Bryan Kingsriter, LMFT,

in affiliation with MN Couple Therapy Center

Signature/Client Consent Form Client Name _____

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign to confirm that you have fully read and understand the information below.

CLIENT/THERAPIST RELATIONSHIP: Therapists and clients have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains professional and serves only the therapeutic process. I can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship.

RISKS AND BENEFITS: Psychotherapy is a way of talking through your problems in order to begin resolving them. You will need to take an active part in psychotherapy by working on and reflecting about the issues you share with me. Psychotherapy has been shown to have many benefits. However, there are no guaranteed results, and at times you may experience uncomfortable feelings. Your work in psychotherapy is intended to promote less distress, better relationships and solutions to problems.

The goal of psychotherapy is to provide an effective therapeutic experience to you. If at any time you feel that I am not a good fit for your needs, please discuss this with me to determine if transferring to a different therapist is right for you. If we decide that other services would be more appropriate, I will try to assist you in finding a provider to meet your needs.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 50-55 minutes long. More frequent sessions may be available if determined appropriate. Because my schedule is often quite full, I recommend that clients schedule appointments for at least several months in advance, so that times that work for you are kept available to you. I understand that schedules change and that appointments may be cancelled. I only ask that if you need to cancel an appointment, you notify me at least 24 hours in advance. This will free your appointment time for another client. If less than 24-hour notice is given, a fee of $80 will normally be charged, to be paid at the next scheduled session unless an alternative is agreed upon.

FEE SCHEDULE: Please consult your medical insurance company about your insurance coverage if you will be using your insurance. It is your responsibility to verify coverage. For various reasons, some clients prefer not to use insurance benefits, and to use Health Savings Accounts or simply pay out of pocket for therapy services. Separate fees for writing reports, phone calls, and legal proceeding are also charged.

You understand that I make no guarantee that your insurance will cover treatment, and that you will be responsible for payment for services if your insurance declines to cover treatment. My normal rates for service are $210 for an initial session, and $150 for subsequent sessions. A $30 per session discount is given for household incomes under $100,000.

PAYMENT/INSURANCE FILING: If you are using insurance benefits, MN Couple Therapy Center will file insurance claims for you, and we will honor any contractual agreements with insurance companies that have specific reimbursement restrictions and claim requirements. If you are not using insurance, I ask for full payment at the time of service, and I will provide you with a statement for services rendered if requested. Outstanding balances of 90 days may be sent to a bill collecting service.

EMERGENCIES: If an emergency arises after hours or on a weekend and you wish to talk to someone right away, your local county crisis service may offer 24-hour intervention. If you are experiencing a life-threatening emergency, call 911 or go to the nearest emergency room. You may leave a message with me and I will call you back as soon as possible. My colleagues at the MN Couple Therapy Center may also be available to discuss your situation with you if I am unavailable for any extended time.

CONFIDENTIALITY: MN Couple Therapy Center follows all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Please see our notice of privacy practices.

Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situation where the therapist has a duty to disclose, or where, in the therapist's judgement, it is necessary to warn or disclose in order to prevent harm to someone; fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, please bring them to my attention.

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of the undersigned therapist, it will be necessary to assign my case to another therapist and for that therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, to take possession of my records and provide me copies at my request, and/or deliver those records to another therapist of my choosing.

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of the Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if my child is the client), and I understand that I may stop such treatment or services at any time.

_____ _____

Signature – Client/Parent Date

_____ _____

Signature- Spouse/Partner/Parent Date

_____ _____

Therapist Date

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

_____ _____

Client/Parent Date

I authorize the payment of medical benefits to the provider of services.

_____ _____

Client/Parent Date