Child & Adolescent Behavioral Health Services Consent

Child's Full Name First Middle Last	Date of Birth

1. Informed Consent

Welcome. This client information form will answer most of your questions about therapy services at Sartell Pediatrics (hereafter referred to as the clinic). Please feel free to ask for clarification or additional information at your initial visit.

What is therapy and how does it work? Therapy is the process of solving emotional problems by talking with a person professionally trained to help people achieve a more fulfilling individual life, marital relationship, or family relationships.

As the client, you have the right to ask your therapist questions about his or her qualifications, background, and therapeutic orientation. The most important factor in the success of therapy is good communication between therapist and client. In some instances, talking about your difficulties may exacerbate your symptoms, however over time you should see an improvement. In addition, not all individuals benefit from therapy or working with a particular therapist. If at any time during the therapy you have questions about whether or not the treatment is effective, feelings about something your therapist has said, suggested, or need clarification of our goals, do not hesitate to bring this up in your session.

Confidentiality. By law and professional ethics, your sessions are strictly confidential. Generally, no information will be shared with anyone without your written permission. If you are seeing another therapist or health professional it may be necessary for us to contact that person so that we can coordinate our efforts. If this is necessary, we will ask for your permission. There are however, a number of exceptions to this confidentiality policy.

a) If we are ordered by the court to testify or release records.
b) Any reports of abuse and/or neglect of a child or vulnerable adult are required by law to be reported to the authorities responsible for investigating child abuse, Adult Protective Services, or other appropriate authorities.
c) If you threaten harm to yourself, someone else, or the property of others, we may be required to call the police and warn the potential victim or take other reasonable steps to prevent the threatened harm.

The issue of confidentiality is critical in treating children. When children are seen with adults, what is discussed should be kept confidential except by mutual agreement. Children seen in individual sessions (except under certain conditions) are not legally entitled to confidentiality (also called privilege); their parents have this right. However, unless children feel they have some privacy in speaking with a therapist, the benefits of therapy may be lost. Therefore, it is necessary to work out an arrangement in which children feel that their privacy is generally being respected, at the same time that parents have access to critical information. This agreement must have the understanding and approval of the parents or other responsible adults and of the child in therapy.

Confidentiality and privilege are limited in cases involving child abuse, neglect, molestation, or danger to self or others. In these cases, the therapist is required to make an official report to the appropriate agency and will attempt to involve parents as much as possible. Parental/Guardian access to information regarding a minor is limited under certain circumstances such as:

a) The therapist determines that that the information is detrimental to the physical or mental health of the patient, or is likely to cause the patient to inflict self -harm, or to harm another, the provider may withhold the information from the patient or parent and may supply the information to an appropriate third party;
b) The therapist has a reasonable belief that the minor has been or may be subjected to domestic violence, abuse, or neglect;
c) The therapist, in their exercise of professional judgment, decides that it is not in the best interest of the minor to give the parent, guardian or other person such access;
d) The child has consented to their own care.

Consultation and Supervision. To provide you with the best possible service, we engage in ongoing supervision and consultation with mental health professionals within our clinic. When discussing client information, confidentiality is highly respected and protected.

Terminating Treatment. You have the right to terminate or take a break from your treatment at any time without permission or agreement. However, if you do decide to exercise this option, the clinic encourages you to talk with your therapist about the reason for your decision in a counseling session in order to bring sufficient closure to your work together. In your final session you can discuss your progress thus far and explore ways in which you can continue to utilize the skills and knowledge that you have gained

through your therapy. You can also discuss any referrals that you may require at that time. Therapists are ethically required to continue therapeutic relationships only so long as it is reasonably clear that patients are benefiting from the relationship. Therefore, if we believe that you need additional treatment, or if we believe that we can no longer help you with your problems we will discuss this with you and make an appropriate referral.

After Hours Emergencies. Therapists at the clinic are not available after usual business hours for emergencies. For after-hours emergencies, or if you need immediate assistance, call 911, your medical group, or your primary care physician. Crisis phone numbers include: Local Crisis Support 320-253-5555; National Suicide Prevention Lifeline (toll-free) 800-273-TALK (8255); Mental Health Crisis Response 800-635-8008.

Emergency Contact. In the event of an emergency or concern for your welfare, we may need to contact a family member or friend on your behalf. To comply with HIPAA (Privacy Act), we are required to have you designate the people we may contact. I authorize you to call the person(s) named above in case of emergency when I cannot be reached. *I understand that this information may be shared with outside agencies (EMT/Police/Hospital, etc.) in the event of an emergency.*

EMERGENCY CONTACT:

Name _____ Relationship _____

Home # _____Work # _____Cell#_____

EMERGENCY CONTACT:

Name _____ Relationship _____

Home # _____Work # _____Cell#_____

Other Medical Providers. At Sartell Pediatrics, we have a strong commitment to your overall health. For that reason it is important to have a close working relationship with your physician, psychiatrist, or other health care provider. We are asking for your permission to communicate with your health care providers. We find that we can serve you best if your other providers are aware of mental health and substance abuse concerns which often impact health and well-being. Please complete the attached release to enable us to communicate with them about your care. We will be happy to answer any of your questions or respond to your concerns regarding this matter. Some insurance companies request that a copy of your intake information be sent to your primary care physician. It is your right to either agree or disagree to this request. If you would not like information sent to your primary care physician's office, please indicate below.

□ I **would like you** to contact my primary care physician/other treating clinician about my care:

Guardian Signature: _____ Date: _____

Primary Care Physician Name & Practicing Location:

_____

□ I **have no immediate need for you** to contact my primary care physician/other clinician at this time:

Client Signature:_____ Date: _____

Guardian Signature: _____ Date: _____

2. Minor Consent

Client Name: _____ Date of Birth: _____

Please check below to indicate the current situation regarding the custody of the minor child:

- □ Parents are married to each other and are the legal parents of the child *(one signature required)*
- □ I am a single parent and have full legal custody of the child *(one signature required)*
- □ My ex-partner/spouse and I share legal custody of the child *(both signatures required)*

  Will he/she agree to treatment of the child? **Yes No**
- □ The child is in the custody of the State of Minnesota. County

□ I am _____ (relationship) to the child, but I do not have custody.

□ Other, please explain: _____

3. Minor Agreement

The involvement of children and adolescents in therapy can be highly beneficial to their overall development. Very often, it is best to see them with parents and other family members; sometimes, they are best seen alone. I will assess which might be best and make recommendations to you.

Because my role is that of the child's helper, I will not become involved in legal disputes or other official proceedings unless compelled to do so by a court of law. Matters involving custody and mediation are best handled by another professional who is specially trained in those areas rather than by the child's therapist.

Treatment of a minor without parental consent is allowed by law under certain circumstances:

a) If the minor is living apart from parents and managing their own financial affairs;
b) If the minor is married or has borne a child;
c) If the treatment involves pregnancy and conditions associated therewith, venereal disease, alcohol, or other drug abuse;
d) If the risk to the minor's life or health is of such a nature that treatment should be given without delay and the requirement of consent would result in delay or denial of treatment;

Any evaluation, treatment, or reports ordered by, or done for submission to a third party such as a court or a school is not entirely confidential and will be shared with that agency with your specific written permission. Please also note that I do not have control over information once it is released to a third party.

The normal procedure for discussing issues that are in my child's/children's therapy will be joint sessions including my child/children, the therapist, and me and perhaps other appropriate adults. If I believe there is significant health or safety issues that I need to know about, I will contact the therapist and attempt to arrange a session with my child/children present. Similarly, when the therapist determines that there are significant issues that should be discussed with parents; every effort will be made to schedule a session involving the parents and the child/children. I understand that if information becomes known to the therapist and has a significant bearing on the child's/children's well-being, the therapist will work with the person providing the information to ensure that both parents are aware of it. In other words, the therapist will not divulge secrets except as mandated by law, but may encourage the individual who has the information to disclose it for the therapy to continue effectively.

I understand that at least one parent must accompany the minor child to his/her first appointment and any subsequent appointments, until discussed with and agreed upon with the therapist/doctor.

I will do my best to ensure that therapy sessions are attended and will not inquire about the content of sessions. If my child prefers/children prefer not to volunteer information about the sessions, I will respect his/her/their right not to disclose details. Unless my child has been abused or is a clear danger to self or others, the therapist will normally tell me only the following:

a) Whether sessions are attended.
b) Whether or not my child is generally participating.
c) Whether or not progress is generally being made.

Minor Signature: _____ ***Date:*** ____/____/_____

Parent/guardian Signature: _____ ***Date:*** ____/____/_____

Parent/guardian Signature: _____ ***Date:*** ____/____/_____

4. Financial Policy

Payment for Services. You are always responsible for your bill. Monthly statements from our billing company will be sent to keep you informed about your account. There are payment options available: Insurance, check, cash, or credit card. In most cases Sartell Pediatrics will be able to bill your insurance company directly. *However, this is a service we provide for you and it carries no guarantee of third-party coverage.*

Sample fees and explanation of some procedures. Unless instructed otherwise, we will submit all charges to your health insurance company. Please note that the prices outlined below are some of the fees we may submit to your insurance company. As claims are processed by your carrier, the amount charged will be adjusted based upon the provisions of your policy. If you do not have insurance or mental health coverage, or choose to be self/private pay, we honor a 30% discount if paid at the time of services, or if a credit card is left on file for payment.

Initial Therapy Intake: ($317) Diagnostic assessment; up to two sessions.

Individual Psychotherapy: ($309) 53+ minute consultation

Assessment/Testing: ($203 per hour) Includes the materials used for the assessment and the costs of scoring.

Professional Consultation Services: ($250) 60 minutes of business, educational, or mental health consultation services.

Payment plans are available, but not subject to discounted pricing.

Account Balance	Length	Monthly Minimum Payment Due
$50.00	2 Months	$25.00
$75.00	3 Months	$25.00
$100.00	4 Months	$25.00
$150.00	6 Months	$25.00
$500.00+	12 Months	$41.67+

Court appearances: ($250.00 per hour with a minimum charge of eight [8] hours, for a total of two thousand [$2,000] dollars) Because the client-therapist relationship is built on trust with the foundation of that trust being confidentiality, it is often damaging to the therapeutic relationship for the therapist to be asked to present records to the court, testify whether factual or in an expert nature, in court or deposition. The therapist asks that clients only request a court appearance in extreme cases. In such cases as the therapist is ordered to testify by the court about his/her counseling with you, the therapist will be monetarily compensated as set forth below.

In the event that it is necessary for the therapist to testify before any court, arbitrator, or other hearing officer to testify at a deposition, whether the testimony is factual or expert, or to present any or all records pertaining to the counseling relationship to a court official, the client agrees to pay the therapist for his or her services, including travel, preparation, and necessary expenditures (copies, parking, meals and the like) at the rate of $250.00 per hour, rounded to the nearest half hour. The client further agrees to pay the $2,000.00 (8 hours x $250.00) two weeks prior to the appearance, presentation of records, or testimony requested.

Private Pay Agreement. I, the client (or person acting for the client), request that the therapist, _____ provide professional services to me or to _____ , who is my _____. I understand that I agree to pay a fee of $_____ per session for these services. I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform him or her, in person or by certified mail, that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship. I agree that I am responsible for the charges for services provided by this therapist to me (or this client). Private pay services are due on the date of service.

Insurance. Most insurance does not cover 100%; therefore, full payment (or co-payment if covered by insurance and the deductible has been satisfied) is expected at the beginning of the hour of the Date of Service (DOS). Insurance requires a medical diagnosis for each procedure - your plan may exclude certain diagnoses and, if so, you will be responsible for charges. Our strongest recommendation is that if you choose to utilize insurance to pay for therapy, **stay well informed regarding your policy**. We will do what we can to assist you with this, but ultimately it is your responsibility.

Insurance Confidentiality Limits. When insurance is used for therapy services, patients should be aware of the limits of confidentiality. Typically, insurance companies only require the following information: length of illness, psychiatric diagnosis, dates of service, and the names of persons being treated. More and more managed care companies require additional information such as family abuse history, alcohol and drug history, treatment goals/interventions, the details of the treatment sessions, and on some occasions, treatment notes. In addition, providers are now required to sign waivers that allow the payers to audit client records. What this means is, if you utilize your insurance benefits for therapy services, you may not have the extent of confidentiality you would otherwise expect.

Scheduling & Cancellations. To ensure we are providing the best clinical care, accessibility, and efficient booking for all patients, each patient will be allowed to schedule a maximum of four appointments, as needed, with their behavioral health provider.

Sartell Pediatrics requires 24-hour advance notice to cancel an appointment without charge. In the event of a late cancellation (less than 24-hour notice) or a missed appointment, you will be charged a fee of $75. Three late cancellations or failed appointments within a 12-month period may result in termination of mental health services at Sartell Pediatrics. This is standard practice and is intended to preserve the time for those who may need it. Please note that insurance companies do not pay for failed or cancelled appointments. In the event that your therapist has to cancel a session, you will be notified promptly so that your session can be rescheduled. You will not be charged for these cancelled appointments.

Collections. In the event you do not pay your bill, Sartell Pediatrics, reserves the right to seek payment through use of a collection agency or through other legal means. The cost of collection may be added to your bill. Returned check fees of $25 are added to your bill.

NOTE: If you are unable to complete your therapy due to financial hardship, please contact our office to discuss alternative payment arrangements.

5. Client Rights and Responsibilities

Client Rights

Consumers of services offered by practitioners licensed by the State of Minnesota have the right:

1) to expect that the practitioner has met the minimal qualifications of training and experience required by state law;
2) to examine the public records maintained by the Board which contain the credentials of the practitioner;
3) to obtain a copy of the rules of conduct from the appropriate Board i.e. the Board of Psychology, Board of Social Work;
4) to report complaints to the practitioner, and if not satisfactorily resolved, to file a complaint with the appropriate Minnesota Board;
5) to be informed of the cost of professional services before receiving the services;
6) to privacy as defined by rule and law. This means that no information will be released from the facility in which the practitioner works without the client's informed, written consent, except for the following:
    a) The practitioner is required by law to report instances of abuse or neglect of a child or a vulnerable adult.
    b) The practitioner is required by law and professional codes of ethics to notify proper persons and/or authorities if the practitioner believes there is a danger to a client or another identified person.
    c) The practitioner is required to report admitted prenatal exposure to harmful controlled substances.
    d) In the event of a client's death, the spouse or parents of the deceased have a right to access the client's records.
    e) The practitioner must produce records or testimony in response to a Court Order and potentially to a subpoena.
    f) Parents or legal guardians of a non-emancipated minor client have the right to access their child's records.
    g) Case discussions with other staff through case management, consultation, testing, and treatment are confidential and are to be conducted as such by all staff.
7) to be free from being the object of discrimination on the basis of race, religion, gender, sexual orientation or other unlawful category while receiving psychological services;
8) to respectful, considerate, appropriate, ethical, and professional treatment;
9) to see information in his/her written record upon request;
10) to be informed of diagnosis, involved in the formulation of the treatment plan, the periodic review of plans and progress, and the formulation of the discharge plan;
11) to be informed of treatment options, expected outcome of treatment, expected length of treatment, and cost in language that he/she can understand, and to have the right to refuse treatment and the consequences of that decision.
12) to discuss needs, wants, concerns, and suggestions with the practitioner.
13) to be advised as quickly as possible if a scheduled appointment time cannot be kept due to illness or emergency.

Client Responsibilities

Each client has the responsibility to:

1) Refrain from physical (and other) abuse of self, others, and property. Clients are responsible for repair or replacement of any property they damage in the facility.
2) Devote reasonable energy and time to therapy work. Therapy is generally "hard (emotional) work." For progress to occur, we recommend making your therapy a high priority in your personal life. Your therapist may regularly assign homework that is intended to help you learn about yourself, and doing your homework is expected to expedite your therapy and decrease your costs.
3) Fulfill contracted behavior.
4) Be honest with your therapist concerning your thoughts and feelings about your therapy and treatment.
5) Keep appointments as made. Your appointment time is reserved for you. Therefore, you will be charged for the appointment unless you give at least 24 hours advance notice. Exceptions may be made for emergencies and other extenuating circumstances.
6) Keep current in paying your fees (deductibles, co-payments, fee-for-service payments). You are required to pay your fee at the beginning of each session. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that occurred prior to the first visit to my office), session fees credited toward the deductible will be collected at the time of the session until the deductible payment is verified by the insurance company or third-party provider. Verification can be made through the billing office, who will contact your insurance company to check your benefit status upon request.
7) Inform those involved in the treatment plan about any changes to physical health, insurance plan, or ability to pay for

contracted services.

8) Parents or caregivers are responsible to supervise the activities of children with respect to use of facilities, material, etc. Children shall not be left unattended in the waiting area.

I (we) have read, understand, and agree to the information and policies described in this client information form.

I have read and understand my rights and responsibilities as noted above.

I have received the Sartell Pediatrics Financial Policy and I understand that I am responsible for the account and agree to abide by the terms of said policy.

Client Signature: _____ ***Date:*** _____/____/_____

Parent/Guardian Signature: _____ ***Date:*** _____/____/_____

Parent/Guardian Signature: _____ ***Date:*** _____/____/_____

6. Notice of Privacy Practices

I have read and understand my rights and responsibilities outlined in the notice of privacy practices form located at the front desk.

Client Signature: _____ ***Date:*** _____/____/_____

Parent/Guardian Signature: _____ ***Date:*** _____/____/_____

Parent/Guardian Signature: _____ ***Date:*** _____/____/_____

I, the therapist, have discussed the issues above with the client. My observations of the person's behavior and responses give me reason to believe that this person is fully competent to give informed and willing consent.

Therapist Signature _____ ***Date:*** _____/_____/_____

Please sign this form and keep a copy for yourself for future reference.