Hope Counseling Center, LLC
Betty Lacine, MS, LPCC, RPT
507-250-6234

Informed Consent/Client Bill of Rights:

Client Name: (print) _____

Informed Consent: In order to insure you understand all aspects of your treatment, please review the following issues and discuss any or all topics that pertain to you with me. I will answer any questions or discuss any procedures, concerns, goals with you that are relevant to the following:

- Benefits of proposed treatment
- The way the treatment is to be administered
- The expected treatment side effects or risks
- Alternative treatment modalities
- Probable consequences of not receiving proper treatment
- The time period for which informed consent if effective
- The right to withdraw the informed consent at any time in writing

Client's Bill of Rights

The right to be informed of client bill of rights

The right to confidentiality of conversations and medical records*

The right to prompt and adequate treatment

The right to participate in the development of your treatment plan

The right upon request or receive information from your clinician regarding alternative programs and/or methods of treatment

The right to refuse treatment

The right to terminate services at any time

The right to be informed of the cost of treatment

I have received and read the informed consent and bill of rights for Hope Counseling Center, LLC. I understand the benefits of receiving treatment and probably consequences of not receiving treatment, and consent to discussing treatment and to being treated, if appropriate. I understand that this consent may be withdrawn by me at any time. I understand that signing my name below indicates I have read and been informed of informed consent and client bill of rights.

Client signature:_____ Date:_____

Hope Counseling Center, LLC
Betty Lacine, MS, LPCC, RPT
421 1st Ave. SW, Suite 300W
Rochester, MN 55902
507-250-6234

Client Name: _____ **Date of Birth:** _____

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)** *

*1. Authorization** I authorize:_____

_____

_____

to disclose the protected health information described below to Betty Lacine, MS, LPCC, RPT at Hope Counseling Center, LLC.

2. This authorization for release of information covers the period of healthcare from: a. □ _____ to _____ .

3. Extent of Authorization**

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse). **OR**

b. □ I authorize the release of my complete health record with the exception of the following information: □ Mental health records

□ Communicable diseases (including HIV and AIDS) □ Alcohol/drug abuse treatment

□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires. If no date is indicated, it will expire 12 months after signature date.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

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7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Client Signature (minor child age 16 or older) Date

_____ _____

Signature of parent/guardian of minor child Date

_____ _____

Please print name Relationship to minor client

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Financial Policy

Thank you for choosing Hope Counseling Center, LLC. If you have health insurance you would like billed, Hope Counseling Center, LLC will submit all claims on your behalf. We ask that you provide the most current information and to notify us of any changes. We suggest you contact your insurer to learn about your mental health benefits and co-payments in order to determine what your personal responsibility will be. You will be responsible to pay any portion not covered by insurance.

Fee Schedule:

Diagnostic Assessment	$200
Outpatient psychotherapy:	
45 min. sessions (38-52 mins.)	160
60 min. session (53 min +)	180
DC-5-Diagnostic assessment of child under5 (includes 3 sessions, home/pre-school observations)	450
Psychological Testing per hour	200
Missed appointmentsor cancelled less than 24 hrs in advance	80

Legal preparation and court appearances: $250/hour with a 4 hour minimum
to be paid in advance of receiving any documents or having therapist appear in court

EAP services are available and will be billed at the contracted amount

NOTE: The following reduced fee schedule applies to any clients who prefer to pay directly and not have them billed to their insurance.

Diagnostic Assessment	$150
Outpatient psychotherapy:	
45 min. sessions (38-52 min.)	100
60 min. session (53 min +)	120
DC-5-Diagnostic assessment of child under5 (includes 3 sessions, home/pre-school observations)	320
Psychological Testing per hour	150

A sliding scale is available for those who need it.

Note: missed appointment and legal fees remain the same as insurance will not pay for these.

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For the services rendered by Betty Lacine at Hope Counseling Center, LLC, I agree to pay all debts for testing, counseling sessions, and other customary charges in accordance with terms set below.

Please initial each blank that pertains to you.

_____ I authorize the release of any medical/ and or other information necessary to process all third party claims and insurance payments to be sent to Hope Counseling Center, LLC.. I am furnishing a copy of my insurance card. I understand that if charges remain after insurance responds, I will pay these charges myself. I understand I am responsible to know my insurance limits, deductions, and copayment schedule. I do not hold Hope Counseling Center, LLC responsible for insurance company errors or refusals for reimbursement for services rendered.

_____ I prefer to personally pay for my therapy services and will receive the cash rates. Please do not submit any bills to my insurance provider.

_____ A photocopy of this notice is to be considered as valid as an original.

_____ I agree to pay my co-payment or fee for service before each appointment.

_____ I acknowledge I will pay for any psychological testing, as it will not be covered by insurance. Permission will be received before the testing is done.

_____ I agree to reimburse Hope Counseling the $80 fee prior to my next appointment for any appointments for which I fail to arrive or any appointments not cancelled 24 hours in advance.

_____ I understand my records may be released by my therapist if subpoenaed by the Court.

_____ If therapist believes I am a danger to myself or others, I consent for the therapist to warn the person in danger or contact medical or law enforcement personnel.

_____ I am aware the therapist is a mandated reporter who must notify appropriate authorities if she suspects or is told of abuse involving children or a vulnerable adult.

_____ I have received a copy of the fee schedule.

_____ I have reviewed and understand the HIPAA privacy rights and notices of privacy practices. I acknowledge I have been told I can request a copy.

_____ _____ _____

Client signature Therapist signature Date

A copy of this agreement will be provided upon request.

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CONSENT FOR TREATMENT OF A MINOR

Minor Client's Name: _____

Date of Birth: _____

Parent/Legal Guardian Name: _____

Relationship to Minor client: _____

Note: divorced parents please include the relevant pages of the divorce decree stating you have full or partial legal custody of this child.

I do hereby authorize Hope Counseling Center, LLC (Betty Lacine) to provide Outpatient Counseling Services to this child. These services may include, but are not limited to psychological assessments, evaluations, individual psychotherapy, family therapy, play therapy.

I understand the consent of both parents is not necessary, but it is the responsibility of the parent giving consent to notify the other parent that their child is receiving treatment.

_____ _____

Parent/Guardian signature Date

_____ _____

Minor client's signature (required if minor is 16 years old) Date

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PERMISSION FOR COMMUNICATION

As a convenience to clients, you can receive a reminder of your appointment one business day before the appointment. Due to privacy concerns you may choose not to have the reminder or to receive it by telephone call, text, or e-mail.

***Please check the appropriate box below and sign*.**

- □ Do not remind me of upcoming appointments.
- □ I hereby authorize Hope Counseling Center LLC to use a reminder call.
- □ I hereby authorize Hope Counseling Center LLC to leave a message on voicemail or with a person who may intercept the reminder call.
- □ I hereby authorize Hope Counseling Center LLC to use a reminder text to my phone.
- □ I hereby authorize Hope Counseling Center LLC to use a reminder e-mail-knowing e-mail is unencrypted and insecure and does not ensure confidentiality.

Client Name: _____

Client phone number: _____

Client e-mail address:_____

_____ _____

Client/Guardian signature Date

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding health information we maintain about you and a brief description of how you may exercise these rights. This Notice further states the obligations we have to protect your Protected Health Information.

"Protected health information" means health information (including identifying information about you) we have collected from you or received from your health care providers, health plans, your employer or a health care clearinghouse. It may include information about your past, present or future physical or mental health or condition, the provision of your health care, and payment for your health care services. We are required by law to maintain the privacy of your Protected Health Information and to provide you with this notice of our legal duties and privacy practices with respect to your Protected Health Information. We are also required to comply with the terms of our current Notice of Privacy Practices.

How We Will Use and Disclose Your Protected Health Information

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). We will use and disclose Health Information only with your written permission. You may revoke such permission at any time by requesting it in writing.

For Payment. We may use or disclose your Protected Health Information with your authorization so that the treatment and services you receive are billed to, and payment is collected from, your health plan or other third party payer. By way of example, we may disclose your Protected Health Information to permit your health plan to take certain actions before your health plan approves or pays for your services. These actions may include:

- making a determination of eligibility or coverage for health insurance;
- reviewing your services to determine if they were medically necessary;
- reviewing your services to determine if they were appropriately authorized in advance of your care; or
- reviewing your services for purposes of utilization review, to ensure the appropriateness of your care, or to justify the charges for your care.

Appointment Reminders, Health-Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us, only with your written permission as given on the Permission for Communication form.

Uses and Disclosures That May be Made Without Your Authorization or Opportunity to Object

Emergencies. We may use and disclose your Protected Health Information in an emergency treatment situation. By way of example, we may provide your Protected Health Information to a paramedic who is transporting you in an ambulance. If a clinician is required by law to treat you and your treating clinician has attempted to obtain your authorization but is unable to do so, the treating clinician may nevertheless use or disclose your Protected Health Information to treat you.

As required by law: We will disclose health information about you when required to do so by federal, state or local law. (Example: for minors SDQ's, ECSII;'s, and CASII;s are required to be reported to the state at 6 month intervals. An identifying number is used, not the child's name.

To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious and imminent threat to your health or safety or to the health or safety of the public or another person. Under these circumstances, we will only disclose health information to someone who is able to help prevent or lessen the threat.

Public Health Activities. We may disclose health information about you as necessary for public health activities including, by way of example, disclosures to:

- report child abuse or neglect;
- notify the appropriate government agency if we believe you have been a victim of abuse, neglect or domestic violence for a vulnerable adult. For non-vulnerable adult: We will only notify an agency if we obtain your agreement to report such abuse, neglect or domestic violence.
    - To a county agency investigating child abuse

Health Oversight Activities. We may disclose health information about you to a health oversight agency for activities authorized by law. Oversight agencies include government agencies that oversee the health care system, government benefit programs such as Medicare or Medicaid, other government programs regulating health care, and civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your Protected Health Information.

Disclosures in Legal Proceedings. We may disclose health information about you to a court or administrative agency when a judge or administrative agency orders us to do so. We also may disclose health information about you in legal proceedings without your permission or without a judge or administrative agency's order when:

- we receive a subpoena for your Protected Health Information. .

Law Enforcement Activities. We may disclose health information to a law enforcement official for law enforcement purposes when:

- a court order, subpoena, warrant, summons or similar process requires us to do so; or
- the information is needed to identify or locate a suspect, fugitive, material witness or missing person; or
- we report criminal conduct occurring on the premises of our facility; or
- we determine that the law enforcement purpose is to respond to a threat of an imminently dangerous activity by you against yourself or another person; or
- the disclosure is otherwise required by law.

If the client is a minor child or vulnerable adult we will also disclose health information about a client who is a victim of a crime, without a court order or without being required to do so by law. For a non-vulnerable adult: we will do so only if the disclosure has been requested by a law enforcement official and the victim agrees to the disclosure.

Military and Veterans. If you a member of the armed forces, we may disclose your Protected Health Information as required by military command authorities. We may also disclose your Protected Health Information for the purpose of determining your eligibility for benefits provided by the Department of Veterans Affairs. Finally, if you are a member of a foreign military service, we may disclose your Protected Health Information to that foreign military authority.

National Security and Protective Services for the President and Others. We may disclose medical information about you to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law. We may also disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or so they may conduct special investigations.

Workers' Compensation. We may disclose health information about you to comply with the state's Workers' Compensation Law.

Uses and Disclosures of Your Protected Health Information with Your Permission.

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

- Most uses and disclosures of psychotherapy notes; and
- communications

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to the therapist and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

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Your Rights Regarding Your Protected Health Information

Right to Inspect and Copy. You have the right to request an opportunity to inspect or copy health information used to make decisions about your care – whether they are decisions about your treatment or payment of your care. Usually, this would include clinical and billing records, but not psychotherapy notes. You must submit your request in writing to Hope Counseling Center, LLC. If you request a copy of the information, we may charge a fee for the cost of copying, mailing and supplies associated with your request. We may deny your request to inspect or copy your Protected Health Information in certain limited circumstances. Note that if copies of protected health information are requested in writing, the writer/therapist will have 30 days to redact any information about any person other than the client from the copies given.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. For as long as we keep records about you, you have the right to request us to amend any health information created by us, used to make decisions about your care – whether they are decisions about your treatment or payment of your care. Usually, this would include clinical and billing records, but not psychotherapy notes. To request an amendment, you must submit a written document and tell us why you believe the information is incorrect or inaccurate. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must submit your request in writing to Hope Counseling Center, LLC.

Right to Request Restrictions. You have the right to request a restriction on the health information we use or disclose about you for treatment, payment or health care operations. To request a restriction, you must request the restriction in writing addressed to Hope Counseling Center, LLC. We are not required to agree to a restriction that you may request. If we do agree, we will honor your request unless the restricted health information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about your health care only in a location or through a certain method. For example, you may request that we contact you only at work or by e-mail. We will accommodate all reasonable requests. You do not need to give us a reason for the request; but your request must specify how or where you wish to be contacted.

Right to a Paper Copy of this Notice. You have the right to obtain a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this Notice of Privacy Practices electronically, you may still obtain a paper copy by requesting one.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. We will not retaliate against you for filing a complaint.

Changes to this Notice

We reserve the right to change the terms of our Notice of Privacy Practices. We also reserve the right to make the revised or changed Notice of Privacy Practices effective for all health information we already have about you as well as any health information we receive in the future. If you would like a copy request that a copy be sent to you in the mail or by asking for one any time you are at our offices.