Personal Identification

Last Name(s):	First Name(s):	DOB(s):

Awakening Connections Therapy LLC - Informed Consent

WELCOME!
I appreciate your trust and confidence in choosing to work with me and I look forward to working with you. My practice style is collaborative and I encourage you to ask questions at any time. This document is provided to help acquaint you with my practice procedures, as well as provide information about your rights and responsibilities with regard to psychotherapy services. You will also find updated information about your rights with regard to the Health Insurance Portability and Accountability Act (HIPAA). If you have questions about any of this information, or if you want clarification of any policy or process, please let me know so we can discuss your concerns.

PROFESSIONAL RELATIONSHIP
Professional psychotherapy, and the process of psychotherapy, is not easily described in general statements. It varies depending on the personalities of the therapist and client, your particular concerns, and your life experience. Meeting with a psychotherapist is not like meeting with a medical doctor. Psychotherapy calls for a very active role on your part, and there are many different methods we may use to address your concerns. Other important people in your life may even be included. Psychotherapy can have additional benefits as you work on the goals and strategies at home that we've talked about during our meetings.

Psychotherapy has many benefits, but there are also some risks. Our meetings may involve discussing challenging moments of your life, and you may experience sadness, guilt, anger, frustration, loneliness, or other uncomfortable feelings. On the other hand, successful psychotherapy can lead to increased satisfaction in relationships, new possibilities for addressing specific concerns, and/or reductions in feelings of distress. But there are no guarantees of what you will experience or the ultimate outcome of our work together.

Our first few sessions will focus on understanding your needs, goals, and presenting concerns. We may decide to take advantage of psychological assessments during this time. After the first few sessions, we will be able to discuss your first impressions of what our work could include and then co-create a potential plan to follow, if we decide to continue our professional relationship. It is important to evaluate this information, along with your own opinions of whether you feel comfortable working together. Since psychotherapy involves a commitment of time, money, and energy, it is important to be selective about the therapist you select. If you have questions about my procedures, we can discuss these whenever they arise. While we co-create possible solutions, you maintain the right to implement them, or decide against implementing any or all of them.

Consent for Treatment

I give Awakening Connections Therapy LLC / Amy-Ann Mayberg, MA, LAMFT permission to complete any necessary psychological assessments, develop a treatment plan and provide psychotherapy treatment for me. I understand that my involvement and participation—both in and out of session—is required for all phases of psychotherapy treatment, and that other treatment may be recommended and/or necessary for the continuation of my care. I understand and acknowledge that no guarantees have been made regarding the outcome of any assessment or treatment by Awakening Connections Therapy LLC / Amy-Ann Mayberg, MA, LAMFT.

Initial(s): _______

Amy-Ann Mayberg, MA, LAMFT
7400 Metro Boulevard, Suite 377
Edina, Minnesota 55439
612.444.6463

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Initiation and Termination of Psychotherapy Services

I understand that Awakening Connections Therapy LLC / Amy-Ann Mayberg, MA, LAMFT will propose a treatment plan following the completion of assessment. I understand that my involvement in the development of this treatment plan is important. The plan may include individual, couple, family and/or group therapy. I understand that if Awakening Connections Therapy LLC / Amy-Ann Mayberg, MA, LAMFT believes that a higher level of care, or an alternate treatment, is indicated after the assessment is complete, or at anytime during treatment, a referral will be made as needed.

I understand that Awakening Connections Therapy LLC / Amy-Ann Mayberg, MA, LAMFT will recommend termination of services as appropriate. If I wish to terminate services prior to that time, I am encouraged to discuss this in session to allow for the creation of a transition plan to assure that I will continue to receive the treatment I need. It is the policy of Awakening Connections Therapy LLC / Amy-Ann Mayberg, MA, LAMFT to assist the client in termination of services at any time the client desires.

Initial(s): _______

Client Rights

I understand I have the right to privacy, the right to dignity, the right to understand, the right to consent to care as well as to refuse care, the right to access my records, the right to request a change to inaccurate information, the right to request restrictions on disclosure to others about me, and the right to a safe environment. I also have the right to know or inquire about the following:

1. The cost of counseling, time frame for payment, access to billing statements, billing procedure for missed appointments, and any issues related to insurance coverage.
2. When the therapist is available and where to call during off hours in case of emergency.
3. The manner in which the therapist conducts sessions concerning intake, treatment, and termination. Clients may take an active role in the process by asking questions about relevant therapy issues, specifying therapeutic goals, and renegotiating goals when necessary.
4. The nature and perspective of the therapist’s work, including techniques used, and alternative methods of treatment.
5. The purpose and potential negative outcomes of treatment. Clients may refuse any treatment intervention or strategy.
6. The anticipated length and frequency of treatment, and limitations that may arise due to difficulties in financing.
7. The liberty of clients to discuss any aspect of their therapy with others outside the therapy situation, including consultation with another therapist.
8. The status of the therapist, including the therapist’s training, credentials, and years of experience.
9. The maintenance of records, including security and length of time they are kept, client’s rights to access personal records, and release policies.
10. The right to request a referral and the right to require the current therapist to send a written report regarding services to the qualified referred therapist or organization upon the client’s written authorization.
11. The procedure followed in the event of the therapist’s death/illness.

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Confidentiality

Information that is shared in the course of psychotherapy between the client and the therapist is considered confidential. This information will not be shared with others outside of the therapeutic relationship without the express written consent of the client, with certain exceptions as noted below.

Initial(s): _______

Limits of Confidentiality

I understand that Awakening Connections Therapy LLC / Amy-Ann Mayberg, MA, LAMFT is a Mandated Reporter. Under Minnesota law, psychotherapists are mandated to report to authorities the known or suspected abuse of a minor child or the known or suspected abuse of a vulnerable adult. Therapists are also mandated reporters of pregnant women using certain illegal drugs.

In addition, as a Mandated Reporter, Awakening Connections Therapy LLC / Amy-Ann Mayberg, MA, LAMFT has a Duty to Protect. Under Minnesota law, psychotherapists are mandated to report to authorities threats of physical harm to self, or threats of physical harm to another person (i.e.: a specific identified person).

Client confidentiality may also be breached in the event of a court order.

Initial(s): _______

Meetings and Schedules

Regular office hours are Tuesday and Friday, beginning at 10am with the last appointment scheduled at 5:00pm. Two evening appointments are available on each Monday and Thursday evening as well, beginning at 5:30pm. The initial session for individual counseling is approximately 75 minutes. Each individual session typically lasts between 50-60 minutes; sessions with couples or families are longer, typically 75 minutes (1-¼ hour) up to 90 minutes (1-$^{1}/_{2}$ hour). Following the initial session is an evaluation period of 2 to 3 sessions, during which we can both decide if I am the best person to provide the services you need in order to meet your goals. I usually suggest one session per week, although some sessions may be shorter or longer or be scheduled more or less frequently. We will determine together how often and for what length of time we meet.

Due to the intense nature of Discernment Counseling sessions, the initial meeting is 2 hours, with the following sessions 90 minutes each (1-$^{1}/_{2}$ hour). It is best to schedule these sessions on a weekly basis.

I ask that you make every effort to be on time for your appointments and I will do the same. If circumstances prevent you from arriving on time, please understand that I must still follow my regular schedule. *If you are unable to keep your scheduled appointment, please let me know* ***at least 24 hours*** *in advance. Please be advised that you will be charged 75% of the full amount (regardless of the reason) for any sessions that are missed or cancelled with less than 24 hours notice.*

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Additional Professional Fees

In addition to weekly appointments, I charge $120 per hour for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one (1) hour. Other services may include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and time spent performing other services you may request. These services may not be covered by insurance.

If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, and **ANY** legal fees that I might incur, even if I am called to testify by another party. I charge $120 per hour for preparation and attendance at any legal proceeding, and in addition, mileage to and from any location. There is an additional charge for copies of your record if required. A 4-hour minimum must be paid 72 hours in advance by cashier's check.

Initial(s): _______

Payment Policy

I am NOT a contracted provider with any insurance company. If you hold health insurance, you may be able to seek reimbursement for a portion of my fees according to the out-of-network benefits outlined in your insurance policy. Whether or not you choose to access out-of-network benefits from your insurance company, ***all payments are your personal financial responsibility. Full payment is due at the beginning of each session.*** I will provide you a receipt to submit to your insurance company so your out-of-network benefits will be credited to you.

Some insurance companies require a prior authorization request to be submitted before the initial session. *Please call your insurance company to know if that is required.* Failure to request authorization prior to the session may result in your insurance company denying payment to you.

You will be expected to pay for each session *at the time of the appointment*, unless we agree otherwise. If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. [If such legal action is necessary, its costs will be included in the claim.]

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Release of Records

I understand that releasing client records is not recommended, as it constitutes a breach in patient confidentiality and the therapeutic relationship. Records will only be released upon receipt of a signed Release of Records form, identifying the specific dates of the record you wish to be released. The form must be returned to Awakening Connections Therapy LLC / Amy-Ann Mayberg MA, LAMFT via mail or in person during office hours.

Copies of records will be made available during business hours at a charge of $0.75 per page. Any information regarding a person other than the identified client named in the Release of Records form will be redacted from the record.

Initial(s): _______

Consent for Release of Information

I understand that other clinic personnel involved in billing, medical records and other necessary duties may see my medical records.

I understand that Awakening Connections Therapy LLC / Amy-Ann Mayberg MA, LAMFT participates in clinical consultation with other mental health providers so as to provide quality services to me. I understand that these persons are also bound by confidentiality.

Initial(s): _______

If I have elected to use a third-party payer, I understand the health insurer may request information in order to process claims, and I consent to this release of information.

Initial(s): _______

Phone and Electronic Communication

When in the office, I may not be immediately available by phone. If I am unavailable, incoming calls will forward to a voicemail that I monitor frequently. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If it might be difficult to reach you, please leave a time when you might be available by phone. Please use voicemail for messages of a critical nature.

I understand that Awakening Connections Therapy LLC / Amy-Ann Mayberg MA, LAMFT does not communicate via email or text regarding client information as confidentiality cannot be assured with these forms of communication. Communication transmitted via email or text should be strictly limited to scheduling appointments.

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After Hours Emergency

I understand that Awakening Connections Therapy LLC / Amy-Ann Mayberg MA, LAMFT will respond to phone calls during business hours and is unable to accept after hours emergency phone calls. If I am experiencing an immediate crisis, an emergency with a risk of safety to myself or another person, I will contact my family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call. I may also contact the Crisis Connection at 612.379.6363, the St. Paul Ramsey Crisis Intervention Center at 651.266.7900, or 911.

Initial(s): _______

Concerns

I understand that Awakening Connections Therapy LLC / Amy-Ann Mayberg MA, LAMFT welcomes feedback and discussion regarding services offered. If questions or concerns about my treatment arise I am encouraged to address these directly. If I am not satisfied with the response to my concerns or complaints I may contact the Minnesota Board of Marriage and Family Therapy at 2829 University Ave SE, Suite #400, Minneapolis MN 55414, phone 612.617.2220.

Initial(s): _______

Notification Regarding Shared Office Space

The therapy office located at 7400 Metro Boulevard, Suite 377, is comprised of individual practitioners. While the sharing of office space may facilitate consultation among therapists, it does not transcend to legal or ethical liability for clients that are not under each therapist's care. Your therapist, and her or his supervisor if she or he is not yet fully licensed, is responsible for your care and for maintaining all rights and privileges related to your treatment.

More specifically, Mindful Families, LLC and Allison Peterson, M.A., LP solely provides office space to Awakening Connections Therapy LLC and Amy-Ann Mayberg MA, LAMFT. These corporations hold no liability outside of maintaining office space for therapists and their clients.

Initial(s): _______

Signatures

My signature below indicates that I, ____(Print Name/s), have read and understand the contents of this informed consent. I affirm that Awakening Connections Therapy LLC / Amy-Ann Mayberg MA, LAMFT verbally discussed this informed consent with me, and any questions I had were addressed.

____ _______________
Signature of Client(s) Date

____ _______________
Signature of Therapist Date