CHAD ALLEN PSYCHOTHERAPY

Individual Psychotherapy & Couples Counseling

Chad T. Allen, MA, LPC
825 Nicollet Mall, Suite 1240
Minneapolis, MN 55402
(612) 314-5520
chadallenpsychotherapy.com

OFFICE POLICIES & INFORMED CONSENT

Welcome to my practice. This document contains important information about my professional services and business policies. It also includes the Minnesota Mental Health Patient Bill of Rights and Notice of Privacy Practices. Although this document is lengthy and sometimes complex, it is very important that you read and understand it. We can discuss any questions you have when you sign it or at any time in the future. When you sign this document, it will represent an agreement between us. Please keep a copy of this agreement for your reference.

About Couple Counseling

Couple counseling is not easily described in general terms. Its nature varies depending on the personalities of the therapist and patients, and the particular problems you are experiencing. There are a number of different approaches and techniques I may use to help you deal with the issues you wish to address. Together we will agree on a specific treatment plan tailored to your particular needs and goals. Psychotherapy is a collaborative process that involves active effort on your part. The success of therapy will depend in large part on the effort you put forward during and outside of our sessions. Progress is also highly dependent on good communication between patients and therapist. If at any time during the therapy you have any questions or concerns, feelings about something I have said or suggested, or need clarification regarding our process, do not hesitate to bring this up.

Couple counseling is an intensely personal process that can have both benefits and risks. Because therapy often involves discussing difficult aspects of your lives, you may experience uncomfortable emotions such as sadness, anger, guilt, frustration,

and loneliness. However, it is important to keep in mind that research has shown that couple counseling can have many benefits. Couple counseling can lead to better relationships with one's self and each other, solutions to problems, and significant reduction in feelings of distress. Given the complex nature of couple counseling, it is important that you know there are no guarantees as to what each unique couple will experience.

Appointments

I offer two appointment options, either **45 minutes** or **55 minutes** in length, and your appointment day(s) and time(s) are reserved specifically for you. During the first few sessions we will decide if I am the best person to provide the services you need and whether a 45-minute session or 55-minute session is most appropriate for your needs. If we decide to continue with ongoing counseling, I will be able to provide you with some impressions of what our work together will involve and a treatment plan to follow. We will usually schedule one or more sessions per week at a mutually agreed upon time. If any of us decide for any reason that you would be better helped by another professional or method of intervention, I will offer referrals for alternative services or providers.

Cancellations & Missed Appointments

Because the success of couple counseling depends on the regularity and continuity of our sessions, the expectation is that we will meet regularly at the time that we decide on together. Once we agree on a regular time or times to meet during the week, I will reserve those hours for you. It is understandable that on occasion you will need to cancel or reschedule a session. If it is necessary to reschedule or cancel an appointment, I require that you provide me with at least **24 hours advance notice** in order to avoid being charged for the session. If I receive notice less than 24 hours in advance and we are able to reschedule the appointment that same week for a mutually convenient time, you will not be charged for the missed session. If I receive notice less than 24 hours in advance and we are not able to reschedule during the same week, or you miss a session with no advance notice, you will be charged the regular fee for the missed session. In addition, you are responsible for arriving at your session on time; if you are late, your appointment will still need to end on time.

Professional Fees

My fee is **$150 per 45-minute session** or **$185 per 55-minute session**. I charge the same fee for other professional services you may need. Other services might

include, but are not limited to, telephone consultations lasting longer than 15 minutes and preparation of records or treatment summaries. I will pro-rate the cost if I work for periods of less than 45 minutes.

I periodically raise my fee proportionate to professional rates, standards, and cost-of-living increases with reasonable advance notice.

Insurance and Payment

I am an in-network provider for PreferredOne and out-of-network for most other insurance companies. As an out-of-network provider, my practice operates on a fee-for-service basis, which means I do not deal directly with your insurance company. I will provide you with a receipt for services, which you may be able to submit to your insurance for out-of-network reimbursement.

Payment for services (including copays, deductibles, and coinsurances) is an important part of any professional relationship. Unless we make other specific arrangements, **payment for my services is due at each session**. I accept payment by check, cash, or credit card. You may also be able to pay directly with your Health Savings Account (HSA) or Flexible Spending Account (FSA) card. Please contact your insurance company or benefits administrator prior to our initial meeting to confirm eligibility.

Please note that it is always your responsibility to pay our full agreed upon fee for services at the time they are rendered, regardless of your insurance arrangements.

Contacting Me

By Phone: You may contact me by phone at (612) 314-5520. Although I am often not immediately available by telephone, a message can be left at this number at any time of day or night. I check my voicemail periodically during business hours and I will always attempt to respond to your call within 24 hours, with the exception of weekends and holidays, and times that I am scheduled to be away from my office. I will give you advance notice of any vacations or other planned absences.

By Email: Because the security of email communications cannot be guaranteed, it is recommended that email be limited to requests for phone contact, appointment arrangements, or requests for information. Please only include general information about yourself and your treatment. Any communication that requires immediate attention or a timely response should be made by phone.

Emergencies

Although you can leave me a message at any time, I am often not available to call you back immediately. In an emergency, please call me, and I will return your call as quickly as possible. However, if you have an emergency requiring immediate attention please also call Crisis Connection at (612) 379-6363, call 911, or go to your nearest emergency room.

If there is an emergency during our work together, or I become concerned about your personal safety, and we are not able to resolve it together, I am required by law and by the ethical rules of my profession to contact someone close to you (for example, a relative, partner/spouse, or close friend). I am also required to contact this person, or the authorities, if I become concerned that you intend to harm someone else. I will contact the emergency contact person you provide on the patient information form.

Ending Treatment

You have the right to end or take a break from your treatment at any time without my permission or agreement. However, if you do decide to exercise this option, I encourage you to talk with me about the reason for your decision in a therapy session so that we can bring sufficient closure to our work together. We can also discuss any referrals you may need at that time.

As the therapist, I also reserve the right to terminate therapy at my discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, or patient needs that are outside of my scope of competence or practice.

If during couple counseling we assess that I am not effective in helping you reach your therapeutic goals, I am obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, I will provide a number of referrals that may be of help to you. If you want another professional's opinion or wish to consult with another therapist, I will assist you in finding someone qualified, and, if you provide a written consent, I will provide the essential information needed.

Professional Records

The laws and standards of my profession require that I keep professional records in paper and/or electronic form, and securely maintain them for a minimum of seven years. Except in unusual circumstances that involve danger to yourself and/or others, you may examine and/or receive a copy of your clinical record by written request. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. The exceptions to this policy are contained in the attached Notice of Privacy Practices.

Confidentiality

In general, the privacy of all communications between a patient and a psychotherapist, and all written and electronic treatment records, are protected by law. In most circumstances, I can release information about your treatment to others only if you sign a written authorization form that meets particular legal requirements of HIPAA. There are a few exceptions, under Minnesota law, when disclosure is required:

- Whenever you enter your psychological status as an issue in a legal proceeding, you have waived the right to past, present, or future confidentiality of any mental health services provided to you. I might therefore be ordered to provide this information by a judge.

- Some situations legally require that I take action to protect others from harm, even if I have to reveal information about a patient's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, I must file a report with the appropriate state agency.

- If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking emergency care (such as medical) for the patient. If the patient presents a danger to self, I may be obligated to seek emergency care (such as medical) for the patient or to contact others who can help provide protection.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult with other health professionals about a case. During such consultations, I make every effort to avoid revealing the identity of my patient. The other professionals with whom I consult are also legally obligated to keep the information confidential. Unless you object, I will not tell you about these consultations unless I believe that it is important to our work together.

In couple counseling, I consider your relationship to be the patient. During the course of our work, I may see one of you individually for one or more sessions or for part of a session. These sessions should be viewed as part of the work that I am doing with the couple unless otherwise indicated. Please know that anything we discuss when your partner is not present may be disclosed to her or him if, in my best judgment, doing so is necessary to effectively help your relationship. (In general, I encourage you to share this information voluntarily with your partner in our sessions.) Other than that I will not disclose confidential information about your treatment to anyone else unless I am required to by law or both partners provide permission to release such information.

Please be aware that either of you could choose to speak about your treatment to outsiders. Although both of you should treat information shared as seriously confidential, it is equally important that you understand that confidentiality is limited in this regard.

Our Agreement

I, the patient, understand I have the right not to sign this agreement. My signature below indicates that I have read this agreement, have discussed those points I did not understand, and have had my questions, if any, fully answered. I understand that any of the points mentioned above can be discussed and may be open to change. Further, I have read the attached Minnesota Patient Bill of Rights and Notice of Privacy Practices (HIPAA). If at any time during the treatment I have questions about any of the subjects discussed in this document, I understand that I can talk with you about them, and you will do your best to answer them.

I understand that after therapy begins I have the right to withdraw my consent to therapy at any time, for any reason. However, I will make every effort to discuss my concerns about my progress with you before ending therapy.

I understand that no specific promises have been made to me by this therapist about the results of treatment, the effectiveness of the procedures used by this therapist, or the number of sessions necessary for counseling to be effective.

I agree to act according to the points covered in this agreement. I hereby agree to enter into couple counseling with this therapist, as indicated by my signature below.

Patient's Signature Date

Patient's Printed Name

Patient's Signature Date

Patient's Printed Name

Psychotherapist's Signature Date

MINNESOTA PATIENT BILL OF RIGHTS

As a consumer of mental health services offered in Minnesota, you have the right to:

1) expect that the provider has met the minimal qualifications of training and experience required by state law;

2) examine public records maintained by the Board of Behavioral Health and Therapy that contain the credentials of the provider;

3) obtain a copy of the Rules of Conduct from Minnesota's Bookstore, Department of Administration, 660 Olive Street, St. Paul, MN 55155, or its current location;

4) report complaints to the Board of Behavioral Health and Therapy;

5) be informed of the cost of professional services before receiving the services;

6) privacy as defined and limited by rule and law;

7) be free from being the object of unlawful discrimination while receiving counseling services;

8) have access to your records as provided in part 2150.7520, subpart 1, and Minnesota Statutes, section 144.292, except as otherwise provided by law;

9) be free from exploitation for the benefit or advantage of the provider;

10) terminate services at any time, except as otherwise provided by law or court order.

NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act (HIPAA)

The following paragraphs outline how the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) legislation affects how records here are kept and managed. The services you are receiving here concern your psychological status, a most private and intimate component of your life, thus protecting your privacy is of utmost importance. This notice explains how, when and why I may use and/or disclose your records, which are known under the HIPAA legislation as "Protected Health Information" (PHI). Except in specified circumstances, I will not release your PHI to anyone. When disclosure is necessary under the law, I will only use and/or disclose the minimum amount of your PHI necessary to accomplish the purpose of the use and/or disclosure.

Safeguards Governing Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" (PHI). Your PHI results from your treatment, your payment, and other related health care operations. I may also receive your PHI from other sources (i.e. other health care providers, attorneys, etc.). You and your PHI receive certain protections under the law.

I am required by law to maintain the privacy and security of your PHI. I will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

If you are receiving any type of psychotherapy service, your PHI is typically limited to basic billing information placed in a locked file in my office and stored in a secure electronic health record. Clinical notes taken during or after sessions are known as Psychotherapy Notes and are not part of your PHI. Except in unusual, emergency situations, such as child abuse, homicidal or suicidal intention, your PHI will only be released with your specific Authorization.

If you are consulting me for any type of a Psychological Evaluation, your rights to privacy may be more limited. For a non-forensic evaluation, the results will likely be forwarded to whoever referred you for the assessment. I will still, nonetheless, have you sign an Authorization allowing me to do so.

If you are consulting me for a forensic psychological evaluation, your rights to privacy have already been waived because you have entered your mental status as

an issue in a legal proceeding. You will therefore not have the type of rights to privacy and confidentiality granted to most other patients. I will still obtain an Authorization from you, allowing me to share information with specified other parties, but please be advised that usual privacy and confidentiality practices do not apply in these instances.

In these cases of Psychological Evaluations, the same type of billing information is gathered from you and kept under locked file and as part of your electronic health record. Clinical notes are much more detailed in these cases, and typically also involve psychological test data. These notes and test data may well be released to other parties, as was already noted.

How Your Protected Health Information May Be Used or Disclosed

In accordance with the HIPAA act and its Privacy Rule (Rule), your PHI may be used and disclosed for a variety of reasons. Again, however, every effort is made to prevent its dissemination. In Minnesota, I am required to obtain your consent to use and/or disclose your PHI for the purposes of treatment, to obtain payment for services you receive, and for normal health care operation—unless the disclosure is to a related entity, or the disclosure is for a medical emergency and I am unable to obtain your consent. For most other uses and/or disclosures of your PHI, you will be asked to grant your permission via a separate signed Authorization form. Typical uses and/or disclosures of your PHI consist of the following:

A. Uses and/or disclosures related to your treatment, the payment for services you receive, or for health care operations:
    1. For treatment: I might use and/or disclose your PHI with psychologists, psychiatrists, physicians, nurses, and other health care personnel involved in providing health care services to you—but only with your specific Authorization. The only conceivable reason that a specific Authorization might not be obtained would be in the case of a medical emergency.
    2. For payment: I may use and/or disclose your PHI to bill and get payment from health plans or other entities with your consent.
    3. For health care operations: I may use and/or disclose your PHI to run my practice, improve your care, and contact you when necessary.
B. Other uses and/or disclosures requiring your specific Authorization on a separate form: Generally, my use and/or disclosure of your PHI for any purpose that falls outside of the definitions of treatment, payment and health care operations identified above will require your signed Authorization using a separate release form. If you grant your permission for

such use and/or disclosure of your PHI, you retain the right to revoke your Authorization at any time except to the extent that a disclosure might already have been made.

C. Use and/or disclosures not requiring your Authorization: The Rule provides that I may use and/or disclose your PHI without your Authorization in the following circumstances:
    1. When required by law: I may use and/or disclose your PHI when existing law requires that I report information including each of the following areas:
        a) Reporting abuse, neglect or domestic violence: I may use and/or disclose your PHI in cases of suspected abuse, neglect, or domestic violence including reporting the information to social service agencies.
        b) Judicial and administrative proceedings: I may use and/or disclose your PHI in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process.
        c) To avert a serious threat to health or safety: I may use and/or disclose your PHI in order to avert a serious threat to health or safety. For example, if I believed you were at imminent risk of harming a person or property, or of hurting yourself, I may disclose your PHI to prevent such an act from occurring.

Your Rights Regarding Your Protected Health Information (PHI)

The HIPAA Privacy Rule grants you each of the following individual rights:

A. In general, you have the right to view your PHI that is in my possession or to obtain copies of your paper or electronic health record. You must request it in writing. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, such as if I fear the information may be harmful to you, I may deny your request. If your request is denied, you will be given in writing the reasons for the denial. I will also explain your right to have my denial reviewed. If you ask for copies of your PHI, I will charge you not more than $.20 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree in advance to it, as well as to the cost.

B. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in

emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. It is your right to ask that your PHI be sent to you at an alternate address or by an alternate method, e.g., email. I am obliged to agree to your request providing that I can give you the PHI in the format you requested without undue inconvenience.

D. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, e.g., those for treatment, payment, or health care operations. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list will include the date of the disclosure, to whom PHI was disclosed (including their address if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

E. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request in writing if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

F. You have the right to get this notice by email. You have the right to request a paper copy of it as well.

G. You have the right to choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health

information. I will make sure that person has this authority and can act for you before I take any action.

H. You have the right to request confidential communication. You can ask that I communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask me to call you at home, and not at work, to schedule or cancel an appointment. I will try my best to do as you request.

How to Complain about These Privacy Practices

If you believe that I may have violated your individual privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint by submitting a written complaint to me. Your written complaint must name the person or entity that is the subject of your complaint and describe the acts and/or omissions you believe to be in violation of the Rule or the provisions outlined in the Notice of Privacy Practices. If you prefer, you may file your written complaint with the Secretary of the U.S. Department of Health and Human Services (Secretary) at 200 Independence Avenue S.W., Washington, D.C., 20201. However, any complaint you file must be received by me, or filed with the Secretary, within 180 days of when you knew, or should have known, the act or omission occurred. I will take no retaliatory action against you if you make such complaints.

Acknowledging Signatures

I have read and understand this Notice of Privacy Practices carefully.

I understand that, with my consent, Federal regulations (HIPAA) allow health service providers to use and/or disclose Protected Health Information (PHI) from my records in order to provide treatment services, obtain payment for the services provided, or for other professional activities known as "health care operations." How, why, and where my PHI might be released is described in this document.

I understand that this consent is voluntary and I may refuse to sign it now or revoke my consent later in writing. I also understand that if I do not sign this form agreeing to these privacy practices, I cannot be treated.

I understand that the terms of this notice are subject to change, and that the changes will apply to all my health information. I understand that the new notice will be available on my provider's website or can be obtained directly from my provider upon request.

I consent to the use or disclosure of my health information as specified above.

Patient's Signature Date

Patient's Printed Name

Patient's Signature Date

Patient's Printed Name

Psychotherapist's Signature Date