

CLIENT INFORMATION, OFFICE POLICIES, & INFORMED CONSENT

I. New Client. _____ **Welcome!** Thank you for choosing to enter treatment. This is an opportunity to acquaint you with information relevant to treatment, confidentiality, and office policies. My name is Ina Lasmane. I am a Licensed Marriage and Family Therapist (LMFT- #1970) in solo practice in the state of Minnesota. Eagle Counseling is an advertising name for Ina Lasmane LLC. I am credentialed with insurance panels under Ina Lasmane, MA, LMFT or Ina Lasmane LLC.

II. My Approach, Goals, & Objectives:

My approach is goal-oriented, strength-based, and integrative. I offer therapeutic approaches that are research-informed and are proven to have good therapeutic outcomes such as Cognitive Behavioral Therapy (CBT), Accelerated Resolution Therapy (A.R.T), Eye Movement Desensitization and Reprocessing (EMDR), Discernment Counseling, Thought Field Therapy (TFT), Art Therapy, and other approaches.

I offer both short-term and long-term treatment. The length of treatment is difficult to predict. Some concerns may require just a few sessions yet others may be long-term. The length of your treatment will depend on the duration and complexity of your concerns, your commitment to treatment, your readiness for change, client-therapist match, and many other complex factors. Remember that it may have taken years for your symptoms or problem to manifest, therefore, it will take time to correct the problem. I encourage clients to practice patience and take small daily steps toward accomplishing their goals.

A therapeutic relationship is like any other relationship. It is only successful when both parties are engaged and fully participate. My part is to conduct treatment and to keep up with new training and research so I can provide you with the most effective methods to resolve your concerns. My part will also include insurance billing, case coordination, and other related services. Often preparation on my part is necessary before each session.

Just going to therapy will not magically cure you. You must do work and play an active role in your treatment. You will be required to provide necessary information and may be asked to complete homework assignments. Your homework will be based on your treatment goals and may involve practicing new behaviors, coping strategies, reading, charting, journaling, or other assignments we mutually agree on. Often your progress in therapy will depend on what you do between the sessions than on what takes place in the sessions.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable levels of feelings like sadness, shame, fear, or anger when recalling unpleasant aspects of your history as part of the healing. Sometimes things may get worse before they get better, because you are no longer denying the problem and/or are actively working through it. Benefits may include feeling calmer, happier, more content, less stressed, improved relationships, resolution of a specific problem(s), and increased life satisfaction. Making changes in your beliefs or behavior can be scary, and sometimes disruptive to the relationships you already have. Please consider carefully whether you are ready to change and whether the risks outweigh the benefits. Although, the therapeutic approaches I use work for most people, how you will respond is difficult for me to predict. Best results are typically achieved by following my recommendations, however it is up to you. You can refuse all or any part of the treatment.

Our first few sessions will involve an evaluation of your situation and needs and we will discuss goals you want to work towards. During this time, we can both decide if I am the best person to provide the services for you. Psychotherapy can involve a significant investment of time, energy, and money. So, it is important that you select a therapist you are comfortable working with. If at any time, you have questions about some aspect of our work together, please discuss them with me directly. If you decide that you do not want to continue in therapy with me, please tell me. If you want me to help you find another therapist or other appropriate resources, I will do so. Your treatment is voluntarily and you may discontinue at any time for any reason.

III. Appointments, Office Hours, & Contact Information:

Appointments. Appointments are typically scheduled for 45-55 minutes. Some insurance carriers only allow 45-minute sessions. Clients are seen weekly or more/less frequently as acuity dictates. Appointments can be scheduled by email at ina@myeaglecounseling.com, through my website at www.myeaglecounseling.com, or by calling at (612) 559-8704. I will only respond during the office hours list below.

Office Hours. Monday, Tuesday, and Thursday: 12:00noon-7:00pm; and Wednesday: 10:00am-4:00pm. I am out of the office on Fridays, weekends, and Holidays.

Crisis & Emergencies. I DO NOT provide crisis phone or internet counseling between the sessions. In the event of crisis or emergency please call Crisis Connection at (612) 379-6363, Hennepin County Suicide Hotline at (612) 873-2222, call 911, or go to the closest emergency room. If you call me in crisis you will be asked to schedule an appointment. Such appointment will be limited to my availability and practice hours listed above. If you need a crisis plan, please let me know ahead of time.

Contact Me. You can contact me by email at ina@myeaglecounseling.com or by phone and text at 612-559-8704. All communications will be returned within one business day (24 hrs) during the office hours listed above. I am not in the office on Fridays, weekends, and Holidays. Please note that I do not provide telephonic or on-line/internet counseling between the sessions – only in-person, face to face. Please keep all communications brief and related to scheduling and practice matters only. Also, please be aware that email and text are not completely confidential communications and can be intercepted; therefore, keep your communications rather general.

Vacations & Time Away from the Office. I am away from the office a few times during the year for vacations or to attend professional meetings. I will not respond to any text, phone, or email messages during those times. I will tell you in advance of any anticipated absences. If you need a crisis plan or to see a therapist during my absence, please let me know.

Fire Hazard & Tornado Warning. In the event of a fire, please exit the office building via front door. In the event of a tornado, seek shelter away from the windows and go to the lower level of the building.

IV. Cancellations and Missed Appointments:

My cancellation policy is **one business day** (24hrs). **For Monday appointments cancellations are due by 3:00pm on Friday. If your appointment falls right after a Holiday, a cancellation is due by 3pm the previous business day.** Because insurance companies do not pay for missed sessions, I will charge you directly for each no-show and each late cancellation. If you leave the session early or show up late, you will be asked to pay the difference. An arrival 20 minutes past your appointment time will be considered a no-show. **FEES: \$140 per each no-show & each cancellation, \$70.00 fee for the 1st incident of a late cancellation.**

If your insurance is Medical Assistance (MA), Medicare/Medicaid, Prepaid Medical Assistance (PMAP), or Ceridian employee assistance programs (EAP), it is illegal for me to charge you for the missed sessions, however I will reinforce my policy such as **TWO** missed session without the required notice will result in discharge. If you have a medical condition or other circumstances that prevents you from providing the appropriate cancellation notice, please inform me immediately. Please provide a detailed explanation of why you missed or will miss the session. Such statements like “something came up” or “family emergency” are too vague for me to consider an exception.

Upon your request, an automated courtesy reminder text or email will be provided to you approximately one day prior to your appointment. The reminders are automatically populated by my schedule via Full Slate. Regardless whether you receive a reminder or not, you are solely responsible for keeping track of your appointment(s).

V. Payments & Debt Policy:

Payment is due at the beginning of each session unless other arrangements have been made. I will file your insurance claims, but you are responsible for paying your deductible, co-insurance, or co-payment as well as familiarizing yourself with your insurance benefit before each session. I accept cash, checks, money orders, and credit/debit (Visa, MasterCard, Discover, and American Express, HSA, and FSA).

Regardless of your insurance plan and payment method, a valid credit card (no debit card) on file is required for all clients except for clients on Medical Assistance and PMAPs. Any charges that are current and due (co-pays, coinsurance, deductible charges, late fees, cancellations, no-shows etc.) will be charged to your credit card unless other arrangements have been made. To save time and resources, I no longer provide paper billing to the client. Receipt will be provided only upon your request.

This is how your credit card will be charged:

- a) **Co-Pays.** Your co-pays are due on the day of the service.
- b) **Co-Insurance & Deductible.** Your coinsurance and deductible charges are due once your claim is processed. It is illegal for me to collect the co-insurance and deductible ahead of time. Your credit card will be charged only when your claim(s) is processed, which can take 14-90 days depending on your insurance plan. Once your claim is processed, you will receive an EOB (explanation of benefits) from your insurance explaining your charges. Your credit card will be charged the amount that you owe me – typically indicated as “patient responsibility” on your EOB. You can choose to elect a different payment method once your claim is processed, but it is your responsibility to inform me of that ahead of time.
- c) **No-shows & Late Cancellations.** If you no-show or cancel late, your credit card will be charged within 24 hours from the incident. **Late Fees:** \$140 each no-show, \$140 each cancellation, \$70.00 fee for the 1st incident of late cancellation.

Other Fees: If your credit card has insufficient funds, has been closed, terminated, or you have recently relocated, please inform me immediately. You will be charged a **\$25.00 fee** for each instance of declined payment or returned check. You will be charged **2%** per month on any balance **30 days past due**. If your account is more than **60 days past due** and suitable arrangements for payment have not been made, I will use legal means to secure payment, including collection agencies or small claims court. Payment plans are available. However, such arrangements, including a partial payment, must be made before your account is 60 days past due.

VI. Notice of Privacy Practice:

Issues discussed in therapy are generally legally protected as both confidential and privileged. However, there are limits to the privilege of confidentiality. These situations include: 1.) Suspected abuse or neglect of any child, elderly person, or a disabled person; 2.) When I as your therapist believe that you are in danger of harming yourself, or you are unable to care for yourself; 3.) If you report that you intend to physically injure a specific identifiable person(s), the law requires me to inform that person(s) as well as the legal authorities; 4.) If I am court ordered to release your information; 5.) When your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc.; 6.) A licensing board may subpoena records from me if relevant to an investigation; 7.) When there is a written release signed by you (client) or your parent/guardian (if a minor) to share, obtain, or exchange information about you; 8.) When consulting with another

professional to improve service, clarify ethical or legal dilemmas, but only to the extent necessary to achieve the purposes of the consultation without disclosing your identity or other confidential information about you; and 9.) When otherwise required by law.

VII. Service Fees & Payment Options:

\$185–Intake or initial appointment/90791 (45-59min), \$120–Individual 90834 (42-52min), \$140–Individual 90837 (53-59 min), \$160–Couples & Family/90847 (45-55 min session), and \$160 – Family without Client Present/90846 (45-55 min session). Insurance reimbursement fees may vary and will be based on insurance-provider agreement. A reduced-fee is available upon request for those in financial need.

Insurance In-Network. I am an in-network provider for Aetna, America’s PPO, BCBS/Blue Cross Blue Shield, Beacon Health, Cigna (EAP only), ESI Eap, Lifeworks (formerly Ceridian), Labor Care, Hennepin Health, Magellan, Metropolitan Health Plan (MHP), MA (Medicaid/Medical Assistance), Medica, Network Advantage, Optum, PreferredOne, Select Care, UBH/United Behavioral Health, U-Care, United HealthCare, and UMR. Please note, that most insurances do not cover services 100%. You might be responsible for a co-pay, co-insurance, or deductible. Having insurance does not automatically guarantee a coverage or payment.

Out-Of-Network. I am out-of-network with Health Partners, Cigna, and other insurances not listed above. Contact your insurance to inquire if you have out-of-network benefits.

Diagnosis. Having insurance pay all or part of your bill for mental health care means that the counselor must give you a mental health diagnosis. Many times, this means that the diagnosis follows you throughout your life and can influence your qualification for health and/or life insurance.

Self-Pay. Because of confidentiality issues with insurance, you may choose to self-pay for services. This option will guarantee the highest level of privacy and confidentiality.

Other Professional Services and Fees. In addition to appointments, it is my practice to charge the therapy rate (\$140 per hour) for other professional services you may require such as report writing, treatment summaries, telephone conversations which last longer than 10 minutes, or the time required to perform any other service which you may request of me.

Please note, I do NOT provide disability determination, parenting & custody evaluation, or handle court issues. My services are designed to assist in alleviating problems through individual or relational psychotherapy. I am not trained for, nor do I maintain records with the intended purpose of court involvement. Should I be called to court by a judge court order, or your records are court ordered or subpoenaed, I will charge the full amount applicable under law for our services. Copies of records are available for \$1.00 per page plus the postage cost. In the event that it is necessary, by court order or by subpoena, for me to testify before any court, arbitrator, or other hearing officer to testify at a deposition, whether the testimony is factual or expert, or to present any or all records pertaining to the counseling relationship to a court official, you agree to pay me for the services, (including but not limited to: travel, necessary expenditures (copies, parking, meals, and the like), time spent speaking with attorneys, reviewing records and preparation of reports) at the rate of \$250 per hour, rounded to the nearest half hour. You further agree to pay me a retainer fee of \$2000 two weeks prior to the appearance, presentation of records, or testimony requested. Checks will not be considered an acceptable form of payment for these services.

VIII. Record Keeping:

The Minnesota government recently passed an amendment to Minnesota Statutes 2014, section 62J.495, subdivision 1 that individual health care providers in private practice with no other providers are exempt from electronic health record (HER). As of 07/01/15 I have reverted to handwritten paper charts to ensure greater confidentiality and privacy of your information. Your paper clinical chart is maintained describing your condition and your treatment and progress in treatment, dates of and fees for sessions, and notes describing each therapy session. Your records will not be released without your written permission, unless in those situations as outlined in the Notice of Privacy Practice section above. Your clinical chart is kept in my office in a locked file cabinet.

Although, your clinical chart is paper, my schedule is electronic. Your appointments are entered as part of my electronic schedule via Full Slate, a HIPAA compliant site. Please note, that your name, date of birth, demographics, insurance, and your appointment date and time will become part of this electronic record. If you feel that the electronic schedule violates your privacy and confidentiality, please let me know and I will seek alternative options.

I am required to keep your records for 7 years after your last date of service, or 7 years after your 18th birthday, if a minor. You are entitled to receive a copy of your records provided you submit a written request. A fee of \$1.00 per page and postage might be charged in accordance with MN Statute 144.292. Certain restrictions in regards to sharing the records may apply as per MN Statute 144.292 and Federal Rule 45CFR 164.524. Also, in the case of couples and family therapy, I cannot release records/information without the written consent of ALL parties’ present/participating in treatment.

IX. Termination & File Closure:

The decision to terminate belongs to you and/or at the therapist’s recommendation when your treatment goals are reached. If termination occurs before adequate treatment has been achieved, I will provide you with referrals to other providers, or you may choose to find your own therapist. Please note that there are a few exceptions where I may terminate therapy. Some examples include: 1.) If I am unable to help because of the kind of problem you have or because my training and skills are not appropriate, I will inform you of that and will refer you to another therapist that may meet your needs; 2.) If attendance is an issue: two or more incidents of either the no-shows, late cancelations,

chronic rescheduling, or tardiness, etc; 3.) Failure to pay for services rendered and/or accruing excessive balance owing; 4.) When it is reasonably clear that the treatment no longer serves your needs and interests; and 5.) If you do violence, destroy property, threaten, verbally, physically, or sexually harass or assault anyone in my office building, including me, I reserve the right to terminate you immediately from treatment. If I terminate you from treatment I will offer you referrals to other sources of care, but cannot guarantee that they will accept you for therapy.

If you are in an active phase of treatment and you have not scheduled an appointment for over 30 days since your last appointment, I will send you a follow-up letter asking you to respond within 10 business days to schedule your next appointment. If I do not hear back from you within that time frame, I will assume that you have chosen to discontinue treatment. You will be discharged and services will be terminated. You can reopen in the future. However, future services may not be guaranteed and will be based on availability.

X. Media Policy, Website Requests, Other Invitations, & Gifts:

Invitations & Gifts. I do not accept gift, invitations to weddings, birthdays, or graduations etc. This would blur the boundaries of our therapeutic relationship. Additionally, if we run into each other in the community I will not acknowledge you to protect your confidentiality.

Use of Touch in Treatment. I do NOT utilize therapeutic touch in my practice. However, a handshake is a socially acceptable form of saying hello, thank you, or goodbye. There will be no exchange of touch of any kind besides a hand shake. However, an EMDR Early Trauma protocol recommends a use of light tapping on the client’s palms or ankles. If your treatment calls for this protocol, we will discuss it ahead of time and decide if it is mutually comfortable.

Networking Sites. I do not accept “friend” and “contact requests” from current or former clients on any social networking site (Facebook, LinkedIn, etc.) as that would compromise your confidentiality and privacy as well as blur the boundaries of our therapeutic relationship.

Google Searches. It is not a regular part of my practice to search for clients on Google, Facebook, or other search engines. Extremely rare exceptions may be made during times of crisis or emergency.

Electronic Communications. Please be aware that email, text, and internet communications are not completely secure and can be intercepted. Therefore, keep your communications to me rather general and related to practice matters only. Everything that you email me will be printed out and will become a part of your record.

Recording. Unless we have specifically discussed it, there will be no video or audio recording of our meetings or any phone conversations. All our discussions are private and confidential.

XI. HIPAA & Client Bill of Rights:

_____ (please initial) I acknowledge that I have read and understood the Notice of Privacy Practice/HIPAA. I understand that I can access this policy at any time by going to www.MyEagleCounseling.com under the “Forms” section.

_____ (please initial) I acknowledge that I have access to the Client Bill of Rights. I further acknowledge that this document is displayed at this therapy office. I understand that I can also access this document at any time by going to the above website.

XII. Complaints:

If you have a complaint about your treatment, me as your therapist, any office policy, or the condition of the office, parking, or common areas of the office building, please inform me immediately and discuss the situation. If you do not feel the complaint has been resolved, you may file a complaint to Board of Marriage and Family Therapy, 2829 University Avenue SE, Suite 400, Minneapolis, MN 55414, phone: (612) 617-2220. You may also inform your insurance carrier and file a complaint if you so choose.

XIII. Consent for Treatment:

By signing below, you are stating that you have read and understood this 4-page policy statement and you have had your questions answered to your satisfaction. I accept, understand, and agree to abide by the contents and terms of this agreement and further consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time for any reason. This policy is subject to change. You will be provided a 30 days’ notice of any changes.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____