Child or Someone with Guardianship

Client Information and Consent Handbook

SGW Psychological Services
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Welcome and thank you for considering SGW Psychological Services LLC ("SGW Psychological Services LLC", "us", "Company") for your mental health needs. This document contains important information about our professional services and business policies.

Psychologist

The undersigned professional is a licensed psychologist. The psychologist is engaged in private practice providing mental health care services to clients directly or via licensed independent contractors of the licensed psychologist's Company. In addition, as the owner and managing member, the undersigned psychologist provides all mental health services through SGW Psychological Services LLC and not personally.

Mental Health Services

While it may not be easy to seek help from a mental health professional, it is hoped that you will be better able to understand your situation and feelings and move toward resolving your difficulties. The psychologist, using her knowledge of human development and behavior, will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to explore your own feelings and thoughts and to try new approaches in order for change to occur. You may bring other family members to a counseling session if you feel it would be helpful or if this is recommended by your psychologist. Please speak with the psychologist before inviting family members.

Appointments

Appointments are made by calling 651-493-9412. Please call to cancel or reschedule at least 24 hours in advance, or you may be charged for the missed appointment. Third-party payments will not usually cover or reimburse for missed appointments. If you are late, you will be charged for the full amount of the appointment and there will be no pro-rating of the fee. If the psychologist has to cancel the appointment, you will be entitled to a refund.

Number of Visits

The number of sessions needed depends on many factors and will be discussed by the psychologist. Your initial session will involve an evaluation of your needs and, depending on your circumstances, further evaluative sessions may be required. At the end of the evaluation process the undersigned psychologist will be able to provide you with some first impressions of what counseling may include and a treatment plan to follow, if both you and psychologist agree to work together in counseling. You should evaluate this information along with your own opinions of whether you feel comfortable working with the psychologist. Counseling involves a large commitment of time, money, and energy, so you should be very careful about the psychologist or therapeutic provider you select. If you have questions about procedures, feel free to discuss them

with the psychologist at any time. If you have doubts, your psychologist will be happy to connect you with referrals for another mental health professional for a second opinion.

Length of Visits

The initial intake and evaluative session, commonly referred to as the diagnostic assessment for psychotherapy, is normally scheduled for one (1) hour and may run longer depending on what the psychologist needs to complete the evaluation. Further evaluative sessions may be scheduled as needed for the psychologist to accurately assess your needs. Please note that some insurance companies only pay for a certain number of diagnostic assessments per year. It is your responsibility to ensure that you have diagnostic assessments left under your insurance coverage prior to the completion of the diagnostic assessment.

Once the evaluation process is completed most counseling sessions run between 45 to 60 minutes in length.

Groups

One 90-minute intake session, billed as a diagnostic assessment, is required to determine if the group is an appropriate fit for your child or the person to whom you are a legal guardian. During the intake session you may be asked to complete one or more assessment instruments. All group sessions are 60 to 90 minutes in length and the number of sessions will vary with the type of group and the level of your participation in the group.

Testing

One 90-minute intake session, billed as a diagnostic assessment, is required in order to complete the psychological evaluation process and to determine if further testing is warranted. For evaluations of minors, the psychologist will determine if it is necessary for your child or the person to whom you are a legal guardian to be present for the interview prior to the appointment. At the conclusion of the initial appointment, the psychologist will inform you and/or your child or the person to whom you are a legal guardian if testing is necessary and, if applicable, of the length of time needed for testing. The intake session will be billed as a diagnostic assessment or therapy session whether testing is deemed necessary or not. The length of time scheduled between the testing interview and testing session(s) is based off of a number of factors, including whether a prior authorization is needed by your insurance company for testing or not. Prior authorizations can delay the ability to do testing for up to 3-4 weeks. It is your responsibility to check whether a prior authorization is needed for psychological testing. Testing sessions may last several hours and may be scheduled as multiple appointments based on the discretion of the psychologist.

Relationship

Your relationship with the psychologist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the psychologist not have any other type of

relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The psychologist cares about helping you, but is not in a position to be your friend or to have a social or personal relationship with you.

If the psychologist encounters you in public setting, in order not to reveal your identity, the psychologist will not acknowledge your presence unless addressed by you first.

Gifts, bartering, and trading services are not allowed and should not be shared between you and the psychologist.

Cancellations

Cancellations must be received at least 24 hours prior to your scheduled appointment; otherwise you may be charged a fee for that missed appointment. The current missed appointment fee is $60 for a 30-minute therapy session or $90 for a 45 or 60-minute session. You are responsible for calling to cancel or reschedule your appointment. Please note that this fee does not apply to Medicare or Medicaid clients.

Payment for Services

For individual counseling, the charge for your initial intake and evaluation session is determined by insurance, generally billing code 90791. 30-minute therapy sessions generally bill as code 90832, 45-minute therapy sessions generally bill as code 90834, and 60-minute therapy sessions generally bill as code 90837. If you are using insurance, the reimbursement rate for these services is generally determined by insurance. If you are paying out of pocket, the charges are as follows:

Service	**Billing Code**	**Charge**
1-Hour Diagnostic Assessment (Therapy Intake or Testing Interview)	90791	$350.00
30-Minute Individual Therapy Session	90832	$185.00
45-Minute Individual Therapy Session	90834	$225.00
60-Minute Individual Therapy Session	90837	$300.00
60-Minute Group Therapy Session	90853	$100.00
Interactive Complexity	90785	$30.00
1st 60-Minutes of Crisis Session	90839	$325.00
Each Additional 30-Minutes of Crisis Session	90840	$200.00
Testing Administration 1st 30 Minutes	96136	$175.00
Testing Administration Subsequent 30-Minute Increments	96137	$175.00
Testing Write-Up/Results 1st 60 Minutes	96130	$300.00
Testing Write-Up/Results Subsequent 60-Minute Increments	96131	$250.00

These fees are subject to change upon thirty (30) days' prior notice to you. If you are unable to pay, or are not willing to pay, the higher fee after receipt of notice, services may be terminated and you may be given referrals to other competent providers. The undersigned psychologist does not

normally accept assignment of insurance benefits but may be required to do so in connection with certain managed care contracts. The undersigned psychologist will look to you for full payment of your account, and you will be responsible for payment of all charges. Different copayments are required by various group coverage plans. Your copayment is based on the Mental Health Policy selected by your employer or purchased by you. In addition, the copay may be different for the first visit than for subsequent visits. You are responsible for and shall pay your copay portion of the undersigned psychologist's charges for services at the time the services are provided. It is recommended that you determine your copayment before your first visit by calling your benefits office or insurance company.

If your account balance remains for any period of 60 days or longer, it is deemed a "past due" account balance. The psychologist may, at their discretion, choose to suspend services with your child or the person to whom you are a legal guardian until the past due balance is paid. If your account balance becomes past due for a period of 90 days or longer, a fee of $50.00 may be applied. If your account balance continues to remain unpaid after 120 days, your account balance may be passed to a collection agency. If this occurs, you will be provided referrals for competent providers in the area and no longer welcome to schedule with the psychologist.

Although it is the goal of the undersigned psychologist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. In the event disclosure of your records or the psychologist's testimony are requested by you or required by law, regardless of who is responsible for compelling the production or testimony, you will be responsible for and shall pay the costs involved in producing the records and the hourly rate charged by the psychologist at the time of the request or service of the subpoena (current rate is $300/hour) for the time involved in traveling to and from the testimony location, reviewing records and preparing to testify, waiting at the location, and giving testimony. Such payments are to be made at the time or prior to the time the services are rendered by the psychologist. The psychologist may require a deposit for anticipated court appearances and preparation. You will not be entitled to a pro-rated refund.

Confidentiality

Discussions between a psychologist and a client are confidential. No information will be released without the client's written consent unless mandated or permitted by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in treatment facilities; sexual exploitation; plans and intent to take one's life; AIDS/HIV and other communicable disease infection and possible transmission; court orders; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the psychologist has a duty to disclose, or where, in the psychologist's judgment, it is necessary to warn, protect, notify, or disclose; sexual exploitation by a mental health professional or member of the clergy; fee disputes between the psychologist and the client; a

negligence suit brought by the client against the psychologist; the filing of a complaint with a licensing board or other state or federal regulatory authority; to regulatory authorities in connection with their compliance or investigatory responsibilities; to employees or agents of the practice for operational purposes; to a supervisor if the psychologist is under supervision and for treatment consultations with other mental health professional when deemed necessary by the psychologist. FOR FURTHER INFORMATION REVIEW THE NOTICE OF PRIVACY PRACTICES FURNISHED TO YOU BY YOUR PSYCHOLOGIST IN CONJUNCTION WITH THIS CLIENT INFORMATION AND CONSENT DOCUMENT. By signing this information and consent form below you acknowledge receipt of a copy of the Notice of Privacy Practices. If you have any questions regarding confidentiality, you should bring them to the attention of the psychologist when you and the psychologist discuss this matter further. By signing this information and consent form below, you are giving your consent to the undersigned psychologist to share confidential information with all persons mandated or permitted by law, with the agency that referred you, and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned psychologist for any departure from your right of confidentiality that may result. Psychologists avoid conflicts of interest in treating minors or adults involved in custody or visitation actions by not performing evaluations for custody, residence, or visitation of the minor. Psychologists who treat minors may provide the court or mental health professional performing the evaluation with information about the minor from the psychologist's perspective as a treating psychologist, so long as the psychologist obtains appropriate consents to release information.

Duty to Warn

In the event that the undersigned psychologist reasonably believes that you are a danger, physically or emotionally, to yourself or another person, by signing this information and consent form below, you specifically consent for the psychologist to warn the person in danger and to contact any person in position to prevent harm to yourself or another person, in addition to medical and law enforcement personnel, and the following persons if listed below:

NAME: _____

TELEPHONE NUMBER: _____

NAME: _____

TELEPHONE NUMBER: _____

NAME: _____

TELEPHONE NUMBER: _____

This information is to be provided at your request for use by said persons only to prevent harm to yourself or another person. This authorization shall expire upon the termination of your counseling with the undersigned psychologist.

You acknowledge that you have the right to revoke this authorization in writing at any time to the extent the undersigned psychologist has not taken action in reliance on this authorization. You further acknowledge that even if you revoke this authorization, the use and disclosure of your protected health information could possibly still be permitted by law as indicated in the copy of the Notice of Privacy Practices of the undersigned psychologist that you have received and reviewed.

You acknowledge that you have been advised by the undersigned psychologist of the potential of the redisclosure of your protected health information by the authorized recipients and that it may not be protected from unauthorized disclosures as required by the federal Privacy Rule.

You further acknowledge that the treatment provided to you by the undersigned psychologist was conditioned on you providing this authorization.

Mandated Reporting

Under Minnesota Law, persons in designated professional occupations are mandated to report suspected child abuse or neglect. Persons who work with children and families are in a position to help protect children from harm. These persons are required by law to report to child protection if they know or have a reason to believe that a child is being abused or neglected or that a child has been neglected or abused within the prior three years. As a mandated reporter, the psychologist may be required to break confidentiality and report certain information to the appropriate authorities.

Risks of Counseling

You may learn things about yourself that you do not like. Often growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety, or pain. The success of our work together depends on the quality of the efforts on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from counseling. Specifically, one risk of marital counseling is the possibility of exercising the divorce option. There are no guarantees in counseling and the psychologist does not make any guarantees with this agreement. You assume the risk of counseling by signing this form. The psychologist is not liable for any adverse reactions to counseling. The psychologist may take any reasonable action necessary during counseling when there is a dangerous circumstance, as determined by the psychologist.

After-Hours Emergencies

Please know that your psychologist and SGW Psychological Services LLC do not provide twenty-four (24) hour crisis or emergency counseling services. Should you experience an emergency necessitating immediate mental health attention, immediately call 911 or if you are able to safely transport yourself, go to the nearest hospital emergency room for assistance.

Contacting Your Psychologist

Your psychologist is often not immediately available by telephone. The office number 651-493-9412 is answered by voicemail that the psychologist will monitor from time to time throughout the day. Although the psychologist is typically in the office during normal business hours s/he will not take calls when with a client. A reasonable effort will be made to return any call made during normal business hours on the same day it is received, weekends and holidays excepted, but there is no guarantee of a returned message or a returned communication time. Messages left after hours or on weekends or holidays will normally be returned the next business day. If you are difficult to reach, please inform your psychologist of times when you will be available. Communications should be prioritized for your next scheduled session or alternatively for alternative more urgent care that is not offered by the Company.

E-Mail and Text Messages

The undersigned psychologist and SGW Psychological Services LLC may use and respond to email and text messages only to arrange or modify appointments. Please do not send emails related to your treatment or counseling sessions as electronic communications are not completely secure and confidential. Any counseling related questions or issues will not be addressed by the psychologist in any electronic communication but will be dealt with during your next counseling session. Any electronic transmissions of information by you are retained in the logs of your service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the service providers. You should know that any e-mails or any communications sent via Facebook, online and specifically the website (www.sgwpsych.com) are not secure and you assume the risks of the insecure transmission.

Social Media

Your psychologist does not accept friend or contact requests from current or former clients on any social networking sites. Adding clients as friends or contacts on these sites can compromise confidentiality and privacy of both the psychologist and the client. It can blur the boundaries of the professional relationship and are not permitted. Any attempt by a client to surreptitiously gain access to the psychologist's personal site(s) will be cause for termination of the counseling.

Psychologist's Incapacity or Death

You acknowledge that, in the event the undersigned psychologist becomes incapacitated or dies, it will become necessary for another psychologist to take possession of your file and records. By

signing this information and consent form below, you give consent to allowing another licensed mental health professional selected by the undersigned psychologist to take possession of your file and records and provide you with copies upon request, or to deliver them to a psychologist of your choice. The undersigned psychologist will select a successor psychologist within a reasonable time and will notify the appointed licensed mental health professional.

Audio and Video Recordings

You acknowledge and, by signing this information and consent form below, agree that neither you nor the undersigned psychologist will record any part of your sessions unless you and the psychologist mutually agree in writing that the session may be recorded. You further acknowledge that the undersigned psychologist objects to you recording any portion of your sessions without the psychologist's written consent. You expressly agree that audio and video recordings used for security purposes are not part of counseling, and are therefore not protected by confidentiality or any other provisions under this agreement.

Domestic Violence

The Company works with patients experiencing or involved with domestic violence. Know that this type of therapeutic relationship creates unique ethics and safety questions for us that we should address at the beginning of the relationship. The Company may have additional forms, such as a "safety plan" that we will complete as part of the therapy. Also, for additional support you may contact 360 Communities Lewis House in Eagan or the National Domestic Violence Hotline, anytime, 24/7. Call 1-800-799-7233 or 1-800-787-3224 for TTY for the National Domestic Violence, or if you're unable to speak safely, you can log onto thehotline.org or text LOVEIS to 22522. Call 651-452-7288 for the Eagan Lewis House. If you are in immediate need of care or safety, call 911.

Distance Counseling (Telehealth or Online Mental Health Counseling)

Distance counseling includes the practice of mental health care delivery, diagnosis, consultation, treatment, transfer of protected health information, and education using synchronous or asynchronous audio, video, or data communications, including email. This is sometimes referred to as "Tele-medicine."

Identity Verification

You may be expected to provide a copy of your driver's license and other identity verifying documentation requested by the undersigned psychologist before any distance counseling services are provided.

Privacy and Security of Communications

All electronic communications between you and the undersigned psychologist will be transmitted using reasonable measures to ensure confidentiality. You will be responsible to secure and protect the functionality, integrity, and privacy of your hardware, files, and communication. Password protection for accessing your hardware and files is recommended. If others will be accessing the same computer, be aware that programs exist that copy every keystroke you make. It is recommended that you schedule your sessions with the undersigned psychologist when and where you can ensure the greatest level of privacy for all communications. Be sure to fully exit all programs and hardware at the end of each session.

Risks Associated with Distance Counseling

There are privacy and security risks and consequences associated with distance counseling despite the policies and procedures in place to guard against them. The risks and consequences include, but are not limited to, interrupted or distorted transmission of data or information due to technical failures and access or interception of your protected health information by unauthorized persons.

By signing this information and consent form below, you acknowledge the limitations inherent in ensuring client confidentiality of information transmitted in distance counseling and agree to waive your privilege of confidentiality with respect to any confidential information that may be accessed by an unauthorized third party despite the reasonable efforts of the undersigned psychologist to arrange a secure line of communication.

Distance counseling services and care may not be as complete or effective as face-to-face services. The undersigned psychologist will continually assess the appropriateness of distance counseling for you. If the undersigned psychologist determines that you would be better served by receiving different therapeutic services, such as face-to-face counseling, recommendations for treatment and treatment providers or facilities will be provided to you.

Communication Interruptions

If you are unable to connect with the undersigned psychologist or are disconnected during a session due to a technological breakdown, please try to reconnect within 5 minutes. If reconnection is not possible the undersigned psychologist can be reached at the following phone number: 651-493-9412.

Consent to Treatment Using Distance Counseling

I, voluntarily, agree to receive synchronous (or asynchronous) assessment, care, treatment, and services through the use of email and texts and authorize the undersigned psychologist to provide such care, treatment, or services as are considered necessary and advisable.

By signing this Agreement, I, the undersigned client, acknowledge that I have read, understood, and agreed to be bound by all the terms, conditions, and information it contains. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Conflicts of Interest

Psychologists avoid conflicts of interest in treating minors or adults involved in custody or visitation actions by not performing evaluations for custody, residence, or visitation of the minor. Psychologists who treat minors may provide the court or mental health professional performing the evaluation with information about the minor from the psychologist's perspective as a treating psychologist, so long as the psychologist obtains appropriate consents to release information.

Legal

This Agreement shall be construed in accordance with, and governed by, the laws of the State of Minnesota as applied to contracts that are executed and performed entirely in Minnesota. The exclusive venue for any court proceeding based on or arising out of this Agreement shall be Hennepin County, Ramsey County, Minnesota, or Dakota County. The parties agree to attempt to resolve any dispute, claim or controversy arising out of or relating to this Agreement by arbitration, which shall be conducted under the then current arbitration procedures of the American Arbitration Association any other procedure upon which the parties may agree. The parties further agree that their respective good faith participation in arbitration is a condition precedent to pursuing any other available legal or equitable remedy, including litigation, arbitration or other dispute resolution procedures. If any legal action or any arbitration or other proceeding is brought for the enforcement of this Agreement, or because of an alleged dispute, breach, default or misrepresentation in connection with any of the provisions of this Agreement, the successful or prevailing party or parties shall be entitled to recover reasonable attorneys' fees and other costs incurred in that action or proceeding, in addition to any other relief to which it or they may be entitled.

Consent to Treatment

I, voluntarily, agree for my child or the person to whom I am a legal guardian to receive Mental Health assessment, care, treatment, or services, and authorize SGW Psychological Services LLC to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my child's or the person to whom I am a legal guardian's care, treatment, or services, and that I may stop such care, treatment, or services my child or the person to whom I am a legal guardian receives through SGW Psychological Services LLC at any time.

By signing this Client Information and Consent form, I, the undersigned parent/guardian, acknowledge that I have read, understood, and agreed to be bound by all the terms, conditions, and information it contains. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

I acknowledge that I received a copy of this signed information and consent form from my psychologist on this _____ day of _____, 20_____.

Parent/Guardian 1 Signature: _____
Date: _____

Parent/Guardian 2 Signature: _____
Date: _____
(If client is a minor and parents are divorced)

[MINORS ONLY next 3 page] - Minor Consent for Treatment Form

Individuals under the age of 18 cannot be treated for health-related services without consent. Exceptions to this are governed by Minnesota Statutes, Chapter 144. Exceptions are summarized below and all other treatment requires parental / guardian consent. In signing below, I give the Company permission to treat my son/daughter. I may revoke this consent at any time with written notice to the Company.

Conditions When Parental Consent Is Not Needed for Treatment of Minors

144.341 Living apart from parents and managing financial affairs, consent for self.

Notwithstanding any other provision of law, any minor who is living separate and apart from parent(s) or legal guardian, whether with or without the consent of a parent or guardian and regardless of the duration of such separate residence, and who is managing personal financial affairs, regardless of the source or extent of the minor's income, may give effective consent to personal medical, dental, mental and other health services, and the consent of no other person is required.

144.342 Marriage or giving birth, consent for health service for self or child.

Any minor who has been married or has borne a child may give effective consent to personal medical, mental, dental and other health services, or to services for the minor's child, and the consent of no other person is required.

144.343 Pregnancy, venereal disease, alcohol or drug abuse, abortion.

Any minor may give effective consent for medical, mental and other health services to determine the presence of or to treat pregnancy and conditions associated therewith, venereal disease, alcohol and other drug abuse, and the consent of no other person is required.

144.344 Emergency treatment.

Medical, dental, mental and other health services may be rendered to minors of any age without the consent of a parent or legal guardian when, in the professional's judgment, the risk to the minor's life or health is of such a nature that treatment should be given without delay and the requirement of consent would result in delay or denial of treatment. 144.3441 Hepatitis B vaccination. A minor may give effective consent for a hepatitis B vaccination. The consent of no other person is required.

144.345 Representations to persons rendering service.

The consent of a minor who claims to be able to give effective consent for the purpose of receiving medical, dental, mental or other health services but who may not in fact do so, shall be deemed effective without the consent of the minor's parent or legal guardian, if the person rendering the service relied in good faith upon the representations of the minor.

144.346 Information to parents.
The professional may inform the parent or legal guardian of the minor patient of any treatment given or needed where, in the judgment of the professional, failure to inform the parent or guardian would seriously jeopardize the health of the minor patient.

144.347 Financial responsibility.
A minor so consenting for such health services shall thereby assume financial responsibility for the cost of said services.

Parental / Legal Guardian Consent:
I give Company permission to treat:

_____ _____ _____
Full Name of Minor Child Social Security Number Date of Birth

My signature indicates that I am the legal parent or guardian of the above named minor and that I am allowing my child to be treated at SGW Psychological Services LLC in the event of an accident, injury, illness, or other medical condition. I understand that I am responsible for all costs incurred and that an insurance-ready bill will be provided for me to submit to my insurance company. I recognize that I have the right to revoke this consent and that this consent is not needed when the above-named individual reaches the age of 18 or meets any of the conditions identified above.

Client/Parent/Guardian 1 Signature: _____
Date: _____

Parent/Guardian 2 Signature: _____
Date: _____
(If client is a minor and parents are divorced)

Parental Waiver of Right to Child's Records [Optional]

I hereby waive my right as parent/guardian to obtain information from and copies of any records from SGW Psychological Services LLC pertaining to the assessment, evaluation, and treatment of the following child: _____. I understand that SGW Psychological Services LLC may refuse to provide me, or any third party acting upon my request or authorization, with information and records pertaining to this child's mental health evaluation and treatment, if disclosure in the opinion of the child's psychologist would negatively impact the child or the child's evaluation and treatment. I hereby release SGW Psychological Services LLC and its agents from any and all liability for good-faith refusal to disclose the child's information or records.

Parent/Guardian Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____