Joanne M. Harste, M.A., LMFT, LLC

Licensed Marriage and Family Therapist
License #1100
(651) 353-5453 (cell)

CLIENT INFORMATION BOOKLET

The Therapy Process

You have the right to know the goals of therapy and the means by which we will try to meet those goals. In fact, you will be actively involved in planning these goals. This will be the focus in our initial sessions together, and we will collaborate on formulating them. We will also periodically assess these goals and our progress in achieving them as time goes by. Just as each client is different, each session varies depending on the needs of the client and the goals set by the client and therapist.

Therapy may seem very different from other relationships in your life. You are encouraged to speak very freely and openly about yourself—much more than you might do in other situations. Every aspect of your life is potentially open for discussion in therapy, even if it doesn't become a focus of treatment. You are encouraged to bring up any issues as they occur in order for us to assess and/or discuss them further. The primary obligation we share in therapy is to be open, honest, and respectful with each other—whatever the topic of conversation or however strong the feelings that arise in our sessions. Most relationships take time to grow, and it may take a while for you to feel able to be this open and at ease in therapy. If you feel that this relationship does not develop within a reasonable time, you have the right to decide to make a change. There are varied approaches to therapy and you may also feel that my approach to therapy is not effective for you. I tend to focus on the whole person within the context of their current relationship, as well as the influences from their past relationships. I tend to be fairly direct in my approach with clients and will often request that you do work outside of sessions to help make change happen more quickly. If you should decide you would like to make a change, I will assist you with the transition to another professional.

My job as a therapist is to assist you to come to know yourself, your relationships, and your life more fully. I may do this in a variety of ways—by listening to the story of your present situation or your history; sorting through and making observations about your thoughts, feelings or behaviors; discussing possible options for ways to think about or address your situation or relationships with others; or inviting you to do "homework" outside of our sessions. The goal of this process is to help you to see the options you have regarding thoughts, feelings and/or behaviors that may be more satisfying for you—as an individual or in various relationships—and to help you make positive change a reality in your life. **This alone does not predict, nor guarantee a successful outcome in therapy.** As a therapist, I can only guide you in the process—the hard work of actually making change happen belongs to the client. An important aspect of therapy is the relationship that develops between client and therapist. Therapy is a process. Initially you may feel uncomfortable, even anxious, talking about sensitive issues. This anxiety generally diminishes as the relationship between client and therapist develops and trust builds. Learning new ways to interact with yourself and others may feel uncomfortable at first. Sometimes things seem to get worse before they get better.

> ***Those around you may struggle as they see you changing. That is why it is generally best to have both parties present when addressing marital problems, or, the family present when addressing family issues. I will generally address these issues with individuals who feel strongly about not having other parties present, or whose significant other/family are not willing to participate in therapy, provided they understand that there is no quarantee those they are in relation to will change along with them, and if that is the case those relationships may experience greater difficulty as the client changes.***

It is critical to stay with the therapy even during these uncomfortable times. As your therapist, I will be available to discuss any of your assumptions, problems, or possible negative side effects of our work together. As we discuss emotions surrounding these issues, you should begin to feel more comfortable. As

you continue to apply new skills, you will feel more courageous about meeting problems directly. While you consider these risks, you should also know the potential benefits of therapy. People who are depressed may find their mood lifting. Others may no longer feel afraid, angry, or anxious. Clients often leave therapy feeling relieved; feeling their relationships have improved and their problem-solving and coping skills are improved. They may grow in many directions—as persons, in their close relationships, in their work or schooling, and in the ability to enjoy their lives.

Most of my clients see me once a week for 3-4 months. After that, we generally meet less often for several more months. Therapy then usually comes to an end. As we near the end of therapy, you and I will discuss discontinuing the therapy, with the understanding that you may choose to return should you feel the need. If you choose to stop therapy at any time, I ask that you agree now to meet for at least one session to review our work together. If you would like to take a "time out" from therapy to try it on your own, we should discuss this. We can often make such a "time out" be more helpful.

Technology Use

Most often I use Zoom for video sessions, because it is encrypted and fully HIPAA compliant. I encourage clients to do a test log in prior to our appointment to make sure that everything is working well on their side. You can check that your mic, speakers, and video are working this way.

It takes a few seconds after you log into the waiting room for us to show up on each other's screens. That's normal. If it seems to be taking an inordinate amount of time, feel free to text, email, or call me so that we can troubleshoot together.

Please be sure to EXIT out of any programs that steal bandwidth prior to our sessions. QUIT (don't just minimize) skype, carbonite, google drive back up, or any other cloud backup service. Please ensure that no one in your home is streaming video or playing graphic heavy online video games as this will decrease our internet connection.

Tech issues are rare and usually very easy to solve. Turning things off and back on again typically fixes most issues.

Additional Pro-Tips for Online Therapy

If others will be nearby while you are in therapy, ensure that you have adequate privacy prior to session. Psychotherapy is serious work. You do not want to be interrupted.

Turn off notifications on your computer and phone once we are connected.

Consider having tissues handy. If you were in my office, I'd provide them for you.

You may be extra cozy because you are somewhere familiar to you and you may feel more casual because the work is online and you are used to socializing that way. Remind yourself prior to the session that you are here to do the meaningful work of positive change.

Research says that the connection between therapist and client is the primary determinant of therapeutic change. I want to make sure that we connect well over video. If it looks off to you, please let me know. Eye contact matters.

Strengths and Limitations of Online Psychotherapy

Telephone, chat, and video sessions have some advantages over in-person psychotherapy. Many of my clients share with me that it is more convenient (no commute) and more comfortable (in their own space). Some clients share that they feel more able to share "deep" things because it is online rather than in person.

Online therapy is not for everyone. If a client has a poor internet connection, a lack of privacy, or otherwise would simply be more comfortable meeting in person, it is better to plan in person sessions. In some clinical situations, such as crises or suicidal or homicidal thoughts, in-person treatment may be the most appropriate treatment choice.

Location of Services
Online therapy allows me to provide services to a broader geographic range of clients than in person services. I am a licensed Marriage and Family Therapist in Minnesota and serve clients here. In limited cases, I may be able to serve clients in other states. In those cases, be aware that I will adhere to the legal regulations of my home state, but will also need to follow the guidelines of the state in which the client resides.

Confidentiality Policy in Emergencies
Should you enter a medical or psychological emergency, I need to know your location so that I am able to get help to you. Please share the location from which you will be conducting our sessions.

Physical Location of Client Receiving Services:
_____
_____
_____
_____
_____

Please sign below to indicate that you agree to share your location with me at the beginning of session should it be different from the one listed above.

_____

Should you need physical or emotional assistance (e.g. approaching a psychological emergency but not at the threshold of needing to be hospitalized or feeling dizzy but not in need to an ambulance), I would like to be able to contact someone to assist you. Please name two emergency contacts, their relationship to you, their phone numbers, and email address. By signing below, you agree that I may, but am not required to, contact either of these people if I am concerned for your safety. In the case that I have dire concerns for your safety, I will do all that I can to protect you, including calling 911 or other emergency responders.

_____Name, Relationship
_____Phone number, Email

_____Name, Relationship
_____Phone number, Email

Confidentiality of Email, Chat, Cell Phone, Video, and Fax Communication
I use secure and encrypted video software for our sessions, and secure email and phone systems for other communications. However, I want you to be aware that if you do not also use secure/encrypted programs on your side of the communication, the communications may not be secure. As a result, I start at a place of sharing as little as possible via these channels and will adapt to your comfort, with documentation, as we proceed. **Security laws state that clients have the freedom to request or opt in to less secure means of communication if they are aware of the risks, comfortable with them, and find it clinically helpful to do so**.

I also want to acknowledge that while I regularly check in on the security of all of our ways of communicating, swift advances in technology preclude my ability to be certain of our security. Just as I

cannot guarantee a physical office space isn't broken into, I also cannot guarantee the absolute security of our work online.

Please ensure that you too are doing your utmost to protect your privacy by considering who has access to your email, text messages, and so on before choosing online therapy. For example, I would discourage you from using your work email for our communications. Another way to protect your privacy is to be sure to fully exit all online counseling sessions and emails before leaving your computer.

Dual Relationships
Not all dual relationships are unethical or avoidable. However sexual involvement between therapist and client is never part of the therapy process, nor are any other actions or dual relationship situations that might impair your clinician's objectivity, clinical judgment or therapeutic effectiveness, nor that could be exploitative in nature.

Other professional fees
The session charge of $155.00 will be used to calculate other professional services you may need, and will be broken down into 15 minute increments when services are provided for periods of time outside of those detailed above. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and time spent performing any other service you may request. If you become involved in legal proceedings that require your clinician's participation, you will be expected to pay for all professional time even if your clinician is to testify for another party. Because of the labor intensity of legal involvement, your clinician charges 200.00 per hour for preparation, driving time, and attendance at any legal proceeding. Please take note of your agreement to avoid involving your clinician in legal proceedings (below).

Contacting your provider
I answer calls and emails as quickly as possible but I am often not immediately available due to many professional responsibilities. Please email or call during normal business hours. Your call will be returned as soon as possible.

If you are ever experiencing a life-threatening or harm-producing emergency please call "911" or go to your nearest emergency room.

Methods of communication
Given the limitations of security for electronic communication, I would like to know which of the following you are comfortable with. Please sign next to each that you are comfortable using for administrative issues like scheduling, invoicing and collecting paperwork if not submitted through my client portal.

_____Email
_____Text via Cellular Phone above
_____Voicemail via Cellular Phone above
_____Other methods. Please list.
_____

Please list your preferred email and phone number:

_____Email

_____Phone Number

Be aware that basic demographic details like your name, email, and location are considered Protected Health Information (PHI) as is anything clinical in nature like your diagnosis or clinical material. Please initial next to each item you consent to.

I consent to allow Joanne Harste to use unsecured email, cell phone text messaging, calls, or voicemail to transmit to me the following protected health information:

____Information related to the scheduling of meetings or other appointments

____Information related to billing and payment

____ Information that is clinical in nature (e.g. treatment summaries, diagnosis)

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I may terminate this consent at any time.

_____Signature

Are there limitations about what you would want me to share via text, email, voicemail, etc? Please share below. I want to ensure we are on the same page!

_____

_____

_____

_____

_____

_____

We will discuss the options you opted into in our meeting including the clinical utility of communicating in any of the ways mentioned above to decide together if we want to include them in your treatment. Should we decide to share more than basic administrative materials electronically, we need to discuss it first in session so that we can weigh the pros and cons. The delivery of any electronic communication can be intercepted, misdirected, or delayed. Decisions about this should be thoughtful, collaborative, and mutually acceptable.

Discharged from care

Psychotherapy is best ended with a process of termination and a scheduled final appointment. This will allow you to review therapeutic gains achieved during treatment; develop a plan of action to maintain those gains; identify what other services or activities may still be needed; and to process any emotions that may exist regarding the ending of the therapeutic relationship. If you decide to end therapy without engaging in the process of termination by not scheduling appointments or by not returning at least two telephone calls or emails, it will be assumed that you are no longer a client of your clinician and you are, therefore, discharged from care.

Both the therapist and the client have the right to end counseling at any time.

Fees and Policies

A session is fifty-five (55) minutes unless otherwise agreed upon.

Clients Utilizing Insurance

The fee of $155.00 per session is payable at the time of each meeting, unless other arrangements have been made.

This provider agrees to submit to your insurance, allowing you to receive the allowed amount per session returned to you by your insurance company. Should your insurance company reimburse this provider, rather than send reimbursement directly to you, this provider will credit your account or issue you a check in the same amount, depending on the client's preference.

Insurance coverages differ, so please check with your insurance company to determine the requirements for mental health coverage. **It is recommended that this be done before the first meeting so the client is aware of the financial implications from the beginning.**

No Insurance

Given the high deductible amounts attached to many policies, increased numbers of people prefer to avoid using their insurance. This option allows you the benefit of not having therapeutic services become a part of your medical record, as well as receiving a reduced fee for the same quality service.

A lesser rate of $140.00 per session will be due at the time of each meeting. This fee reduction is available due to the decreased administrative tasks associated with services.

*Though the services will not be submitted to insurance, a receipt can be issued to you if you hope to submit to an HSA for reimbursement. In this case, a diagnostic code must often be provided.

Forms of Payment

You may use cash, check, money order, VISA or Debit Card as means of payment. If the bank returns a check, you will be charged a $30.00 fee and denied the right to write checks as payment for any future sessions. Additional fees will be charged for psychological testing.

In all cases, whether utilizing insurance or not, the client is fully and directly responsible to Joanne M Harste, MA LMFT for the payment of services rendered. Insurance claim submission is provided as a courtesy by the therapist and in no way transfers ultimate responsibility for payment away from the client. If payment becomes problematic you are encouraged to discuss this directly with me. If my fees change during the course of treatment, you will be given adequate notice of these changes.

Cancellation Policy

If you need to cancel an appointment for any reason, you must do so at least 24 hours in advance of your appointment time. ***You will be charged for missed/failed appointments and for any appointment cancelled with less than a 24-hour notice (except in cases of illness, emergency, severe weather, or by discretion of the therapist).*** *Excessive cancellations or requests for appointment changes are disruptive to the therapeutic process. Should this become a concern, the therapist reserves the right to terminate treatment*

Telephone Contacts and Emergencies

I am available, as time permits, between your regular sessions to discuss problems and/or handle emergencies. I can be reached at the number given above, during regular office hours. Most often you will receive my voice mail where you can leave a confidential message that I will return as my schedule permits. This voice mail system is available 24 hours a day and I retrieve messages regularly throughout the weekdays. Please leave your name, number, and time you can be reached. If you need immediate assistance, please indicate the message is urgent AND call the Crisis Connection hotline @ (612) 379-6363, call 911, or go to the emergency room of a hospital near you. Fees for telephone contacts will be prorated, based on the standard hourly fee. This fee also applies to excessive administrative time such as copying or releasing of records, heavy consultation work, or any other form of contact with third parties that is not directly related to specific therapeutic goals.

Damage to Physical

In the event that you as a client, or any other person attending sessions with you cause damage to any item in therapist's office space or to the office space itself, client will be responsible for the cost of repairs or replacement of/to the item or property damaged or destroyed.

Confidentiality/Therapist-Client Privilege

"Confidentiality" means that anything that occurs in psychotherapy is not divulged by the therapist to anyone outside the therapeutic relationship. The contents of an intake, assessment or counseling session are considered to be confidential. Neither verbal information nor written records about a client can be shared with another party without the written c--onsent of the client or the client's legal guardian. This special

protection is known as the "therapist-client privilege." Specifically, "privilege" refers to the client's ability to protect information in a legal proceeding.

It is my policy to not release any information about a client without having a signed release of information form. However, there are situations that are exceptions to this rule. The exceptions to confidentiality and the therapist-client privilege are listed below:

Mandated reporting: *Extreme situations that are exceptions to confidentiality and in which the therapist MUST by law file a report with the appropriate social service agencies and legal authorities, as well as notify individuals that may be affected by the situation. All other reasonable means would be exhausted before this option is used, and even then, your cooperation would be encouraged.*

1. If you are a danger to yourself physically, or become incompetent mentally, as determined by the therapist's evaluation.
2. If you disclose an intention or a plan to bring physical harm to others.
3. If you have physically, sexually, or (severely) emotionally harmed or neglected a minor or a dependent/vulnerable adult, or, if a minor or dependent adult is in danger of being abused. This would include parental admitted prenatal exposure to controlled substances that are potentially harmful.
4. If professional misconduct by another health care professional is reported.

Situations in which privilege does not apply or is limited: *Any time you give permission to provide information to another party, there is limited confidentiality. In these cases, and in most of the situations listed above, the therapist can reveal information only to someone who has a need to know, and entire records and/or irrelevant information may not be disclosed. Whenever information will be shared with other persons, every effort will be made to ensure (but not guarantee) that the receiving person also maintains confidentiality. Situations in which confidentiality may not apply or may be limited are:*

1. If you are being evaluated or treated for a third party (disability, custody, etc).
2. If you are using third-party coverage (insurance) to pay for therapy.
3. If you request or give permission for information to be obtained from or provided to a third party (another therapist, a physician, a teacher, an employer, etc).
4. If the client is a non-emancipated minor, parents or legal guardians have the right to access the minor client's records.
5. If your therapist is being supervised, his/her supervisor may know the details of the case, but the supervisor is also bound by confidentiality.
6. If your therapist is unavailable and temporary coverage is required (emergencies, etc).
7. When a professional or legal disciplinary meeting is being held regarding another health care professional's actions, related records may be required in order to substantiate disciplinary concerns.
8. When a court order requiring client records has been placed.
9. If you bring a lawsuit against this therapist.
10. In the event of a client's death.
11. In the event of the therapist's disability or death.

In the case of non-payment of fees for service: *At time of intake, the client signs a consent for treatment, stating he/she agrees to be responsible for any payment not covered by insurance. In the event that the client does not make payment, respond to notices sent by therapist in an effort to make arrangements for payment, confidentiality may be breeched as necessary to:*

1. Turn account over for collection.
2. Attempt to collect fees in Small Claims Court.

In addition to the above, special circumstances apply to group, couple, parent-child, and family therapy (any time more than one person is involved in treatment). ***Simply put, other individuals in the therapy***

room are not bound by the therapist-client privilege and may not hold information confidentially; the therapist is not responsible for disclosure by these individuals. It is also important to understand that in couple, parent-child, or family therapy, individual secrets about important information may interfere with therapy, and the therapist may encourage you to share this critical information with significant others. In certain instances, it may be difficult to continue therapy if you choose not to reveal important information.

As the client, you have the right of access to your records. It is generally best for your therapist to discuss the information contained in them with you or to provide you with a summary for a specific purpose.

If you are not satisfied with services you have received, you are encouraged to speak with your therapist directly addressing your concerns. If you are still not satisfied, you may file a grievance with the Minnesota Board of Marriage and Family Therapy.

Litigation Limitation

Client agrees that should there be legal proceedings including, but not limited to, divorce, custody evaluations, injuries and lawsuits, neither client nor your attorney, nor anyone else acting on your behalf will call on this therapist or Joanne M Harste MA LMFT LLC to participate in these proceedings, the activities leading up to or occurring after said proceedings. Client specifically agrees that therapist will not be called upon to testify in court or to release therapy records for any reason except when ordered to directly by the court.

In the event therapist is compelled to comply with a legal request from you or a legal professional acting on your behalf, clients agrees to be billed at the rate of $155.00 per hour for all time spent responding to this matter. Client further agrees that this time will be prorated in 15 minute increments and rounded up. Time will be billed for all work related to clients or legal professional's request including, but not limited to, reviewing files, making copies, transportation to and from offices, court rooms, copy shops, conversations with attorneys or agents of the court, waiting on hold, drafting letters, and speaking to custody evaluators. Client also agrees that additional direct expenses including, but not limited to, copy and ink costs, transportation and parking fees, fax fees and mailing fees will incur an extra charge in addition to the fees charged for therapist's or therapist's agent's time.

Consultation/Supervision

It is standard practice in the mental health field to consult with other mental health professionals and supervisors to gain additional insight and skills in our work with clients. As I participate in this practice, identifying information will be altered to protect your confidentiality.

Therapist Title/Training

- Licensed in the State of Minnesota as a Marriage and Family Therapist
- Undergraduate work at Hamline University in St. Paul
- Master of Counseling Psychology from Bethel College
- Prior to entering private practice in 2001, I worked for the University of Minnesota on two research studies, designed as prevention/early intervention programs for children who were at high risk for problem behaviors (i.e., alcohol, drugs, violence, etc.).
- I am committed to empowering individuals, couples, and families to take charge of their lives as a means of enhancing their relationships and improving the quality of their lives.

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CLIENT BILL OF RIGHTS

Consumers of Marriage and Family Therapy Services offered by Marriage and Family Therapists licensed by the State of Minnesota have the right:

1. to expect that a therapist has met the minimal qualifications of training and experience required by state law;
2. to examine public records maintained by the Board of Marriage and Family Therapy which contain the credentials of a therapist'
3. to obtain a copy of the code of ethics from the State Register and Public Documents Division, Department of Administration, 117 University Avenue, Saint Paul, MN 55155;
4. to report complaints to the Board of Marriage and Family Therapy, University park Plaza Building, 2829 University Avenue Se, Suite 330, Mpls, MN 55414-3222;
5. to be informed of the cost of professional services before receiving the services'
6. to privacy as defined by rule and law;
7. to be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services;
8. to have access to their records as provided in Minnesota Statutes, section 144.335, subdivision 2; and
9. to be free from exploitation for the benefit or advantage of a therapist [i.e. whether emotional, financial, sexual, religious, political, or personal advantage or benefit of the therapist].

CONSENT TO TREATMENT

After reading the information in the Client Information Booklet and discussing any questions or concerns with your therapist, please sign below.

I am/we are entering into this therapy contract with full understanding, participation, and consent. I/we have read the *Client Information Booklet* provided by the therapist and understand and agree to its contents. I/we understand that the therapist cannot guarantee any particular outcome as a result of therapy. I/we also agree to the limits of confidentiality stated in the *Client Information Booklet* and understand their meanings and ramifications.

I/we also understand that I/we have a right to a second opinion from another mental health professional at any time and that I/we may register a legitimate concern with the appropriate person or agency as indicated in the *Client Information Booklet.*

I/we understand that I/we are entering into an agreement with Joanne M. Harste, M.A., LMFT, LLC. I/we understand that signing this contract acknowledges that there are no other agreements between the parties other than the ones contained within this contract. This contract cannot be modified orally and can only be modified by a writing signed by both parties.

_____I understand the confidentiality and security limitation of electronic communication and acknowledge any use of said communication is not covered within the therapist-client privileged communication.

_____I understand Joanne M Harste MA LMFT LLC provides outpatient services only; it does not provide 24-hour care and thus cannot insure any availability for immediate crisis intervention that I may require. I understand the direction within this agreement to call 911 or go to the nearest emergency room if I am in crisis and/or need immediate assistance.

_____I am aware that 55 minutes is the industry standard session duration.

_____I agree to the litigation agreement stating that neither I, nor my attorney, nor anyone else acting on my behalf will call on this therapist or Joanne M Harste MA LMFT LLC to testify in court or otherwise participate in any legal matter, nor will a disclosure of the therapy records to outside parties be requested.

Initial

_____I intend to use insurance and agree to take personal financial responsibility for my session at the rate of $155.00 per 55-minute therapy hour.

_____I intent to pay privately for my sessions at the adjusted rate of $140.00 per 55-minute therapy hour.

_____I agree to pay for any missed or failed appointments (for which I have not provided a minimum of 24 hours advance notice). I agree to provide payment in full prior to or at the beginning of my next scheduled visit.

For all Clients, Insurance and Private Pay

_____I agree to pay Joanne M Harste MA LMFT LLC at the time of service for all sessions.

_____I understand that Joanne M Harste MA LMFT LLC will submit to my insurance company for services provided to me but that submission of claims is no guarantee of reimbursement (does not apply to private pay).

_____If my insurance company sends payment to Joanne M Harste MA LMFT LLC for sessions which I have previously paid, Joanne Harste MA LMFT LLC agrees to provide timely reimbursement to client (does not apply to private pay).

Client (signature):_____Date:_____

(please print name):_____

Parent/guardian(signature):_____Date:_____

(please print name):_____

Joanne Harste, LMFT

Date_____

DX Code_____

Patient Information

Patient Name (Print)_____Date of Birth_____
Cell Phone:_____
Street Address_____Home Phone_____
Okay to Leave Message?____Yes____No
City_____State_____ZIP_____Work Phone_____
Okay to Leave Message?____Yes____No
Soc Sec #_____Emergency Contact_____Emergency Phone_____

Sex: ____M ____F Age_____ Relationship Status: ____Single ____Married ____Widowed ____Divorced ____Partnered

Employer_____Occupation_____

Referred by_____May we acknowledge this referral?_____

Primary Insurance

Primary Insurance Company_____Phone_____

Ins Claims Address_____City_____State_____Zip_____

Policy/ID_____Group/Plan ID_____

Name of Policyholder_____ Relationship_____

Address_____City_____State_____Zip_____

Soc Sec #_____Employer_____Date of Birth_____

Secondary Insurance

Secondary Insurance Company_____Phone_____

Ins Claims Address_____City_____State_____Zip_____

Policy/ID_____Group/Plan ID_____

Name of Policyholder_____ Relationship_____

Address_____City_____State_____Zip_____

Soc Sec #_____Employer_____Date of Birth_____

Responsible Party

Name_____Relationship_____

Address_____Phone_____

Assignment and Release

II the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorized the healthcare provider to release all necessary information to A.C.E. Billing, Inc, to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

Joanne M. Harste, M.A., LMFT, LLC

Licensed Marriage and Family Therapist
License #1100
(651) 353-5453 (cell)

FEE POLICY & FEE CONTRACT

Client Name_____
Responsible party_____
Address_____
Intake Date_____
Therapist_____

FEE POLICY

1. The fee of $155.00 per 50 minute session is payable at the beginning of each session, unless other arrangements have been made. You may use cash, check, money order, VISA or debit card .
2. The client is fully and directly responsible to Joanne M. Harste, M.A., LMFT for the payment of services rendered.
3. Insurance coverages differ, so please check with your insurance company to determine the requirements for mental health coverage.
4. A receipt may be provided which the client can submit to his/her insurance company.
5. Additional fees will be charged for psychological testing.
6. If payment becomes a problem, you are encouraged to discuss this directly with me
7. If my fees change during the course of treatment, you will be given adequate notice of these changes.
8. You will be charged for missed appointments or appointments cancelled with less than a 24-hour notice (except in cases of illness, emergency or severe weather). PLEASE NOTE: We are unable to charge insurance companies for missed appointments, so you will be responsible for covering the cost.
9. Fees for telephone contacts will be prorated, based on the standard hourly fee.

FEE CONTRACT

_____I understand the current fee schedule and my responsibility for payment of fees.

_____I understand that services will be out-of-network with my insurance company. I would like billing information to send to my insurance company. I understand that payment is due at time of service and I will be reimbursed from my insurance company.

_____I understand it is my responsibility to determine coverage for services by calling my insurance company. This may include the need for *pre-authorization of services*. Insurance companies may also require *treatment plans* throughout the course of treatment. I also agree to inform therapist of these requirements.

_____I would like therapist to call insurance company, but understand that insurance companies hold me (the client) responsible to verify any information provided in my subscriber information book. *Insurance companies may fail to provide ALL information to subscriber or therapist. Be sure to verify with insurance company that they will reimburse for provider licensed as an LMFT.*

_____I would like therapist to mail billing information to my insurance company, but understand that payment is due at time of service and I will be reimbursed from my insurance company.

I, _____ have been given a copy of the current fee schedule and have been given the opportunity to discuss my financial situation with my therapist. I understand I will be responsible for all fees as indicated on the current fee schedule and as outlined on this payment contract. I am also aware that I may be charged a late cancel/ no show charge.

_____ _____

Signature of Client, or Guardian Date

Statement of Information Practices
Joanne M. Harste, M.A., LMFT, LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Understanding Your Mental Health Record Information

A record will be kept of each of your visits. Typically, this record contains an assessment history, current symptoms, diagnosis, treatment, and a plan for future care or treatment. This information serves as a:

a. Basis for planning your care and treatment.
b. Means of communication among any other health professionals who contribute to your care.
c. Legal document describing the care you received.
d. Means by which you or a third-party payer can verify that you actually received the services billed for.
e. Tool to assess the appropriateness and quality of care you received.
f. Tool to improve the quality of health care and achieve better patient outcomes.
g. Tool to document compliance with regulatory, licensing and accreditation standards.

Understanding what is in your health records and how your health information is used helps you to:

a. Ensure its accuracy and completeness.
b. Understand who, what, where, why and how others may access your health information.
c. Make informed decision about authorizing disclosure to others.
d. Better understand the health information rights detailed below.

Your Rights Under the Federal Privacy Standard

You have certain rights with regard to the information contained in your health records. You have the right to:

1. Request restriction on uses and disclosures of your health information for treatment, payment, and health care operations. “Health care operations” consists of activities that are necessary to carry out quality of operations, such as quality assurance and peer review. The right to request restriction does not extend to uses or disclosures permitted or required under §164.502(a)(2)(i) (disclosures to you), §164.510(1) (for facility directories, but note that you have the right to object to such uses), or §164.510 (uses and disclosures not requiring a consent or an authorization). The latter uses and disclosures include, for example, those required by law, like mandatory communicable disease reporting, mandatory reporting of abuse or neglect of children or vulnerable adults, as well as mandatory reporting under the Tarisoff Act describing the duty to warn if safety of self or others is in jeopardy. In those cases, you do not have a right to request restriction. The Consent to use and disclose your individually identifiable health information provides the ability to request restriction. We do not, however, have to agree to the restriction. If we do, however, we will adhere to it unless you request otherwise or we give you advance notice.

2. Ask me to communicate with you by alternate means, if the method of communication is reasonable, we must grant the alternate communication request. Again see the consent form.

3. Obtain a copy of this notice of information practices. Although we have posted a copy in prominent locations throughout the facility and on our website, you have a right to a copy upon request.

4. Inspect and copy your health information upon request. Again, this right is not absolute. You do not have a right of access to the following:

a. Any information that would cause harm to the client, family member or involved party.
b. Information compiled in reasonable anticipation of or for use in civil, criminal, or administrative actions or proceedings.
c. PHI that is subject to the Clinical Laboratory Improvement Amendments of 1988 ("CLIA"), 42 U.S.C. §263a, to the extent that the provision of access to the individual would be prohibited by law.
d. Information was obtained from someone other than a healthcare provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of information.

5. A summary of any decision to deny access. For these reviewable grounds (see below), another licensed professional must review the decision of the provider denying access within 60 days. If we deny you access, we will explain why and what your rights are, including how to seek review. These "reviewable" grounds for deniable include:

a. Licensed healthcare professional has determined, in the exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety of the individual or another person.
b. PHI makes reference to another person (other than a healthcare provider) and a licensed healthcare provider has determined, in the exercise of professional judgment, that the access is reasonably likely to cause substantial harm to such other person.
c. The request is made by the individual's personal representative and a licensed healthcare professional has determined, in the exercise of professional judgment, that the provider of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person.

If we grant access, we will tell you what, if anything, you have to do to get access. *We reserve the right to charge a reasonable, cost-based fee for making copies.*

6. Request amendment/correction of your health information. We do not have to grant the request if:

a. We did not create the record. If, as in the case of a consultation report from another provider, we did not create the record, we cannot know whether it is accurate or not. Thus, in such cases, you must seek amendment/correction from the party creating the record. If they amend or correct the record, we will put the corrected record in our records.
b. The records are not available to you as discussed immediately above.
c. The record is accurate and complete.

If we deny your request for amendment/correction, we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut), and how you can complain. If we grant the request, we will make the correction and distribute the correction to those who need it and those you identify to us that you want to receive the corrected information.

7. Obtain an accounting of "non-routine" uses and disclosures—those other than for treatment, payment, and health care operations. To individuals of protected health information about them. We do not need to provide an accounting for:

a. The facility directory or to persons involved in the individual's care or other notification purposes as provided in §164.510 (uses and disclosures requiring an opportunity for the individual to agree or to object, including notification to family members, personal representatives, or other persons responsible for the care of the individual, or the individual's location, general condition, or death.

b. National security or intelligence purposes under §164.512(k)(2) (disclosures not requiring consent, authorization, or an opportunity to object, see chapter 16).
c. Correctional institutions or law enforcement officials under §164.512(k)(5) (disclosures not requiring consent, authorization, or an opportunity to object).
d. Those uses and disclosures that occurred before April 14, 2003.

I must provide the accounting within 60 days. The accounting must include:

a. The date of each disclosure.
b. The name and address of the organization or person who received the protected health information.
c. A brief description of the information disclosed.
d. A brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure or, in lieu of such statement, a copy of the written authorization, or a copy of the written request for disclosure. The accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable cost-based fee.

8. Revoke your consent or authorization to use or disclose health information except to the extent that we have already taken action in reliance of the consent or authorization.

Our Responsibilities Under the Federal Privacy Standard

In addition to providing you your rights, as detailed above, the federal privacy standard requires us to:

1. Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.

2. Provide you with this notice, upon request, as to our legal duties and privacy practices with respect to individually identifiable health information we collect and maintain about you, including those who agree to receive the Statement of Information Practices electronically.

3. Abide by the terms of this notice.

4. Train our personnel concerning privacy and confidentiality.

5. Implement a sanction policy to discipline those who breach privacy/confidentiality or our policies with regard thereto.

6. Mitigate (lesson the harm of) any breach of privacy/confidentiality.

WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION WE MAINTAIN. SHOULD WE CHANGE OUR INFORMATION PRACTICES, WE WILL MAIL A REVISED NOTICE TO THE ADDRESS YOU HAVE SUPPLIED US.

We will not use or disclose your health information without your consent or authorization, except as described in this notice or otherwise required by law.

Examples of Disclosures for Treatment, Payment, and Health Operations

If you give us consent, we will use your health information for treatment.

Example: Upon each visit, your therapist will record information in your record to diagnose your condition and determine the best course of treatment for you.

If you give us consent, we will use your health information for payment.

Example: I may send a bill to you or to a third-party payer, such as a health insurer. The information on or accompanying the bill may include information that identifies you, your diagnosis, treatment received, and modality.

If you give us consent, we will use your health information for health operations.

Example: A quality assurance person from your insurance carrier may use information in your health record to assess the care and outcomes in your case and the competence of the caregiver.

Other health operations include:

Business associates: We provide some services through contracts with business associates. Examples include certain diagnostic testing, a transcribing, billing, and shredding service, psychiatrists, volunteers, and the like. When we use these services, we may disclose your health information to the business associate so that they can perform for services rendered. Other business associates, like office cleaning and computer maintenance for example, do not receive client health information but could come into contact with such information by the nature of the service provided. To protect your health information, however, we require all business associates to appropriately safeguard your information and understand client confidentiality.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition in an emergency situation where 911 is called on site. This information is protected through use of a consent unless in an emergency situation.

Marketing continuity of care: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You have the right to decline such contact.

Workers compensation: We may disclose information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information purposes as required by law or in response to a valid subpoena.

Health oversight agencies and public health authorities: If a member of our work force or a business associate believes in good faith that we have engaged in unlawful conduct or otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or public, they may disclose your health information to health oversight agencies and/or public health authorities, such as the department of health.

The federal Department of Health and Human Services (DHHS): Under the privacy standards, we must disclose your health information to DHHS as necessary for them to determine our compliance with those standards.

Statement of Information Practices

Client Acceptance Form

The policies that you have just read describe how medical information about you may be used and disclosed and how you can get access to the information. Your understanding of this material is important and any concerns or questions should be addressed immediately.

Your signature below signifies that you have read, understand and accept this information.

_____ _____

Client Signature Date

_____ _____

Parent or Guardian Signature Date

Child Intake

Date:_____ Child's Name:_____
Parent(s)' Name(s):_____

Family
Who are the members of your household? Please list names and ages (including pets):
_____
_____
_____
What role does extended family play in your life?_____
_____
_____
Please list some family strengths:_____
_____
What ways does your family like to share time together?_____
_____

Generally, how do you use or not use the following parenting strategies:
Praise:_____
_____
_____
Loss of privileges:_____
_____
_____
Time-out/ Grounding:_____
_____
_____
Parent-Child quality time:_____
_____
_____
Rewards:_____
_____
_____
Chores/ Contributing to family:_____
_____
_____
Other approaches used to discipline or shape your child's character:_____
_____
_____
_____
_____

Development:

Child's approximate due date:_____ Birth date:_____

Birth and delivery story:_____

_____

_____

_____

Was your child breast fed or bottle fed?_____ until what age?_____

Where was your child's first home?_____

Did your child receive care by a child care provider?_____

If so, please list the name of providers below as well as the approximate timeframe in which they cared for your child:_____

_____

_____

_____

Did your child develop typically? If not, please indicate areas where development was outside the typical range:_____

_____

_____

_____

Academic:

What are your child's favorite subjects in school?_____

_____

_____

Do you have any school-related concerns?_____

_____

_____

During the past year has your child received any special services within the school for attention, behavior, learning, or emotional difficulties?_____

_____

_____

_____

Does your child have an IEP?_____ If so, when was it last reviewed?_____

Friendships:

Does your child have at least one friend his/her age who he/she hangs out with?_____

What types of activities does your child tend to be active in when spending time with his/her peers?_____

_____

_____

Do you have any concerns with regard to your child's ability to make or maintain friendships?_____

_____

_____

Extracurricular:

Does your child participate in any extracurricular activities (sports, clubs, music, art, etc.)?_____
_____
_____
What is the time commitment tied to the above activities?_____
_____

Health

When was your child's last medical exam?_____
Is your child on medication for the treatment of any physical or mental health problems?_____ If so, please list the name of the treating physician and the medication(s) prescribed:

Physician_____ Medication(s)_____
Physician_____ Medication(s)_____

During the past year has your child had problems in any of the following areas?

Wetting the bed?_____ Soiling him/herself during day hours?_____
Frequent headaches or stomachaches?_____
Difficulty sleeping?_____ Nightmares?_____
Getting stuck on one idea or repeating a behavior over and over?_____
Do you have any concerns about your child's eating habits?_____
If so, what are they?_____

Behavioral

Please underline any of the following behaviors that your child engages in regularly:

Breaking rules
Arguing
Asking for help
Losing his/her tember
Not following directions
Sharing
Asking questions
Running away
Stealing
Starting fires
Expressing emotion
Skipping school
Biting
Hitting/Kicking
Using feeling words
Failing to complete school work
Lying
Expressing needs
Crying
Talking excessively
Sleeping excessively
Spending time alone

Emotional/Psychological

Has your child had difficulties with excessive worrying or fears?_____
If so, what does he/she tend to worry about or be fearful of?_____
_____
Does this problem interfere with his/her life?_____ If so, in what ways?_____
_____
_____
Have you noticed your child experience several days at a time when he/she feels sad or depressed?_____
Have you noticed your child experience a decrease in interest around things he/she usually likes to do?_____ If so, when did this begin?_____
What specific changes did you notice?_____
_____

Stressors

Please circle any of the following stressors your child or family has encountered, as well as the approximate date(s) surrounding their occurrence.

Unemployment of a parent_____
Divorce of parent(s)_____
Death of a loved one_____
Serious Illness_____
Physical Abuse_____
Sexual Abuse_____
Emotional/Verbal Abuse_____
Eviction from home_____
Legal problem_____
Hospitalization_____
A move or change of households_____
Others:_____

Has your child ever had a terribly frightening experience in which he/she was in danger of being killed or badly hurt?_____ If so, please describe the experience:_____
_____
_____
_____

Additional Concerns

On the lines below, please list any additional concerns:

_____
_____
_____
_____
_____

Joanne M. Harste, M.A., LMFT, LLC
Licensed Marriage and Family Therapist
License #1100
(651) 353-5453 – cell

Agreement Regarding Minors

The involvement of children and adolescents in therapy can be highly beneficial to their overall development. Although it is often best to see them with parents and other family members, there are times when they are best seen alone. I will assess which might be best for your child and make recommendations to you. Whether seen alone or with family members, the support of all the child's caregivers is essential, as is their understanding of the basic procedures involved in counseling young people.

The general goal of involving children and adolescents in therapy is to foster their development at all levels. At times, it may seem that a specific behavior change is needed, such as to get the child to obey or reveal certain information. Although those objectives may be part of overall development, they may not be the best goals for therapy. Again, I will evaluate and discuss these goals with you.

Because my role is that of the young person's helper, I would prefer not to become involved in legal disputes or other official proceedings unless it becomes an unavoidable necessity. Matters involving custody and mediation are best handled by another professional who is specially trained in those areas.

The issue of confidentiality is critical in treating children and adolescents. When children are seen with other people (i.e., in family therapy), what is discussed is known to those present and should be kept confidential except by mutual agreement. Children and adolescents seen in individual sessions (except under certain conditions) are not legally entitled to confidentiality (also called privilege). Parents of minors have a right to this information. However, unless young people feel they have some privacy in speaking with a therapist, the benefits of therapy may be lost. It will be necessary that we work out a general agreement in which your child feels that his or her privacy is generally being respected and yet one in which you as caregiver have access to critical information.

The following circumstances override this general agreement allowing privacy to children and adolescents and legal information to parents (*please refer to the Client Information Booklet for a full explanation of the limits to confidentiality and therapist-client privilege):*

- Confidentiality and privilege are limited in cases involving child abuse, neglect, molestation, or danger to self and others. In these cases, the therapist is required to make an official report to the appropriate agency and will attempt to involve parents as much as possible.

- Any evaluation, treatment, or reports ordered by, or done for submission to a third party such as a court or a school are not entirely confidential and will be shared with that agency with your specific written permission. NOTE: I do not have control over information once it has been released to a third party.

Now that the various aspects surrounding confidentiality have been stated, a more specific agreement between you and your child/children can be created. Please see the other side of this form.

I/We,

_____

Name(s) and relationship(s) to child/adolescent

agree that my/our child/children,

_____

name(s)

should have privacy in his/her/their therapy sessions, and I/we agree to allow this privacy except in extreme situations, which I/we will discuss with the therapist. At the same time, except under unusual circumstances, I/we understand that I/we have a legal right to obtain this information.

I/we will do my best to ensure that therapy sessions are attended and will not inquire about the content of the sessions. If my child prefers/children prefer not to volunteer information about the sessions, I/we will respect his/her/their right not to disclose details. Basically, unless my child has/children have been abused or is/are a clear danger to self or others, the therapist will normally tell me/us only the following:

- Whether sessions are attended
- Whether or not my child is/children are generally participating
- Whether or not progress is generally being made

The normal procedure for me/us to discuss issues that are in my child's/children's therapy will be joint sessions including my child/children, the therapist, and me/us, and perhaps other appropriate adults. If I/we believe there are significant health or safety issues that I/we need to know about, I/we will contact the therapist and attempt to arrange a session with my child/children present. Similarly, when the therapist determines that there are significant issues that should be discuss with parents, every effort will be made to schedule a session involving the parents and the child/children. I/we understand that if information becomes known to the therapist and has a significant bearing upon the child's/children's well being, the therapist will work with the person providing the information to ensure that both parents are aware of it. In other words, the therapist will not divulge secrets except as mandated by law, but may encourage the individual who has the information to disclose it for therapy to continue effectively.

Parent(s)/Guardian(s):

Please make any additions or modifications as desires: _____

_____

Signature:_____

Date:_____

Signature:_____

Date:_____

Minor(s):

Please make any additions or modifications as desires:_____

_____

Signature:_____

Date:_____

Signature:_____

Date:_____

Therapist(s):

Signature:_____

Date:_____