THE Relationship THERAPY CENTER

Insurance/Fee Registration Form

Date_____ Diagnosis **(Therapist will Fill In)** _____

Therapist_____

Child's Information

Child's Name (Print)_____ **Date of Birth** _____
Last Name First Name Initial

Street Address_____ Home Phone _____

City_____State_____ZIP_____ Cell Phone _____

Ok to Send Appointment Reminder Messages? ☐ Yes ☐ No

E-Mail Address_____ Ok to Leave/Send Messages? ☐ Yes ☐ No Work Phone _____

Gender: ☐ Female ☐ Male ☐ Other Age _____

Responible Party's Employer:: _____

Referred by _____ May we acknowledge this referral? ☐ Yes ☐ No

Primary Insurance

Primary Insurance Company_____ Phone _____

Ins Claims Address_____City_____State_____Zip_____

Policy / Member ID_____Group/Account #_____

Policy Holder Information: (if the client is not the employee/policy holder)

Name_____ **Date of Birth** _____
Last name First Name Initial

Address_____City_____State_____Zip_____Relationship_____

Employer_____

Secondary Insurance

Secondary Insurance Company_____Phone _____

Ins Claims Address_____City_____State_____Zip_____

Policy / Member ID_____Group/Account #_____

Policy Holder Information: (if the client is not the employee/policy holder)

Name_____ **Date of Birth** _____
Last name First Name Initial

Address_____City_____State_____Zip_____Relationship_____

Employer_____

Responsible Party (Who is responsible for payment for the child's services?)

Name _____ Relationship _____

Address_____ Phone _____

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail client statements. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature (Required) Relationship Date

ACH/Credit Card Authorization

Our Top Priority at the Relationship Therapy Center is to provide you with the most effective and efficient therapy possible. In an effort to increase our efficiency and decrease the amount of time you and your therapist spend on the financial aspects of therapy – we require all clients of the Relationship Therapy Center have a valid payment method on file.

Our Automated Payment Program is intended as both an advantage to you and to our office. You won't need to spend valuable session time dealing with payment nor will you need to spend time outside of therapy writing out checks and making payments. The program eliminates monthly statements and therefore helps us to keep the cost of health care down. In this intake process, please provide valid payment information below. The information will be held securely. You will always have the option to pay fees using another payment method at the time of service. Charges to your bank account or credit card will be determined as follows:

Copays/Self Pay Charges* – Copays are due on the date of service, per your contract with your insurance company. Self-pay charges are also due on the date of service. This includes any other services not covered by insurance such as phone sessions. You may present another method of payment prior to, or at the time of service. ***If another method of payment is not offered by the date of service, the method of payment you authorize below will be charged.***

Coinsurance and/or Deductibles* – These amounts are determined after your insurance company has completed processing your claim. The time frame for claims to be processed ranges from 7-28 days. ***At that time, if a balance remains on your account the method of payment authorized below will be charged.*** You can always check the status of your claims on your insurer's website.

Late Cancellation or No-Show Charges – These charges are generated by your provider if you fail to show up for a scheduled appointment, or if you do not give adequate notice (48 hours) for canceling an appointment. ***If you incur such a charge, the method of payment authorized below will be charged.***

Client Portal – In order to provide you with quick and accurate access to the financials of your therapy – you will be given access to our secure online Client Portal. The Client Portal will allow you to look at your bill at any time. You will also be able to securely message your therapist or our billing team on the Client Portal.

Method of Payment – ***If possible – we ask that you utilize our ACH Option***. This process will debit charges from your checking account and saves us approximately 3% in transaction fees. This savings allows us to keep the cost of health care down. If ACH is not a viable option – please choose our credit card option. If you are providing us with an HSA or HRA account – we ask that you provide a backup credit card. The backup card will only be charged if the HSA/HRA comes back with insufficient funds. If the HSA/HRA comes back with insufficient funds and we charge the backup card, we are unable to reverse the charge and apply the charge to your HSA/HRA at a future date. We can provide you with a receipt for your payment which you can submit to your HSA/HRA.

Client Name (printed) _____ **Card/Account Holder Name** _____

Billing Address _____ **City, State, Zip** _____

ACH Option - Checking Account – Check Here ☐

9 Digit Routing Number _____ Account Number _____

Credit Card Option - Check Here ☐ ☐ **Check here if this is an HSA card**

Account Number _____ Exp Date _____ Security Code _____

If the above credit card information is from an HSA or HRA account, please also furnish a backup credit card. This card will only be charged if the above card is declined.

Backup CC Account Number _____ Exp Date _____ Security Code _____

SIGNATURE _____ DATE _____

By signing above I authorize the Relationship Therapy Center Inc. to charge the payment method indicated in this authorization form according to the terms outlined above. I certify that I am an authorized user of the bank account or credit card and that I will not dispute the payment with my credit card company or banking institution; so long as the transaction corresponds to the terms indicated in this form.

*If cost is prohibitive – please talk with your therapist about possible options.

THE RELATIONSHIP THERAPY CENTER, INC. (RTC)

RTC ST LOUIS PARK
5407 EXCELSIOR BLVD, SUITE A, B, D, & E
ST LOUIS PARK, MN 55416
PHONE: 612-787-2832

CLIENT INFORMATION BOOKLET

This booklet will help acquaint you with our office procedures, as well as provide information about you and your child's rights and responsibilities with regard to therapy. You will also find updated information about you and your child's rights pursuant to the Health Insurance Portability and Accountability Act (HIPAA). If you or your child have any questions about this information, please discuss them with your child's therapist at any time. Some of the forms you are filling out ask for similar information. This is due to the forms being for different purposes (eg insurance). We apologize for the redundancy and thank you for taking the time to fill out the forms.

PLEASE READ CAREFULLY

DIRECTIONS TO THE RELATIONSHIP THERAPY CENTER – 5407 Excelsior Blvd, Suites A, B, D & E, St Louis Park:

1. Take Highway 100 to Excelsior Blvd Exit
2. Take a Right (East) on Excelsior Blvd
3. Take a Right into the Miracle Mile Parking Lot
4. Take another Right in the Parking lot and go all the way to the West end of the Parking lot – next to Hoigaards.
5. As you face Hoigaards to the Right of their entrance is a door with a green awning that **says 'Wooddale Offices.'** Enter that door and go up the stairs. We have 4 suites on that floor, A, B, D, & E (Suites A and B are at the top of the stairs and Suites D & E are most of the way down the hall on the right).
6. Please have a seat in the waiting room and your therapist will be with you at the appointed time.

PROFESSIONAL RELATIONSHIP

Professional therapy is not easily described in general statements. It varies depending on the personalities of the therapist and child, and the particular concerns your child is experiencing. There are many different methods your therapist may use to deal with the concerns you and your child hope to address. Therapy is *not* like a medical doctor visit. Instead, it calls for a very active effort on you and your child's part. It might even include other important people in your life. Therapy can be more successful as you and your child work on goals and strategies at home that your child has talked about during sessions.

Therapy can have benefits and risks. Since therapy may involve your child discussing unpleasant experiences of their life, your child may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy has also been shown to have many benefits. Successful therapy can lead to more satisfaction in

relationships, new possibilities for addressing specific problems, and/or reductions in feelings of distress. But there are no guarantees of what you or your child may experience.

The first few sessions will involve an evaluation of your child's needs and goals. By the end of the evaluation, you, your child, and your therapist will be able to discuss your first impressions of what therapy could include and a potential plan to follow. It is important to evaluate this information along with your child's and your own opinions of whether it makes sense to work together. Since therapy involves a commitment of time, money, and energy, it is important to make sure your child's therapist is a good fit. If you or your child have questions about any procedures, please discuss these with your therapist whenever they arise.

MEETINGS & PROFESSIONAL FEES

We conduct an intake session that ranges from 45-60 minutes at a cost of $205. Following the intake session is an evaluation period that will last from 2 to 3 sessions. During this time, you, your child, and your therapist will all decide if this is a good fit to help you reach your child's goals. You, your child, and your child's therapist will work together to determine how often and for what length of time to meet. Depending on your child's particular situation – therapists most commonly suggest either weekly meetings. Our fees are as follows – 45 minutes - $140; 53-60 minutes - $185; 75 minutes - $230; family sessions – 50 minutes - $185. **Once an appointment is scheduled, WE NEED 48 HOURS ADVANCE NOTICE OF CANCELLATION. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. All cancellations or no shows without a 48 hour notification will incur a charge of $100**. If you are reserving a multiple hour session the cancellation fee is **$100 per hour and 5 days notice is required in order to cancel these sessions without a cancellation fee. All charges related to your therapy will be automatically charged to your credit card according to the ACH/Credit Card Authorization Form on the second page of this packet.** This includes charges noted in the next section "Connecting, Coaching, & Additional Professional Fees Outside of Session." All out-of-network and fee-for-service clients are entitled to a Good Faith Estimate for the costs of services.

CONNECTING, COACHING, & ADDITIONAL PROFESSIONAL FEES OUTSIDE OF SESSION

We strive to provide as much support as possible during your child's session. Sometimes children request extra help outside of session and want a prompt response. Some of these children want help using skills in the heat of the moment and others just want support around a particular situation. Whatever the need – RTC therapists offer outside contacts of up to 10 minutes for $80 each (therapist availability varies). Clients can also choose to buy a package of 6 contacts at the rate of $295 – a 38% savings over the individual price. These contacts can include phone calls, texts, or e-mails. For other professional services you or your child may require the rate is $220 per 60 minutes. These services include writing reports, some consulting with other professionals with you and your child's permission, and the time spent performing any other service you or your child may request of your therapist. These services may not be covered by insurance. If you or your child become involved in legal proceedings that require therapist participation, you will be responsible to pay for all of your child's therapist's professional time at the rate of $325 per hour, including preparation and transportation costs, even if a 3rd party is the requestor.

CONTACTING YOUR CHILD'S THERAPIST

Due to the nature of therapy hours, your child's therapist may not be immediately available by phone due to being in session with clients. When unavailable, your child's therapist's telephone is answered by voice mail that is monitored frequently. Your child's therapist will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform your child's therapist of some times when you will be available. If you are unable to reach your child's therapist and feel that you can't wait for a return call, contact your family physician or the nearest emergency room and ask for the psychologist/psychiatrist/social worker on call. You can also contact one of the following**: the Crisis Connection** at (612) 379-6363, the **St. Paul Ramsey Crisis Intervention Center** at (651) 221-8922, **COPE** at (612) 596-1223 or your local emergency services at 911.

BILLING, PAYMENTS, & INSURANCE

If paying privately, session fees are due at time of service. If your child has Blue Cross/Blue Shield, Preferred One, Aetna, Health Partners, or Cigna copays and deductible payments are also due at time of service (unless your child's insurance requires another arrangement). **If your child is covered by an insurance policy other than the insurances listed above, please see our out of network policy on page 14 of this packet. Your portion of the payment is due at the time of the session.** If you are behind more than two sessions, no appointments will be scheduled until payment for previous sessions are made. The only exception to this policy is when insurance coverage is unknown or insurance claims are delayed. If you need a receipt of payment please let us know and we will provide one. If your account is 60 days past due and arrangements for payment have not been agreed upon, RTC has the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court which will require RTC to disclose otherwise confidential information. In most collection situations, the only information released regarding a client's treatment is their name, the nature of services provided, and the amount due. If such legal action is necessary, you will be responsible for all costs associated with it (collection agencies usually charge between 33-50% of the original amount.) **ALL LATE BILLS WILL BE ASSESSED A 1.5% MONTHLY SERVICE CHARGE. All returned checks incur a $35 fee.**

INSURANCE REIMBURSEMENT & CONFIDENTIALITY (If Using Insurance)

You and your child should be aware that your child's contract with your health insurance company requires that RTC provide them with information relevant to the services that are provided to your child. RTC is required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your child's entire clinical record. In such situations, RTC will make a reasonable effort to release only the minimum information about your child that is necessary for the purpose requested. This information will become part of the insurance company files and will likely be stored in a computer. Although all insurance companies claim to keep such information confidential, RTC has no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. It is important to remember that you always have the right to pay for your child'sd services yourself to avoid the problems described above - unless prohibited by your insurer's contract. RTC will provide you

with a copy of any report submitted, if you request it and it is permitted by law. By signing this Agreement, you agree that RTC can provide requested information to your carrier.

CONCERNS

We urge you to discuss with your child's therapist any questions or concerns you may have with the therapy your child receives. If you are not satisfied with the results of that discussion and additional measures are necessary, a formal concern or complaint may be made with the Clinic Owner, Jeb Sawyer, at 612-483-4994.

SUPERVISION & CONSULTATION

At the Relationship Therapy Center we endeavor to provide the best therapy possible. Part of this process is regular consultation among therapists to ensure we are providing the best standard of care for your child. Some of our therapists are also actively under supervision while working towards their licensure. These therapists include Rachel Nygaard, Efrén Solanas, Erin Egertson, Carol Hoopman, Lucreshia Grant, Sam Egertson, Camrie Trautman, Todd Faehner, Breana Foley, Nathan Miller, Dionne Wagner, James Olson, Fiona McGovern, Rachel Wang, Kristi Murchie, Hailey, Sonstegard, and Trisha Witmer. If you have any need to reach out to a supervisor, please call Theresa Benoit at 612-850-8065.

TELEHEALTH CONSENT

By signing at the end of this document you attest to understanding that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.
By signing this form, I understand and agree to the following:

1. Your child has a right to confidentiality with regard to their treatment and related communications via Telehealth under the same laws that protect the confidentiality of their treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined below in the 'Confidentiality' section of this document also apply to your child's Telehealth services.
2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of your child's therapist, that your child's psychotherapy sessions and transmission of treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of treatment information could be accessed by unauthorized persons.
3. I understand that miscommunication between myself or my child and their therapist may occur via Telehealth.
4. I understand that there is a risk of your child being overheard by persons near them and that I am responsible for using a location that is private and free from distractions or intrusions.
5. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my child's therapist believes they would be better served by in-person therapy, their therapist will discuss this with me and my child and refer your child to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.
6. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while my child may benefit from Telehealth, results cannot be guaranteed or assured.
7. I understand that some Telehealth platforms allow for video or audio recordings and that myself, my child, nor my therapist may record the sessions without the other party's written permission.
8. I understand that my child's therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my child's therapist may not be able to assist me in an emergency situation. If my child requires emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

THE Relationship THERAPY CENTER

CHILD'S PERSONAL HISTORY

DEMOGRAPHICS & CONTACT INFO

Child's Age: _____ **Child's Gender:** □ Female □ Male □ Other (specify) _____

Child's Sexual Orientation: □Straight/Heterosexual □Gay/Lesbian □Bisexual □Other(specify) _____

Child's Ethnicity: □Alaska Native/American Indian-Tribe: _____ □ Asian □ Black/African American
□Native Hawaiian/Pacific Islander □White/Caucasian □Other(specify) _____
□Decline to answer

Name of Person Completing this Form: _____ **Relationship to Client:** _____

Parent 1

Parent 1's Name _____ Primary Phone _____ Secondary Phone _____
Parent 1's Address _____City _____ State _____ Zip _____

Parent 2

Parent 2's Name _____ Primary Phone _____ Secondary Phone _____
Parent 2's Address _____City _____ State _____ Zip _____

Legal Guardian _____ Phone Number (if different than above) _____
Child's School/Daycare _____

Name of Child's Doctor: _____ Phone Number: _____
Month and Year of Last Visit: _____
Any significant information from last visit: _____
_____

Name of Psychiatrist: _____ Phone Number: _____
Month and Year of Last Visit: _____
Any significant information from last visit: _____
_____

REASONS FOR SEEKING THERAPY & TREATMENT HISTORY

Primary Reason(s) for seeking services (check all that apply)

☐ ADD/ADHD
☐ Anger
☐ Anxiety
☐ Depression
☐ Grief/Loss
☐ Violent Outbursts
☐ School Problems
☐ Eating Disorder
☐ Sleeping Problems
☐ Fear/Phobias
☐ Sexual Concerns
☐ Alcohol/Drug Use
☐ Traumatic Events
☐ Parents' Separation/Divorce
☐ Abuse Victim
☐ Addictive Behaviors
☐ Behavioral Concerns
☐ Other
(Specify):_____

How long have the behaviors you are concerned with been present? _____
_____

What is the primary reason you are bringing in your child today? _____
_____
_____

If everything went as well as possible in therapy – what would be your ideal outcome of therapy? _____

_____

_____

Please ***list stressors or challenges*** that are influencing your child's behavior_____

_____

_____

Please list any ***psychiatric or "mental"*** problems your child has been diagnosed with_____

_____

_____

Please list any ***medical or "physical"*** problems your child has been diagnosed with _____

_____

_____

Please list any **medications your child currently takes,** and what they are taken for: _____

_____

_____

Has your child ever been **hospitalized for psychological or psychiatric reasons**? ☐No ☐ Yes
If Yes, please describe when and where, and for which reasons: _____

_____

_____

Please tell us about any other **mental health professionals** your child has consulted with in the past (approximate dates, type of professional seen, reason for consultation, nature of treatment, outcome of the treatment) _____

_____

_____

_____

_____

CURRENT HABITS

Please describe your child's *current habits* in each of the following areas:

Smoking:_____
Drinking: _____
Drug Use: _____
TV Use: _____
Internet Use: _____
Video Game Use: _____
Caffeine Intake:_____
Exercise: _____
Eating: _____
Sleeping: _____
Fun and relaxation: _____
Chores and responsibilities:_____

_____

RELATIONSHIPS

Please describe your child's relationships with the following people, if applicable:

Biological Mother:_____
Biological Father: _____
Step-parents: _____
Legal Guardians: _____
Siblings:_____
_____
Extended Family: _____
Friends:_____
Romantic Partner(s): _____
Total number of close, supportive relationships: _____

STRESSFUL LIFE EVENTS

Please describe any significant or stressful life events that your child has been experiencing:

	No	Yes	If yes, please describe
A recent move or change in school?			
Abuse or neglect?			
Bullied or ignored by peers?			
Academic difficulties?			
Weight control issues?			
Sexual orientation concerns?			
Self-injury?			
Death or Illness of a loved one or pet?			
Family conflict?			
Separation or Divorce?			
Other?			

What are your child's positive qualities? What do you like about your child? What qualities have helped your child to succeed at overcoming difficulties in the past?

Please tell us about your child's interest (sports, hobbies, talents, etc.)

Does your child agree that the problem that he/she/they are seeking help for is problematic?

What concerns do you have about your child attending therapy?

Is there anything else you would like to mention?

CONFIDENTIALITY AGREEMENT

Information about clients and their families is confidential with exception to the following:

1) Authorization by the client and/or family (valid authorization form).
2) Therapist's duty to warn another in the case of potential suicide, homicide or threat of imminent, serious harm to another individual.
3) Therapist's duty to report suspicion of abuse or neglect of children or vulnerable adults.
4) Therapist's duty to report prenatal exposure to cocaine, heroin, phencyclidine, methamphetamine, and amphetamine, THC (marijuana), excess & habitual use of alcohol or their derivatives.
5) Therapist's duty to report the misconduct of mental health or health care professionals.
6) Therapist's duty to provide a spouse or parent of a deceased client access to their child or spouse's records.
7) Therapist's duty to provide parents of minor children access to their child's records. Minor clients can request, in writing, that particular information not be disclosed to parents. Such a request should be discussed with the therapist.
8) Therapist's duty to release records if subpoenaed by the courts or a court order issued by a judge.
9) Therapist's obligations to contracts (e.g. to employer of client, to an insurance carrier or health plan.)
10) In case of emergency – including serious injury or concern of serious injury to client, therapist will have the option of contacting client's emergency contact noted below.
11) If paying with a credit card – our credit card processor may require us to provide proof of service – which can include a signed receipt or a signed agreement. This is universally true if you decide to dispute the charge.
12) At times at the Relationship Therapy Center we will work collaboratively as team to provide the best care for clients by having you see multiple RTC therapists. During this process the therapists regularly share confidential information. If you prefer your information not be shared during this collaborative process, please notify your therapists in writing.
13) At The Relationship Therapy Center of Minnesota, Inc. we undertake an extensive consultation process to insure clients are receiving the highest level of care. Consultation members are available upon request and include supervisors and clinical members. The purpose of this consultation is to obtain additional insight, further therapeutic skills, and insure the highest possible service to our clients. Every effort will be made to provide only those details necessary to gain feedback and maintain all confidentiality. Therapist reserves the right to consult with other clinicians at the Relationship Therapy Center about any/all aspects of our work together, and reveal identifying information if necessary.

- **My signature below indicates I understand the above limits of confidentiality for myself and my child**
- **The Client Bill of Rights is posted in the waiting room. Please review this.**
- **In addition, your signature below indicates that you have read the pages 1-10 of this document and agree to abide by its terms during our professional relationship and agree to the financial obligations of therapy and consultation.**
- **Your signature also serves as an acknowledgement that you have received pages 1-6 of the AGREEMENT described above or have refused a copy of the information.**

_____ _____

Client Signature Date

_____ _____

Client Signature or Parent/Guardian for minor Date

EMERGENCY CONTACT:

_____ _____

Emergency Contact's Name Emergency Contact's Phone Number

MINNESOTA NOTICE FORM

Notice from the Relationship Therapy Center, Inc (RTC)
Policies and Practices to Protect the Privacy of Your Client's Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

RTC may *use* or *disclose* your child's *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your child's health record that could identify you and/or your child.
- *"Treatment, Payment, and Health Care Operations"*
  – *Treatment* is when your child's therapist provides, coordinates, or manages your child's health care and other services related to your child's health care. An example of treatment would be when your child's therapist consults with another health care provider, such as your child's physician or a psychologist.
  - *Payment* is when RTC obtains reimbursement for your child's healthcare. Examples of payment are when RTC discloses your child's PHI to your child's health insurer to obtain reimbursement for your child's health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within our [office, clinic, practice group, etc.], such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies your child.
- "*Disclosure*" applies to activities outside of the clinic such as releasing, transferring, or providing access to information about your child to other parties.

II. Uses and Disclosures Requiring Authorization

RTC may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when RTC is asked for information for purposes outside of treatment, payment or health care operations, RTC will obtain an authorization from you before releasing this information. RTC will also need to obtain an authorization before releasing your child's psychotherapy notes. *"Psychotherapy notes"* are notes your child's therapist has made about their conversations during a private, group, joint, or family counseling session, which have been kept separate from the rest of your child's medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) RTC has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

RTC may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If your child's therapist knows or has reason to believe a child is being neglected or physically or sexually abused, or has been neglected or physically or sexually abused within the preceding three years, your child's therapist must immediately report the information to the local welfare agency, police or sheriff's department.

- **Adult and Domestic Abuse:** If your child's therapist has reason to believe that a vulnerable adult is being or has been maltreated, or if your child's therapist has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, your child's therapist must immediately report the information to the appropriate agency in this county. Your child's therapist may also report the information to a law enforcement agency.

  "*Vulnerable adult*" means a person who, regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:
  (i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and
  (ii) because of the dysfunction or infirmity and the need for assistance, the individual has an impaired ability to protect the individual from maltreatment.

- **Health Oversight Activities:** The Minnesota Board of Marriage & Family Therapy and the Minnesota Board of Behavioral Health and Therapy may subpoena records from RTC if they are relevant to an investigation it is conducting.

- **Judicial and Administrative Proceedings**: If you or your child is involved in a court proceeding and a request is made for information about the professional services that RTC has provided to your child and/or the records thereof, such information is privileged under state law and RTC must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when your child is being evaluated for a third party or where the evaluation is court-ordered. Your child's therapist will inform you in advance if this is the case.

- **Serious Threat to Health or Safety**: If you or your child communicate a specific, serious threat of physical violence against a specific, clearly identified or identifiable potential victim, your child's therapist must make reasonable efforts to communicate this threat to the potential victim or to a law enforcement agency. Your child's therapist must also do so if a member of your family or someone who knows you or your child well has reason to believe your child is capable of and will carry out the threat. Your child's therapist may also disclose information about your child necessary to protect your child from a threat to commit suicide.

- **Worker's Compensation**: If your child files a worker's compensation claim, a release of information from your child's therapist to your child's employer, insurer, the Department of Labor and Industry or you will not need your prior approval.

IV. Patient's Rights and Clinician's Duties

Patient's Rights:

- *Right to Request Restrictions* –You and your child have the right to request restrictions on certain uses and disclosures of protected health information. However, RTC is not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You and your child have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen at RTC. On your request, RTC will send bills to another address.)

- *Right to Inspect and Copy* – You and your child have the right to inspect or obtain a copy (or both) of PHI (and psychotherapy notes) in RTC's mental health and billing records used to make decisions about your child for as long as the PHI is maintained in the record. Your child's therapist may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, your child's therapist will discuss with you the details of the request and denial process.

- *Right to Amend* – You and your child have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your child's therapist may deny your request. On your request, your child's therapist will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, your child's therapist will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from RTC upon request, even if you have agreed to receive the notice electronically.

Clinician's Duties:

- RTC is required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- RTC reserves the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will send you a copy by mail or give you a copy in session.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision your child's therapist makes about access to your records, or have other concerns about your child's privacy rights, you may contact the clinic owner, **Jeb Sawyer, at 612-483-4994.**
If you believe that your child's privacy rights have been violated and wish to file a complaint with *our office*, you may send your written complaint to:

Jeb Sawyer, MA, LMFT
5407 Excelsior Blvd, Suite B
St Louis Park, MN 55416

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. Your child's therapist will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on 4/14/03

RTC reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that your child's therapist may maintain. RTC will provide you with a revised notice by mail or in session.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED OR REFUSED A COPY OF THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____

Signature of Client (Parent/Guardian for Minor) Date

_____ _____

Signature of Client (Parent/Guardian for Minor) Date

POLICY ON OUT OF NETWORK INSURANCE V3.0

APPLICABLE TO ALL INSURERS EXCEPT BLUE CROSS AND MOST PLANS THROUGH PREFERRED ONE, AETNA, HEALTH PARTNERS, AND CIGNA.

Increasingly over the past 9 years most Insurance Companies have saved money by decreasing benefits for out of network providers. The result has been a lot of confusion about benefits for these plans.

Therefore, at the Relationship Therapy Center we want to give you as much pertinent information up front so you can make informed decisions regarding your therapy experience. Please make sure you understand the following:

- If your child does not have an insurance plan through Blue Cross, Preferred One, Aetna, Health Partners, or Cigna – your child's provider is going to be out of network (some Health Partners, Preferred One and Cigna plans are out of network also). Out of Network benefits are almost always different than in network benefits.

- When checking benefits the information we receive from some insurers has become either unreliable or impossible to attain. The result is that we need to pass this responsibility on to you as the responsible party. We strongly recommend you contact your child's insurer and obtain their *Out of Network Benefits* directly from them. Because insurers are so unpredictable we no longer check out of network benefits for clients.

- You will be responsible for paying your child's portion of the bill. The estimated amount for the session is due at the time of session.

- If your child has out of network coverage and you obtain a code from your insurer – we can not use that code to bill insurance. Some insurers will say that it works – we have universally found that it never works.

- We do not accept EAP plans.

By signing below you agree to the above information and terms:

_____

Responsible Party Printed Name

_____ _____

Responsible Party Signature Date

NOTICE OF NON-COVERED SERVICES

At the Relationship Therapy Center we strive to provide the most cutting edge treatments. Unfortunately, not all of these services are covered by Healthcare Insurers. Please understand the following procedures will not be covered by your insurance and will be your sole responsibility (fees for these services are in parentheses):

- **Sessions longer than 1 hour (Some Blue Cross Policies do cover both a family and individual session in one day.) Each additional 53-60 minutes ($185). 45 minute sessions ($140). Family therapy – ($185).**
- **Therapy services via phone calls, e-mails, and texts. Billed by the minute ($3/minute)**
- **Other professional time including writing reports, some consulting with other professionals with your permission, and the time spent performing any other service you may request of your therapist. If you become involved in legal proceedings that require therapist participation, you will be responsible to pay for all of your therapist's professional time, including preparation and transportation costs, even if a 3rd party is the requestor ($325 for each 60 minutes).**
- **Coaching Services – price determined by length (from $75-$185)**
- **Family Therapy (90846 & 90847) is not covered by all insurers ($185 for 45 Minutes)**
- **Telehealth is not covered by some insurers (from $95-$185)**
- **Psychoeducation classes ($50-$495)**
- **Individual Intensive Therapy Group – 3 Days ($999-$1,499)**
- **Fill in other services that will not be covered below:**

We are happy to provide a receipt for all services you receive and we encourage you to follow up with your child's insurer or health savings plan to see if you are eligible for reimbursement.

Please talk to us with any questions you may have.

By signing below I:

- Understand the specific services listed above are non-covered through my child's health insurer and
- Understand all charges will be my responsibility

_____ _____

Client Signature Date