# NEW CLIENT INFORMATION & FINANCIAL POLICIES CONSENT FORM

## CLIENT INFORMATION

Client First Name (legal): _____ Middle Initial: _____

Client Last Name (legal): _____ Suffix: _____

Preferred Name: _____ Date of Birth: _____ Sex (legal): _____

Gender Identity: _____ Marital Status: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Main Phone: _____ Type: _____ OK for Voicemail? ☐ Yes ☐ No

Phone 2: _____ Type: _____ OK for Voicemail? ☐ Yes ☐ No

Phone 3: _____ Type: _____ OK for Voicemail? ☐ Yes ☐ No

Phone 4: _____ Type: _____ OK for Voicemail? ☐ Yes ☐ No

Home Email: _____

Work Email: _____

How did you hear about us? _____

## CONSENT TO RECEIVE ELECTRONIC NOTIFICATIONS

Ellie Mental Health is able to send electronic notifications to your email address and/or as a call or text (if you have texting capability; available for most cell phone providers) to your phone. Please be aware of any costs associated with texting to your mobile phone – check with your mobile service provider if you have questions before agreeing to receive text messages.

An email or text message would arrive to your email or phone and may include things like appointment reminders or notifications about your client portal account. If you agree now, you can always opt out of

electronic notifications in the future by following the instructions in the email or text message, or by calling our office.

I authorize Ellie Mental Health to send electronic notifications as follows (**please choose up to two emails and/or one phone option**):

Email to the following email address(es), listed in the Client Information section above:
☐ Home Email
☐ Work Email
☐ Home & Work Email
☐ Do not send email notifications

☐ Phone call ☐ Text message to the following phone number, listed in the Client Information section above:
☐ Main Phone
☐ Phone 2
☐ Phone 3
☐ Phone 4
☐ Do not send text/phone notifications

*Please let us know if any of this information changes to ensure message delivery.

X _____ _____
Signature of Client/Parent/Guardian Date

## EMERGENCY CONTACT INFORMATION

Name: _____ Phone: _____

Relationship to Client: _____

## 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

## FINANCIAL POLICIES ACKNOWLEDGEMENT AND AGREEMENT

PRIVATE PAY: You are considered to be a 'Private Pay' client until you provide Ellie Mental Health with your completed insurance information to determine your qualification and acceptance of health insurance coverage. All payments are due at the beginning of each session. Ellie Mental Health accepts cash, checks, or credit cards (MasterCard, Visa or American Express). Ellie Mental Health offers sliding fee scale options for most of the services that we provide. In order to determine your eligibility for reduced rates of services, Ellie Mental Health will ask you about your income and ability to pay during the intake session.

CREDIT CARD ON FILE REQUIRED: To streamline billing and payment and provide a convenient way for patients to pay their bills, Ellie Mental Health requires all patients keep an active credit card on

file with us. If your credit card on file needs to change, please notify us immediately. All payments are due at the beginning of each session, and immediately upon receipt of any billing statement. Circumstances when your card would be charged include but are not limited to: missed or canceled sessions without 24-hour notice; missed co-payments, coinsurance, and deductibles; any non-covered services and/or denial of services by insurance.

INSURANCE SUBMISSION FOR OUR CLIENTS: If you have current health insurance coverage and would like our business office to submit claims on your behalf, you will need to 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.

PREPARATION OF FORMS AND REPORTS: Should you request forms or reports to be completed on your behalf, we will assist you in the process. Completion of forms or reports requires that a provider 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 $250 per hour.

COURT APPEARANCES: The client-provider relationship is built on trust with the foundation of that trust being confidentiality. It is often damaging to the therapeutic relationship for the provider to be asked to present records to the court, testify whether factual or in an expert nature, in court or in a deposition. The provider asks that the client only request a court appearance in extreme cases. In such cases, as the provider is ordered to testify by the court about his/her treatment with you, the provider will be monetarily compensated as set forth below.

Unless otherwise limited by law, in the event that it is necessary for the provider 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 treatment relationship to a court official, the client agrees to pay the provider for his or her services, including travel, preparation and necessary expenditures (copies, parking, meals and the like) at the following rates: The cost for a therapist to appear in court is $250 per hour, rounded to the nearest half hour, with a minimum charge of eight (8) hours, for a total minimum of two thousand ($2000) dollars. The cost for a medication management prescriber to appear in court is $400 per hour, rounded to the nearest half hour, with a minimum charge of eight (8) hours, for a total minimum of three-thousand two hundred ($3200) dollars.

The client further agrees to pay the minimum charge amount(s) outlined above two weeks prior to the appearance, presentation of records or testimony requested. If the hearing is cancelled, the client must notify the provider as soon as they know. Additionally, any cancellation of a hearing when at least 3 days' notice is given to the provider, will result in a refund of half the paid court fees. If a hearing is settled in under 72 hours, clients are ineligible for a refund of their court deposit. Unless otherwise

specified in writing, the providers of Ellie Mental Health do not agree to provide services as expert or forensic witnesses, and any oral or written communication or testimony required and/or provided by them will be limited to factual information only.

RETURNED CHECKS: We will 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.

CANCELLATIONS & NO-SHOWS: Any missed appointments in which 24 hour prior notice was not given may be charged a Late Cancel Fee of $85. Any missed appointments in which no prior notice was given may be charged a No Show Fee of $100.
I, the undersigned, have read and understand the above policies.

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

## 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 discussed things outside of sessions.

## CONFIDENTIALITY

Issues discussed in therapy are important and are ordinarily protected as confidential and/or "privileged." However, there are limits to the rights of confidentiality and privilege, and in some situations we may be required to disclose otherwise confidential or privileged information and/or records even if you do not authorize us to do so. These situations include but are not necessarily limited to when:

1. We have reason to believe that there has been abuse or neglect of a child, elderly person or a vulnerable adult.
2. We have reason to believe that you are in danger of harming yourself or another person or you are unable to care for yourself.
3. We have reason to believe that you have a plan or intention to harm a specific person, persons, or other potential victim, in which case we would notify the potential victim(s) and/or law enforcement authorities.
4. We receive a court order, subpoena, or other legal process requiring us to disclose otherwise confidential or privileged information and/or records.

5. We are required by your insurance company or other third party payor to disclose information and/or records in order to, for example, process a claim for reimbursement or coverage, respond to an audit, or facilitate a case review or appeal.
6. A natural disaster or other emergency even creates a risk of damage to or destruction of the information or records.
7. We are required by a licensing board or other regulatory authority to disclose information and/or records.
8. We are required by the Patriot Act.
9. We are otherwise required by any federal, state or other statute, rule, order or other law to disclose the information and/or records.

Due to Minnesota Regulatory requirements and the value Ellie Mental Health places on case consultation and quality client care, your therapeutic and rehabilitative sessions may be observed by peers and/or supervising staff. You will be consulted and consent will be requested before any shadowing or observation takes place.

## 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.

## CLIENT NOTICE FOR FILING A COMPLAINT

The nature of the services provided by Ellie Mental Health are voluntary. If at any point in the relationship with your provider you are unhappy or feeling uncomfortable you are encouraged to first contact Ellie Mental Health supervisors to talk about your concerns. Ellie Mental Health 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 Ellie Mental Health as a first means of filing 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)

## RELEASE OF RECORDS

All client information is considered strictly confidential (subject to limitations authorized or required by law) and will not be given out to anyone without your prior written consent or other legal authorization. In the event of a request for copies of or a transfer of client records, the records will be forwarded only after receipt by Ellie Mental Health of proper signed written authorization from the client or other authorized persons. Please note that email and text communication is not secure and therefore confidentiality cannot be guaranteed.

## RECORDING

Ellie Mental Health does not permit the audio, video or other electronic recording by clients of any services provided without the express written permission of an authorized representative of Ellie Mental Health. Any violation of this policy may result in immediate termination of the services being provided.

Sessions conducted by student interns may include recording of sessions for use in supervision. These recordings may not be used for any other purpose than for use in supervision, are stored on a password protected device and are destroyed at the termination of services. Recording sessions are limited to sessions where the client has provided consent to do so.

## AFTER-HOURS EMERGENCIES

Ellie Mental Health providers are not available for after-hours emergencies. Messages are checked weekdays during the hours of 8:00 am and 7:00 pm. To leave a message, call your provider directly or call 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:

- Throughout Minnesota: call **CRISIS (**274747)
- NATIONAL SUICIDE & CRISIS LIFELINE: 988
- NATIONAL SUICIDE PREVENTION LIFELINE: 1-800-273-8255 (TALK)
- RIVERWIND CRISIS SERVICES: 763-755-3801
- MINNESOTA LINKVET: 1-888-546-5838
- ANOKA COUNTY CRISIS: 763-755-3801
- CARVER COUNTY CRISIS: 952-442-7601
- CLAY COUNTY CRISIS: 1-800-223-4512
- CROW WING COUNTY CRISIS: 800-462-5525
- DAKOTA COUNTY CRISIS: 952-891-7171
- HENNEPIN COUNTY CRISIS: 612-596-1223 (adult) 612-348-2233 (child)
- ITASCA COUNTY CRISIS: 218-326-8565
- OLMSTEAD COUNTY CRISIS: 1-844-274-7472
- RAMSEY COUNTY CRISIS: 651-266-2700

- STEARNS COUNTY CRISIS: 1-800-635-8008
- WASHINGTON COUNTY CRISIS: 651-275-7400
- WINONA COUNTY CRISIS: 1-844-274-7472

## 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.

Client's Full Name: _____ Client's DOB: _____

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.

Client's Full Name: _____ Client's DOB: _____

X _____ _____

Signature of Client/Parent/Guardian Date