Embark Mental Health

3240 E Bison Trail, Suite 200
Sioux Falls, SD 57108
P: (605) 961-4746 **F:** (605) 961-4747

Informed Consent

Welcome to Embark Mental Health. Brittany Tennant, Sarah Varilek, and Nicole Velgersdyk own and operate the branding and marketing of Embark Mental Health. However, we operate as individual clinicians during the therapeutic process. Within the clinical portions of this document, the language changes to reflect the relationship between the client and individual clinician.

This document contains important information about my professional services and business policies. By signing this document, it represents an agreement between us. I can discuss any questions you have when you sign or at any time in the future. Please feel free to contact me by phone or from the website. However, when with clients or otherwise unavailable, I ask you leave a message on my confidential voicemail, and I will do my best to answer in a timely manner.

WHAT TO EXPECT FROM COUNSELING

Counseling is a relationship between people that works best with transparency of your rights and responsibilities and helping you to understand what these are, as discussed within this consent form. The terms counseling and therapy can be used interchangeably such as in the marketing and website material. However, for the purposes of clarity within this document I will be using the term counseling.

As a counselor, I believe counseling is an opportunity that can benefit you by growing your insights and guiding you to make changes you want in your life. However, there are also risks of participating in counseling by discussing unpleasant situations or experiencing uncomfortable feelings. By addressing these risks, you brave your fears, learn to manage your feelings, practice mindfulness, and empower yourself to solve or work through your life challenges. There are never guarantees in life, including your success in counseling. You are the most important part of your success with actively working on making these changes. I recommend the work I do with you in counseling also is practiced and reflected on outside of our counseling sessions for additional growth.

At the beginning of counseling, you can expect my focus on getting to know you through a comprehensive evaluation of your needs. I also believe counseling will feel beneficial to you, with noticing your progress, as we work together to develop treatment goals. During these beginning sessions, I will help to determine additional needs or referrals. In addition, I hope you will assess if you feel comfortable working with me. I know mental health professionals vary in personalities, approaches, and specialties; therefore, if you have questions about how I approach counseling, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you to find another mental health professional to fit your needs.

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APPOINTMENTS

Appointments will ordinarily be 45-55 minutes in duration, once per week or bi-weekly at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide **at least a 24-hour notice.** This time frame is important for me to help get in clients who were unable to get in during the week. If you miss a session without canceling, or cancel with less than 24 hour notice, my policy is to collect $175. It is important to note that insurance companies do not provide reimbursement for missed sessions; thus, you will be responsible for the portion of the fee as described above. If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

CLIENT EMERGENCIES

If you are having an emergency/crisis or unable to keep yourself safe and are not able to reach me, please call:

1. Avera Behavioral Health Center: 1-800-691-4336
2. Helpline Center: 1-800-273-8255
3. Local emergency number 911 or go to your Local emergency room

CONFIDENTIALITY

Confidentiality is a foundation for counseling to ensure trust and increase openness with our sessions. If you would like me to have contact with or release records to others, I require a written consent of this request on a Release of Information form. There are also limitations to confidentiality in counseling, which are as follows:

- When there is a risk of harm to self or others
- Mandatory reporters of abuse and neglect
- Court order/subpoena to release information in legal cases
    - If you become involved in a court case, I recommend full disclosure of this anticipated process to review confidentiality. You will be expected to pay for the professional time required even if another party compels me to testify.
- In the case of minors, I believe parental involvement is essential as they are part of your support system. You can benefit from this team approach in the discussion of general concerns as well as treatment goals and progress. I encourage minors to share their concerns, with help from me as a facilitator, to their parents/guardians.

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I also follow HIPPA guidelines, which are available through our Notice of Privacy Practices documents. You may also refer to this website for additional questions about HIPPA: https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

CONSULTATION/COLLABORATION:

There may be times I consult with colleagues for the purposes of education or if another therapist's perspective is needed to enhance client services. Your full name and other identifying information would not be shared in this scenario. We may need to collaborate with other professionals involved in your situation, in that scenario, a release of information will need to be signed by the client before communication can occur.

PROFESSIONAL RECORDS

I am required to keep appropriate records of the mental health services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

INSURANCE AND BILLING

At Embark Mental Health, it is important for me to understand your resources for payment of your appointment as such through insurance or private pay. Most insurance companies may cover some of your mental health treatment. With your permission, our billing service will help me to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage, understanding authorization requirements, and for letting me know if/when your coverage changes.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information that will become part of the insurance company files. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

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Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

In addition, if you plan to use your insurance, I encourage you to understand all aspects of your coverage including authorization needed prior to services, amount of time of service payment, and deductibles or out-of-pocket amounts. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Also, your amount for co-insurance or co-payment must be paid at the time of the visit by check, cash or credit card.

If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

Once we have all of the information about your insurance coverage, I will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, unless prohibited by my provider contract.

You will be sent a monthly bill that reflects your charges, what you have paid, and what your insurance company has paid. You are expected to pay your balance in a timely manner. If your bill is delinquent and suitable arrangements for payment have not been agreed to, I have the option of using legal means to secure payment, including collection agencies or small claims court. If legal options must be used, you will forfeit your right to confidentiality to the extent necessary to process the legal claim against you. Ultimately, you, and not your insurance company, are responsible for the full payment of your bill.

Late fees are as scheduled and will begin after 90 days:

- **Outstanding balances up to $250 will have a late fee of $25**
- **Outstanding balances up to $251-$500 will have a late fee of $50**
- **Outstanding balances up to $501-$750 will have a late fee of $75**
- **The pattern of late fees continues incrementally and will be applied at the end of each billing cycle.**

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PROFESSIONAL CODES AND FEES

For both insurance and private pay, please review the following for charges per session. Your insurance company may request these codes to identify coverage of services. I will discuss appropriate and recommended time per session to meet your needs.

CPT Code	Description	Fee
90791	Psychiatric Diagnostic Evaluation (Intake)	$200
90837	Psychotherapy 55 minutes	$175
90834	Psychotherapy 45 minutes	$160
If cash payment for session (private pay), a discount of $15 is applied. Collection of fees will be collected prior to the session.		
Other Fees (your full responsibility as they are not charged to insurance)		
	No Show	Full fee of session missed
	Court	$300/hour
	Copies of Mental Health Notes	$12.00 (1-25 pages) and $.50 per copy - pages 25+

OFFICE AGREEMENT

Embark Mental Health is comprised of a group of licensed mental health clinicians. I understand that Embark Mental Health shares branding, marketing, and office space; however, they operate as separate businesses. Therefore, they are not liable for situations occurring during the course of each other's business practices.

COURT POLICY

I understand that information discussed in therapy is for therapeutic purposes and is not intended for use in any legal proceedings. I agree not to subpoena my therapist to testify for or against any party or to provide records in a court action. If court ordered or subpoenaed, the client, parent, or guardian will be responsible for fees associated with court (see above.)

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CLIENT RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

CONSENT TO COUNSELING

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

_____

Client Name

_____ _____

Signature of Client or Parent/Guardian *Relationship to Client*

_____ _____

Printed Name of Client or Parent/Guardian *Date*