Twin Cities Therapy
6800 France Avenue South, Suite 520
Edina, MN 55436
Cell 612.518.7300 Fax 612.524.5553

COUPLES CLIENT INFORMATION PACKET

This packet will help acquaint you with my office procedures, as well as provide information about your rights and responsibilities with regard to consultation. You will also find updated information about your rights pursuant to the Health Insurance Portability and Accountability Act (HIPAA). If you have any questions about this information, please discuss them with me 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 (e.g. insurance). In any case, I apologize for the redundancy and thank you for taking the time to fill out the forms.

PROFESSIONAL RELATIONSHIP

Professional consultation is not easily described in general statements. It varies depending on the personalities of the consultant and client, and the particular concerns you are experiencing. There are many different methods we may employ to attend to the concerns that you hope to address. Consultation is not like a medical doctor and calls for a very active role on your part. It might even include other important people in your life. Consultation can be more successful as you work on goals and strategies at home that we've talked about talk about during our sessions.

Consultation can have benefits and risks. Since consultation may involve discussing unpleasant experiences of your life, you may experience feelings like sadness, guilt, anger, frustration, loneliness, and/or helplessness. On the other hand, consultation has also been shown to have many benefits. Successful consultation 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 will experience.

Our first few sessions will focus on understanding your needs, goals, and presenting concerns. After these first few sessions, we will be able to discuss your first impressions of what our work could include and then co-create a potential plan to follow, if we decide to continue with consultation. It is important to evaluate this information along with your own opinions of whether you feel comfortable working together. Since consultation involves a commitment of time, money, and energy, it is important to be selective about the consultant you select. If you have questions about my procedures, we can discuss these whenever they arise. While we co-create possible solutions, you maintain the right to implement them, or decide against implementing any or all of them.

If more than a year goes by since our last session together, I will consider that you have decided to seek therapy elsewhere or have halted the therapeutic process. Our therapeutic relationship is thus legally severed. Should you wish to come back to therapy, feel free to schedule with me. Please note I am required by insurance to submit a new diagnosis and will require you to fill out new intake paperwork to update your files and you will be charged the intake session fee.

MEETINGS & PROFESSIONAL FEES

I conduct an intake session that ranges from 55-75 minutes at a cost of $220. Following the intake session we can both decide if I am the best person to provide the services you need in order to meet your goals. I will usually suggest one 55-minute session per week for a time and then we can meet less frequently as it makes sense to all parties given the work at hand. My fee per 55 minutes is $170. **Cancellations made less than 24 hours in advance will be subject to a $80 fee. Failure to show up for a session without a cancellation will be subject to an $110 fee. It is important to note that insurance companies do not provide reimbursement for cancelled or missed sessions.**

ADDITIONAL PROFESSIONAL FEES

In addition to weekly appointments, I charge $170 per 55 minutes for other professional services you may need, though I will break down the hourly cost if I work for periods of less than 55 minutes. Other services include report writing, telephone conversations lasting 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 of me. These services may not be covered by insurance. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, and **ANY** legal fees that I might incur, even if I am called to testify by another party. I charge $225 per hour for preparation and attendance at any legal proceeding in addition to mileage to and from any location.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. [If such legal action is necessary, its costs will be included in the claim.]

INSURANCE REIMBURSEMENT

At the present time I am a provider for Blue Cross Blue Shield, UCare and Preferred One. You should be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I 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. Though all insurance companies claim to keep such information confidential, I have 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 my services yourself to avoid the problems described above [unless prohibited by contract]. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

Please do not submit your claims unless I instruct you to do so as this might reject our claim to your health care provider. I process all insurance claims on your behalf unless your insurance plan specifically states that you must pay me directly and get reimbursed from them, in which case I will provide you with the necessary receipts for reimbursement.

CONTACTING ME

Due to the nature of my work schedule, I am often not immediately available by phone as I am usually with a client. When I am unavailable, my telephone, 612-518-7300 is answered by voicemail, which I monitor frequently. I am also available by email at Kathy@TwinCitiesTherapy.com and I will make every effort to return your call, text and/or email within 24 hours. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call or you can contact the Crisis Connection at (612) 379-6363 or your local emergency services at 911. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

For the sake of privacy, I have a policy of not accepting Friend requests on Facebook or Linking requests on LinkedIn.

CONCERNS

I urge you to discuss with me any questions or concerns you may have with the consultation you receive. 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 Minnesota Board of Psychology, whose number is 612.617.2238

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 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.
9) Therapist's obligations to contracts (e.g. to employer of client, to an insurance carrier or health plan.

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

1) The cost of counseling, 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, treatment, and termination. Clients may take an active role in the process by asking questions about relevant therapy issues, specifying therapeutic goals, and renegotiating goals when necessary.

4) The nature and perspective of the therapist's work, including techniques used, and alternative methods of treatment.

5) The purpose and potential negative outcomes of treatment. Clients may refuse any treatment 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 clients to discuss any aspect of their therapy with others outside the therapy situation, including consultation with another therapist.

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 therapist or organization upon the client's written authorization.

11) The procedure followed in the event of the therapist's death/illness.

MINNESOTA NOTICE FORM

Notice of Twin Cities Therapy
Policies and Practices to Protect the Privacy of Your Client's Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU 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

I may *use* or *disclose* your *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 health record that could identify you.
- *"Treatment, Payment, and Health Care Operations"*

– *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or a psychologist.

- *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

- *Health Care Operations* are activities that relate to the performance and operation of my 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 my [office, clinic, practice group, etc.], such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I 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 I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your 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) I have 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

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

- **Child Abuse:** If I know or have 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, I must immediately report the information to the local welfare agency, police or sheriff's department.

- **Adult and Domestic Abuse:** If I have reason to believe that a vulnerable adult is being or has been maltreated, or if I have knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, I must immediately report the information to the appropriate agency in this county. I 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 Psychology may subpoena records from me if they are relevant to an investigation it is conducting.

- **Judicial and Administrative Proceedings**: If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law and I 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 you are being evaluated for a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case.

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

- **Worker's Compensation**: If you file a worker's compensation claim, a release of information from me to your 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 have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You 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 seeing me. On your request, I will send your bills to another address.)

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

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I 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, I 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 me upon request, even if you have agreed to receive the notice electronically.

Clinician's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I 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 I make about access to your records, or have other concerns about your privacy rights, you may contact **Minnesota Board of Psychology, whose number is 612.617.2238.**

If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to:

Twin Cities Therapy
6800 France Avenue South, Suite 520
Edina, MN 55436
P :: 612.518.7300 F :: 612.524.5553

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

You have specific rights under the Privacy Rule. I 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 08.18.22

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail or in session.

Twin Cities Therapy Couples Client Intake Form

Date_____

IF YOU ARE USING INSURANCE, PLEASE ATTACH A PHOTOCOPY OF YOUR HEALTHCARE CARD OR BRING IT WITH YOU TO OUR FIRST SESSION.

Client Name

(Print)_____
Last Name First Name Initial

Street Address_____

City_____State_____Zip_____

Cell Phone ( )_____ Work/Home Phone ( )_____

Email _____ SSN _____

Sex: Female Male Age _____ Date of Birth: _____

Partner Status: Single Married Widowed Divorced Separated Other

Employer_____

Occupation _____

Hobbies/Special Interests_____

Primary Insurance Company_____

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

Name_____
Last name First Name Initial

Relationship To Client_____

Address_____

City_____State_____Zip_____

Date of Birth_____ Phone Number _____

EMERGENCY CONTACTS

My first priority in therapy is to maintain the safety of each of my clients. Due to this priority, if there comes a time when I am *severely* concerned with your safety or in a medical emergency, I ask that you provide two names of people I could call to check in with to insure your safety. If you are the parent of a client, there may be times when I am unable to contact you immediately and need someone else to verify your child's safety. Please list these individuals below.

First Emergency Contact Name _____ Relation to You? _____

Home Phone _____Work Phone _____ Cell/Other Phone _____

Second Emergency Contact Name_____ Relation to You? _____

Home Phone _____Work Phone _____ Cell/Other Phone _____

MEDICATIONS

Name of prescribing Psychiatrist or Doctor _____

Clinic Name _____

Address _____

Phone Number _____ Date of last appointment for meds _____

Medication(s) you are currently taking:

Name	What diagnosis is this treating?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Client 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 patient statements. I authorize the use of this signature on all insurance submissions.

_____	_____	_____
Responsible Party Signature	Relationship	Date

My signature indicates I understand the above limits of confidentiality.

_____	_____
Client Signature	Date
_____	_____
Client Signature or Parent/Guardian for minor	Date

I consent to treatment, have read and understand my rights listed above.

_____	_____
Client Signature	Date
_____	_____
Client Signature or Parent/Guardian for minor	Date

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 THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____	_____
Signature of Client (Parent/Guardian for Minor)	Date
_____	_____
Signature of Client (Parent/Guardian for Minor)	Date

CONFIDENTIAL QUESTIONNAIRE

Who referred you to Twin Cities Therapy?_____

What is the main concern or problem that brought you to therapy at this time?

_____

_____

_____

Who is the Person/Issue you are most concerned about and why?

_____

_____

_____

PROBLEM LIST

Listed below are possible challenges for you. Please rate each according to **your** degree of concern by circling the scale number and explain briefly, if you feel it would be helpful, what makes them a concern.

1.	Depression?	(Low) 1 2 3 4 5 6 7 8 9 10 (High)
2.	Suicidal Thoughts/Actions?	(Low) 1 2 3 4 5 6 7 8 9 10 (High)
3.	Worry/Anxiety?	(Low) 1 2 3 4 5 6 7 8 9 10 (High)
4.	Family/Relationship Conflict?	(Low) 1 2 3 4 5 6 7 8 9 10 (High)
5.	Verbal Abuse/Behavior?	(Low) 1 2 3 4 5 6 7 8 9 10 (High)
6.	Sexual Abuse/Behavior?	(Low) 1 2 3 4 5 6 7 8 9 10 (High)
7.	Physical Abuse/Behavior?	(Low) 1 2 3 4 5 6 7 8 9 10 (High)
8.	Legal Problems?	(Low) 1 2 3 4 5 6 7 8 9 10 (High)
9.	Internet Usage Concerns?	(Low) 1 2 3 4 5 6 7 8 9 10 (High)

10. Alcohol/Chemical Health Concerns? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

11. Gambling Concerns? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

12. Spiritual/Faith Concerns? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

13. Other Problem/Behavior? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

ASSESSMENT

Why do you think these problems are present for the two of you?

_____

_____

_____

PROBLEM SOLVING

What is the main goal or need you have for your first session?

_____

_____

_____

What attempts have the two of you made in the past to deal with these concerns?

Thank you for taking the time to fill out these extensive forms. My hope is the time you've taken will be the beginning of a fruitful consultation.

Twin Cities Therapy Significant Other's Intake Form

Date_____

Significant Other's Name

(Print)_____
Last Name First Name Initial

Street Address_____

City_____State_____Zip_____

Cell Phone ( )_____ Email _____

Work/Home Phone ( )_____

Sex: Female Male Age _____ Date of Birth: _____

Partner Status: Single Married Widowed Divorced Separated Other

Employer/School _____

Occupation_____

Hobbies/Special Interests_____

EMERGENCY CONTACTS

My first priority in therapy is to maintain the safety of each of my clients. Due to this priority, if there comes a time when I am *severely* concerned with your safety or in a medical emergency, I ask that you provide two names of people I could call to check in with to insure your safety. If you are the parent of a client, there may be times when I am unable to contact you immediately and need someone else to verify your child's safety. Please list these individuals below.

First Emergency Contact Name _____ Relation to You? _____

Home Phone _____Work Phone _____ Cell/Other Phone _____

Second Emergency Contact Name_____ Relation to You? _____

Home Phone _____Work Phone _____ Cell/Other Phone _____

MEDICATIONS

Name of prescribing Psychiatrist or Doctor _____

Clinic Name _____Phone Number _____

Medication(s) you are currently taking:

Name	What diagnosis is this treating?
_____	_____
_____	_____
_____	_____

My signature indicates I understand the above limits of confidentiality.

_____ _____

Client Signature Date

_____ _____

Client Signature or Parent/Guardian for minor Date

I consent to treatment, have read and understand my rights listed above.

_____ _____

Client Signature Date

_____ _____

Client Signature or Parent/Guardian for minor Date

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 THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____

Signature of Client (Parent/Guardian for Minor) Date

_____ _____

Signature of Client (Parent/Guardian for Minor) Date

CONFIDENTIAL QUESTIONNAIRE

1. What is the main concern or problem that brought you to therapy at this time?

_____

_____

_____

2. Who is the Person/Issue you are most concerned about and why?

_____

_____

_____

PROBLEM LIST

Listed below are possible challenges for you. Please rate each according to **your** degree of concern by circling the scale number and explain briefly, if you feel it would be helpful, what makes them a concern.

1. Depression? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

2. Suicidal Thoughts/Actions? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

3. Worry/Anxiety? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

4. Family/Relationship Conflict? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

5. Verbal Abuse/Behavior? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

6. Sexual Abuse/Behavior? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

7. Physical Abuse/Behavior? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

8. Legal Problems? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

9. Internet Usage Concerns? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

10. Alcohol/Chemical Health Concerns? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

11. Gambling Concerns? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

12. Spiritual/Faith Concerns? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

13. Other Problem/Behavior? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

ASSESSMENT

Why do you think these problems are present for the two of you?

_____

_____

_____

PROBLEM SOLVING

What is the main goal or need you have for your first session?

_____

_____

_____

What attempts have the two of you made in the past to deal with these concerns?

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Thank you for taking the time to fill out these extensive forms. My hope is the time you've taken will be the beginning of a fruitful consultation.