Mindful Way Counseling, LLC
Individuals ○ Couples ○ Families

Phone: 612-389-2332
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www.MindfulWayCounseling.Org

IMPORTANT SIGNATURES OF INFORMED CONSENT

I, _____________________________________, **agree and give consent for psychotherapy and treatment** by Mindful Way Counseling, LLC. I understand that there are certain risks involved, as outlined in the policies. I understand that I have entered into this therapeutic relationship voluntarily and may terminate treatment at any time, however there might be risks involved in terminating treatment early. I understand that there are no guarantees for treatment outcomes. I agree to hold harmless and indemnify the therapist and staff from any damages, suits, claims, or liabilities arising from this therapeutic relationship as I understand the nature of counseling and the risks involved.

Confidentiality _______(initial)

I understand that confidentiality will be maintained at all times within legal requirements of the State of Minnesota and ethical guidelines according to the Social Work, Marriage and Family Therapy, Behavioral Health, and Psychology Codes of Ethics. I understand that confidentiality will *not* be maintained if I threaten or give reason to believe that I will harm myself or others or if child or elder abuse, neglect, or maltreatment is suspected, as mandated reportable by law.

Privacy Practices (HIPAA) Receipt Acknowledgement _________ (initial)

I acknowledge that I have received a copy of Mindful Way Counseling, LLC 's *Patient Notification of Privacy Rights,* in the New Client Counseling Policies, as required by the *Health Insurance Portability and Accountability Act (HIPAA),* which describes how records and information about my treatment will be handled. My initials above and signature below attest to this receipt. If I have questions, the information has been explained and/or summarized for me. I also can contact Mindful Way Counseling, LLC with questions about my records and information and how it is being handled.

Credentials, Supervision, and Consultation _________ (initial)

The Therapist is Licensed by the State of Minnesota and is a LICSW (clinical social worker), LMFT (marriage and family therapist), or LPCC (clinical counselor) or is seeking licensure and under clinical supervision. Cases will be discussed with other counseling professionals within the clinical agency solely for the purpose of gaining additional perspective, input and treatment direction. If the therapist is under supervision I understand that they will participate in clinical supervision with other counseling professionals. If my therapist is under supervision for completion of licensing requirements, all clients will be notified additionally of this fact.

Insurance Billing ___________ (initial)

I understand that insurance coverage is not a guarantee and that I am responsible for anything not covered by insurance or deemed retroactively not covered by insurance. I understand that in order for Mindful Way Counseling, LLC to bill to my insurance, that Mindful Way Counseling, LLC must share information about my treatment, diagnosis, and therapy appointments with my insurance company. By choosing to use my insurance and by signing this agreement, I wave my rights to confidentiality in regard to my insurance company. I hereby consent and authorize Mindful way Counseling, LLC to bill to insurance and release reasonably necessary information to do so. I understand that my therapist will do everything in my therapist's power to release the reasonably minimum amount of information needed to bill to my insurance company. I release Mindful Way Counseling, LLC and its agents from any and all liability arising from the release of information and records requested by insurance.

Account Responsibility ___________ (initial)

I understand that I am responsible for payments to Mindful Way Counseling, LLC for all services and associated fees involved in this treatment. I understand that payment is expected at the time of the session(s), without exception for all private pay and commercial insurance clients. I also understand that failure to pay the estimated and expected fees will terminate treatment and the settlement of any unpaid fees will be turned over to a collection agency, which will include my information.

Appointments & Missed Appointments ___________(initial)

I understand that appointments must be kept and that I should arrive on time for scheduled appointments. If the I am late for the session, appointments may be canceled or if held will not be the full appointment time. If I am 12 or more minutes late for a scheduled appointment, I understand that I am responsible for a missed appointment fee and will not be seen. Cancellations will be made more than 24 hours in advance to scheduled appointments, if cancellations occur between 3—24 hours prior to the appointment, a late cancelation fee will be charged to my account. Some therapists require longer notice and will notify you if that is the case. Cancellations made within 3 hours of the appointment is also considered a missed appointment, and I will be charged a missed appointment fee. The standard length of sessions is 45 minutes, unless medically necessary according to insurance standard and guidelines to extend sessions beyond that. If medical necessity is met, this will be explained to me.

Litigation ___________(initials)

I agree that I will neither call on my therapist, nor will any lawyer or other service acting on my behalf call on my therapist, to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. I understand that my record is for the purpose of therapeutic goals and not for any other reason and therefore would not benefit any court or legal proceedings (such as, but not limited to, divorce, custody disputes, parental evaluations, injuries, lawsuits, etc).

I have read, understand and agree to the Statement of Informed Consent:

Client/Parent/Guardian Signature ____. Date _________________

*Digital Submissions: Type signature, then E-sign on the portal.

Client Name: ____ Name & relationship of person who signed: _________________________________

Client Date of Birth: _____________