RPS | REED PSYCHOLOGICAL SERVICES

CLIENT INFORMATION PACKET

This information packet will help you become familiar with our approach to therapy, our policies and procedures, and rights and responsibilities related to your care at Reed Psychological Services, PLLC (RPS). You will also find information about the Health Insurance Portability and Accountability Act (HIPAA) and your Protected Health Information (PHI). You may be asked to complete additional forms that ask for information about you and your mental health needs in order for us to determine the best therapy options for you as you begin this journey. If you have any questions about this information, please feel free to discuss this with us at any time.

THE FOLLOWING DOCUMENTS ARE INCLUDED FOR YOU TO REVIEW, COMPLETE AND SIGN PRIOR TO YOUR FIRST APPOINTMENT:

- INTRODUCTION TO CARE AT REED PSYCHOLOGICAL SERVICES
- COST OF CARE AT RPS
- CLIENT REGISTRATION FORM
- INSURANCE AND BILLING AUTHORIZATION
- FINANCIAL POLICY AND AGREEMENT TO PAY FOR SERVICES
- CONSENT TO RECEIVE OUTPATIENT MENTAL HEALTH SERVICES
- CONFIDENTIALITY AGREEMENT
- CLIENT(S) BILL OF RIGHTS

LOCATION OF OUR CLINICS

Reed Psychological Services, PLLC has two locations, one in Plymouth, MN and one in Minnetonka, MN. Please contact us if you need directions from your specific location.

Lake West Building
14525 West Hwy 7
Suite 255
Minnetonka, MN 55345

Willow Creek Building
9800 Shelard Parkway
Suite 110
Plymouth, MN 55441

RPS | REED PSYCHOLOGICAL SERVICES

INTRODUCTION TO CARE AT REED PSYCHOLOGICAL SERVICES

Welcome to Reed Psychological Services (RPS)! RPS is deeply committed to providing the highest quality therapeutic services to children, adolescents, adults, couples, and families in the Twin Cities Metro Area. Our mission is to deliver the most effective and contemporary evidence-based strategies within an empathic and empowering therapeutic environment.

Psychotherapy, also called "talk therapy" is a process whereby psychological problems are treated through communication and relationship factors between an individual and a trained mental health professional. Individual and group psychotherapy varies depending on the clinical approach and style of the clinician, and the specific needs, preferences and personality traits of the client(s). At RPS, there are many different approaches and methods our clinicians may use to help you achieve your therapeutic goals. Effective psychotherapy calls for active engagement on your part, and may include (with your permission) other important people in your life.

Psychotherapy can have benefits and risks. Since it may involve discussing unpleasant experiences in your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, research has shown that psychotherapy has many benefits. Successful psychotherapy can lead to more satisfaction in relationships, new possibilities for addressing specific problems, and/or reductions in feelings of distress. There are no guarantees of what you will experience because each person who enters psychotherapy is very unique.

Your first few sessions will involve an evaluation of your needs and goals. By the end of the evaluation, you will be able to discuss your first impressions of what your therapy could include and a potential plan to follow. During this time, you and your therapist together will decide if your therapist is the best person to provide you with therapeutic services. Therapy can involve a significant investment of time, energy, and money so it is important you select a therapist you are comfortable working with. If at any time you have questions or concerns about your treatment, please discuss these with your therapist or feel free to contact the Owner, Dr. Eva Reed at 763.251.6491 or via email at eva@reedpsychology.com. If you decide you do not want to continue in therapy, please inform your therapist. We do recommend a final session for closure. If you want help finding another therapist or other appropriate resources, we will happily assist you in doing so.

RPS providers come from diverse educational and training backgrounds, with varied sets of clinical expertise and specialties. Providers who work in our clinics are Psychologists, Professional Clinical Counselors, Clinical Social Workers, Marriage and Family Therapists, Drug and Alcohol Counselors, and Mental Health Trainees. Your provider's credentials are available on our website and with our front desk. Your provider will also discuss their qualifications with you during your first appointment.

COST OF CARE AT RPS

You will be expected to pay the full fee for each session at the time of the appointment unless we are billing insurance. In that case, we will ask that you pay any copayment or coinsurance required by your particular plan. You may use cash, credit cards, PayPal, or checks made out to Reed Psychological Services, PLLC. ***Follow up sessions may not be scheduled until you are paid in full in order to avoid you or the clinic incurring a debt or financial difficulty.*** ***Please refer to the Financial Policy and Agreement to Pay for Services for more information.***

SERVICE	FEE
Diagnostic Evaluation (60 minutes)------------	$250
Psychotherapy (60 minutes)---------------------	$200
Psychotherapy (45 minutes)---------------------	$175
Psychotherapy (30 minutes)---------------------	$100
Group Psychotherapy (per 60 minutes)------	($75-100) *fees vary per group*
Family Psychotherapy (60 minutes)------------	$200
Couples Psychotherapy (60 minutes)---------	$200
Psychological Testing (per 60 minutes)-------	*Rates vary by type of testing and provider*
Discernment Counseling (60 minutes)---------	$275
Missed Appointment or Late Cancel----------	$50-100 *not covered by insurance*

We provide private pay and sliding scale fee options for clients without insurance and/or who are experience financial hardship

Fees may be updated or changed. RPS will notify you if there have been any changes to our fee schedule.

Medication Management Rates: Our Nurse Practitioner has a separate fee scale. This will be provided upon request.

Missed Appointments or Late Cancelations: Once an appointment is scheduled, you will be expected to pay a fee decided per your provider unless you provide **24 hours advance notice of cancellation**. It is important to note that insurance companies do not provide reimbursement for cancelled sessions and you must pay for the time reserved for your session. New sessions may not be scheduled without payment.

Other Fees: In addition to appointment fees, we charge $200 per hour for other professional services you may need, though we will pro-rate the hourly cost if we work for periods of less than 60 minutes. Other services include report writing, telephone conversations or email taking longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request. These services may not be covered by insurance. If you become involved in legal proceedings that require our participation, you will be expected to pay for all of our professional time, including preparation and transportation costs, even if we are called to testify by another party. We charge $250 per hour for preparation and attendance at any legal proceeding in addition to mileage to and from the location.

RPS | REED PSYCHOLOGICAL SERVICES

CLIENT REGISTRATION FORM

Date___________________

Client Name (first name, middle initial, last name) _________________________________

Date of Birth__________________

Street Address____

City_______________________________________ State____________ ZIP__________

Home Phone (_____) ___________________________________ May we leave a message? (( ) yes ( ) no

Work Phone (_____) ____________________________________ May we leave a message? ( ) yes ( ) no

Email Address ____May contact via email? ( ) yes ( ) no

Soc. Sec. #___________----____________----_________

Sex: Female___ Male___ Gender Identity: _____________________

Marital Status: Single___ Married___ Widowed___ Divorced___ Separated___ Other:___________

Employer____Occupation______________________

Referred by: Psychology Today___ RPS Website___ Another Provider ___Friend/Family___

Other ______________________________________May we acknowledge this referral? ( ) yes ( ) no

Are you (the Client) receiving psychiatric services, or psychotherapy elsewhere? ( ) yes ( ) no

Have you had previous psychotherapy?

( ) no

( ) yes, with (previous therapist's name and organization)_______________________________________

Are you currently taking prescribed psychiatric medication (antidepressants or others)? ( ) yes ( ) no

If yes, please list: ____

Prescribed by (name and organization): ____

Complete if Client is under 18 years old and/or has legal guardianship:

Parent/Legal Guardian Name ____

Parent/Guardian Primary Phone (_____) _________________ May we leave a message? (Yes , No)

Parent/Guardian Email Address ____________________________May contact via email? (Yes , No)

Second Parent/Legal Guardian Information (Optional)

Parent/Legal Guardian Name____

Parent/Guardian Primary Phone (_____) _________________ May we leave a message? (Yes , No)

Parent/Guardian Email Address ____________________________May contact via email? (Yes , No)

In case of emergency please contact the following person(s):

Emergency Contact________________________ Emergency Phone (_____) __________________

Relationship to Emergency Contact___________________________

INSURANCE AND BILLING AUTHORIZATION

INSURANCE INFORMATION

RPS provides in network services for a wide variety of insurance providers. We are in-network with the following insurance companies: Blue Cross Blue Shield, , HealthPartners, Preferred One, Fairview's Preferred One Plan-BHP, Magellan, Cigna, UCare, TriCare, Medicare, Medica/UBH/Aetna, and Medical Assistance. We also provide documentation of billing and services if you prefer out of network coverage.

Please call the number on your insurance card to verify your coverage for mental health services. If you are out-of-network, your insurance company can give you information on your out of pocket expenses. You can also submit receipts from our clinic for reimbursement under certain out-of-network plans.

Verification of mental health benefits and preauthorization for services: As a courtesy to you, we obtain information regarding your mental health benefits and preauthorization. You will be provided with the information we are given by your health plan and we encourage you to refer to your policy manual or call your plan to confirm the information provided to us.

Co-payments: Co-payments are set by your insurance provider. They may be listed on your insurance card, otherwise they can be obtained by calling the plan. Co-payments are due at each appointment.

Deductibles: The amount you need to pay before insurance "kicks in". Often resets every January 1st. If the deductible required by your plan has not been reached, we may need to collect the full amount for services at the time of your appointment.

Referrals: If you are covered by a managed care insurance plan which requires referrals, you must obtain referral forms from your primary care physician prior to your visit. Please note that a written referral is a requirement of the insurance company and that we must adhere to the plan's administrative requirements in order to receive payment on your behalf.

Limits: Frequently, mental health benefits are limited per calendar or plan year. Please consult your policy manual regarding your maximum calendar year or plan year benefits.

Testing: Neuropsychological, psychological, and developmental testing benefits are always verified by our staff. Most insurance companies limit the number of testing hours covered. If you require testing beyond the number of hours authorized, you have the option of paying for the additional hours required for testing.

INSURANCE AUTHORIZATION: At times, your health insurance company may require that we provide them with information relevant to the services that we provide to you. We may have to provide a clinical diagnosis. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. If you pay for your services out-of-pocket, we are not required to give you a formal diagnosis and this allows for more freedom in therapy. By signing our *Financial Policy and Agreement to Pay for Services*, you agree that we can provide requested information to your insurance carrier. **Please call the number on the back of your insurance card to find out more about your coverage.**

RPS | REED PSYCHOLOGICAL SERVICES

Primary Insurance Company: ____

Policy/ID #_________________________ Group/Plan #__________________

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

Name__________________________________ Relationship_____________

Address________________________________

City____________________ State_____ Zip_______ Date of Birth_________

Secondary Insurance Company (if applicable):___________________________

Policy/ID #_________________________Group/Plan #__________________

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

Name__________________________________ Relationship _____________

Address____

City______________________ State_____ Zip_______ Date of Birth__________

<u>AUTHORIZATION TO USE CREDIT CARD:</u> We accept payment by cash, credit cards, or checks made out to Reed Psychological Services, PLLC. All co-pay, co-insurance, sliding fee scale, payment plan, and deductible amounts are due on the date of service. **If client payments are not made on the date of service, or if arrangements for an alternate payment plan have not been made, the credit or debit card on file in our office will be charged for the full account balance on the fifteenth of each month.**

Who is responsible for payment? Please complete if responsible party is different than Client:

Name ________________________________Relationship to Patient_____________________

Phone___________________ Address__________________City_________Sate____Zip________

Card Type (Visa, MasterCard, other)_________________

Card#______________________________________Expiration Date__________

V-Code (3-digit code) __________ Billing Address: ( ) Check if same as Client

Address____

City_______________________________ State_______ Zip_______________

Please initial next to your preferred payment method:

_______ I prefer RPS to charge the credit or debit card for the full account balance on the fifteenth of each month.

_______ I prefer to make payments on the date of each service. *If payments are not made on the date of service, my credit or debit card on file will be charged for the full account balance on the fifteenth of each month.*

_______ I am on an alternative payment plan with RPS. *If you are experiencing a financial hardship and need an alternative payment schedule, please talk to the front desk or speak to your provider about options.*

RPS | REED PSYCHOLOGICAL SERVICES

FINANCIAL POLICY AND AGREEMENT TO PAY FOR SERVICES

Reed Psychological Services, PLLC is committed to providing caring and professional mental health care to all of our clients. As part of the delivery of mental health services, we have established a financial policy that provides payment policies and options to all consumers. The financial policy of the clinic is designed to clarify the payment policies as determined by the management of the clinic. Payment for services is considered part of your treatment and we want to ensure that you understand your financial rights and responsibilities related to your care at RPS. Understanding and completing this form will allow you to get the most out of your care and help us to best serve you.

Payment Responsibility: Payment for service is expected at the time of your appointment. We offer in-network and out-of-network insurance services. We also accept private pay and sliding scale options, when financial hardship is indicated. All co-pay and past due balances are due at the time of check-in unless previous arrangements have been made with the clinic. If you are unsure if you have a copay or deductible, please call the customer service number on the back of your insurance card to verify your coverage and benefits. We accept payment by cash, credit cards, or checks made out to Reed Psychological Services, PLLC. You are responsible for updating RPS on changes to your insurance and payment methods. For your convenience, we will keep a credit card on file and charge your balance monthly.

Telehealth: For telehealth sessions, RPS will charge the credit or debit card on file at the time of each appointment, unless an alternative payment plan is arranged.

Insurance: It is important to understand that our financial relationship is with you and not your insurance company. Your medical insurance policy is a contract between you and your insurance carrier and RPS is not a party to that contract. As a result, your coverage and responsibilities are determined by your policy and you are responsible for understanding and following their required procedures. On your behalf, we will submit all claims for our services with your primary and secondary insurance providers. It is your responsibility to provide us with sufficient, accurate, and up-to-date insurance information. If there is a discrepancy with the information you provide us, you will be considered self-pay (full fee or sliding scale fee) until this information is supplied. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. It is your responsibility to know if you have a copay or deductible. If you are unsure of your coverage and benefits, please call the customer service number on the back of your insurance card. We are in-network with several insurance providers. Out-of-network insurance means that you're responsible for paying for your sessions in full at the time of service and then we send you home with a "superbill" or receipt to be sent into your insurance company.

Cancellation and Late Fees: We require 24-hour advanced notice if you are unable to make your appointment. If an appointment is not cancelled at least 24-hours in advance, you will be charged a fee for missed sessions (fees vary per provider). It is important to note that insurance companies do not provide reimbursement for cancelled sessions and you must pay for the time reserved for your session. New sessions may not be scheduled without payment. A pattern of late cancellations or no shows may result in an attendance contract. Failure to adhere to attendance contracts will result in discharge from services at RPS.

Statements and Alternative Payment Options: We will send you a monthly itemized billing statement listing each office visit showing the balance owed. Statement balances are due upon receipt. If you are unable to pay your statement balance in full, it may be possible to establish a payment plan. Clients who have large bills due and are unable to make full payment of their bill should contact the clinic as soon as possible to make payment arrangements. Payment plans may reduce your monthly bill. The term and payment amount is determined by the amount owed. When financial hardship is indicated, a financial questionnaire with supporting documentation must be completed and approved for reduced monthly payments.

Collection Procedures: It is never our intention to cause hardship to our clients, only to provide you with the best care possible and the least amount of stress. It is our policy to help work out payment terms according to our client's financial needs. If you do not discuss payment options or make an honest attempt to pay your bill in a timely fashion, accounts will be turned over to a collection agency. All past due accounts will be sent three statements, 30, 60, and 90 days overdue. If no resolution is reached after 120 days from the date of service, the account will be sent to a collection agency or attorney, and you may be discharged from the practice.

I acknowledge that I have reviewed and agree to Reed Psychological Services, PLLC financial policy. I accept responsibility for the payment of any fees associated with my care. I understand that payments are due on the date of service. I agree that Reed Psychological Services, PLLC may bill the credit card on file for any payments which are my responsibility, that have not been paid on the date of service. I hereby consent for Reed Psychological Services, PLLC to utilize my credit card information for any outstanding balance. At times, your health insurance company may require that we provide them with information relevant to the services that we provide to you. By signing our Financial Policy and Agreement to Pay for Services, you agree that we can provide requested information to your insurance carrier. I understand and agree that such terms may be amended by the practice from time to time. This will remain in effect for all services rendered during your time as a client of Reed Psychological Services, PLLC. Questions regarding the financial policies can be directed to our front desk staff.

____   ____________________

Client(s) Signature or Parent/Guardian for minor   Date

____

Person Responsible for Payment of Account (If different from Client)

Signature____ Date________________

CONSENT TO RECEIVE OUTPATIENT MENTAL HEALTH SERVICES

HIPAA NOTICE OF PRIVACY PRACTICES

Effective as of October 1, 2014.

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH AND SUBSTANCE ABUSE INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). This Notice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes permitted or required by law. It also describes your right to access and control your health information in some cases. Your PHI means any of your written and oral health information which can be used to identify you. This is health information that is created or received by your health care provider, and relates to your past, present, or future physical or mental health. We are committed to protecting the privacy of the personal and mental health information you disclose to us. We are required by law to maintain the confidentiality of information that identifies you and the care you receive. When we disclose information to other persons and companies to perform services for us, we require them to protect your privacy, too. We must also provide certain protections for information related to your medical diagnosis and treatment, including HIV/AIDs, and information about alcohol and other substance abuse. We are required to give you this Notice about our privacy practices, your rights and our legal responsibilities.

WE MAY USE AND DISCLOSE YOUR MENTAL HEALTH INFORMATION:

For TREATMENT: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

For PAYMENT: Your PHI will be used, as needed, to obtain payment for your health care services. For example, we may contact your insurer to verify what benefits you are eligible for, to obtain prior authorization, and to receive payment from your insurance carrier.

For HEALTHCARE OPERATIONS: We may use or disclose, as needed, your PHI in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. We may also call you by name in the waiting room when your provider is ready to see you. You may revoke this authorization at any time, in writing, except to the extent that your provider or the provider's practice has taken action in reliance on the user or disclosure indicated in the authorization. Under the law, we must make disclosures to you upon request and when requested by the Secretary of the Department of Health and Human Services to investigate or determine our compliance.

For APPOINTMENTS AND SERVICES: We may use or disclose your PHI, as necessary, to contact you to remind you of an appointment, or tell you about treatment alternatives or health related benefits or services.

To INDIVIDUALS INVOLVED IN YOUR CARE, such as your parents, if you are a minor, or your conservator.

WITH YOUR WRITTEN AUTHORIZATION: We may use or disclose mental health information for purposes not described in this Notice only with your written authorization

WE MAY USE YOUR MENTAL HEALTH INFORMATION FOR OTHER PURPOSES WITHOUT YOUR WRITTEN AUTHORIZATION:

As REQUIRED BY LAW when required or authorized by other laws, such as the reporting of child abuse, elder abuse or dependent adult abuse.

For HEALTH OVERSIGHT ACTIVITIES to governmental, licensing, auditing, and accrediting agencies as authorized or required by law including audits; civil, administrative or criminal investigations; licensure or disciplinary actions; and monitoring of compliance with law.

In JUDICIAL PROCEEDINGS in response to court/administrative orders, subpoenas, discovery requests or other legal process.

To PUBLIC HEALTH AUTHORITIES to prevent or control communicable disease, injury or disability, or ensure the safety of drugs and medical devices. Health Oversight; Food or Drug

Administration requirements; Coroners, Funeral Directors and Organ Donation Programs

To LAW ENFORCEMENT for, example, to assist in an involuntary hospitalization process, or military activity and national security

To THE STATE LEGISLATIVE SENATE OR ASSEMBLY RULES COMMITTEES for legislative investigations.

For RESEARCH PURPOSES subject to a special review process, and the confidentiality requirements of state and federal law.

To PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY of an individual. We may notify the person, tell someone who could prevent the harm, or tell law enforcement officials.

To PROTECT CERTAIN ELECTIVE OFFICERS including the President, by notifying law enforcement officers of potential harm.

For WORKER'S COMPENSATION: If you file a worker's compensation claim, we must furnish a report to your employer, incorporating our findings about your injury and treatment in order to determine your eligibility for compensation.

YOU HAVE THE FOLLOWING RIGHTS:

To Receive a Copy of this Notice, upon request, when you obtain care from Reed Psychological Services, PLLC.

To Request Restrictions. You have the right to request a restriction or limitation on the mental health information we disclose about you for treatment, payment or health care operations. You must put your request in writing. Your request must state the specific restriction and to whom you want the restriction applied. We are not required to agree with your request. If we do agree with the request, we will comply with your request except to the extent that disclosure has already occurred or if you are in need of emergency treatment and the information is needed to provide the emergency treatment.

To Inspect and Request a Copy of your Mental Health Record except in limited circumstances.

Under federal law, you may not inspect or copy the following records: Psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to law that prohibits access to such PHI. A fee will be charged to copy your record. You must put your request for a copy of your records in writing.

You may request to receive in an electronic format any of your records that are stored and readily producible in an electronic format. If you are denied access to your mental health record for certain reasons, we will tell you why and what your rights are to challenge that denial.

To Request an Amendment and/or Addendum to your Mental Health Record. If you believe that information is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record). Your request for amendment and/or addendum must be in writing and give a reason for the request. We may deny your request for an amendment if the information was not created by us, is not a part of the information which you would be permitted to inspect and copy, or if the information is already accurate and complete. Even if we accept your request, we do not delete any information already in your records. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

To Receive An Accounting of Certain Disclosures we have made of your mental health information. You must put your request for an accounting in writing.

To Request That We Contact You By Alternate Means (e.g., fax versus mail) or at alternate locations. Your request must be in writing, and we must honor reasonable requests.

Changes to this notice. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for information we already have about you as well as any information we receive in the future.

Contact Information: If you have any questions about this Notice, please contact RPS at 763-577-2489.

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of Health and Human Services. Or, you may file a complaint with us by notifying our office manager. You will receive notification in the event of a breach that affects your unsecured PHI.

REED PSYCHOLOGICAL SERVICES, PLLC POLICIES AND PROCEDURES

CONTACTING YOUR CARE TEAM:

BY PHONE: Your provider is available by phone during their business hours. Some of our providers have out of office phone contact policies for mental health emergencies. When they are unavailable, our telephone is answered by our receptionist during business hours (8 am- 8 pm, Monday through Friday) or voicemail after hours. We 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 us of the best time to reach you.

EMAILING OR TEXTING YOUR PROVIDER: Email and Text Messaging are commonly used ways of exchanging information, however, there is no guarantee that this form of communication is secure. RPS cannot ensure the security or privacy of the information exchanged. If you want to email your therapist please confirm their policy and preference since each clinician's preference may vary. Although they add convenience and expedite communication, it is very important to be aware that email and text communication can be accessed relatively easily by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through them.

You should also know that any email or text messages your therapist receives from you and any response sent back to you may become a part of your legal record and may be revealed if your records are summoned by a legal entity. If you communicate confidential or private information via SMS (text) or email, we will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and your therapist and our clinic will honor your desire to communicate on such matters via email or text messaging.

Please do not use email for mental health emergencies. Due to computer or network problems, emails may not be deliverable, and your therapist may not check emails daily.

CRISIS RESPONSE: If you are unable to reach your 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] on call or you can contact the *Crisis Intervention Center (Hennepin County) (612) 873-3161, the Hennepin County Mobile Crisis Team (COPE) (612)-596-1223, the St. Paul Ramsey Crisis Intervention Center at (651) 221-8922, the Suicide hotline (612) 873-2222or your local emergency services at 911*. If we will be unavailable for an extended time, we will provide you with the name of a colleague to contact should the need arise.

SOCIAL MEDIA POLICY: Please note that RPS is on various social media websites as a way to market the services we offer. To protect your confidentiality RPS encourages you to consider the public nature of social media before liking, fanning or following our social media postings. Messaging on Social Networking sites such as Twitter, Facebook, Google+, or LinkedIn is not secure. It could compromise your confidentiality to use wall postings, @replies, or other means of engaging with RPS or your therapist online if we have an already established client/therapist relationship. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you have questions, please contact your therapist or our clinic administrator who can help clarify questions you may have

HOW TO ACKNOWLEDGE IN PUBLIC SETTINGS: If one of our staff or therapists happens to see you outside of our counseling office setting in the public, we will only acknowledge you if you greet or acknowledge us. This is to respect your confidentiality.

ELECTRONIC RECORDS: RPS utilizes a HIPAA-compliant electronic healthcare record (EHR) system in order to protect your confidentiality and privacy. The EHR provider has a Business Associate Agreement (BAA) with us that complies with HIPAA standards.

RELEASE OF RECORDS: Minnesota law and professional standards require that we keep treatment records. You are entitled to examine and/or receive a copy of your records if you request it in writing. It is our recommendation that you and your therapist discuss the contents of your record together. Because these are professional records, they can be misinterpreted or difficult to understand by those who are not mental health professionals. All information regarding patients is considered strictly confidential and will not be given out to other entities or individuals without your written consent, unless otherwise allowed by law. In the event of a request for transfer of records, the records will be forwarded upon completion of a consent form. Fees may apply for the copying and transmission of records.

TREATMENT OF MINORS:

PARENT AUTHORIZATION FOR MINOR'S MENTAL HEALTH TREATMENT: Treatment of children and adolescents is best done with the involvement of their caregivers and parents. Children with unmarried or divorced parents typically benefit from regular contact with both parents, unless it can be shown that this contact threatens the child's safety or mental health. Therapy is confidential, but not secret. Parents are entitled to understand the nature of their child's problem as well as the method and course of treatment.

In cases where there is joint (split) legal custody between parents or guardians who are not married or cohabitating, we require both parents' authorization and signature for treatment of their minor child/children. We believe it is best to identify and resolve potential parental conflicts or disagreements before treatment begins. We will not proceed with treatment if one parent is unavailable or unwilling to consent and we do not have a note from the child's medical doctor or legal representative determining that it is appropriate to proceed with the consent of only one parent. ***Please notify us if authorization from another parent/guardian is needed prior to treatment.***

DISCLOSURE OF MINOR'S TREATMENT INFROMATION TO PARENTS: Therapy is most effective when a trusting relationship exists between the provider and the client. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. Parents will be provided with general information about their child's treatment, but NOT specific information the child has disclosed in therapy without the child's consent. However, parents will be informed immediately if a child discloses information which puts them at risk of serious and imminent harm. In other situations, a child's provider may believe that it is important for parents to know about a particular situation that is going on in their child's life. In these situations, the provider will encourage the child to tell the parents and support the child in communicating this information. Parents are encouraged to consult with the child's provider about the disclosure of treatment information.

DISCLOSURE OF MINOR'S TREATMENT RECORDS TO PARENTS: Parents may have access to their child's medical records, however, often with mental health records it is often determined to not be in the best interest of the child or adolescent. Minnesota State Law entitles parents with legal custody to information regarding their child's treatment and generally entitles parents to copies of their child's health records. Minnesota State Law allows for an exception to the release of copies of health records in the case of mental health. Mental health records are kept confidential to protect the child's ability to speak freely about their relationships and concerns regarding each parent. It is rarely in the child's best interest to have therapy records read by parents. Parents are encouraged to meet regularly with their child's therapist and to stay informed of what is occurring in therapy. Arrangements can be made to observe appointments, review records in the office, and freely share information regarding the child's health and treatment.

Please note that child providers may have additional policies and procedures related to the treatment of minors. These will be discussed with minors and their parent(s)/guardian(s) at the prior to treatment.

INFROMED CONSENT TO TELEMEDICINE SERVICES: RPS offers Telemedicine psychotherapy services. Telemedicine allows your therapist to diagnose, consult, treat and educate using interactive video communication regarding your treatment. Minnesota State law requires Telemedicine to be delivered by means of real-time two-way, interactive audio and visual communications to provide or support health care delivery. RPS utilizes a HIPAA compliant Telemedicine service, Doxy.me. Telemedicine may be used as a substitute for in-office visits when it is determined an appropriate and effective means of delivering care, such as when access to transportation is limited by mode or distance from RPS clinics.

CONFIDENTIALITY: Clients have the right to confidentiality with Telemedicine under the same laws that protect the confidentiality of medical information for in-person psychotherapy. Similarly, the same limits to confidentiality exist with Telemedicine. It is important to note that Minnesota State Law requires your therapist to document your location for all Telemedicine sessions.

COST: Cost of Telemedicine care is the same for in-office services. Minnesota State Law requires insurance providers to cover Telemedicine services where it is determined an appropriate and effective means of delivering care, however, limits to Telemedicine coverage vary by insurance provider and plan.

RISKS AND BENEFITS: It is important that clients understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, while clients may benefit from Telemedicine, results cannot be guaranteed or assured. It is important that clients further understand that there are risks unique and specific to Telemedicine, including but not limited to, the possibility that therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. In addition, Telemedicine treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services.

You have the right to discuss Telemedicine care options and policies and procedures related to the provision of Telemedicine services with your therapist. Your therapist will also discuss Telemedicine safety protocols before, during, and after you receive Telemedicine services with RPS.

ENDING TREATMENT: You have the right to end your treatment at any time without permission or agreement. However, if you do decide to exercise this option, we encourage you to talk with your therapist about the reason for your decision in one or more termination sessions so that you and your therapist can bring sufficient closure to your work together. You and your therapist can also discuss any referrals you may need at that time.

As a therapy service, we also reserve the right to terminate therapy at our discretion. Reasons for termination include, but are not limited to untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, or patient needs that are outside of your provider's scope of competence or practice. If we are to end treatment, we will provide you with appropriate referrals.

Reed Psychological Services, PLLC , reserves the right to change the policies, practices, and procedures described in this document. We will notify you in writing of any significant changes. ***By signing this document, you are attesting that you have received, read, fully understand and consent to the disclosures, terms, and conditions above, contained in the CONSENT TO RECEIVE OUTPATIENT MENTAL HEALTH SERVICES. By signing this document, you are also consenting to participation in services provided by Reed Psychological Services, PLLC.***

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Client(s) Signature or Parent/Guardian for minor Date

CONSENT TO RECEIVE MEDICAL CARE AND TREATMENT

The following information and informed consent are required for participation in RPS' medication management services. This form must be completed prior to medical consultation at RPS.

CONSENT FOR MEDICAL CARE AND TREATMENT:

You have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedures to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved.

I consent to and authorize the health care providers who may be involved in my care to provide such diagnosis, care and treatment considered necessary for the care I am seeking or as may otherwise be advisable for my well being. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, or test, performed at Reed Psychological Services, PLLC.

PATIENT RIGHTS AND RESPONSIBILITITES: I understand that I have the right, and the responsibility, to participate in my care and treatment. I understand that I have the right to be informed about the treatment being recommended, and the responsibility to ask questions if I do not understand it. I agree to provide accurate and complete information about my health history and presenting complaint, to agree upon a treatment plan, and follow that plan. I agree to participate and cooperate in my own care and treatment. I understand that my health care providers will treat me with respect, and I agree to do the same for them. If I have any concerns regarding any treatment recommended by my health care provider, I will ask questions and discuss the potential risks and benefits.

USE AND DISCLOSURE OF HEALTH INFORMATION: I understand that Reed Psychological Services, PLLC will use and disclose my health information for the purposes of treatment, payment, and healthcare operations. I understand, acknowledge and consent to the release of my personal health information for the purposes outlined in this section and as may otherwise be permitted by law.

I understand and acknowledge that Reed Psychological Services, LLC may record medical and other information related to my treatment in electronic format and that such information will be used in the course of my treatment, for payment purposes, and to support healthcare operations. I give consent for my treating health care providers to exchange information with other health care professionals and providers (for example physicians, consultants, hospitals, nursing homes, home health agencies and pharmacies) about my prior and current health conditions to facilitate treatment, as outlined on specific Release of Information forms.

As applicable, I specifically consent to the release by Reed Psychological Services, LLC of any and all information, test results and records regarding my treatment for drug or substance abuse, alcoholism, mental health, HIV or AIDS to: 1) my treating physicians and other healthcare providers, and; 2) any private health insurance plan, Medicare, Medicaid, other governmental insurance program or other third-party payer identified to obtain payment for the treatment and services provided to me.

LATE CANCEL / NO SHOW APPOINTMENTS: I understand that once I have scheduled time with the provider for consult, I am obligated to pay a fee unless cancelled more than 24 hours before the scheduled visit. The visit fee will be sent to my insurance for processing and a co-pay may be due at the time of service.

If I cancel my appointment within 24 hours of the scheduled appointment or do not show up to the appointment, I will incur a late cancel/no show fee of $100. Exceptions to the fee will be at the provider's discretion for medical related reasons and inclement weather.

***PATIENT CERTIFICATION:* I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. I intend for this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. I consent to treatment at this office or any other satellite office under common ownership. This consent will remain fully effective until it is revoked in writing. I understand that I have the right at any time to discontinue services.**

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Client(s) Signature or Parent/Guardian for minor Date

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Printed Name of Patient or Parent/Guardian for minor

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CONFIDENTIALITY AGREEMENT

By law, information about client(s) and their families is confidential with some of the following main exceptions:

1. Authorization by the client(s) 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 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(s) 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 client(s) 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.
9. Therapist's obligations to contracts (e.g. to employer of client(s), to the paying agency or person, to an insurance carrier or health plan.
10. Therapist's duty to offer a detailed HIPAA Notice of Privacy Practices of Protected Health Information.

At Reed Psychological Services, we will sometimes consult with other therapists and providers. The purpose of this consultation is to attain additional insight, further therapeutic skills, and ensure the highest possible service to our client(s). Every effort will be made to provide only those details necessary to gain feedback. Your name and identifying information will never be used for these purposes.

My signature indicates I understand the above limits of confidentiality:

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Client(s) Signature or Parent/Guardian for minor Date

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CLIENT(S) BILL OF RIGHTS

As a client(s), you have the right to know and inquire about the following:

1. The cost of therapy, time frame for payment, access to billing statements, billing procedure for missed appointments, and any issues related to insurance coverage.
2. When the therapist is available and where to call during off hours in case of emergency.
3. The manner in which the therapist conducts sessions concerning intake, consultation, and termination. Client(s) may take an active role in the process by asking questions about relevant consultation issues, specifying goals, and renegotiating goals when necessary.
4. The nature and perspective of the therapist's work, including techniques used, and alternative methods of consultation.
5. The purpose and potential negative outcomes of therapy. Client(s) may refuse any intervention or strategy.
6. The anticipated length and frequency of treatment and limitations that may arise due to difficulties in financing.
7. The liberty of client(s) to discuss any aspect of their therapy with others outside the consultation situation, including consultation with other professionals.
8. The status of the therapist, including the therapist's training, credentials, and years of experience.
9. The maintenance of records, including security and length of time they are kept, client's rights to access personal records, and release policies.
10. The right to request a referral and the right to require the current therapist to send a written report regarding services to the qualified referred clinician or organization upon the client's written authorization.
11. The procedure followed in the event of the therapist death or illness.

Complaints may be submitted to any staff member without fear of recourse or punishment. If you feel your rights have been violated, you may file a grievance. Complaints about unprofessional conduct can be made to the mental health governing agencies located at 2829 University Ave SE, Minneapolis, MN 55414:

Minnesota Board of:	Suite	Phone	Email
Psychology	320	612.617.2230	psychology.board@state.mn.us
Behavioral Health & Therapy	210	612.548.2177	bbht.board@state.mn.us
Social Work	340	612.617.2100	social.work@state.mn.us
Marriage & Family Therapy	400	612.617.2220	mft.board@state.mn.us
Nursing	200	612.317.3000	nursing.board@state.mn.us

Your signature below indicates that you have read all pages of this document and agree to abide by its terms during our professional relationship. Your signature also serves as an acknowledgement that you have received this CLIENT INFROMATION PACKET and have been offered detailed HIPAA Notice of Privacy Practices of Protected Health Information.

____________________________________ ____________________

Client(s) Signature or Parent/Guardian for minor Date