FINANCIAL POLICIES CONSENT
ANNUAL UPDATE

Client Full Name (legal): _____

Client Date of Birth: _____

INSURANCE INFORMATION

If this section is not completed, you are considered to be paying out of pocket (Private Pay).

Will you be utilizing EAP (Employee Assistance Program) sessions? ☐ Yes ☐ No
If yes, please complete the following:

EAP Name: _____ Number of Allowed Sessions: _____

Authorization #: _____ Exp Date: _____

Primary Insurance Carrier: _____

Member ID: _____ Group Number: _____

Subscriber's Full Name (if someone other than Client): _____

Subscriber's Address: _____

City: _____ State: _____ Zip: _____

Subscriber's Date of Birth: _____ Relationship to Client: _____

Secondary Insurance Carrier: _____

Member ID: _____ Group Number: _____

Subscriber's Full Name (if someone other than Client): _____

Subscriber's Address: _____

City: _____ State: _____ Zip: _____

Subscriber's Date of Birth: _____ Relationship to Client: _____

You will be required to supply a copy of the front & back of your insurance card(s) to a member of the Ellie Mental Health team.

CLIENT ACKNOWLEDGEMENT OF RESPONSIBILITY FOR PAYMENT OF SERVICES

I authorize Ellie Mental Health 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 Mental Health.

I agree to notify immediately any representative with Ellie Mental Health 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 Mental Health 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 for any reason, any and all remaining balances will be due immediately and payable by you, regardless of claim submission status.

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 uncovered or ineligible charges and/or unpaid balance. If the insurance information provided to Ellie Mental Health 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 Mental Health and all members of the Ellie Mental Health staff from any and all liability in the unlikely event that a problem arises from my treatment.

I understand that I am responsible for payment of services rendered to me by Ellie Mental Health, 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. If I receive direct reimbursement for Ellie Mental Health services, it is my responsibility to provide those payments for my services rendered, directly to a representative of Ellie Mental Health, immediately. I acknowledge that this contract agreement is between my health insurance carrier and me, not Ellie Mental Health. I have obtained pre-authorization from my insurance company, if preauthorization is a requirement to receive benefits.

I, the undersigned, affirm and certify that the above information is complete and accurate to the best of my knowledge.

X _____ _____

Signature of Client/Parent/Guardian Date

CLIENT ACKNOWLEDGEMENT AND AGREEMENT FOR BILLING CHARGES

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. I understand that in order to put my credit card information on file, I must contact my therapist or call Ellie Mental Health's main phone line at 651-313-8080 to supply my credit card information.

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 Mental Health 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.

X _____ _____

Signature of Client/Parent/Guardian Date

CLIENT INFORMED CONSENT FOR TREATMENT
& NOTICE OF PRIVACY PRACTICES ANNUAL UPDATE

Client Full Name (legal): _____

Client Date of Birth: _____

CLIENT NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you are able to access this information. Please review it carefully. Protecting our clients' 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 Mental Health, 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 Mental Health's Compliance Department by email at: compliance@elliementalhealth.com or by phone at: 651.313.8080.

X _____ _____

Signature of Client/Parent/Guardian Date

TELE-HEALTH INFORMED CONSENT

I consent to engaging in tele-health with Ellie Mental Health, as a part of the therapy process and my 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 withdrawal 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 Mental Health 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 Mental Health 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 an 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/Parent/Guardian Date

CLIENT RIGHTS AND CONSENT FOR SERVICES

Ellie Mental Health does not discriminate based on race, color, national origin, creed, religion, sexual orientation, public assistance status, marital status, age, disability, or sex, including sex stereotypes and gender identity. Please also reference Minnesota Patients' Bill of Rights (https://www.health.state.mn.us/facilities/regulation/billofrights/docs/mn_pts_rights_eng_reg.pdf).

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 Mental Health 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/Parent/Guardian Date