



COUPLES OR FAMILY CONSENT FOR TREATMENT

As a consumer of Mental Health Services, each adult member of a couple or family who is present at a therapy appointment has a right to certain things from a therapist and each adult has an obligation to provide certain things to a therapist. Please read the following information and ask me if you have any questions.

While working as a couple or intact family and for therapeutic purposes, it is the policy of The Jonas Center that anything shared individually whether by phone, email, text or in person, may be shared with the spouse/partner/family member at the therapist's discretion. However, any written documentation requested will be managed as specified in the PRIVACY AND RIGHTS POLICY (See Below). In certain situations, such as family therapy when the parents are divorced and other situations, The Jonas Center Policy is that each parent has a right to their individual privacy as specified in the PRIVACY AND RIGHTS POLICY.

Per mental health licensing requirements, in couples or family therapy, each family member present is considered a client. When insurance is used however, most insurance companies require the therapist to diagnose one individual as the identified client. As a result, the couple or family therapy will be documented under that individual identified client. Other than insurance documentation, the information provided by each adult member is considered that member's information and will be managed as specified in the PRIVACY AND RIGHTS POLICY.

Every adult family member over age 18 must sign this Consent.

EMERGENCIES

In case of any emergency, please call 320-864-6139 or 952-361-9700. We will respond to your call as soon as possible. When we are not available, we will instruct you to: 1.) Call 911 or 2.) Go to your closest emergency room

FEES

\$250 per diagnostic hour/\$200.00 per clinical hour. An additional charge of \$25 per clinical hour may be added for Interactive Complexity when dealing with complicated situations. Full payment including deductible or insurance co-payment is expected at the time of service. Please remember that YOU are responsible for the charges incurred regardless of your insurance plan. Please be sure to verify insurance coverage.

Court Costs: I understand that if a therapist is asked or required to appear in court on my behalf and all costs associated with the court proceeding including but not limited to preparation time, travel time, attorney meetings/telephone calls, depositions, etc. will be billed at \$200 per hour. I understand that these costs are NOT reimbursable through my insurance.

Collections: I understand that if I do not pay my bill or set up a payment plan within 90 days of it being due, then my contact information and balance due will be forwarded to a collections agency.

CANCELLATIONS

If you need to cancel your appointment, please do so as soon as possible. There will be a \$75.00 charge for late cancellations--appointments cancelled with less than 24 hour notice. Two late cancellations or failed appointments may result in termination of services with The Jonas Center.

PRIVACY AND RIGHTS POLICY

The Health Insurance Portability and Accountability Act (HIPAA) and the Minnesota Health Records Act provide privacy protections and client rights for the use and disclosure of Protected Health Information (PHI). A Notice of Privacy Practices is attached for your review. No one but you has access to your PHI without your written consent with a few exceptions: 1.) Child Neglect or Abuse, 2.) Vulnerable Adult Neglect or Abuse, 3.) Subpoenaed Health Oversight (Licensure) Activities, 4.) Court Orders for Judicial and Administrative Proceedings, 5.) Serious Threats of Health or Safety Regarding Yourself or Someone Else, 6.) Worker's Compensation, 7.) for insurance audit purposes and 8.) Written Request of Privacy



from a Minor. Other exceptions may arise, however, it is our intention to do everything possible to keep information about you private.

You are not required to, however it is important for you to provide accurate and complete information regarding your current and past mental health and medical conditions as well as any treatments you have received or medications you are or have taken in order to provide the best services possible. Also, please notify your therapist of any changes in your physical or emotional health.

CONSULTATION

Your situation may be reviewed during consultations with other mental health professionals in order to provide you with the best possible ongoing services. *Identifying information will not be disclosed.*

TERMINATION OF SERVICES

Upon completing the last documented appointment, your formal relationship with The Jonas Center will be considered terminated either through mutual agreement between you and your therapist OR not more than TWO months following your last appointment.

COMPLAINTS

Please contact your therapist or James Jonas, Director as soon as possible regarding any complaint you have. If it is not satisfactorily resolved, you may contact the following licensing boards: Minnesota Board of Social Work 2829 University Avenue SE #340 Minneapolis MN 55414 (Phone: 612-617-2100)(www.socialwork.state.mn.us), the Minnesota Board of Marriage and Family Therapy 2829 University Avenue SE #330 Minneapolis MN 55414 (Phone: 612-617-2220) (www.bmft.state.mn.us), the Minnesota Board of Psychology 2829 University Avenue SE #320 Minneapolis MN 55414 (Phone: 612-617-2230)(www.psychologyboard.state.mn.us), or the Minnesota Board of Behavioral Health and Therapy 2829 University Avenue SE #210 Minneapolis MN 55414 (Phone: 612-617-2178) (www.bbht.state.mn.us).

COMMUNICATION VIA CELLPHONE OR EMAIL AND APPOINTMENT REMINDERS

By providing us with your cellphone number(s) and/or email, you are consenting to our contacting you by cellphone, text or email. Please be advised that text messages and emails are generally not secure because they lack encryption and we do not know with certainty that the message is received by you. Also, your mobile provider may store text messages.

- ____ Please initial to receive appointment reminders.
- ____ Please initial to receive Client Portal message notifications.

This Consent is in effect until the end of treatment or one year from the dated signature below.

I have read and understand the above information. I have received a copy of the Notice of Privacy Practices.

Adult Client Signature: _____ Date: _____

Adult Client Signature: _____ Date: _____

Adult Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____