LESLIE ROOT COUNSELING
SUITE 201 4445 WEST 77TH ST, EDINA MN, 55435 LESLIEROOTCOUNSELING.COM

INFORMED CONSENT FOR TREATMENT

CANCELLATION POLICY

If you fail to cancel a scheduled appointment **48 hours in advance**, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee is charged for missed appointments or cancellations with less than a **48-hour notice**. I _____ Understand late cancelations will result in my credit card being charged the full amount of the scheduled session.

Signed_____ Dated_____

TERMINATION POLICY

The following policy should be adhered to after 30 days without communication or notice from a client:

A. The clinician should make 3 attempts to reach the client at the identified phone number in order to assess the client's needs at that time.
B. If the client is able to be reached it should be discussed with the client how he or she would like to proceed with care. That may include termination of care, referrals to other clinicians, or continuation of care.
C. In the event that the client is not able to be reached the clinician should send a letter to the client informing them they have 10 business days to respond to the letter so the plan for treatment may be discussed or their file will be closed.
D. If there is no response at that time, a termination summary should be written and the client's file should be closed. A letter should be sent to the client indicating the course of action taken by the clinician and any necessary referrals should be included.
E. The following policy should be adhered to when the clinician is aware of the client's decision to terminate therapy, there has been collaboration of client and therapist deciding the client will be discharged from therapy, or termination at the request of staff:
A. The clinician should write a termination summary, closing the file and a letter should be sent to the client indicating the file has been closed. The clinician should provide the client with any requested referrals or follow-up that is agreed upon.

Each termination summary will include:

1. Identifying information – Client name, DOB, file number
2. Date of initial session
3. Date of termination
4. Course of treatment
5. Presenting Problem
6. A brief summary of services
7. Client's condition upon discharge
8. Discharge rationale/recommendations
9. Therapist signature and date

COURT APPEARNCES

I do not work with court proceedings. I would not be considered an expert in a case of divorce or other custody situation. If I am served a subpoena to attend court or if for any reason your records are requested for court proceedings or your therapist is asked to testify in court, I require an advanced notice of at least 30 days prior to the scheduled court date. In addition, our standard fee for an appearance in court regardless of actual time spent in court is $2000/day. This fee is set to compensate the therapist for time taken away from billable time and for any associated costs with the appearance in court. If any hourly costs incur a rate of $250 an hour is subject to be paid by the client requesting all forms. I cannot release any documentation without consent from all parties present in therapy, consent must be provided in physical documentation form, LRC counseling reserves the right to request parties be present to sign the requested documentation.

E-MAIL POLICIES

Voicemail and Email are to be used for scheduling and rescheduling appointments. Please do not email your therapist information related to your therapy sessions, since email is not completely secure or confidential. If you send an email, I will respond only to confirm appointments. Be aware that all emails are retained in the logs of your and our Internet service providers. While it may be unlikely that someone reads these, they are available to be read by the system administrator of the Internet Service Provider. You should also know that any emails received from you become part of your legal and therapy records.

Therapy Services Fees

Our fees for services are as follows:
Individual Session(50 minutes) $160
Family Session (80 minutes) $235

AUTHORIZATION FOR THE TREATMENT OF MINORS OR PERSONS UNDER GUARDIANSHIP

I authorize Leslie Root Counseling to provide mental health services and/or treatment to my child or person for whom I am guardian. _____

INFORMED CONSENT FOR TREATMENT

A copy of Life Love Healing “Information About and Informed Consent for Psychological Services” has been offered to me. I understand its contents and agree to abide by its terms to include giving general consent for treatment. I may at any time decline specific recommendations. General consent for treatment includes evaluation, psychotherapy, involvement in treatment planning, and psychological testing (if indicated). Signature indicates acceptance and agreement of the above stated LLH Counseling policies and practices

Signature _____ Date _____

INFORMATION AND INFORMED CONSENT ABOUT OUR PSYCHOLOGICAL SERVICES

Life Love Healing Wellness Center is staffed with individuals with training in marriage and family therapy, child development and psychology. We are committed to providing quality counseling and mental health care. Effective therapy requires a working partnership between client and therapist. In order to engage in such a partnership, you need to know about your rights and responsibilities as a client.

Getting to Know You

In the first session you will complete introductory paperwork and meet with your therapist. You will talk about your reasons for coming and your current situation. You will be asked questions about the history of your family as well as your own history. You and your therapist will develop a treatment plan focusing on your behavioral health needs within your first two sessions. The frequency of your sessions will be based on your individual assessment.

Treatment Process

Therapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you bring forward. There are many different methods your therapist may use to deal with the problems you would like to address. You and your therapist will work together to identify treatment goals; the length of time in therapy will vary according to your individual needs and will be discussed throughout the course of your care. Therapy is not like a medical doctor visit; instead, it calls for a very active effort on your part. In order for the therapy to be successful, you will have to work on things we talk about both during sessions and at home. Therapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, and helplessness. On the other hand, therapy has also been shown to have benefits such as better relationships, solutions to specific problems, and significant reduction in feelings of distress. But there are no guarantees of what you will experience as therapy can be of significant assistance to some clients, of some assistance to others, and of no assistance to other clients. For some clients in therapy, thoughts and feelings of suicide can arise. It is important for you to inform your therapist if you begin to experience suicide thoughts or feelings in order for the proper therapy help be provided to you.

Privacy and Mandated Reporting

Please see the “Notice of Privacy Practices” for a complete description of the uses and disclosures of your Protected Health Information (PHI). As a part of clinical practice, therapists have the right and an obligation to consult with and receive supervisory assistance regarding their work with clients. The purpose of such consultation is to increase the effectiveness of the treatment. In consultation, clinical staff take care to assure that the client’s identity is protected and that any information conveyed to another mental health professional will be kept private.

Records

Laws and standards require that we keep records of services provided to clients. You are entitled to receive a copy of the records, or your therapist can provide a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. Therefore, if you wish to see your records, it is recommended that you review them with your therapist so that you can discuss them with him/her. If another professional has referred you to LLHWC you will be asked to sign a General Authorization Form to allow your therapist to consult with the referring professional. You have the right to decide whether or not to sign the General Authorization Form.

Payments
You will be expected to pay for each session at the time it is held or unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested.

Bill of Rights
As consumer of mental health services in Minnesota, you have rights as described in the Bill of Rights attached to this document. You are encouraged to read it.

Areas of Competence
As a client, you have a right to request a written statement of competencies by the mental health professional providing services to you. You also have a right to be informed of treatment alternatives in understandable terms and to know the costs of those services.

Emergency Services
In the case of an emergency we advise clients to call 911. If clients are in need of crisis services they are advised to contact Hennepin County Crisis at
Contact Number: 612-596-1223
Phone calls made after business hours will be answered by a recording, after which you can choose to leave a message.

Staff Rights
Professional and support staff at Life Love Healing Wellness Center have the right to expect respectful treatment by clients in the course of offering services. This includes the right to expect that agreements reached about payment amounts and procedures and about appointment times will be honored by each client

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

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NAME OF INDIVIDUAL: _____

This is to acknowledge I was made aware that I can request a copy of Life Love Healing Wellness Center Services' Notice of Privacy Practice with an effective date of 3/1/14.

Individual's (or Legal Representative's) Name:

_____

Individual's (or Legal Representative's) Signature:

_____

Date: _____

Capacity or Authority of Legal Representative (if applicable)*:_____
*May be requested to provide verification of representative status.

For Office Use Only

We made the following efforts to obtain written acknowledgement of receipt of the Notice of Privacy Practices:

However, acknowledgement could not be obtained because:

□ Individual refused to sign
□ Communication barriers prohibited obtaining the acknowledgement
□ An emergency situation prevented us from obtaining acknowledgement
□ Other (please specify):

_____
_____
_____
_____