Nancy Dawn Van Beest, LMFT
Licensed Marriage and Family Therapist
License #2052 State of Minnesota
MN Couple Therapy Center
1611 County Rd. B, Suite 204 Roseville, MN 55113
651-340-4597

INFORMED CONSENT, PRIVACY POLICIES (CONFIDENTIALITY) AND AGREEMENT TO RECEIVE SERVICES

Introduction
This document provides important information to you about your treatment and services. The purpose is to help you make an informed decision about participating in treatment. According to the ethics of the Marital and Family Therapy profession, everyone participating in the session is part of the treatment unit and is a client. Therefore, each person who will be in the session must read and sign this consent form. Please read the entire document carefully and ask your therapist any questions you may have regarding its contents before you sign it.

Participation and Reactions
Participating in therapy can result in a number of benefits to you, including a better understanding of your personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that led you to seek therapy. You may experience improvement in self-confidence and self-esteem, reduced anxiety and improved mood, and increased comfort at work, school, on the job or in social settings. Working toward these benefits, however, requires effort on your part and can sometimes result in clients experiencing discomfort. Intense feelings of sadness, guilt, anxiety, depression, loneliness, or helplessness may be aroused. Such feelings can be a normal part of the therapy process, and are usually temporary. The issues you work on in therapy can also result in unintended or unexpected consequences for personal relationships.

It is my intention to provide services that will assist you in determining and reaching your goals. I believe therapists and clients are partners in the therapeutic process, and we will work together to determine the best treatment options for you. However, any decisions regarding your choices and options belong to you and should be carefully considered. For instance, the decision to stay together as a couple or to separate, can only be made by that couple. We can discuss your progress at any time and explore other strategies or options if you feel you are not making the progress desired. Due to the varying nature and severity of problems and the individuality of each client, I am unable to predict length of therapy or guarantee a specific outcome or result. If you are ever concerned that our work together is not helping, let's discuss it.

Client's Rights
1. You have the right to decide to end our psychotherapy work at any time without prejudice. If you wish, I will provide you names of other qualified therapists.
2. You have the right to ask any questions about procedures used during therapy.
3. You have the right to refuse the use of any therapeutic technique. I will inform you if I intend to use any unusual procedures and explain any risks involved.
4. You have the right to learn about alternative methods of treatment.

Privacy and Confidentiality
The confidentiality of all counseling interactions is protected by law. Anything you tell me is considered privileged information and will be held in confidence by me. I will not release any information to others about you unless you give me explicit permission to do so in writing. However, there are certain situations in which, as a therapist, I am mandated by law to reveal information obtained during therapy to other persons or agencies without your permission. Also, I am not required by law to inform you of my action in this regard. These circumstances include: medical emergencies; a threat of danger to yourself or others; reasonable suspicion of current physical/ sexual, child or dependent adult or elder abuse; abandonment or neglect; a court order; third party billing claims requirements; receipt of a properly

executed consent form; and where otherwise legally required (such as to comply with worker compensation laws; or to comply with the USA Patriot Act).

If you participate in couple or family therapy I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. However, it is important for you to know that I utilize a "no-secrets" policy when conducting family or couples therapy, and that **the "relationship" is considered the client**. This means I retain the right to share any information you give me with your partner or family members who participate in therapy, if I feel it is therapeutically important to do so.

Electronic Technology
Please be aware that there are certain risks with the use of any electronic technology with regards to privacy and confidentiality. Faxes can be sent erroneously to the wrong address. Computers, e-mail and cell phone communication can be accessed by unauthorized people which can compromise the privacy and confidentiality of such communication. I sometimes use a cell phone for telephone communication with clients. Most of my client records are kept on an electronic health records system which is HIPAA compliant. Because all mental health providers are being required by law to use electronic health records now, you may not opt out of having your records kept and used electronically. However, I take measures to protect and keep your records secure, including use of a firewall, virus protection, and passwords.

E-mail: You are welcome to use e-mail communication with me, however I will assume that you are doing so with the knowledge and understanding that at this time it is not HIPAA compliant unless I so indicate, and that e-mails can be vulnerable to unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them.

Appointment scheduling and cancellations
Intake sessions are typically scheduled for 60 — 75 minutes and are billed at a higher rate due to the longer time and increased paperwork. All other regular sessions begin at ten minutes past the hour, and last for fifty-three to fifty-five minutes; however I may at my discretion (and with your agreement) extend the time slightly. Appointments are typically scheduled once a week. Experience shows that this frequency allows for greater stability and progress to be made. I don't recommend meeting less often until you are experiencing noticeable symptom reduction and/or greater relationship stability. Your consistent attendance greatly contributes to a positive outcome.

Missing a session: Since scheduled appointment times are reserved especially for you, if an appointment is missed or cancelled without 24 hours' notice by phone, you may be charged the full fee for that session. (Insurance companies will not pay for missed sessions.) Exceptions may be made for illness, certain extreme weather conditions or a genuine emergency. If you should miss a session for any reason, please contact me ASAP. After two no-shows with no contact, all remaining sessions will be cancelled until a conversation has occurred between therapist and client.

Fees for Service
I reserve the right to periodically adjust the following fees; you will be notified of any such adjustments in advance. In addition, this fee may be adjusted by contract with insurance companies or other third party payers, or need-based arrangements with clients.
Fees for service:
$225 – Intake 60 — 75 mins.
$170 – Regular session — 53-55 mins. (effective 2.1.2017)

If you are not using insurance for your therapy and these fees present a financial hardship for you, please do not hesitate to speak to me about my sliding scale, which covers a broad income range.

Insurance: If you wish to use your insurance, please verify and understand the limits of your coverage, as well as any co-payments and deductibles. Co-pays are payable with a personal check, cash or credit card at the time of each session. Most insurance companies require a clinical diagnosis which will become part of their files and your permanent health record. The insurance company may exert a certain amount of influence on the number and frequency of sessions. Not all issues/conditions/problems that are

the focus of psychotherapy are reimbursed by insurance companies. For example, some policies will not pay for relationship or couples' therapy, or will require one of the partners to receive a diagnosis.

If I am not covered by your insurance, you may be able to request out-of- network reimbursement from your insurance, or use your flexible spending account or HSA. Check with your insurance provider about this option, and about what percentage of the fee they will cover. You are responsible for any and all fees not reimbursed by your insurance company, managed care organization, and any other third party payer.

If you are using insurance, this form authorizes me, Nancy Dawn Van Beest, LMFT to release your ICD-10 diagnosis and for it to be printed on your Health Claim Form. You are responsible for all co-pays and/or co-insurance. If you have not met your deductible, you will be charged the session rate until the deductible has been met. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.
_____ **(Initial here) I specifically understand this information.**

Private Pay: Payment is by personal check, cash or credit card at the time of each session. Receipts for payments you make are provided upon request. If your personal check or charge is returned you will be charged a $25 fee.

Therapist Availability
I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. You may leave a message at any time on my confidential voicemail by calling 651-340-4597 and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. Please understand that our group practice is unable to provide continuous 24-hour, weekend or holiday emergency/crisis services.

CRISIS CONTACTS: In an emergency or crisis please call 9-1-1 or go to the nearest emergency room. You may also call: Crisis Connection at 612-379-6363, available 24 hrs./day; the Men's Line (612-379-6367) a 24-hour counseling line for men and others who want to talk with someone about issues of abuse and violence in their lives; or National Suicide Prevention Lifeline (statewide 1-800-273-TALK) a 24-hour crisis line for people in danger of harming themselves.
_____ **(Initial here) I specifically understand this information.**

Professional Consultation
Professional consultation is a component of a healthy psychotherapy practice. I may occasionally consult with clinical, ethical or legal professionals without revealing any personally identifiable information about you or your situation. Such consultation is a benefit to clients who receive the value of additional resources in my work.

Client Litigation
I will not voluntarily participate in any litigation, or custody dispute, in which you and another individual, or entity, are parties. I have a policy of not communicating with your attorney and will not generally write or sign letters, reports, declarations, or affidavits to be used in your legal matter. I will generally not provide records or testimony unless compelled to do so. I will not make any recommendation as to custody or visitation. I will make efforts to be uninvolved in any custody dispute. It is agreed that should there be legal proceedings neither you, nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will disclosure of the psychotherapy records be requested. Should I be subpoenaed or ordered by a court of law to appear as a witness in an action involving you, you agree to reimburse me for any time spent in preparation, travel, writing, waiting, missed therapy sessions with other clients or any other involvement of any kind whatsoever in the legal proceedings, at my rate for these specialized services of $500/hour plus any personal expenses including but not limited to meals, any and all travel expenses including lodging at the vendor of my choice, mileage, communication and internet fees.
_____ **(Initial here) I specifically understand this information.**

Termination
The length of your treatment and the timing of the eventual termination of your treatment will depend on the specifics of your treatment plan and progress. Planning your termination is something we do in collaboration. You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either you or I may elect to initiate a discussion of your treatment alternatives, which may include referral, changing a treatment plan, or terminating therapy.

The HIPAA NOTICE OF PRIVACY PRACTICES, posted in this office or given to you at intake, details the considerations regarding confidentiality, privacy, and your records. Periodically, the HIPAA NOTICE OF PRIVACY PRACTICES may be revised. Any changes will be posted in our office, but you will not receive an individual notification of the updates. It is imperative that you read and understand the limits of privacy and confidentiality before you start treatment.

I have read the HIPAA NOTICE OF PRIVACY PRACTICES, and have had my questions about privacy and confidentiality answered to my satisfaction. I understand that the HIPAA NOTICE OF PRIVACY PRACTICES is incorporated by reference into this agreement.
_____**(initial here.)**

ACKNOWLEDGEMENT
By signing below, I acknowledge that I have read and understand this *Informed Consent: Disclosure Statement & Agreement for Services*. have reviewed and fully understand the terms and conditions of this agreement. I have discussed such terms and conditions with my therapist, Nancy Dawn Van Beest, LMFT, and have had any questions about it answered to my satisfaction. I agree to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy with Ms. Van Beest. Moreover, I agree to hold my therapist, Nancy Dawn Van Beest, LMFT, free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment. I also have read about Privacy and Confidentiality and understand that my therapist is a mandated reporter and certain information, by law, may be reported. I also have been notified in this Informed Consent of whom to contact in case of a mental health crisis or emergency.

PRINTED NAME_____

Signature _____**Date** _____

PRINTED NAME (If more than one client) _____

Signature _____**Date** _____

I further understand that I am financially responsible for payment for services rendered, and if using insurance am obligated to pay all charges denied by my insurance carrier. I understand I will be charged a cancellation/no show fee as described in this agreement <u>for appointments not cancelled at least 24 hours</u> (more if possible) by phone.

PRINTED NAME_____

Signature _____**Date** _____

By initialing here, I authorize communication with the referring party for the purpose of assessment and treatment planning. _____ **I agree.** _____**I do not agree**. (Please initial.)

Thank you! I am pleased to welcome you into my therapy practice and I look forward to our work together!

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