NEW CLIENT INFORMATION & FINANCIAL POLICIES CONSENT FORM

CLIENT INFORMATION

Client First Name (legal): _____ Client Last Name (legal):_____

Date of Birth: _____

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.

By signing at the end of this document, I authorize Ellie Mental Health to send electronic notifications to the email address(es) and phone numbers as indicated in the Client Information section above.

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

CLIENT ACKNOWLEDGEMENT OF RESPONSIBILITY FOR PAYMENT OF SERVICES

I authorize Ellie Mental Health to release any medical information to my insurance company that 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, or if my group or individual health insurance plan does not cover my treatment or is terminated during the course of my treatment, I am responsible for any uncovered or ineligible charges and/or unpaid balance. 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 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.

By signing at the end of this document, I affirm and certify that the above information is complete and accurate to the best of my knowledge.

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, including co-payments, and immediately upon receipt of any billing statement. Circumstances when your card would be charged, and to which I give consent, 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.

IDENTIFICATION AND INSURANCE SUBMISSION FOR OUR CLIENTS: Ellie requires a copy of your insurance identification card and driver's license for all clients, especially those with current health insurance coverage that would like our business office to submit claims on your behalf.

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 not that while therapeutic services may be offered via telephone or video exchange, insurance may not cover the cost of these services. Additionally, therapeutic services are not to be conducted 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: Due to the confidentiality of the client-provider relationship The provider does not typically testify in court without a court order requiring them to do so. In such cases, the provider will be monetarily compensated as set forth below.

Unless otherwise limited by law, the client agrees to pay the provider for his or her time preparing for and testifying, including travel, and necessary expenditures (copies, parking, meals and the like) at the following rates: The cost for a therapist to appear in court/arbitration or at a deposition is $250 per hour, rounded to the nearest half hour, for a total of two thousand ($2000) dollars per a maximum 8-hour day. The cost for a medication management prescriber to appear in court/arbitration or at a deposition is $400 per hour, rounded to the nearest half hour for a total minimum of three-thousand two hundred ($3200) dollars per a maximum 8-hour day.

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, and the client will be reimbursed up to half of the fees, excluding any time already incurred. 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 hereby give consent to access my credit card or to bill me directly for these charges.

By signing at the end of this document, I attest that I have read and understand the above policies.

CLIENT INFORMED CONSENT FOR TREATMENT & NOTICE OF PRIVACY PRACTICES

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 receive a court order, subpoena, or other legal process requiring us to disclose otherwise confidential or privileged information and/or records.
4. 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.
5. We are required by a licensing board or other regulatory authority to disclose information and/or records.
6. 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

Please review Ellie Mental Health's Notice of Privacy Practices found on its website at https://elliementalhealth.com/client-notice-of-privacy/

If client is a minor, by signing this document, you consent to Ellie uploading any applicable divorce

decree/custody agreement to the minor's electronic health record.

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 GRIEVANCE

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 grievance. Our grievance procedure and form can be found on our website at elliementalhealth.com

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.

RECORDINGS

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 purpose other than for use in supervision, are stored on a password protected device and are destroyed at the termination of services. Ellie Mental Health's recording of any kind are limited to sessions where the client has provided explicit 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.

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 and Minnesota Client Rights & Protections. A copy of these rights are located in every Ellie Mental Health location and can be found online at elliementalhealth.com.

Please note, if you would like Ellie Mental Health to have a copy of your healthcare directive, you are responsible for providing this information. This is not a requirement but can be helpful in providing the best treatment in case of emergencies.

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 understand that it is my responsibility to read and understand the policies for all services whether I am attending now or ever attend these services in the future. 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.

By signing at the end of this document, I attest that I have read and understand the above policies.

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. I understand that my therapists' ability to provide out-of-state teletherapy to me may be dependent on that state's licensure requirements and/or my insurance requirements. I agree to keep my therapist updated if I plan to engage in therapy outside of the state in which my therapist is located.
7. 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 988.

If client is a minor, parent/guardian MUST sign below. Minor signature is not valid.

X _____ _____

Signature of Client/Parent/Guardian Date