Individual, Couple & Family Psychotherapy
Serving Cologne, Eden Prairie & Glencoe

925 12th St E, Ste 101; Glencoe, MN 55336
320.864.6139 | 952.361.9700 | fax: 320.864.6130
www.thejonascenter.com

Consent for Treatment

As a consumer of Mental Health Services, you have a right to certain things from a therapist and an obligation to provide certain things to a therapist. Please read the following information and ask me if you have any questions.

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 either: 1.) Call 911, or 2.) Go to your closest emergency room to receive care.

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 hours notice (Exceptions for illness or inclement weather or other emergencies). 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 the clinical file 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 your therapist with 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.

TELEMEDICINE: I understand that one therapeutic option may be Telemedicine or the use of electronic information and communication technologies to deliver psychotherapy to an individual when they are in a different location than the therapist. I understand that Telemedicine therapy is different from in-person therapy and that if the therapist believes I would be better served by another form of therapy such as in-person therapy, then I will be referred to two therapists in my geographic area. I understand that there are unique risks to Telemedicine including but not limited to the possibility that the therapy sessions could be disrupted, interrupted or distorted by technical failures or could be accessed by unauthorized persons. Precautions such as using HIPAA compliant software will be taken by the therapist. I understand that all fees are the same as outlined in the Fees section above.

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 the text messages.

_____Please initial to receive appointment reminders. Cell Phone:_____

_____Please initial to receive Client Portal message notifications. Email:_____

_____Please initial to give permission to securely store & charge your credit/debit/HSA card. Please complete our Pre-Authorized Healthcare Payment form with your therapist, on the Client Portal or on our website.

This Consent is in effect until the end of treatment or one year from the dated signature below. Signing below indicates you have read and understand the above information and received a copy of the Notice of Privacy Practices.

Parent/Client Signature:_____Date:_____

Therapist Signature:_____**Date:**_____

05-20-19