Outpatient Services Contract

Welcome to my practice. This document contains important information about my professional services, business policies, your rights as well as our mutual responsibilities and obligations. It also contains information about the Health Insurance Portability and Accountability Act (HIPPA), a federal law that provides privacy protection and patient rights about the use and disclosure of your Protected Health Information PHI). Although these documents are long and sometimes complex, they are very important that you understand them. Please read it carefully and discuss any questions you have with me. When you sign this, it will represent an agreement between us.

Professional Services:

- **Psychotherapy:** I am committed to providing professional therapeutic services to individuals, couples, families and groups. I have met the requirements and training for a Licensed Psychologist and will continue to maintain these requirements.

  Psychotherapy can have benefits and risks. Since it involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. On the other hand therapy has been shown to have benefits for people who participate in it. However there are no guarantees of what you will personally experience. I understand Therapy is not an exact science and I acknowledge that no guarantees have been made to me as the result of assessment or treatment.

  When we first meet, I will conduct a diagnostic assessment. By the end of that evaluation, I will be able to provide you with feedback, recommendations and offer you some first impressions of our work will include should we decide to work together. You should evaluate this information along with your opinion of whether you feel comfortable working with me. Therapy involves a commitment of time, money and energy, so you should be very selective in whom, you chose for your therapist.

  During this time, I will also decide if I am the best person to provide the services you need. An intake assessment can also be just for the purpose of assessment and referral; coming in for an intake doesn't mean we are consenting to treatment together. If I cannot provide the service, I will consult with others and/or refer you to other resources.
  If we decide to continue, we will create a treatment plan that will include the goals you will hope to achieve through therapy. A therapy appointment lasts 30-60 minutes, unless it is a Prolonged Exposure session which is 60-90 minutes.
  As best practices as a psychologist I participate in a weekly consultation group where I may consult with other professionals (legal and clinical) on your case. To what degree it is possible, every reasonable attempt will be made to avoid revealing your identity to other professionals whom I consult with.

I understand the first appointment is for a diagnostic assessment only, to determine whether or not services are appropriate for me at this time. This is not a "Consent for Treatment" agreement. This assessment does not establish a therapeutic relationship with the assessment therapist.

- **Couples Therapy**

  If you are receiving therapeutic services at Rachel Rippel MA, LP, LLC for "Couples Counseling," your client record is defined and maintained in an original manner due to the fact that insurance companies do not pay for Couples Counseling services. Maintenance of your client record in this way is in accordance with the Board of Psychology code of ethics.
  Client shall be informed that the definition of "client" within the specific context of Couples Counseling is *the relationship between the couple.* In other words, each individual within the couple is not treated separately, but the couple as a unit is treated together. Therefore all records of your treatment may include full identifying information **for both individuals** such as name and date of birth. This definition of client applies to files, paperwork, and all other paper/electronic records pertaining to your services with me here.

  Due to the relational nature of therapy work with couples, there are additional limits to your confidentiality. It is my policy that **both individuals** comprising the "client" couple must provide written consent for authorization of records pertaining to their Couples Therapy, at the beginning of treatment. The clinical rationale for this requirement is because, again, I am treating the *relationship as the client* rather than any one individual thus both individuals are consenting to treatment with this understanding that all information disclosed is shared information and will be kept as part of their "client" record.

  In the event that either individual within the couple requests records or if a third party requests records, the entire file will be disclosed since both names are on the file. The exclusion to this requirement for written authorization of records is if either/both individuals are also receiving individual therapy services, in which case neither party is required to give written authorization in advance for access to their *individual* treatment records.

  It is my policy that when working with couples, we adhere to a "No secrets" policy. That means that no individual should disclose any information to me in private that he/she/they wish to keep private. Any disclosure of information made in this manner will be shared and made transparent to all involved parties at the discretion of Rachel. The exception to this "No secrets" policy is in the case of reported domestic violence/abuse.

- **Contacting me:** You can contact me by telephone, email or mailing address. I monitor my voicemail frequently and make every effort to return you call as quickly as possible, however it is a non-urgent voicemail. If you are a DBT or EXRP client you will have a coaching number to reach me at. Please always leave your telephone number in your message to make it easier to respond to you. If I will be unavailable for an extended period of time, I will provide you with the name of a colleague to contact, if necessary. I am aware that electronic means of communication such as cell phones, emails and texts are not confidential.

- **Emergencies:** Upon our first meeting I will provide you with a list of crisis numbers if you should need them. Do not leave me a voicemail if it is an emergency as I may not get your call that day. Please do not email me for emergency purposes. If you are a DBT client you will have specific guidelines around emergencies that we will cover in our session. If you are unable to reach me, call 911, the Crisis Connection at 612-379-6363, or go to your nearest hospital.

Business Policies:

- **Professional Fees:** My fee for a Diagnostic Assessment (45-60 minutes) is $185.00. My fee for a returning session is $160.00 (45-60 minutes). My fee for DBT group therapy is $160.00. For a returning Prolonged Exposure and ERP session is $160.00-200.00$ (60-90 minutes). I charge $160.00 for couples therapy sessions, insurance does not pay for couples therapy. Insurance companies do not cover anything longer than 60 minutes or home visits. In addition to these appointments, I charge $160.00 for other professional services you may need, though I will break down the hourly cost if I work for periods less than one hour. Other professional services may include telephone consultations lasting longer than 15 minutes (not including coaching calls), attendance at meetings, preparing/sending written documents with other professionals you have authorized, and copying and sending records. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge my hourly fee for preparation and attendance of any legal proceeding. I also charge for transportation costs.

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have an insurance coverage which requires another arrangement that we have agreed upon. If the latter is the case, you will be expected to pay any co-pay, deductible payment and/or coinsurance at the time of the session. Payment scheduled for other professional services will be agreed to when they are requested. Payment can be made by cash, check or credit card and a receipt will be given. Credit cards may be stored in the EHR system Rachel use for the purposes of copays, deductibles and missed appointment fees. I understand Rachel will charge my card for these things. I am authorizing Rachel to charge my card for these fees. _____ (initial).

- **Health Insurance Reimbursement:** I am an "In-Network Provider" and a "Out-Of-Network Provider" for some health insurance companies. You will be responsible for knowing your health coverage benefits and are responsible for full payment of my fees. It is your responsibility to be familiar with the terms of your policy and to inform me of any changes with your policy. I agree to notify you immediately if my insurance changes or is terminated. Rachel uses an outside billing company to process payments. If your account is unpaid past 60 days it may be sent to collections. Any fees incurred during the collection process will be added to your balance.

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. All diagnoses come from a book entitled the DSM-V. There is a copy in my office and I will be glad to let you see it and learn more about your diagnosis, if applicable.) Sometimes I have to provide additional clinical information such as treatment plans or summaries, or entire record (in rare cases). This information will become part of the insurance company files and may be stored on a computer. Though insurance companies claim to keep such information confidential, I have no control over what they do with it. By signing this you are agreeing that I can provide requested information to your carrier. My provider may bill the insurance company as a courtesy to me, and I may subsequently receive notice from the insurance company that all or part of these charges is considered by them to be “uncovered services” (deductibles, co-payments, co-insurance, etc.).

However, I understand and acknowledge in advance that I am seeking these services knowing that they may not be covered. I agree to cover the full cost, less any insurance payment. I know that these or similar services may be covered by my insurance company, or covered at a higher rate, if I use providers within my network. I understand that it is my responsibility to know my insurance plan and that I am responsible for knowing what and how much my insurance carrier will cover.

I agree to notify the clinic immediately if my insurance changes or is terminated. I will also update the clinic immediately regarding any changes of address or telephone number. I understand that I am expected to attend all scheduled appointments or cancel them with 24-hour notice. If I do not do this, I understand that I may be charged a "no show" or "late cancel" fee (the fee does not apply to MA, Medicare clients).

- **Cancellation/Missed Appointment Policy:** Once an appointment is scheduled, **you will be expected to pay for it unless you provide 24 BUSINESS HOURS ADVANCE NOTICE of CANCELLATION**. You will be charged my **full fee of $160.00** for appointments cancelled less than 24 hours notice (Late Cancel) or for appointments that you did not show up for (No Show). Insurance will not pay for Late Cancels or No Shows. If you feel that your need to cancel has extenuating circumstances, feel free to discuss the matter with me. You will be expected to pay the charge before or at the time of our next appointment in order to maintain future appointments with me. (this excludes MA clients). **I understand if I am more than 15 minutes late I may not be able to be seen.**

- **Professional Records:**
  I am required to keep appropriate records for the psychological services that I provide. Your records are maintained in a locked location. I keep brief records that you were here, reasons for seeking therapy, goals and progress, diagnosis, topics we discuss, your medical history, and records I have received from other providers. Records are required to be kept for 7 years mandated by Minnesota law.

Client Rights:

- **Confidentiality:** Your privacy and confidentiality will be strictly maintained. My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Policies. You have been provided a copy of that document and we have discussed those issues. Limits to when I cannot protect your confidentiality is when:
  - You are a danger to yourself or someone else
  - Supervision/Consultation
  - Child abuse or neglect/Vulnerable adult abuse or neglect
  - Court order
  - You are a minor
  - Abuse from another health care worker

- **Grievance Procedure:** If you are dissatisfied with the services you receive, I encourage you to discuss the concerns with me. If you do not feel comfortable sharing your concerns with me, please contact the Minnesota Board of Psychology by mail at 2829 University Ave SE, Suite 320, Minneapolis, MN 55414, or phone (612-617-2700).

FIREARMS POLICY:

I understand that Rachel Rippel M.A, LP, LLC bans guns in these premises. I agree that I will not bring a gun into 12301 Whitewater Dr Suite #30 Minnetonka, MN 55343.

By signing this document, you acknowledge that you have been provided a copy of the Notice of Privacy Practices and we have discussed any questions you may have.

Client Responsibilities:

- Psychotherapy calls for an active effort on your part. In order for the therapy to be successful, you will need to work on the things we talk about both during our sessions and outside of them.
- You are responsible for giving accurate and complete information that will enable me to assess your situation and problem.
- You are responsible for honoring your financial agreement with me.

Please remember we can reopen any of these conversations at any time during our work together.

Consent to Psychotherapy: Your signature below indicates that you have read this agreement and Notice of Privacy Practices and agree to abide by its terms during our professional relationship. I will provide you a copy of this form if you wish.

_____ _____

Client Signature Date

_____ _____

Client Signature Date

_____ _____

Rachel Rippel MA, LP Date