RIVER VALLEY BEHAVIORAL
HEALTH & WELLNESS CENTER, LLC
8640 Eagle Creek Circle – Savage MN 55378
Phone 952-746-7664 – Fax 952-224-4867

Adult Client

1. Informed Consent

Welcome. This client information form will answer most of your questions about therapy services at River Valley Behavioral Health & Wellness Center, LLC (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. The process of change will, in many ways, be unique to your particular situation. Who you are as a person will help to determine the ways in which you go about changing your life. The process of change begins by first clearly defining the problem, and then discussing your thoughts and feelings, understanding the origin of the difficulty and developing new skills and healthy attitudes about yourself and others.

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 or 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, several exceptions to this confidentiality policy.

1. If we are ordered by the court to testify or release records.
2. If you are a victim or perpetrator of child abuse, we are required by law to report this to the authorities responsible for investigating child abuse.
3. If you are a victim or perpetrator of elder or dependent adult abuse, we are required by law to report this to Adult Protective Services or other appropriate authorities.
4. 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.

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.

Vacations: You will be given reasonable notice before your therapist goes on vacation. If your therapist is going to be out of town or unavailable, another therapist will be available for emergencies. The name and phone number of this individual will be provided to you ahead of time. If you feel that you will need continuing treatment during this time, you and your therapist will make arrangements ahead of time with another therapist.

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.

Pet Policy: For the health and safety of our patients, River Valley has a No-Pets policy. Only working service dogs are permitted in the clinic. River Valley complies with the Americans with Disabilities Act (ADA) allowing access for all individuals to public places; therefore, we do allow working service dogs to accompany our patients. Service animals are individually trained to perform work or tasks for people with disabilities. Service animals are required to be leashed or harnessed except when performing work or tasks where such tethering would interfere with the dog's ability to perform the work or tasks. Dogs whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA. Should you arrive to an appointment with a pet that is not a service animal, you will be asked to remove the animal from River Valley. To avoid any disruption or inconvenience, we ask that you please leave your pet at home.

After Hours Emergencies: **Therapists at the clinic are not available after usual business hours for emergencies.** Messages are checked routinely. Please leave a message on the clinic voice mail (***952-746-7664***) and your therapist will return your call as soon as possible. For after-hours emergencies, or if you need immediate assistance, call 911, your medical group, or your primary care physician. Crisis phone numbers include: Crisis Connection at 612-379-6363 or toll free 1-866-379-6363; National Suicide Prevention Lifeline 1-800-273-TALK (8255); St. Francis Emergency Department at 952-428-2200.

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 River Valley Behavioral Health & Wellness Center, LLC, 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 agree to this request and would like for immediate contact between you and my primary care physician**.**

Signature: _____ Date: _____

Releases must be signed for each person who will be contacted.

I decline contact between you and my primary care physician at this time. Should something arise, I will complete a release of information form.

Signature: _____ Date: _____

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

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

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

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

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

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

I, the therapist, have discussed the issues above with the client (and/or the person acting for 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:*** _____/_____/_____

2. Financial Policy

Assignment of Insurance Benefits:

Private insurance companies and governmental insurance programs such as Medicare and Medicaid, require you to sign an assignment of benefits for us to bill your insurance company directly. Minnesota State Law requires a signed patient consent to release medical information to your insurance company and any other parties cooperating in the delivery of your care.

By Signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance of my prior consent. I understand that if I revoke this authorization, I will need to pay for services out of pocket.

This consent is given freely with the understanding that:

1. Any and all records, whether written, oral or electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except for otherwise provided by law.
2. Information used or disclosed pursuant to this authorization may be subject to re-disclosure and is no longer protected.
3. A photocopy or fax of this consent is as valid as the original.

I understand that copays are due at the time of service and that deductibles, coinsurance and charges not covered by my insurance company are due within 30 days of insurance processing.

If you are not using health insurance, full payment is due at the time of your visit unless alternative arrangements have been made with the practitioner.

Fees & Explanation of some procedures:

Initial Therapy Intake ($275 per session): Diagnostic assessment. **First two sessions.**

Individual Psychotherapy: ($175 for 45-minute session, $250 for 60-minute session)

Dietitian Intake: ($120 per session) – Currently not available

Dietitian Follow-up Appointment: ($120 for 1 hour, $60 for 30 minutes) – Currently not available

Assessment/Testing: Includes the materials used for the assessment and the costs of scoring. $225 per hour.

Group Therapy: Time will vary from 1 to 2 hours in accordance with the individual group and number of participants. $50-$75 for 60-minute session.

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

Fees, Phone Calls, and Reports. ($150, pro-rated) Phone calls, letters, and reports to facilitate scheduling, information sharing, etc. and requiring up to 10 minutes of time are free of charge. After 10 minutes, you are billed at a prorated $150 per hour rate. Scheduling paid telephone sessions is welcome when a situation is particularly urgent or because of travel or geographical difficulties. These services are not covered by insurance.

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 DOS.

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 River Valley Behavioral Health & Wellness Center, LLC 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*.

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). If you elect to have us bill your insurance company, you will have 90 days from the DOS to pay the balance in full, regardless of whether your insurance company has responded (most insurance companies reimburse within 60 days of billing). Deductibles that are not met require payment in full on the 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.

Cancellations: 24-hour notice must be given to cancel an appointment without charge. **PLEASE NOTE: This does not include Sundays or holidays. In the event of a late cancellation (less than 24 hours' notice) or a missed appointment, you will be charged a fee of $100.00 for a follow-up appointment or $150.00 for an intake (first) appointment for established clients** (already seen in the clinic at least one time by any provider). The only exceptions to this policy are if the school district in your area is closed or Savage school district is closed; or if client is hospitalized for any medical reason. Insurance companies do not cover late cancel or missed appointments fees. Client is required to pay this fee prior to or at the client's next scheduled appointment.

Furthermore, if you are more than **15 minutes late** for your therapy session or more than **5 minutes late** for your medication management appointment, you will be asked to reschedule your appointment. This would be considered a late cancellation and you will be charged the late fee.

Two late cancellations or failed appointments may jeopardize your services and/or result in termination of services at River Valley Behavioral Health & Wellness Center, LLC. If in the event that your provider 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.

Initials_____

Text and Phone Reminders: As a courtesy, River Valley provides clients with the option of a phone call or a text reminder, which you may sign up for on your client demographic form. **THESE REMINDERS ARE A COURTESY AND ARE NOT GUARANTEED. YOU CANNOT USE CONFIRM FEATURE OR CANCEL AN APPOINTMENT THROUGH TEXT.** If you need to cancel and appointment, please do so at the front desk or call 952-746-7664. However, if you do not receive a reminder due to technological difficulties, the responsibility ultimately falls on the client.

Initials_____

Maximum Balance: A client, family or couple, can maintain no more than a $300.00 total balance for all services in the clinic without jeopardizing use of the clinic services. Any account that has a balance over $300.00 and is over 30 days past due will have a 2 percent interest charge added to the balance. We reserve the right to terminate services with a client who is failing to maintain his/her financial responsibility. Exception will be made for clients who have contacted River Valley Behavioral Health & Wellness Center, LLC and have established an alternative payment plan.

Under the Patient Protection and Affordable Care Act (ACA), there is a three-month grace period when a premium due is not received for members who receive premium subsidy. During this grace period, carriers may not dis-enroll members and, during the 2nd and 3rd months of this grace period, are required to notify providers about the possibility that claims may be denied in the event that the premium is not paid in full.

When River Valley receives notice that a premium has not been paid the patient account will switch to private pay. As with all patient accounts **payment is due at the time of services** and any balance over 300.00 will need a firm payment plan in place in accordance with our current collections policy, and in order that services at River Valley may be continued.

Collections: In case you do not pay your bill, River Valley Behavioral Health & Wellness Center, LLC, reserves the right to seek payment through use of a collection agency or through other legal means. When outside agencies are used your personal health, information may be released for the purpose of collecting on the debt. The cost of collection may be added to your bill. Returned check fees of $30 are added to your bill. ***Returned check fees of $30 are added to your bill.***

NOTE: If you are unable to complete your therapy due to financial hardship, it may be possible to work out a payment plan that is more suitable to your financial situation without jeopardizing the financial operation of the clinic.

Authorization for Client Information to be disclosed:

While I am a client at River Valley Behavioral Health and Wellness Center, or until this permission is revoked through written request, I hereby authorize _____Relationship to client_____
(name of designated person)

_____ To make or check on appointments

_____ To have access to financial information

_____ I do not give authorization to anyone at this time

Patient Portal and Newsletter:
At your request, we can sign you up for our client portal, however it is important that you understand that the internet is not a secure delivery system**. Please initial your selections**.

_____ Please sign me up for the patient portal _____ Please sign me up for RVBHWC Newsletter

Email address: _____

Notice of Privacy Practice:
I acknowledge that I have received/been offered a copy of HIPAA notice of privacy practice.

Client/Guardian Signature: _____ Date: _____

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3. 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 based on 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 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.

Acceptance of Clinic Policies: You have received the River Valley Behavioral Health & Wellness Center, LLC Financial Policies and the Client Rights and Responsibilities. It is understood that you are responsible for the account and agree to abide by the terms of said policy.

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

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

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

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