Mental Health Therapy Information

Provider Information –

Caitlin J. Bishop, MA, LPCC

Email: cbishop@regencyhhc.com
Phone: 651-488-4655
Fax: 651-488-4656

Professional Relationship –

The professional relationship is not easily described in general statements. It varies depending on the personalities of the consultant and client, and the concerns you are experiencing. There are many different methods we may employ to attend to the concerns that you hope to address. The relationship is not like a medical doctor and calls for a very active role on your part. It might even include other important people in your life.

Therapy can have benefits and some risks. Since consultation may involve discussing challenging experiences in your life you may experience sadness, guilt, shame, anger, frustration, loneliness, etc. On the other hand, therapy may have benefits. Successful therapy can lead to increased satisfaction in relationships, new possibilities for addressing specific concerns, and/or reductions in feelings of distress. But there are no guarantees of what you will experience.

The first few sessions will focus on understanding your needs, goals, and presenting concerns. After these first few sessions, we will be able to discuss your first impressions and then co-create a potential plan with goals to work toward if we decide to continue therapy. It is important to evaluate this information along with your own opinions of whether you feel comfortable working together. Since therapy involves a commitment of time, money and energy, it is important to be selective about the therapist you select. If you have questions about my procedures, we can discuss these whenever they arise. While we co-create possible solutions, you maintain the right to implement them, or decide against implementing any or all of them.

Meetings & Professional Fees –

I conduct an initial session of 55 minutes at a cost of $160 . Following the initial session, is an evaluation period of 2 to 3 sessions during which we both decide if I am the best person to provide the services you need to meet your goals. The fee for these 55 minute sessions is $150 . I typically suggest one session per week at a time, but we can work together to determine how often we meet. Once an appointment hour is scheduled, you will be financially responsible if you were to cancel with at least 24-hour notice. If you are unable to attend due to circumstances beyond your control, such as an unforeseen emergency, sudden illness, etc., the fee is waived. It is important to note that insurance companies do not provide reimbursement for cancelled session charges. Periodically, we are faced with an issue of raising rates. While this is not an annual change, there have been times where the rate increased $10.00/hour. In the event of a change, we will post these changes in our individual offices at least 90 days in advance and make every effort to verbally provide you of the changes.

Revised: 5.8.2020

Mental Health Therapy Information

Additional Professional Fees –
In addition to weekly appointments, I charge $150 per 55 minutes for other professional services you may need, though I will break down the hourly cost if I work for periods of less than 55 minutes. Other services may include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries and time spent performing other services you may request. These services may not be covered by insurance.

If you become involved in any legal proceedings that require my participation, you will be expected to pay for all my professional time, including preparations and transportation costs and any legal fees that I might incur, even if I am called to testify for another party. I charge $150 per hour for preparation and attendance and in addition, mileage to and from any location.

Billing and Payments –
You will be expected to make co-pays or deductibles for each session *at the time of the session*. If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information released would be his/her name, the nature of services provided and the amount due. If such legal action is necessary, its costs will be included in the claim.

Insurance Reimbursement –
Your health insurance company requires an assessment covering a broad range of topics, typically more than may be covered in our initial session and we are required to provide your insurance provider with information relevant to therapeutic services, including a clinical diagnosis. I will make every effort to release only the minimum information necessary for purpose requested by your insurance company to process your claim. Upon request, you may have a copy of any report I submit. This information will become a part of the insurance company files and while your insurance company may endeavor to keep this information confidential, we have no control over what happens to the information once it is submitted. Your private information might become part of a national medical information data bank and could be used in determining future insurability. To avoid problems described above, you may opt to pay for services yourself. Most insurance companies require that we coordinate care with your Primary Care Physician, so it is important we have your written consent to do so. We process all insurance claims on your behalf. *Please do not submit insurance claims unless we instruct you to do so, as this might reject our claim to your insurance provider.*

Contacting Me –
You may leave me a message on my confidential voicemail or e-mail me. Email or text is used to make or change appointments, or for general questions NOT requiring an immediate response. For more detailed and sensitive information, please leave a voicemail. I will make every effort to return your call or e-mail within 24 – 48 hours, except for weekends and holidays. If it might be difficult to reach you, please leave times when you might be available by phone.

Mental Health Therapy Information

Concerns –

I urge you to discuss with my any questions or concerns you may have with the services you receive. If you are not satisfied with the results of that discussion and additional measures are necessary, a formal concern or complaint may be made with Stephanie Johnson, Director of Operations whose number is: 651-488-4655. If the results of that consultation are not satisfactory, you may call the Board of Behavioral Health and Therapy at 612-548-2177.

Emergency and Crisis Resources –

If you are experiencing an emergency contact 911, your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If experiencing crisis, other crisis lines are listed below:

Hennepin County Crisis 24-hour Hotline: 612-596-1223 (adults); 612-596-2233 (children)
National Suicide Prevention Lifeline: 1-800-273-8255
Anoka county Crisis 24-hour hotline: 763-755-3801
Acute Psychiatric Services at HCMC: 612-873-3161 (Crisis), 612-873-2222 (suicide hotline)
Behavioral Emergency Center, Fairview Riverside: 612-672-6600 – Walk-in Emergency Center
Carver/Scott County Crisis 24-hour hotline: 952-442-7601
Dakota County Crisis 24-hour hotline: 952-891-7171
By Cell Phone in Metro: Call **CRISIS** (**274747)
By Cell Phone Statewide: Text MN to 741741

Consent and Signatures

Patient Name:_____ Patient DOB:_____

Patient Signature: _____ Date: _____

If applicable OR if patient is under 18 years of age:

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____ Date: _____

Revised: 5.8.2020

Consent for Mental Health Services

In reviewing and signing this consent, you are consenting to Outpatient Mental Health Services that may or may not include individual, group and family psychotherapy services. Providers may also bill insurance if clinical consultation is necessary for case coordination. In the event of acute crisis, you are consenting to crisis psychotherapy services. Services are rendered in an Outpatient Clinic Setting in Maple Grove, MN with an independently fully licensed clinician or a trainee under direct supervision of a fully licensed clinician. While maintaining confidentiality of patient information, these providers may at any time consult with other licensed professionals as needed. In addition, mental health clinicians under this entity are considered mandated reporters in the State of Minnesota.

By signing this consent form, you agree that your protected health information may be disclosed to and used by Regency Home HealthCare for the purpose of providing you a different mental health treatment, or for insurance coverage purposes if appropriate.

The priority is maintaining safety and privacy of those with whom we consult. If there comes a time when there are concerns for your safety or the safety of others in your life, I may need to contact them. I ask you to provide two names of people I could call if I am concerned about your safety. If you are the parent of a client I am seeing, there may be times when I am unable to contact you immediately and need someone else to verify your child's safety. Please list these individuals below:

Emergency Contacts

Name (first/last): _____ Relationship:_____

Mobile Number:_____ Work Number:_____

Email:_____

Name (first/last): _____ Relationship:_____

Mobile Number:_____ Work Number:_____

Email:_____

Consent and Signatures

Patient Name:_____ Patient DOB:_____

Patient Signature: _____ Date: _____

If applicable OR if patient is under 18 years of age:

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____ Date: _____

Revised: 5.8.20

Patient Insurance Registration

Date: _____ Time: _____

Legal Name (First and last): _____ DOB: _____ Age: ____

Address: _____City: _____ Zip Code: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Chosen name if different than legal name: _____

If under 18, Parent/Guardian/Emergency Contact Legal Name: _____

Address (if different then listed above): _____ City:_____

Zip Code:_____ Relationship: _____ Current Legal Guardian? Y or N (please circle)

If applicable, Parent/Guardian/Emergency Contact Legal Name: _____

Address (if different then listed above): _____ City:_____

Zip Code:_____ Relationship: _____ Current Legal Guardian? Y or N (please circle)

Who referred you or your family member: _____

(For Office Purpose Only -

Scan Driver's License Here)

Primary Insurance Info: Insurance Policy

Name: _____

Policy Number: _____ Group Number: _____

Policy Holder Full Name: _____ Policy Holder DOB: _____

(For Office Purpose Only -

Scan Insurance Card Here)

Revised: 5.8.2020

Patient Insurance Registration

Secondary Insurance Info: Insurance Policy Name:_____

Policy Number: _____ Group Number: _____

Policy Holder Full Name: _____ Policy Holder DOB: _____

(For Office Purpose Only -

Scan Card Here)

Financial Responsible Party Information

Name:_____ Relationship:_____

Address: _____City: _____ Zip Code: _____

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider (therapist) listed on this form for all insurance benefits, if any, otherwise payable for services rendered. I understand that I am financially responsible for all charges not covered by insurance. I hereby authorize the use of this signature on all insurance submissions. I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider (therapist) listed on this form all insurance benefits, if any, otherwise payable for services rendered. I understand that I am financially responsible for all charges not covered by insurance. I hereby authorize the healthcare provider (therapist) to release all information necessary to secure payment of benefits and to mail billing statements. I authorize the use of this signature on all insurance submissions. *I understand Caitlin J Bishop is not a Medicare provider and cannot accept Medicare of any type for reimbursement of services.*

_____ _____ _____

Signature of Responsible Party Relationship (self, parent, etc.) Date

Revised: 5.8.2020

Confidentiality Agreement

Information about clients and their families is confidential with exception to the following:

1.) Written authorization by the client and/or family (valid authorization form).
2.) Therapist's duty to warn another in case of potential suicide, homicide or threat of imminent, serious harm to another individual.
3.) Therapist's duty to report suspicion of abuse or neglect of children or vulnerable adults.
4.) Therapist's duty to report prenatal exposure to cocaine, heroin, phencyclidine, methamphetamine, and amphetamine or their derivatives, THC, or excessive & habitual alcohol use.
5.) Therapist's duty to provide a spouse or parent of a deceased client access to their child or spouse's records.
6.) Therapist's duty to provide parents of minor children access to their child's records. Minor clients can request, in writing, that specific information not be disclosed to parents. Such a request should be discussed with the therapist.
7.) Therapist's duty to release records if subpoenaed by the courts.
8.) Therapist's obligations to contracts (e.g. to employer of client, to an insurance carrier or health plan).
9.) For clinical consultation with other licensed professionals, or trainees. The purpose of consulting with colleagues is to obtain additional insight, further therapeutic skills, and ensure the highest possible services to the people we serve. During consultation, every effort is made to provide only details necessary to gain adequate feedback.

Communication: Email, Text & Other Non-Secure Means

It may become useful during our work to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Please know that these methods, in their typical form, are not confidential means of communication and may be susceptible to a third party who may be able to intercept and eavesdrop on those messages, even though we offer encrypted email. The kinds of parties that may intercept these messages may include, but are not limited to:

- People in your home or other environments who can access your phone, computer or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with Regency Home HealthCare
- Third parties on the internet such as server administrators and others who monitor internet traffic

If there are people in your life you don't want access to these communications, please communicate with your Regency Home HealthCare provider about ways to keep your communications safe and confidential.

(see next page)

Confidentiality Agreement

(Cont.)

I consent to Regency Home HealthCare providers use of email and mobile phone text messaging when transmitting your protected health information, such as:

- Information related to scheduling meetings or other appointments
- Information related to billing and payment
- Non-emergency related correspondence

My signature indicates that I have been informed of the risks, including but not limited to my confidentiality in therapy, of transmitting protected health information by unsecured means. I understand that I am not required to sign this agreement to receive therapy. I also understand that I may terminate this consent at any time.

Consent and Signatures

Patient Printed Name:_____ DOB:_____

Patient Signature: _____ Date: _____

If applicable OR if patient is under 18 years of age:

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____ Date: _____

HIPAA Minnesota Notice Form

Notice of Regency Home HealthCare
Policies and Practices to Protect the Privacy of Client Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORAMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORAMTION. PLEASE REIVEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations.

Regency Home HealthCare may *use* or *disclose* your *protected health information* (PHI), for *treatment, payment and health care operations* purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- Treatment, Payment and Health Care Operations
    - Treatment is when a clinician provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when a therapist consults with another health care provider, such as your family physician or a psychologist.
    - Payment is when reimbursement for your health care is obtained. Examples of payment would be to disclose PHI to your health insurance company to obtain reimbursement for your health care or to determine eligibility or coverage.
    - Health Care Operations are actives that relate to the performance of operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits, and administrative services, and case management and care coordination.
- Use applies only to activities within my [office, clinic, practice group, etc.], such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- Disclosure applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment or health care operations when your appropriate authorization is obtained. An authorization is written permission above and beyond the general consent that permits only specific disclosures. In those instances, when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. Psychotherapy Notes are notes that I made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given different protection than PHI.

You may revoke all authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I know or have reason to believe a child is being neglected or physically or sexually abused or has been neglected or physically or sexually abused within the preceding three years, I must immediately report the information to the local welfare agency, police, or sheriff's department.
- **Adult and Domestic Abuse:** If I have reason to believe that a vulnerable adult is being or has been maltreated, or if I have knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, I must immediately report the information to the appropriate agency in the county. I may also report the information to law enforcement agency.

Vulnerable Adult: a person who, regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:

(i) That impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care or supervision

(ii) Because of the dysfunction or infirmity and the need for assistance, the individual has an impaired ability to protect the individual from maltreatment.

- **Health Oversight Activities:** The Minnesota Board of Behavioral Health and Therapy may subpoena records from me if they are relevant to an investigation it is conducting.
- **Judicial and Administrative Proceedings**: If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law and I must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case.
- **Serious Threat to Health or Safety:** If you communicate a specific, serious threat of physical violence against a specific, clearly identified or identifiable potential victim, I must make reasonable efforts to communicate this threat to the potential victim or to a law enforcement agency. I must also do so if a member of your family or someone who knows you well has reason to believe you are capable of and will carry out the threat. I also may disclose information about you necessary to protect you from a threat to commit suicide.
- **Worker's Compensation:** If you file a worker's compensation claim, a release of information from me to your employer, insurer, the Department of Labor and Industry or you will not need your prior approval.

IV. Client's Rights and Clinician's Duties

Client's Rights:

- Rights to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of your protected health information. However, I am not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI (and psychotherapy notes) in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- Right to Accounting – You generally have the right to receive and accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Clinician's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will send you a copy by mail or give you a copy in session.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Stephanie Johnson, Director of Operations at 651-488-4655.

If you believe that your privacy rights have been violated and wish to file a complaint with me or my office, you may send your written complaint to:

Regency Home HealthCare
10467 93rd Ave. N.

HIPAA Minnesota Notice Form

Maple Grove, MN 55369

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice became effective 1/10/2020.

We reserve the right to change the terms of this notice and to make new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail or in session.

I have read and understand the statements in this HIPAA Notice Form.

Consent and Signatures

Patient Printed Name:_____ DOB:_____

Patient Signature: _____ Date: _____

If applicable OR if patient is under 18 years of age:

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____ Date: _____

Revised: 5.8.2020

Client Responsiblities

REGENCY Home HealthCare

As A Client You Have A Responsibility To

1. Ask questions and get clarification regarding your diagnosis and suggested treatment plan.
2. Be willing to be an active and collaborative partner in the therapeutic relationship.
3. Inform your therapist of any changes in your behavior and/or physical or mental health status that could affect your care, including compliance with any prescribed medications.
4. If using insurance, inform your therapist of any changes in your health insurance plan.
5. Be on time for scheduled appointments. If running late, please inform therapist by phone, email or text. Please do not text or email while driving.
6. Cancel appointments if you are unable to keep them, so others may use the time slot. Please adhere to a minimum of a 24-hour notice to cancel your appointment. Thank you!
7. Limit email communications primarily to scheduling issues (making appointments, rescheduling or canceling appointments). Email is not monitored sufficiently for therapeutic or crisis correspondence.
8. Understand that for your confidentiality and to minimize the possibility of dual relationships, your therapist will not accept invitations for any social medica connections (i.e., Facebook, Instagram, SnapChat, LinkedIn, etc.).
9. Inform your therapist if you would prefer to "opt out" of text message or email appointment reminders.
10. Understand that, depending on our financial agreements, co-pays, deductible amounts of full session fees are due at the time of service. Delays may occur with insurance reimbursement, or may accrue due to unmet deductible amounts, therefore, balances on your account will be reviewed monthly. Please understand, should a balance accumulate on your account, it will be limited to $300.00, and must be paid within 45 days. If a balance remains unpaid without prior arrangement, additional fees and suspension or termination of services may result.

I have read and understand my responsibilities as a client listed above.

Consent and Signatures

Patient Printed Name:_____ DOB:_____

Patient Signature: _____ Date: _____

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Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____ Date: _____

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Rights to Inquire

You Have The Right To Know and Inquire About

1. The cost of counseling, time frame for payment, access to billing statements, billing procedure for missed appointments, and any issues related to insurance coverage.
2. When the therapist is available and where to call during off hours in case of emergency.
3. The way the therapist conducts sessions concerning intake, treatment, and termination. Clients take an active role in the process by asking questions about relevant therapy issues, specifying therapeutic goals, and renegotiating goals when necessary.
4. The nature and perspective of the therapist's work, including techniques used, and alternative methods of treatment.
5. The purpose and potential negative outcomes of treatment. Clients may refuse any treatment intervention or strategy.
6. The anticipated length and frequency of treatment and limitations that may arise due to difficulties in financing.
7. The liberty of clients to discuss any aspect of their therapy with others outside the therapy situation, including consultation with another therapist.
8. The status of the therapist, including therapist's training, credentials, and years of experience.
9. The maintenance of records, including security and length of time they are kept, client's rights to access personal records, and release policies.
10. The right to request a referral and the right to require the current therapist to send a written report regarding services to the qualified referred therapist or organization upon the client's written authorization.
11. The procedure followed in the event of the therapist's death/illness.

I consent to this consultation, have read and understand my rights listed above, and have reviewed the Client Bill of Rights.

Consent and Signatures

Patient Name:_____ Patient DOB:_____

Patient Signature: _____ Date: _____

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Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____ Date: _____

Revised: 5.8.2020

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Behavioral Emergency Center, Fairview Riverside: 612-672-6600 – Walk-in Emergency Center
Carver/Scott County Crisis 24-hour hotline: 952-442-7601
Dakota County Crisis 24-hour hotline: 952-891-7171
By Cell Phone in Metro: Call **CRISIS** (**274747)
By Cell Phone Statewide: Text MN to 741741

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