Riverstone
Psychological Services

511 Northern Hills Drive NE, Suite #2
Rochester, MN 55906
(507) 923-7321

Registration Form

Today's Date _____

Patient Information

Patient Legal Name (Print) _____
Last Name First Name Middle Initial

Patient Preferred Name _____ Date of Birth _____
Last Name First Name Middle Initial

Street Address _____ Home phone _____
City _____ State _____ ZIP _____ Work phone _____
Social Sec. # _____ Emergency Contact _____ Emerg Phone _____
Sex assigned at birth: __Male __Female Gender Identity: _Male _Female _Other_____
Pronouns: _____ Age ____ Marital Status: __Single __ Married __Partnered __Divorced __Separated __Widowed __Other
Employer_____ Occupation_____
Email address (Optional) _____ Referred by: _____

Primary Insurance.

Primary Insurance Company _____ Phone _____
Ins Claims Address _____Website:_____ City _____ State ____ ZIP _____
Policy/ ID# _____Group/ Plan # _____
Policy Holder Information: (If the patient is not the employee/ policy holder)
Name _____ Relationship _____
Last Name First Name Initial
Address _____ City _____ State ____ ZIP _____ Date of Birth _____
Social Sec. # _____Employer _____

Secondary Insurance

Secondary Insurance Company _____ Phone _____
Ins Claims Address _____ City _____ State ____ ZIP _____
Policy/ ID# _____Group/ Plan # _____
Policy Holder Information: (If the patient is not the employee/ policy holder)
Name _____ Relationship _____
Last Name First Name Initial
Address _____ City _____ State ____ ZIP _____ Date of Birth _____
Social Sec. # _____Employer _____

Responsible Party (Where should the patient's portion of the bill be sent, if not to the patient?)
Name _____ Relationship _____

Address ____Phone____________________

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether paid by the insurance or not. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits, which may include demographic information, diagnosis, mental health services provided, insurance coverage, medical history, hospitalizations, and financial update. I understand and give permission for this information to be shared via fax, telephone, e-mail, or U.S. mail. I authorize the use of this signature on all insurance submissions.

Financial Responsibility

I understand that I am responsible for all charges for services provided to me, including any amount not paid by my insurance plan or third-party payor. This applies if Medicare or any other third-party payor covers me. I understand that Riverstone Psychological Services, Inc. reserves the right to pursue delinquent accounts through small claims court and/ or by other legal means, in which case release of client information may be necessary. If there are fees incurred in collecting, the client will be responsible for any and all fees. I understand that this authorization expires one year from the signed date.

Name of Policy Holder	Signature	Date of Birth	Date
Client's Name	Signature		Date
Parent/ Guardian's Name	Signature	Relationship to Patient	Date

INFORMED CONSENT

Welcome to Riverstone. This document contains important information about our professional services and business policies. Although these policies are sometimes long and complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Psychological Services

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. We, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy 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 psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy 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. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, we will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

Appointments

Appointments will ordinarily be 45-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. You are responsible for coming to your session on time; if you are late, your appointment will still need to end on time. If you need to cancel or reschedule a session, we ask that you provide me with 24 hours notice. If it is possible, we will try to find another time to reschedule the appointment. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; if you miss an appointment or if you do not provide 24 hours advance notice of cancellation of an appointment, you may be charged **$100.00 for the missed appointment or late cancellation**, unless other arrangements have been made with your counselor. If you have a standing appointment time and miss it without notice, you may lose that standing appointment and must verify with your counselor before returning for your next appointment.

Professional Records

We are required to keep appropriate records of the psychological services that we provide. Your records are maintained in a secure location in the office. We keep brief records noting that you were here, your reasons for seeking therapy, the

goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records we receive from other providers, copies of records we send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to the information in your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, we recommend that you initially review them with us, or have them forwarded to another mental health professional to discuss the contents. If we refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional , which we will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

Contacting Us

We are often not immediately available by telephone. We do not answer the phone when we are with clients or otherwise unavailable. At these times, you may leave a message on our confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from us or we are unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) contact Crisis Response for Southeast MN (we can provide these numbers for you and they are listed in the phone book), 2) go to your Local Hospital Emergency Room, or 3) call 911 and ask to speak to the mental health worker on call. We will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering our practice.

Parents & Minors

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

Limits of Confidentiality

Contents of all therapy sessions, written and verbal, are Confidential; this information cannot be shared with another party without the written consent of the patient or the patient's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect When a patient discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. When a patient discloses or implies a plan for suicide, the mental health professional can notify legal authorities and make reasonable attempts to notify the patient's family.

Maltreatment of Children and Vulnerable Adults If a patient states or suggests the he or she is abusing or neglecting a child/vulnerable adult, or has recently engaged in maltreatment of a child/vulnerable adult, or a child/vulnerable adult is in danger of maltreatment, the mental health professional is required to report this information to the appropriate authorities.

Prenatal Exposure to Controlled Substances Mental health professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful to the unborn child.

Minors/ Guardianship Parents or legal guardians of non-emancipated minor patients have the right to access the patient's mental health records.

Insurance Providers (when applicable) Insurance companies and other third-party payers may request access to information regarding patients' services, including but not limited to types of services, dates/ times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

Research and Measurement of Therapy Effectiveness This agency regularly collects data regarding program effectiveness and ways to improve patient outcomes. Where possible, all data are stripped of identifying information; when anonymity is not possible, data are coded to protect privacy of participating individuals. All individuals who wish to be excluded from this process may do so without penalty
and need to formally communicate this wish to an agency representative.

Insurance

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, my billing service and I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-IV. There is a copy in my office and I will be glad to let you see it to learn more about your diagnosis, if applicable.). Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee (which is called co-insurance) or a flat dollar amount (referred to

as a co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit by check or cash. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount, that must be paid by the patient before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions with me until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. Once we have all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, unless prohibited by my provider contract.

If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

Fees & Financial Policy

Rates for Clinical Services

We bill your insurance whenever possible; however, you are responsible for any co-payments or amounts not covered by your insurance. All co-pays, deductible amounts, and private pay fees are due in full on the day of service, unless other arrangements have been made in advance. Any check returned for insufficient funds will be charged an additional $30 service fee. This office accepts cash, checks, and debit/credit cards.

Our fee for an intake evaluation is $250.00, unless it is covered by your insurance. Our fee for a regular 50-minute session is $200.00. Some fees will vary, depending on the type of service provided and the length of time completing the service. Minnesota Department of Human Services sets the standard for certified DBT reimbursement, which is currently $42.00 per 15 minutes for individual DBT sessions and $19.06 per 15 minutes for group sessions.

Non-Clinical Services

Non-clinical services are services not typically covered by your insurance. This includes document preparation, travel time, requests for records, phone consultations, and court appearances.

If you request any letters, forms, or any other paperwork to be completed (beyond what is required by your insurance for provision of services), such as FMLA or disability forms, please be advised that there is a fee for document preparation. Our fee is $100.00 per half hour. FMLA paperwork generally requires a minimum of 30 minutes to complete, due to the need for supporting clinical documentation. Short-term disability often takes longer to complete and may require additional assessments beyond our regular intake evaluation. The time required to make copies or prepare and send faxes, and any other administrative business (e.g. preparing releases of information or requests for records; phone calls to lawyers or other non-clinical calls) not directly related to the provision of clinical services, will also be assessed based on a rate of $100.00 per half hour, with a minimum fee of $50.00. Clinical records will be provided/ transferred at $30 per request.

Please be advised: we will not complete any FMLA, disability, or any other paperwork or letters of support unless we have met with you for at least 6-8 sessions. We will also not complete any FMLA or disability paperwork if we do not believe we can support it based on what you have presented at intake and during sessions.

If travel is required for provision of services, we bill in 15 minute increments, at $50.00 per increment.

Court appearances are billed at $250 per hour for the time spend at court *whether the therapist is called to testify or not*.

Phone calls longer than 10 minutes are billed at $50.00 per 15 minutes; a 30-minute call will be $100.00. Please be advised that insurance companies have never reimbursed therapists for crisis calls; it is one of the reasons why clients are referred to crisis services. (This phone call charge *does not apply to DBT skills phone coaching calls*, which are considered included in the cost of the DBT program.)

Outstanding and Overdue Accounts

If your account balance is not paid each month, your account will be considered outstanding. There will be a $3.00 monthly finance charge on any unpaid balances. Your therapist will contact you to discuss the possibility of setting up a payment plan to resolve your bill. Services may be discontinued to avoid additional charges should the balance go over $200. If payments are not made for two consecutive months, your account will be considered overdue. You will receive a letter identifying your account as overdue and identifying payment options that will allow you to pay your account in full. If you do not contact us and make payment in full, all services will be discontinued until bill is paid in full. Should your account balance become delinquent, the process will be started to resolve your account in small claims court. You will be responsible for the balance of your account, all fees incurred in the process, and $1500 for clinical time in this process.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this *Agreement* and *the Notice of Privacy Practices and Rights* and agree to their terms; that you agree to the above limits of confidentiality and understand their meanings and ramifications. You acknowledge that you had an opportunity to receive and review the Riverstone Psychological Services Privacy Notice and Bill of Rights.

_____

Client's Name Signature Date

_____

Parent/ Guardian's Name Signature Relationship to Patient Date

Authorization for Agency Practices

Please read the following agency practices below. You need to choose whether you will give or not give your consent for Riverstone Psychological Services, Inc. to engage in that practice as it relates to you or the patient's case. You may change or rescind your consent at any time by notifying your therapist in writing. There is no penalty for declining or rescinding consent.

Authorization for correspondence
By checking the circles, you are giving Riverstone Psychological Services, Inc. permission to correspond with you via

- o US Mail
- o Telephone
- o Email: _____

Permission for access of contact information
I agree to allow my therapist to keep my name, phone number, and address with her/ him after hours for the purpose of scheduling, emergency response, and, if applicable, DBT skills phone coaching.

- o I give consent
- o I DO NOT give consent

Permission to video record
I hereby give Riverstone Psychological Services, Inc. permission to video record the patient's or my therapy session. I understand that the purpose of this video is for clinical consultation. I understand and agree that this video is not a part of the patient's or my clinical file and will be erased after it is used. I understand that all identifying information about me or the patient will be protected. *If you are part of the adult DBT program, video recording of the therapist during session is a required part of the programming to ensure therapist adherence to the DBT model and improve clinical skills.*

- o I give consent
- o I DO NOT give consent

Permission for audio recording
I hereby give Riverstone Psychological Services, Inc. permission to audio record the patient's or my therapy session. I understand that the purpose of this recording is for clinical consultation or educational purposes. I understand and agree that this video is not a part of the patient's or my clinical file and will be erased after it is used. I understand that all identifying information about me or the patient will be protected.

- o I give consent
- o I DO NOT give consent

Permission for intern/ student observation and assistance
For the purpose of improving and expanding the availability of mental health providers in the community, this agency regularly offers internship and practicum-type experiences to students training to become counselors. We request

permission from each service recipient to have the student observe and, as appropriate, participate in the provision of services. With permission, this student may be present in some or all of the patient's or your sessions, take notes on his or her observations for the purposes of record keeping here at the agency, review records, and discuss his or her learning experiences with his or her university peers and professor. The student is legally bound, under your therapist's license, to protect your confidentiality in exactly the same way your therapist does. Your name, identifying information, and medical records will not be shared outside of this agency, even when the student is participating in class discussions, now and in the future. The student is under the supervision of Dr. Jami Hoxmeier, Ph.D., L.P.

- o I grant permission for intern/ student observation and, as appropriate, provision of services.

- o I DO NOT grant permission for intern/ student observation and, as appropriate, provision of services.

Medicare recipients: I have an Advanced Directive: ___YES ___NO ___Don't Know

I understand the information provided in this document and its ramifications. My signature below indicates that I have indicated my consent or lack of consent for each policy. I also understand that this authorization will expire in one year from the date of my signature.

_____

Client's Name Signature Date

_____

Parent/ Guardian's Name Signature Relationship to Patient Date