CENTER FOR SPORTS AND THE MIND
CLIENT/INSURED INFORMATION

Today's Date: ____________________ Name of Therapist: ________________________________

Name of Client: ____ DOB: __________

Address: ____

(Street)

____

(City) (State) (Zip Code)

Home Phone: ____________________ O.K. to leave message? Yes ☐ No ☐

Work Phone: ____________________ O.K. to leave message? Yes ☐ No ☐

Cell Phone: ____________________ O.K. to leave message? Yes ☐ No ☐

Email: ____________________ O.K. to leave message? Yes ☐ No ☐

Single: ☐ Married: ☐ Other: ☐ Male: ☐ Female: ☐

If a minor, names of parents: ____

Employer/School: ____

Emergency Contact: ______________________________ Phone Number: ____________________

How would you like statements and invoices sent to you? ☐ **Email** ☐ **Regular Mail**

PRIMARY CARDHOLDER:

Type of Insurance: ____

Group ID#: ______________________________ Member ID#: ______________________________

Name: ____

Address: ____

(Street)

____

(City) (State) (Zip Code)

Date of Birth: ____________________ Social Security #: ______________________________

Home Phone: ____________________ O.K. to leave message? Yes ☐ No ☐

Work Phone: ____________________ O.K. to leave message? Yes ☐ No ☐

Cell Phone: ____________________ O.K. to leave message? Yes ☐ No ☐

Client's relationship to insured: ____

Please turn over and sign page 2

How did you hear about CSM? ☐ **Yellow Pages** ☐ **Insurance** ☐ **Friend/Family** ☐ **Self-referral** ☐ **Web Site** ☐ **School** ☐ **Former Client** ☐ **County** ☐ **Other**

CENTER FOR SPORTS AND THE MIND

CANCELLATION POLICY

CSM requires 36 hour notice for a cancellation. If notice has not been received, a cancellation fee of $100.00 will be charged to you (not insurance submittal). Any requests for exception to a failed appointment charge need to be sent in writing to the business office and discussed with your therapist. **CLIENT'S INITIALS: ______________**

BILLING POLICY

It is CSM's policy to bill a client's insurance company, EAP, managed care group, or other paying organization for therapy services performed. Any additional payments (i.e., co-pays, deductibles, etc.) are due prior to therapy.

All payments collected prior to therapy are estimates based on information received from the insurance company/paying organization. Therefore, additional payments may be required (or amounts may be due to the client) based on the accuracy of the insurance company/paying organization's estimate.

Our fees for services are as follows: Intake $180 Individual Session $160 Family Session $160

If you have a balance due we will bill you by mailing you an invoice. Bills are mailed or emailed on a monthly basis. When fees for service are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (i.e. diagnosis, treatment plan, case notes, testing) is not disclosed. If a debt remains unpaid, it may be reported to credit agencies, and the client's credit report may state the amount owed, time frame and the name of the clinic. If you have provided us with credit card information, we reserve the right to bill your card in accordance with the credit card agreement you have signed.

COURT APPEARANCES

If for any reason your records are requested for court proceedings or your therapist is asked to testify in court, we 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 $1200/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.

REQUESTS FOR INFORMATION FOR COURT PROCEEDINGS

If you would like your records to be released for court proceedings, CSM is required to release this information in accordance with relevant state laws and adherence to ethical codes for LMFT's in the State of MN and AAMFT. To protect the integrity of you therapeutic process and follow said laws and ethical codes Foundations Counseling cannot release information unless a release is granted by all members of the treatment unit or by an order from the court to release the information. Releasing records that were created in context of therapeutic process can compromise the integrity and effectiveness of the process.

RELEASE /EXCHANGE

I authorize the release or exchange of information from CSM to my insurance company, EAP, managed care group, and/or other paying organization to facilitate payment and continued coverage under the mental health benefit of my policy. I authorize the release of the minimum amount necessary of my personal health information to Mental Health Billing Professionals, Inc. and to my insurance company, if applicable, in order to obtain payment for services here. I hereby instruct my insurance to pay directly to Clinician named herein, all benefits payable under my insurance policy upon receipt of claims billing for services rendered.

ASSIGNMENT OF BENEFITS

I consent to have CSM submit claims on my behalf to my insurance company, EAP, managed care group, or other paying organization and receive payment according to the guidelines of my policy.

AUTHORIZATION FOR THE TREATMENT OF MINORS OR PERSONS UNDER GUARDIANSHIP

I authorize CSM 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 CSM "Information About and Informed Consent for Psychological Services" has been given 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 Foundations Counseling policies and practices

____ ____________________

(Signature) (Date)

Center for Sports and The Mind

INFORMATION AND INFORMED CONSENT ABOUT OUR PSYCHOLOGICAL SERVICES

The Center for Sports and the Mind 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 abut 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.

Email, Cell Phone and Fax Communications: It is very important to be aware that communication by email, cell phone and fax can be relatively easily accessed by unauthorized people and as such the privacy and confidentiality of such communication can be compromised. Emails, in particular, are vulnerable to unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through them. Faxes can easily be sent erroneously to the wrong address. Please notify your clinician at the beginning of treatment if you decide to avoid or limit the use of email, cell phone or fax communication.

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 CSM 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.

Electronic Records: Foundations Counseling Services maintains all records related to treatment by electronic means on a secure server maintained by Kasa Solutions, Inc. that is in compliance with all regulations related to the confidentiality of protected health information. If you would like more information related to the manner in which your confidentiality is protected under this system, it is available upon your request.

Payments/Insurance Reimbursement

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested.

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. Your therapist will provide you with whatever assistance he/she can in helping you receive the benefits to which you are entitled; however, you are responsible for full payment of fees. It is important that you find out exactly what mental health services your insurance policy covers. If you have questions, it is often helpful to call your plan administrator. We can provide you with whatever information we can based on our experience, and will help you to understand the information you receive from your insurance company. If it is necessary to clear up any confusion, we can call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasing become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available, and plans often require an authorization before they provide reimbursement for services. These plans are often limited to short term treatment approaches, and it may be necessary to seek approval for more therapy after a certain number of sessions.

Most insurance companies require that you authorize your therapist to provide the company with a clinical diagnosis. Oftentimes the therapist has to provide additional clinical information such as treatment plans or summaries. This information will become part of the insurance company's files. If requested, your therapist will provide you with a copy of any reports sent to your insurance company.

Once insurance coverage information is obtained, you and your therapist will discuss what you can expect to accomplish with the benefits you have and what will happen if they run out before you feel ready to end therapy sessions. It is important that you always have the option to pay for therapy services yourself to avoid the issues described above.

Code of Ethics
You have the right to obtain a copy of the code of ethics from the Board of Marriage and Family Therapy, 2829 University Ave, SE, STE 330, Minneapolis, MN 55414-3222.

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
As a part of our services to clients, we provide a 24 hour voice messaging service by calling our office phone number 952-393-6828. 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 Foundations Counseling Services 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.

Complaints
If you feel you have been treated poorly or not received competent treatment services, we encourage you to discuss your concerns with your therapist. If your concerns are not addressed you can register a written complaint to the MN Board of Marriage and Family Therapy at 612-617-2220.

CENTER FOR SPORTS AND THE MIND

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

NAME OF INDIVIDUAL: ____

This is to acknowledge I was made aware that I can request a copy of CSM Notice of Privacy Practice with an effective date of 9/1/05.

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): ____

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