ACTS Therapy LLC
8170 Old Carriage Court North, Shakopee MN 55379
Phone: 612.483.4464; Fax: 952-465-3901
ATTN: Lisa Marie Raines, MA Adlerian Counseling & Psychotherapy, LMFT
lisa@acts-therapy.com
http:///www.acts-therapy.com

Treatment Contract/Registration

WELCOME! The most important goal of therapy is to help you feel and do better in your life. This is a solution-focused, goal directed approach for a wide variety of problems, from crises in daily living to ongoing mental health issues. It is especially important that you keep in close contact with family and supportive friends during a crisis and that you assume responsibilities for helping yourself. Treatment will be provided in the least restrictive environment possible.

We understand at times you may be in a psychological or life threatening crisis. Since our counselors are frequently in session with other clients and thus may not be immediately available to assist you through your crisis we ask that you follow the crisis procedures outlined below. Please discuss any questions you have about these procedures with your practitioner.

In a crisis situation please do the following:

1. If you are in a life-threatening crisis please go to the nearest emergency department or call 911 no matter what time of day it is.
   If you are in urgent need to talk to your therapist, please call or text your therapist. Include a phone number in any message you leave AND indicate that it is an urgent matter
2. If you are in crisis after 5:00 pm Monday through Friday, on the week-ends or on holidays, you may call the Crisis Connection at 612-379-6363. This is a free charge for you

Signatures indicate that you have read, understand and agree to the above.

Client Signature	Date
Parent Signature	Date
Therapist Signature	Date

Registration Form

CLIENT INFORMATION

Client name__________________________________Email_______________________________________

Address____________________________City___________________State_____Zip_________________

Home Phone_______________ Work Phone________________ Cell Phone________________________

Gender__________________ Date of Birth__________________ Relationship Status________________

Social Security #_______________________________ Employer_________________________________

Emergency Contact________________________________ Phone________________________________

INSURANCE

Primary Insurance Co: _____________________________________ Phone________________________

Address____________________________City___________________State_____Zip_________________

ID#___________________________ Policy #___________________Group #_______________________

Co-pay amt per visit _______Deductible _____Yes: _____No: Amount________: Effective date_______:

Prior Authorization or Referral Name and phone____

POLICY HOLDER INFORMATION

Insured Person___________________________________ Social Security #_______________________

Address____________________________City___________________State_____Zip_________________

Date of Birth__________ Relation to Client _______________Employer___________________________

SECONDARY INSURANCE

Insurance Co: ____ Phone________________________

Address____________________________City___________________State_____Zip_________________

ID#___________________________ Policy #___________________Group #_______________________

RESPONSIBLE PARTY

Name____Relationship_______________________

Address____Phone_____________________

I assign all benefits from insurance or other third-party coverage to be paid. I understand that by signing this form I acknowledge that if my insurance carrier or HMO/PPO does not cover certain service, I will pay for them in full. I authorize the release of any medical information necessary to process any claim for services provided. A photocopy of this authorization may be honored.

Signature: ____Date_______________________

Consent, Disclaimers, Fees, Waivers, and Other Conditions for Service

______: I/we, the undersigned, understand that these sessions are for individual, family and/or couple therapy. If more in-depth treatment, including possible use of medications, is needed in the opinion of ACTS Therapy LLC, I/we understand that the appropriate referrals for me/us will be made according to professional standards of practice.

_____: I/we understand that a confidential file (the medical record) about my/our appointments and proceedings will be kept. I/we can examine this file in the therapist/counselor's presence at a time arranged in advance by the client(s).

______: I/we understand that release of the medical record requires my/our signature on a statement of consent. In addition, I/we understand that exceptions to confidentiality are:

- Indicators that a minor is being abused or neglected
- Indicators that an elder or vulnerable adult is being abused or neglected
- Indicators that a pregnant female is abusing alcohol and/or drugs
- Indicators that a family member or I present a risk for causing harm to self or others

Should ACTS Therapy LLC find or suspect that any of these conditions are present, I/we expect that a break of confidentiality will occur to protect me/us and/or others.

______: I /we understand that ACTS Therapy LLC retains the professional privilege and right to, in an appropriate manner, confidentially consult with other professionals regarding my/our situation. Names will not be used unless serious danger in some form is believed to be imminent.

_____: I/we understand that there is a right to privacy in the individual, couple, and or family therapy process ACTS Therapy Therapists are not in a position to monitor me/us on a daily basis. Consequently, responsibilities that I/we agree to fulfill when receiving serves are:

- To independently schedule and attend appointments with sufficient frequency to meet my/our needs
- To voluntarily notify the therapist/counselor about any dangers and risks, and discuss the circumstance
- To monitor my own phone, text, email or technology if choosing to contact therapist in this manner

_____: I/we understand that ACTS Therapy LLC fee for service and notification guidelines:

- If utilizing insurance:
  - Eligibility for services will be attempted if client(s) gave insurance information before first appointment. HOWEVER this does not guarantee payment for the services. Some situation that may fall into this category are as follows:
    - A diagnosis that your insurance company deems "not medically necessary"
    - Marriage/couple's counseling
    - A diagnosis that your insurance company has excluded from coverage
    - A service rendered that is not covered under your Member Benefit Contract

- While we will attempt to obtain prior authorization your insurance company may deny continued sessions for a variety of reasons. If this happens and you decide you would like to continue in therapy, there is an appeals process with your insurance company.
- If your insurance no longer covers services and you wish to continue therapy, you may do so with the understanding that you are responsible for the total payment at the time service is rendered.
- You are responsible to find out if a deductible is required and to pay that until amount reached and to pay full amount of fee until deductible is met
- Co-pays and Deductibles are due at the beginning of each session.
- Cancellations or changes must be arranged 24 hours in advance. A charge will be imposed if the client or clients "no show".

_____: I/we understand that should ACTS Therapy LLC be requested to render any type of service on my/our behalf "between sessions" and/or "out of session", I/we agree to ACTS Therapy at the rate of $25.00 per 15minute increment (25.00 minimum). This includes consultations, phone calls, letters and memorandum writing, attendance at and or/testimony for hearings etc. Mileage will also be billed at the federal rate. This does not include time to schedule appointment or notification of a change in appointments.

- Additional fees may be charged for assessments or testing or educational material utilized to reach your goals

_____: I/we understand that the internal office area of ACTS Therapy or satellite locations are covered under HIPPA. The commons area including receptionist area is not protected under HIPPA

_____: I/we understand that technology such as text messages, emails or other media are not protected by HIPPA. If you choose to text, email or contact your therapist utilizing technology the therapist is not responsible for breach of confidentiality. It is the policy of ACTS Therapy to text or email reminders for appointments; It is the policy of ACTS therapy to allow each therapist to determine policy regarding responding to text, email or other technology.

_____: I/we understand that a therapy dog is on site with some of our therapists. If allergic please request a dog free zone.

_____: I/we understand that if our therapist is not fully licensed they will follow the guidelines of their board and the state of Minnesota in regards to billing and supervision. This provides the client with the expertise of your therapist as well as the consultation of a supervisor licensed by the state of MN.

_____: I/we have been provided with a copy of the Bill of Rights

_____: I/we understand that there is no guarantee that I/we will benefit from receiving individual, couple, and/or family therapy.

I/we am/are seeking services from ACTS Therapy LLC under my/our own free will and understand the content explained in this agreement. ACTS Therapy LLC has reviewed each item with me/us. I/we understand and accept the conditions outlined above and acknowledge that I/we am/are free to discontinue services at any time by providing appropriate notice. We need your signature giving your consent to these policies in order to proceed with providing therapy to you.

____:______________

Signature Date

____:______________

Signature Date

____:______________

Therapist Date

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Release of Information Consent Form

I ___________________________authorize **ACTS Therapy LLC** to use and disclose the specific health information described below concerning:

Name____

Address_____________________City_____________________State_________Zip__________

Phone________________________________ Fax:_____________________________________

Name____

Address_____________________City_____________________State_________Zip__________

Phone________________________________ Fax:_____________________________________

_____Academic testing results

_____Behavior programs

_____Case notes

_____Intelligence testing results

_____Medical reports

_____Personality Profile

_____Progress reports

_____Psychological testing results

_____Service plans

_____Summary reports

_____Vocational testing results

_____Entire record

_____Psychological reports

_____Other (specify)___________________

The above information will be used for the following purposes

______Planning appropriate treatment or program

_____Determining eligibility for benefits or program

_____Updating files

_____Continuing appropriate treatment program

_____Case review

_____Other (specify)_____________________

I understand that I may revoke this consent at any time by providing written notice and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive this information

Client's name (please print)____

Client's signature____Date__________

Spouse/Parent Signature:____ Date__________

Witness (if client is unable to sign: ____________________________________Date___________

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Person informing of client of rights: ___________________________________Date___________

Payment Contract for services

Bill to: Person responsible for payment of account: _________________________

Address: ____________________ City: __________ State: __________ Zip ______

Federal Truth in Lending Disclosure Statement for Professional Services

Fees for Professional Service

I understand that the below fees are the reasonable and customary fees charged by ACTS Therapy LLC. If for any reason my insurance company or EAP refuses payment I agree to pay ACTS Therapy LLC the following rates per session.

A fee of $165.00 for Intake/Assessment

A fee of $150 for individual therapy (up to a 45 minute session)

A fee of $175.00 for Individual Therapy (52 + minute session)

A fee of 175.00 for Family/Couples Therapy

Cash Fee is $100 for up to a 45 minute session.

Late Cancellation Fee: $65

Client/Guardian: ____

Date: ________________________

Authorization and Consent to Treat Minors (Children and teens under age 18 years)

As the parent/guardian of ______________________________________,
DOB______________________

I am authorizing and giving my consent for ACTS Therapy LLC to provide psychological services to my adolescent/child. I understand that I may revoke this consent at any time. My signature indicates that I am legally able to give such consent and that no other parties are required to be notified in order for their consent to also be given.

Signature: ____

Date: ____________________________________

Special Confidentiality Agreement for Parents

Your child has the right to private, confidential communication with the therapist providing care. This means that some of the issues that they discuss will stay between them and that we will not disclose that information to anyone, including you, unless we have been given permission by your child to do so. We need your child to be open and honest with us in order to understand and treat the full range of issues your child is dealing with, and they may be too scared, angry, or ashamed right now to share those issues with you. We also recognize it is very important for you to know what your child is going through in order to do your job as a parent, which is why we will always encourage your child to be honest with you. We will encourage, prepare and support your child so that they feel safe enough to share those issues with you.

Consistent with ACTS Therapy policy, Minnesota law, and the federal patient privacy law known as HIPAA, your child will need to give his/her consent for us to disclose:

- All Mental Health records for children age 16 or older.
- All information concerning pregnancy, sexual activity, STD's and drug/alcohol use or abuse, regardless of the child's age
- Any information that your child's provider believes, if released, could cause harm to your child or to someone else, or that would significantly harm the treatment relationship with your child.

You should know that this confidentiality has limits. If there is any threat to your child's life, we have the duty to inform you and help to create a plan for safety. In addition, there are situations that we are mandated to report and cannot keep confidential. Those situations include: threats against another person, physical or sexual abuse, neglect, and pregnant women who report using drugs

We recognize how challenging it can be for a parent to raise a child, especially when the child has problems or a mental illness. We know how badly you might want to know everything your child has kept a secret from you, too. We want to be your partner in supporting your child's physical and mental wellbeing, and even when we can't discuss certain details about your child with you, we will always be there for you; guiding you and giving your child the best advice possible to protect him/her and encourage healthy decisions, including being open and honest with you.

I have read this from and I understand that I may not be able to receive all the information my child provides to ACTS Therapy LLC.

_______________________________________ _______________________________________

Parent /Guardian Signature Parent/Guardian Signature

Date__________________________ Date __________________________

Adapted from Prairie Care notice

Credit Card Authorization

Authorization for ACTS Therapy to be good for one year:
Client Name:
Cardholder Name
Credit card Type (Please Circle One)
Visa or Master Card
Card Number:
Expiration Date
CSC (3 digit code on back)
Address of Cardholder:

Amount to be charged following these guidelines.
Late Cancel = $65.00
Deductible if not met and clients determine not to continue utilizing ACTS Therapy LLC
Unpaid balance: If clients determine not to continue utilizing ACTS Therapy and balance is over 30 days old.
Unpaid Co-pay's that are over 30 days old
Receipt will be sent to address of cardholder any time a charge is made to ACTS Therapy LLC

Signature of cardholder

Date:

Bill of Rights

Consumers of marriage and family therapy services offered by marriage and family therapists licensed by the State of Minnesota have the right:

1. **To expect that a therapist has met the minimal qualifications of training and experience required by state law;**
2. **To examine public records maintained by the Board of Marriage and family Therapy which contain the credentials of therapist;**
3. **To obtain a copy of the code of ethics from the Board of Marriage and Family Therapy, 2829 University Avenue SE, Suite 330, Minneapolis, MN 55414-3222;**
4. **To report complaints to the Board of Marriage and Family Therapy by calling (612)617-2220;**
5. **To be informed of the cost of professional services before receiving the services;**
6. **To privacy as defined by rule and law;**
7. **To be free from being the subject of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services;**
8. **To have access to their records as provided in Minnesota Statutes, section 144.335, subdivision 2 and**
9. **To be free from exploitation for the benefit or advantage of a therapist**