ellie FAMILY SERVICES

www.elliefamilyservices.com
phone: 651.313.8080 fax: 651.925.0610

Financial Policies and Informed Consent

NOTE: ALL INFORMATION IS REQUIRED FOR INSURANCE

CLIENT INFORMATION

Client Legal Name: _____

Client Preferred Name: _____

Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Leave Msg.? Yes / No

Work Phone: _____ Leave Msg.? Yes / No

Cell Phone: _____ Leave Msg.? Yes / No

Email: _____

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship to Client: _____

Phone: _____

Address: _____

_____

PRIMARY INSURANCE

Insured Full Name: _____ Relationship to Client: _____

Date of Birth: _____ Gender (legal): Female ☐ Male ☐

Home Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Primary Insurance Carrier: _____

Member ID#: _____ Group #: _____

Employer: _____

Employer Address: _____

Employer City: _____ State_____ Zip_____

Effective Date: _____ Insurance Phone #: _____

Claims Mailing Address: _____

Copay: $_____ Co-Insurance: _____

Annual visit limitation: YES ☐ NO ☐ Annual Allowable: _____

Individual Deductible: $_____ Family Deductible: $ _____

Maximum Out-of-Pocket: $_____ Sessions Covered: _____

PRIOR AUTHORIZATION REQUIRED? YES ☐ NO ☐

Authorization #: _____ Authorized # of sessions: _____

Authorization date: from _____ to _____

SECONDARY INSURANCE

Insured Full Name: _____ Relationship to Client: _____

Date of Birth: _____ Gender (legal): Female ☐ Male ☐

Secondary Insurance Carrier: _____

Member ID#: _____ Group #: _____

Effective Date: _____ Insurance Phone #: _____

Claims Mailing Address: _____

Copay: $_____ Co-Insurance: _____

Annual visit limitation: YES ☐ NO ☐ Annual Allowable: _____

Individual Deductible: $_____ Family Deductible: $ _____

Maximum Out-of-Pocket: $_____ Sessions Covered: _____

PRIOR AUTHORIZATION REQUIRED? YES ☐ NO ☐

Authorization #: _____ Authorized # of sessions: _____

Authorization date: from _____ to _____

CLIENT ACKNOWLEDGEMENT AND AGREEMENT FORM

I agree to notify immediately any representative with Ellie Family Services, PLLP whenever there are any changes in regards to my health condition and/or health insurance plan coverage. I understand that I am ultimately responsible for payment to Ellie Family Services, PLLP for any and all services rendered to me at the time of my visit; this includes deductible balances, co-insurance and co-payments. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be due and payable immediately.

If my group or individual health insurance plan does not cover mental health treatment or my individual or group plan is terminated during the course of my treatment, I am responsible for any unpaid balance. If the insurance information provided to Ellie Family Services, PLLP is later determined to be inaccurate, resulting in denial of claim(s), I am responsible for the amount denied. I accept full responsibility for my treatment and I release Ellie Family Services, PLLP and all members of the Ellie Family Services, PLLP staff from any and all liability in the unlikely event that a problem arises from my treatment.

Your signature below, authorizes your clinician to furnish your health insurance carrier with all information that they may request regarding your treatment for yourself and/or dependents. You are responsible for ineligible charges not covered under your insurance plan. If you discontinue treatment for any reason, any and all remaining balances will be due immediately and payable by you, regardless of claim submission status.

I, the undersigned, affirm and certify that the above information is complete and accurate to the best of my knowledge and consent to mental health care in the Ellie Family Services, PLLP. office. If I receive direct reimbursement for Ellie Family Services, PLLP services, it is my responsibility to provide those payments for my services rendered, directly to a representative of Ellie Family Services, PLLP, immediately. I acknowledge that this contract agreement is between my health insurance carrier and me, not Ellie Family Services, PLLP.

X_____ _____

Signature of Client Date

CLIENT ACKNOWLEDGEMENT OF RESPONSIBILITY FOR PAYMENT OF SERVICES

I understand that I am responsible for payment of services rendered to me by Ellie Family Services, PLLP, regardless of whether I am reimbursed for these services by my insurance company and that any inaccuracy in information on this form may result in nonpayment by my insurance company. I have obtained pre-authorization from my insurance company, if preauthorization is a requirement to receive benefits.

X_____ _____

Signature of Client Date

TELE-THERAPY INFORMED CONSENT

I consent to engaging in tele-health with Ellie Family Services, as a part of the therapy process and by treatment goals. I understand that tele-health psychotherapy may include mental health evaluation, assessment, consultation, treatment planning, and therapy. Tele-health will occur primarily through interactive audio, video, telephone and/or other audio/video communications.

I understand I have the following rights with respect to tele-health:

1) I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawl of any program benefit to which I would otherwise be eligible.
2) The laws that protect the confidentiality of my personal information also apply to tele-health. As such, I understand that the information released by me during the course of my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the tele-health interaction to other entities shall not occur without my written consent.
3) I understand that there are risks and consequences from tele-health including but not limited to, the possibility, despite reasonable efforts on the part of Ellie Family Services that: the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons. In addition, I understand that tele-health based services and care may not be as complete as in-person services. I understand that if my therapist believes I would be better served by other interventions I will be referred to a mental health professional who can provide those services in my area. I also understand that there are potential risks and benefits associated with any form of mental health treatment, and that despite my efforts and efforts of my therapist, my condition may not improve, or may have the potential to get worse.
4) I understand that I may benefit from tele-health services, but that results cannot be guaranteed or assured. I understand that the use of Skype, FaceTime, GoToMeeting, and Google audio/video systems are not 100% secure and may have issues with wifi connectivity. All attempts to keep information confidential while using these systems will be made but a guarantee of 100% confidentiality cannot be made with inherent issues with these communication systems. Signing this form shows an awareness of these issues and a decision by this client to use these systems for tele-health services. I will not hold Ellie Family Services or its staff liable for gathering or use of client information by these service providers.
5) I understand I have the right to access my personal information and copies of case notes. I have read and understand the information provided above. I have discussed these points with my therapist, and all of my questions regarding the above matters have been answered to my approval.

6) By signing this document, I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer based psychotherapy services. If I am in crisis or in an emergency I should immediately call 911 or go to the nearest hospital or crisis facility. By signing this document, I understand that emergency situation may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if I am in a life threatening or emergency situation, and/or if I am abusing drugs or alcohol and are not safe. By signing this document, I acknowledge I have been told that if I feel suicidal I am to call 911, local county crisis agencies or the National Suicide Hotline at 1-800-784-2433.

x _____ _____

Signature of Client Date

CLINIC POLICIES

PRIVATE PAY: *"You are considered to be a 'Private Pay' client until you provide* Ellie Family Services, PLLP *with your completed insurance information and forms to determine your qualification and acceptance of health insurance coverage."*

All payments are due at the beginning of each session. Ellie Family Services, PLLP accepts cash, check or credit cards (MasterCard, Visa or American Express).

A Private Pay therapy session amount is: $_____ and to be paid at the beginning of each visit. Client Initials:_____

A Private Pay Medication Management session amount is: **$200 Intake / $150 Follow-Up**, and to be paid at the beginning of each visit. Client Initials:_____

A Private Pay Psychological Testing hourly rate is: $_____ per hour, and to be paid at the beginning of each visit. Client Initials:_____

Ellie Family Services, PLLP offers sliding fee scale options for ALL of the services we provide, excluding Medication Management. In order to determine your eligibility for reduced rates of services, Ellie Family Services, PLLP will ask you about your income and ability to pay during the intake session.

INSURANCE SUBMISSION FOR OUR CLIENTS: If you have current health insurance coverage and would like our business office to submit claims on your behalf, we would be happy to do so, providing you supply us with a copy of your insurance identification card and driver's license.

TELEPHONE/TEXT CONSULTATIONS: Telephone/Text conversations with your clinician other than setting an office appointment time, are considered an "office visit" and you may be charged a prorated hourly fee. Please note that while therapeutic services may be offered via telephone exchange, insurance will not cover the cost of these services. Additionally, therapeutic services are not to be made

over text messaging or other electronic exchange unless specifically addressed in the treatment plan and both the clinician and client agree to terms regarding electronic exchanges.

CHECK POLICY: We gladly accept your check for our services. However, you will be charged $30 for a returned check. Thereafter, payment must be made either with cash or credit card.

AFTER-HOURS EMERGENCIES: Ellie Family Services, PLLP clinicians are not available for after-hours emergencies. Messages are checked weekdays during the hours of 8:00AM and 7:00PM. To leave a message, call your clinician directly or our main office. For after-hours emergencies or if you need immediate assistance, call 911, your medical group or primary care physician. Here are some crisis phone numbers:

- **CRISIS CONNECTION 612-379-6363 Toll Free: 1-866-379-6363**
- **NATIONAL SUICIDE PREVENTION LIFELINE: 1-800-273-8255 (TALK)**
- **RIVERWIND CRISIS SERVICES: 763-755-3801**
- **MINNESOTA LINKVET : 1-888-546-5838**
- **DAKOTA COUNTY CRISIS: 952-891-7171**
- **RAMSEY COUNTY CRISIS: 651-266-2700**
- **HENNEPIN COUNTY CRISIS: 612-596-1223**

CONFIDENTIALITY: Issues discussed in therapy are important and are legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. These situations include:
1. Suspected abuse or neglect of a child, elderly person or a vulnerable adult.
2. When I believe you are in danger of harming yourself or another person or you are unable to care for yourself.
3. If you report that you intend to physically injure someone, the law requires me to inform that person as well as the legal authorities.
4. If I am ordered by a court to release information as part of a legal involvement.
5. When your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc.
6. In natural disasters whereby protected records may become exposed.
7. As required by the Patriot Act.
8. When otherwise required by law.

ABOUT THERAPY: The major goal is to help you identify and cope more effectively with problems in daily living and to deal with internal conflicts in order to achieve more satisfying personal and interpersonal relationships. This purpose is accomplished by:
1. Increasing personal awareness of obstacles and strengths.
2. Taking personal responsibility to make the changes necessary to attain your goals.
3. Identifying specific psychotherapy goals.
4. Utilizing all available community, medical and self-help resources.

Participation in therapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of therapy often requires discussing the unpleasant aspects of your life. However, therapy has been shown to have benefits for individuals who undertake

it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Therapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

RELEASE OF RECORDS: All client information is considered strictly confidential and will not be given out to anyone without your prior written consent. In the event of a request for a transfer of client records, the records will be forwarded only upon the completion along with signature of the Client Consent form along with a payment fee based on the current Minnesota Department of Health maximum allowed amount. Please note that email and text communication is not secure and therefore confidentiality cannot be guaranteed.

PREPARATION OF FORMS AND REPORTS: Should you request forms or reports to be completed on your behalf, we will assist you in the process. To complete forms or reports requires that a therapist review a patient's chart and often will require a discussion with the client. There is a minimum charge of $35 up to a maximum of $150 per hour.

*Court appearances: $250 per hour with a minimum charge of eight (8) hours, for a total of two thousand ($2000) dollars. The client-therapist relationship is built on trust with the foundation of that trust being confidentiality. It is often damaging to the therapeutic relationship for the therapist to be asked to present records to the court, testify whether factual or in an expert nature, in court or in a deposition. The therapist asks that the client only request a court appearance in extreme cases. In such cases, as the therapist is ordered to testify by the court about his/her counseling with you, the therapist will be monetarily compensated as set forth below.

In the event that it is necessary for the therapist to testify before any court, arbitrator, or other hearing officer to testify at a deposition, whether the testimony is factual or expert, or to present any or all records pertaining to the counseling relationship to a court official, the client agrees to pay the therapist for his or her services, including travel, preparation and necessary expenditures (copies, parking, meals and the like) at the rate of $250.00 per hour, rounded to the nearest half hour. The client further agrees to pay the $2,000.00 (8 hours X $250.00) two weeks prior to the appearance, presentation of records or testimony requested.

X _____ _____

Signature of Client Date

CANCELLATION POLICY

I hereby give consent to assess my credit card or to bill me directly, at a rate of $100, for any missed appointments in which I have not given 24 hour prior notice. I also agree to a fee assessed of $85 for any appointments cancelled and re-booked without 24-hour prior notification to my therapist.

I also give consent to charge my credit card for any outstanding balance at the end of each month for deductibles, co-payments, co-insurance or other amounts my insurance carrier determines as payable by me.

If my health insurance carrier has not paid a claim within 60 days of the date of submission, I accept responsibility for payment in full of any outstanding balance and authorize Ellie Family Services, PLLP to apply these charges to the credit card on file for the full amount. I may then collect directly from my health insurance carrier.

I understand that should clinic fees or policies change, I will be notified in writing of said changes. I further understand that I retain the right to revoke this authorization, if done so in writing and faxed or mailed to the appropriate location. My visits would be suspended until a new payment arrangement is arranged.

Cardholder Name: _____ Billing Zip Code: _____

Credit Card #: _____ Expiration Date: _____

Card Type: _____ CVV/Auth. Code: _____

X _____ _____
Signature of Client Date

CLIENT NOTICE OF PRIVACY PRACTICES

This notice describes how your health may be used and disclosed and how you are able to access this information. Please review it carefully. Protecting our client's privacy has always been important to this practice. A new federal and state law entitled the Health Insurance Portability and Accountability Act (HIPAA), went into effect on April 14, 2003 and requires us to inform you of our policy. At Ellie Family Services, we are very careful to keep your health information secure and confidential. This law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment; for example, a review of your file by a physician specialist, with whom we may involve in your care plan.

We may use or disclose your health information for payment for your services. For example, we may send a report of your progress to your health insurance company. We may disclose your health information for our normal healthcare operations. For example, one of our staff members will enter your information into our computer. We may share your medical information with our business associates, such as a billing representative or service. We have a written contract with each business associate which requires them to protect your privacy. We may use your information to contact you. For example, we may send newsletters or other information to you. We may also want to call and remind you about appointments. If you are not home, we may leave this information on your answering service or with the person who answers the telephone unless you have instructed us otherwise. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will advise you if we are able to fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. You have the right to transfer copies of your health information to
another practice. You have the right to see or receive a copy of any of your health information. You have the right to request an amendment or change to your health information. Supply us, in writing, your request to make changes. If you request to include a statement in your file, please submit it to us in writing. We reserve the right to make the changes or not, however, we will accommodate your request by including your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any details of this notice, we will notify you of the changes, in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington DC, 20201. If you believe that your privacy has been compromised or if you are seeking more assistance regarding your personal health information, we ask that you first contact Ellie Family Services PLLP, Chief Executive Officer, Erin Pash at: erin@elliefamilyservices.com or 651.313.8080x100.

X _____ _____
Signature of Client Date

CLIENT NOTICE FOR FILING A COMPLAINT

The nature of the services provided by Ellie Family Services, PLLP are voluntary. If at any point in the relationship with your provider you are unhappy or feeling uncomfortable you are encouraged to first contact EFS supervisors to talk about your concerns. EFS supervisors want you to be happy with your services and encourage open communication to help ensure your wellness needs are being met.

In addition to reaching out to EFS as a first means of filling a complaint you are also able to file a formal complaint with the following government agencies:

MN Dept. of Human Services
Equal Opportunity and Access
P.O Box 64997
St. Paul, MN 55164
651-431-3040 (voice)
866-786-3945 (tty)
651-431-7444 (fax)

MN Dept. of Human Rights
Freeman Building
625 Robert Street North
St. Paul, MN 55155
651-539-1100 (voice)
651-296-1283 (tty)
651-296-9042 (fax)

X _____ _____
Signature of Client Date

CLIENT RIGHTS AND CONSENT FOR SERVICES

I authorize Ellie Family Services, PLLP to release any medical information to my insurance company which may be deemed necessary in order to process an insurance claim. It is my intent that a copy of this authorization carries the same force and effect as the original. I certify that the information provided on this form is correct to the best of my knowledge. I authorize my insurance company to assign benefits to Ellie Family Services, PLLP.

I have read and understand the above policies. I further understand that the information I have furnished is to be used for management purposes and the agency will ensure confidentiality. I may inquire about or object to the methods and/or type of information stored. My rights are protected under the State and Federal Confidentiality laws and any release of information requires my consent except where required and permitted by law, including child abuse and/or neglect and the intent to harm others or myself. I give my consent to Ellie Family Services, PLLP to provide evaluation, treatment and/or other services that we mutually determine to be appropriate. I am participating voluntarily and I understand my right to refuse or discontinue treatment at any time. I have had the opportunity to discuss my reasons for seeking services and I understand my responsibilities in the therapeutic relationship.

X _____ _____

Signature of Client Date