapy.

\_\_\_\_\_ **Emergency Procedures: In the event of a life threating emergency, call 911. In event of other crisis, call Crisis Connections at 612-379-6363 or 211 First Call for Help. If you have a crisis plan with your therapist, follow that first.**

\_\_\_\_ **(If applicable)** I understand I am working with an intern or pre-licensed practitioner who is working under a direct supervisor. The pre-licensed staff may not be credentialed with Optum insurance.

\_\_\_\_ Inactive Records: Your complete record will be retained for seven years after you have completed treatment. At the end of the seven years, the record will be entirely destroyed, leaving only the name of the client and date of record destruction.

\_\_\_\_ Therapy is successful for some people, moderately successful for others, and for some not successful at all. It is important to attend sessions at the frequency that the therapist recommends. The initial symptoms of problems that were presented to the therapist may initially become more intense. Discussion of treatment goals, diagnosis and direction can be brought up with my therapist at any time. You may stop therapy services at any time after giving your therapist 24-hour notice or discussing in session.

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

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

Client (Minor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

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