SPECTRUM COUNSELING

Counseling Agreement
Informed Consent

THERAPY PATIENT BILL OF RIGHTS

1. A therapy patient has the right to know their therapist's credentials, experience, and professional background.

2. A therapy patient has the right to ask any therapist their outcome rates. These rates are determined by doing follow-up tracking with a reasonable percentage of patients after they leave therapy to see how they are maintaining. One year follow up is ideal. Outcome rates (successful or not), should be made available to all potential patients/clients upon request but of most use to the patient are outcome rates that are specific to the patient's disorder.

3. A therapy patient has a right to receive a comprehensive and thorough psychosocial evaluation/history.

4. A therapy patient has a right to a diagnosis and prognosis at as early a stage of therapy as possible. Additional experts including, but not limited to, psychiatrists, addiction specialists, and so on may be required to assist the therapist in reaching a diagnosis.

5. A therapy patient has the right to a written treatment plan that should be created together with the therapist and utilized, with necessary amendments and changes, throughout the course of therapy.

6. A therapy patient has a right to understand the costs of individual therapy sessions and projected costs of total therapy sessions upon request, before committing to a course of therapy.

7. A therapy patient has the right to a beginning, middle and an end to therapy. If protracted or ongoing therapy is required, then the patient has the right to understand why their diagnosis might warrant this course of action.

8. A therapy patient has the right to expect to achieve specific goals and objectives by agreed-upon target dates.

9. A therapy patient has the right to have his or her own treatment responsibilities explained thoroughly as well as understand the therapist's responsibilities to the therapy process and to the patient. This includes the responsibility of the therapist to try a different course of treatment and/or refer patients to another therapist if therapy is ineffective after a reasonable period of time.

10. A patient has the right to complete confidentiality as provided for by state and federal laws and regulations.

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THERAPUETIC RELATIONSHIP

The relationship between client and therapist is very important and different from other relationships. The therapists' responsibility is to listen, make observations, and reflect back thoughts, behaviors, feelings, values, and beliefs that may be interfering with the clients' ability to accomplish life goals. The client is expected to talk freely, honestly, and openly about feelings and life experiences. Therapy can result in a number of benefits, including improved relationships and a reduction in psychological symptoms. However, there is no guarantee that therapy will yield positive or intended results. Creating lasting change takes time and effort. A client is free to terminate therapy at any time. The therapist is also free to refer the client for specialized treatment and/or discontinue therapy if a client is resistant to treatment. The therapist will make referrals for a change in treatment if, and when it is necessary for continuance of care.

HIPPA COMPLIANCE

Spectrum Counseling is in compliance with HIPAA, the Health Insurance Portability and Accountability Act. A copy of HIPAA requirements and compliance will be available to you upon request. Client information is kept strictly confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the clients' legal guardian. Noted exceptions are as follows:
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. Please note that not all emails and text messages are HIPPA compliant.

EXCEPTIONS TO CONFIDENTIALTY

As a mandated reporter in the state of Minnesota your therapist is legally obligated to violate confidentiality under the following circumstances:

- ♣ When the therapist has reason to suspect that the client has been, or is currently, involved in the abuse or neglect of child
- ♣ When the therapist has reason to suspect that the client has been, or is currently, involved, in the abuse or neglect of vulnerable adults
- ♣ If a client is pregnant and taking street drugs
- ♣ If the client reports sexual misconduct by another counselor
- ♣ If a client is a serious danger to themselves, i.e., if suicidal
- ♣ If a client is a serious danger to someone else, i.e., if homicidal
- ♣ If the courts order copies of records.

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CONFIDENTIALTY EXCEPTIONS FOR MINORS

Parents and guardians have a legal right to access a minor client's records. However, minor clients do have the rights to complete confidentiality in obtaining counseling at age 16-18 (the age of consent), for pregnancies and associated conditions, sexually transmitted diseases, and information about alcohol or drug abuse. A health professional may inform a minor's parent or guardian of treatment if, in the professional's judgement, failure to inform the parent or guardian would seriously jeopardize the minor's health

APPOINTMENTS

Routine therapy appointments are 45-60 minutes in length. You and your therapist will work together to personalize a schedule to fit your needs. To make, or change an appointment, call 612-226-9301 or email: spectrumappt@gmail.com.

CANCELLATION POLICY

If you need to cancel or reschedule an appointment for any reason, please do so 24 hours in advance. You will be charged $75 for appointments not cancelled within 24 hours. Exceptions will be made in cases of emergency, illness, or severe weather.

HOURS AND EMERGENCIES

You may leave a message anytime at 612-961-3111. Calls are typically returned within 24 hours. If you need immediate assistance, please call 911, or you may call 211 (United Way First Call for Help, or the Crisis Center at 612-873-3161. Please go to the nearest hospital emergency room if necessary.

COMPLAINTS

You are urged to discuss with your therapist any questions, concerns, or problems you may have about the therapy you receive. Oftentimes, part of the therapeutic process involves working through misunderstandings or misconceptions. You also have the right to file a complaint with the Minnesota Department of Health, 121 East 7th Street, St. Paul, MN 55101 (612-623-5522), The Minnesota Board of Marriage and Family Therapy, 2829 University Ave SE, Minneapolis, # 400, MN 55414, The Minnesota Board of Behavioral Health & Therapy, 2829 University Ave SE # 210, Minneapolis, MN 55414. You may also contact: U.S. Department of Health and Human Services, 233 N. Michigan Ave., Suite 240 Chicago, IL 60601 Customer Response Center: (800) 368-1019 Fax: (202) 619-3818 TDD: (800) 537-769 Email: ocrmail@hhs.gov

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FEE POLICY

1. The fee of $175.00 per session is payable at the beginning of each session unless other arrangements have been made. The intake session fee is $ 225.00. You may use cash, check, or credit card.
2. The client is fully and directly responsible to Spectrum Counseling for the payment of services rendered. Insurance coverage differs, so please check with your insurance company to determine the requirements for mental health coverage.
3. Additional fees will be charged for psychological testing.
4. If payment becomes a problem, you are encouraged to discuss this directly with your therapist to consider other alternatives.
5. If fees change during the course of treatment, you will be given adequate notice of these changes.
6. You will be charged $75.00 for missed appointments or appointments cancelled with less than a 24-hour notice (except in cases of illness, emergency or severe weather).
7. Fees for telephone contacts will be prorated, based on the standard hourly fee.
8. You will allow Spectrum Counseling to keep your credit card on file and bill directly should there be any out of pocket expenses.

INSURANCE PAYMENTS

Insurance coverage differs, so please check with your insurance company to determine your benefits for mental health coverage. Please be aware that the information your insurance company provides to you or Spectrum Counseling is not a guarantee of the benefits provided or paid by the insurance company.

- Please keep my credit card information on file, which I authorize to be used to pay for my visits and/or outstanding balance. (Credit card information is kept confidential and no unauthorized staff members have access to your credit card number.)
- This new policy will be going into effect for my account when my new insurance plan's anniversary date comes due. I agree to notify Spectrum Counseling when that new deductible is in effect.

Main policy holder_____

Date of birth_____**Relationship**_____

My insurance carrier is _____

Fee $225.00 Intake **$175.00 50-60 minute session**

Co-pay $_____**Payable at each visit.**

- I accept full responsibility for service provided by Spectrum Counseling
- Fees for telephone contact will be prorated based om the standard hourly fee.

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CREDIT CARD INFORMATION

Please keep my credit card information on file, which I authorize to be used to pay my copays and/or outstanding balance after my claims have been processed. (Credit card information is kept confidential and no unauthorized staff members have access to your credit card number).

Please use this credit card information for co-pays and/or outstanding balances:

_____Visa _____MasterCard _____American Express _____HSA

Card #_____

Expiration Date _____Security Code_____

Name on the Card_____

- I will pay my copay at EACH session.
- I will be charged for missed appointments or appointments cancelled with less than a 24 hour notice. INSURANCE WILL NOT PAY for missed or late cancelled appointments.
- Payment is expected with 30 days after insurance has paid. You will receive an invoice notifying you of your responsibility.

I have read and understand Spectrum's Counseling Agreement.

I have been advised of Spectrum Counseling's privacy policy and compliance with HIPAA.

I understand the current fee schedule and my responsibility for payment of fees. I have been given a copy of the current fee policy and have been given the opportunity to discuss my financial situation with my therapist. I understand I will be responsible for all fees as indicated on the current fee schedule and as outlined on this payment contract. I am also aware that I may be charged a fee for a late cancel or no show appointment. I have read and understand the terms of the counseling agreement.

Client Signature_____Date_____