



AGREEMENT FOR PSYCHOTHERAPY SERVICES/ INFORMED CONSENT

Client 1 Name: _____ DOB: _____

Client 2 Name: _____ DOB: _____

Parent/Guardian 1 Name: _____

Parent/Guardian 2 Name: _____

Welcome to Ascend Family Institute, LLC (hereafter “Ascend”). It can take a lot of courage to enter into psychotherapy, particularly if you are unfamiliar with the process. This document is intended to help answer your practical questions, and we are more than happy to discuss any remaining concerns in person at your initial appointment.

This document contains important information about our professional services and business policies. Although these documents are long and sometimes complex, it is very important that you read them carefully. When you sign this document, it will also represent an agreement between us and become a part of your electronic medical record. You may revoke this Agreement in writing at any time. That revocation will be binding on us (and our clinic) unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

This agreement applies to all providers at all locations of Ascend Family Institute, LLC.

CONSENT FOR SERVICES

C1-P/G1: _____ C2-P/G2: _____ I have received and understand the Notice of Privacy Policy regarding my privacy rights per federal HIPAA laws.

C1-P/G1: _____ C2-P/G2: _____ I have received and understand the Minnesota Client Bill of Rights.

C1-P/G1: _____ C2-P/G2: _____ Consent for Services: With enough knowledge, and without being forced, I enter into psychotherapy with this provider. I will keep my provider fully up to date about any changes in my feelings, thoughts, and behaviors. When difficulties arise I will let my provider know so that we can address them in an honest and direct manner. I understand the basic goals and methods of psychotherapy and that my provider may use different methods of helping me and my family and/or minor child based on the unique factors associated with the presented needs. I have no important questions or concerns that the provider has not discussed with me. I understand that reaching the agreed upon therapeutic goal(s) is not guaranteed and that psychotherapy has varying levels of effectiveness for different individuals.

I also understand that my therapeutic goal(s) may evolve and change based on new insights and/or changes to my life situation.

I am agreeing to participate in the following types of services, while acknowledging that the course of psychotherapy may change, and the participants may change, by agreement of all required parties.

- _____ Individual Psychotherapy
- _____ Couples Psychotherapy
- _____ Family Psychotherapy
- _____ Group Psychotherapy

I also agree that the following individuals will be part of the psychotherapy process:

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Risks and Benefits: I further understand that the initial symptoms or problems presented may initially become more intense because confronting important questions about who I am and who I want to be may at times cause internal conflict. I understand the psychotherapy requires an active investment of various resources (emotional, time, financial, and others) that may lead to uncomfortable feelings like sadness, anger, or frustration. On the other hand, I understand psychotherapy has also been shown to have many benefits. Psychotherapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. I understand there are no guarantees of what I as an individual and/or my family or minor child will achieve as outcomes.

Alternatives: I understand there are many viable alternatives to psychotherapy, such as, but not limited to, self-help books, support groups, medication and other medical interventions, and psychotherapy interventions other than what is offered at Ascend Family Institute and that I am welcome to discuss any options with my provider at any time.

Couple and/or Family Psychotherapy: I understand that couple and family psychotherapy can be beneficial in maintaining healthy family relationships that can positively impact the physical and mental health of individual family members. However, family psychotherapy can also pose unique challenges because more than one person is involved in the process. I agree to the following regarding couple and family psychotherapy:

- Information discussed is for therapeutic purposes and is not intended for legal purposes
- Signing this agreement means that I will not subpoena information from psychotherapy and try to use it later in legal proceedings
- Phone calls, texts, or emails between sessions should be used primarily for scheduling purposes only and not to communicate information to the therapist that I do not want other family members to know, unless that information is related to my safety.

- Sometimes in the course of couple or family psychotherapy, the provider will have sessions that do not include all family members. In such cases, the provider will not report back to other family members what was discussed without the permission of the family member who shared the information. However, anytime the provider believes that the couple or family cannot make progress toward their stated goals, he or she reserves the right to terminate psychotherapy. While the provider will not pass information between family members when specifically asked not to, if the unwillingness to engage in open communication will hinder goals, psychotherapy will not continue. Providers are not secret-keepers in family systems.
- If a couple or family breaks up and a family member contacts the family provider for individual services, the family provider reserves the right to proceed according to his or her clinical judgment. Referrals for some family members may be provided when the provider anticipates a potential conflict of interest. The decision of which family member(s) continue in psychotherapy with the family provider is at the provider's discretion.

There may be times when the provider appears to take someone's side or be against someone else. The provider is on the side of the family or couple *relationship* and will do what he/she deems necessary to improve it.

Group Psychotherapy: I understand that if I participate in group psychotherapy, my identity may be disclosed to other group members, family members of other group members (ex. parent night in DBT group), or facilitators of experiential activities (ex. guest yoga instructor). I understand that my attendance at such events will be taken as my consent to participate. I also understand I can leave at any time if I don't feel comfortable. I also understand the provider will make every effort to let all other group participants, their family members, and other experiential facilitators know that the strictest confidentiality is expected of them but that Ascend Family Institute cannot guarantee the confidentiality of those individuals.

Differentiation from Other Services: Psychotherapy is a process by which concerns, symptoms, and behaviors are treated in the hopes of symptom reduction and increased overall functioning and satisfaction with life. Psychotherapy is not coaching (coaching is not reimbursable by insurance). Psychotherapy is also not a custody evaluation. When a custody evaluation is performed, it is an extensive process meant to provide recommendations related to parenting time outcomes for minor children. Because Ascend does not conduct custody evaluations, our providers also do not make the recommendations that would typically ensue from one.

PROFESSIONAL BOUNDARIES

I understand that psychotherapy is a professional relationship. Though my provider cares deeply about my life, the relationship is different from a friendship. This means I will not be friends with my provider on social media or see my provider outside of sessions simply because the professional boundaries for mental health providers do not allow for it. In addition, I understand ethical boundaries prevent my provider from having both concurrent personal and

professional relationships with me and/or my family members or from having a personal relationship with me following the termination of our work together in psychotherapy.

TERMINATION OF SERVICES

I understand that I can terminate therapeutic services at any time. When doing so, I agree to notify my provider and schedule a final session. I understand that if I miss three appointments in a row without informing my provider, he/she will begin the process of terminating my psychotherapy. If my provider believes there to be a conflict of interest, he or she may terminate services with me but will not do so without providing me with viable alternatives to seek treatment from another qualified professional.

If your provider leaves Ascend, you will be given the following options:

1. If your provider is able to see you at his/her new place of employment and you wish to continue with the same provider, you can make the choice to transition services to the new location.
2. If you would rather continue at Ascend, we will set up an intake appointment with a new provider.
3. If you would like information about providers outside Ascend (or no one at Ascend has a specific competency needed for your case), we will provide some referral options or resources for you to find referral options.

In the unfortunate circumstance that your therapist is no longer able to see you because of incapacitation or death, Ascend will work with you to find an alternative provider either within Ascend or someone else if a better fit for you happens to be outside our agency.

PSYCHOTHERAPY FEES

Services	Intern	Mental Health Professional/Practitioner
90791 Intake (60 min)	\$100	\$200
90832 Individual/Family Psychotherapy (30 min)	\$40	\$85
90834 Individual/Family Psychotherapy (45 min)	\$55	\$110
90837 Individual/Family Psychotherapy (60 min)	\$80	\$160
90846, 90847 Family Psychotherapy (45-50 min)	\$70	\$140
90853 Group psychotherapy session	\$50	\$50
90853, S9480, H2019 DBT Intensive Outpatient Group (90 minutes)	\$165	\$165
90785 Interactive Complexity (added on to codes above in appropriate circumstances)	\$10	\$16
90839 Crisis Psychotherapy (60 min)	\$110	\$225
90840 Crisis Psychotherapy (30 min add on to 90839 above)	\$55	\$115
Psychological Testing		

The fees listed above represent the fees Ascend Family Institute, LLC bills to your insurance company. The amount you are responsible for is the “allowed amount” on your explanation of benefits, which may be paid by the insurance company, owed by you, or a combination thereof. Total charges will not be known until your care is complete and your claims have been billed to and processed by the insurance company if you are using insurance to pay for your services.

I understand I am responsible for all charges not covered by my insurance company.

*Sliding fee scale available upon request for all cash clients seeing intern, mental health practitioner, or licensed mental health professional. Fees are as of September 1, 2016 and are adjusted periodically.

FINANCIAL AGREEMENT

I understand that if I am a parent seeking psychotherapy for a minor child, I am the financial guarantor of my client’s account. If I am an adult seeking services for myself, I am the financial guarantor of my own account. By signing below, I agree to the above fee schedule and understand payment (cash, check, Visa, MasterCard, Discover, or American Express) is due in full (including copays) at the beginning of each counseling session. I also agree to pay a fee of \$30 plus the amount of the check for any returned checks.

I understand the following regarding use of insurance or the sliding fee scale:

In-network Insurance: If I have insurance coverage with a company that Ascend Family Institute is **in-network** with, I have the following options:

C1-P/G1: _____ C2-P/G2: _____ Bill my insurance using an approved diagnostic code at the fees listed above

C1-P/G1: _____ C2-P/G2: _____ Pay the fee listed above in full (or on the sliding fee scale if my income is less than \$90,000 annually)

Out-of-network Insurance: If I have insurance coverage with a company that Ascend Family Institute is **out-of-network** with, I have the following options:

C1-P/G1: _____ C2-P/G2: _____ Bill my insurance using an approved diagnostic code (in which case I could be responsible for the difference between what my insurance covers and the *full* amount listed above, regardless of what the allowed amount would be for an in-network provider)

C1-P/G1: _____ C2-P/G2: _____ Decide not to use my insurance and pay in cash, using the sliding fee scale above, which is an objective fee scale based on my income and other factors

No Insurance Coverage: If I do not have insurance coverage, I have the following option:
C1-P/G1: _____ C2-P/G2: _____ Pay the fee listed above in full if my income exceeds \$90,000 annually
C1-P/G1: _____ C2-P/G2: _____ Pay the appropriate amount based on the sliding fee scale if my income is less than \$90,000 annually

The agreed upon fee per 50-minute session is _____.

Comments or notes about fees or fee arrangements:

Note: Should you become involved in any legal action in which you or someone else require the provider's participation, Ascend charges \$175 per hour for all time spent to meet our obligations, including but not limited to personal preparation, professional consultation, travel to and/or attendance at any legal proceeding. The extra fee is due to the sometimes complex nature of preparation and the extra costs that can be incurred for a provider while preparing. Clients will need to pay in advance of any legal preparation.

It is your responsibility to pay your balance within 30 days of receiving your bill. If your balance remains unpaid and you have not contacted Ascend to set up an agreed-upon payment plan with a credit card on file, Ascend reserves the right to send your account to collections after a bill remains unpaid for 60 days or longer.

I give permission for Ascend to utilize a collections agency to secure payment of my balance and share the necessary information with that agency if I have a bill that has been outstanding for more than 60 days.

CREDIT CARD AUTHORIZATION

I understand I am welcome to pay for my services in cash or check, or use my Visa, MasterCard or Discover debit or credit card. I understand Ascend follows the Payment Card Industry Data Security Standard (PCI DSS) set of requirements designed to ensure that all companies that process, store, or transmit credit card information maintain a secure environment for financial data.

C1-P/G1: _____ C2-P/G2: _____ I am choosing to authorize Ascend Family Institute to store my credit card information within their electronic record keeping system (maintained by Valant Medical Solutions) using Complete Merchant Solutions, LLC's (CMS) file vault, for which CMS and Deutsche Bank AG are the Guaranteed Parties.

Please choose one or more of the following options:

C1-P/G1: _____ C2-P/G2: _____ Recurrent Authorization: Please automatically charge my copays when I have a session on the date of service.

C1-P/G1: _____ C2-P/G2: _____ Recurrent Authorization: Please charge my card for my sessions as they occur (and process to insurance, if applicable) and any other fees that I incur.

C1-P/G1: _____ C2-P/G2: _____ Recurrent Authorization: Please charge my card on the 15th day of each month for my entire balance.

I understand that if I fail to make payments owed for attended sessions, if I do not attend a scheduled session, or if I cancel a session less than 24 hours from the start time of the session, and do not make the required payment(s) within 7 business days, Ascend Family Institute, LLC has my permission to charge the card listed above according to the Cancellation Policy/No-Show Policy below. I understand that if I am having difficulty paying I can speak with my therapist about alternative arrangements.

CANCELLATION POLICY/NO-SHOW POLICY

I understand I am welcome to come to any part of my scheduled session, even if I have to be late. If I am running late, I will call my provider to let him/her know. If I need to cancel or reschedule an appointment, I will give my provider twenty-four (24) hours' notice. **I understand failure to attend a session without giving notice will result in a fee equal to the full amount for the session and that this fee cannot be billed to my insurance meaning I will be responsible to pay it in full.** I also understand that canceling a session with less than twenty-four (24) hours notice will result in a \$100 fee, or the cost of my full session if my agreed upon fee per session is less than the late cancel fee. I understand that exceptions for unforeseen or unavoidable situations are at the discretion of the provider. I understand that I will not be charged if I have a death in my immediate family or an emergency hospitalization for myself or an immediate family member. I also understand that insurance will not cover the payment for a missed appointment or a late cancel fee. **You may call 763.244.4900 to make any necessary changes to your appointments times and schedule.**

Should a client have three no show/no cancellation occurrences, the client will no longer be allowed to schedule future appointments. However, should the client desire to continue therapeutic services, the client may call in the morning he or she wishes to have an appointment and request a same-day appointment. If the clinician has availability in his/her schedule, the client will be given the opportunity to obtain the appointment slot.

CONFIDENTIALITY (AND EXCEPTIONS TO CONFIDENTIALITY)

Federal and state law, as well as ethical codes protect the privacy and confidentiality of both your identity as our client and the information you share with us. You should be aware that we practice with other mental health professionals and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have

been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

Under the rules governing mental health professionals in Minnesota, a provider or counselor, and employees and professional associates of the provider, must not disclose any private information that the provider, employee, or associate may have acquired in rendering services except as follows:

- When state law mandates the report of suspected abuse or neglect of a child or vulnerable adult or prenatal exposure to drugs and alcohol.
- When failure to disclose the information presents a clear, present, and imminent danger to the health or safety of any individual (including but not limited to threat of suicide or homicide).
- When records are subpoenaed by the courts or other regulatory agencies, including the following:
 - When the person, employee, or associate is a defendant in a civil, criminal, or disciplinary action arising from the psychotherapy. If a client files a complaint or lawsuit against us, we may disclose relevant information regarding that client in order to defend ourselves.
 - When the patient is a defendant in a criminal proceeding and the use of the privilege would violate the defendant's right to a compulsory process or the right to present testimony and witnesses in that person's behalf.
 - If a government agency, pursuant to their lawful authority, is requesting the information for health oversight activities, we may be required to provide it for them. Also, if a client identifies a health professional and discloses that the health professional has violated his or her ethical code when treating a client/patient, including but not limited to initiating sexual contact with a client/patient throughout the term of treatment or within two years of the termination of treatment, the appropriate board must be notified.
 - If a client files a workers' compensation claim, we must, upon appropriate request, disclose information related to the claim to appropriate individuals, which may include that client's employer, the insurer or the Department of Labor and Industry.

If you are involved in a court proceeding and a request is made for information concerning the professional services we provided for you, such information is protected by the privilege law. We cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order Ascend to disclose information.

I understand the provider is required to participate in legal proceedings when court-ordered, and I understand the provider's fee for involvement in legal proceedings.

- When a client is a minor, parents have access to records. Minor clients can request, in writing, that particular information not be disclosed to parents. Such a request should be discussed with the provider. As a general rule, all minor clients under the age of eighteen (except when the minor is married or has born a child) must have the consent of their parents or guardians to receive on-going therapeutic services. Parents who share joint legal custody BOTH need to consent for ongoing mental health services for their child(ren). **I understand that when a client is a minor, parents have access to records and that the provider can withhold records anytime that harm could come from records being released.**
- When the provider presents the case in consultation with other professionals, supervisors, or consultants, who are bound by the legal framework of privacy and confidentiality, for professional development and guidance purposes. Similarly, we may use examples from your case, without revealing personal details that could identify you, when training other students and providers. **I give permission to this provider to present my case in consultation with other professionals, supervisors, or consultants, who are bound by the legal framework of privacy and confidentiality, for professional development and guidance purposes and to use examples from my case that would not identify me when training other students and professionals in the field of mental health.** It is assumed that your provider may consult with other providers who work for Ascend Family Institute, LLC, whether or not those other providers are also working on your case, to get feedback about how to best provide your care. Also, if your provider is unlicensed as a mental health professional in the state of Minnesota, he or she is under supervision, inside and/or outside Ascend Family Institute, and will receive feedback about your care from his/her supervisors.

Unlicensed staff indicate name(s) and contact information for current supervisor(s) here:

- Deb Link (deb@ascendfam.com and 763.244.4900)
- Jenn Knapp (jenn@ascendfam.com and 763.244.4900)
- Samantha Colai (samantha@ascendfam.com and 763.244.4900)

- Client authorizes this provider (Ascend Family Institute LLC) to release any information necessary to process insurance claims. By doing so the client authorizes payment of medical benefits to this provider (Ascend Family Institute LLC) for mental health services. Ascend Family Institute LLC cannot guarantee confidentiality of records held by insurance companies. You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. We are required to provide a clinical diagnosis. Sometimes we

are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we 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. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we can provide requested information to your carrier. **I give permission to this provider to release any information necessary to process insurance claims.**

- All other private information must be disclosed only with the informed consent of the client. When a patient agrees to a waiver of the privilege accorded by this section, and in circumstances where more than one person in a family is receiving psychotherapy, each such family member agrees to the waiver. Absent a waiver from each family member, a marital and family provider cannot disclose information received by a family member.

ELECTRONIC HEALTH RECORDS DISCLOSURE

Ascend keeps and stores records for each client in a record-keeping system produced and maintained by Valant Medical Solutions. Ascend uses Navicure as a claims clearing house to store, process, and transmit claims to 3rd party payers. In addition, Ascend uses Microsoft Office 365 as an email server and for document storage (documents and emails stored on Microsoft Office 365 are accessed via the Internet and via laptops owned by Ascend or by staff members of Ascend), as well as communication between providers. Our VoIP phone services and electronic fax services are provided through Intermedia Net, Inc. These systems are all “cloud-based,” meaning the records are stored on servers which are connected to the Internet. Here are the ways in which the security of these records is maintained:

- Ascend has entered into a HIPAA Business Associate Agreements with Valant Medical Solutions, Inc., Navicure, Microsoft, and Intermedia Net, Inc. Because of this agreement, Valant Medical Solutions, Inc., Navicure, Microsoft, and Intermedia Net, Inc. are all obligated by federal law to protect these records from unauthorized use or disclosure. Other professionals who have access to Protected Health Information, or PHI (collections agency, accountant, etc.) have also entered into a business associate agreement with Ascend.
- The computers on which these records are stored are kept in secure data centers, where various physical security measures are used to maintain the protection of the computers from physical access by unauthorized persons.
- Valant Medical Solutions, Inc., Navicure, Microsoft, and Intermedia Net, Inc. employ various technical security measures to maintain the protection of these records from unauthorized use or disclosure.
- Ascend has its own security measures for protecting the devices that we use to access these records:

- On computers, we employ firewalls, antivirus software, passwords, and full disk encryption through File Vault (Apple) or BitLocker (Windows) to protect the computer from unauthorized access and thus to protect the records from unauthorized access.
- When providers access the records via the Internet from a personal computer or other electronic device that does not have the above precautions, such as full disk encryption, Ascend's policies prohibit staff from downloading any documents onto their personal computer from the online records keeping system.
- As a general rule, Ascend does not allow staff to access electronic medical records via mobile devices. When mobile devices are used, we use passwords, remote tracking, and remote wipe to maintain the security of the device and prevent unauthorized persons from using it to access my records.
- Other devices that contain PHI, such as thumb drives, are stored inside a locked punch button key box that requires a staff member to enter a digital code to open.
- Because our documents and records are all stored electronically in cloud-based programs, we do not back-up data to any physical servers or external hard drives. The backed-up data is stored in a manner consistent with our business associate agreement with Valant Medical Solutions, Inc., Navicure, Microsoft, and Intermedia Net, Inc.

Here are things to keep in mind about Ascend's record-keeping system:

- While our record-keeping company and Ascend both use security measures to protect these records, their security cannot be guaranteed.
- Some workforce members at Valant Medical Solutions, Inc., Navicure, Microsoft, and Intermedia Net, Inc., such as engineers or administrators, may have the ability to access these records for the purpose of maintaining the system itself. As a HIPAA Business Associate, Valant Medical Solutions, Inc., Navicure, Microsoft, and Intermedia Net, Inc. is obligated by law to train their staff on the proper maintenance of confidential records and to prevent misuse or unauthorized disclosure of these records. This protection cannot be guaranteed, however.
- Valant Medical Solutions, Navicure, and Microsoft, keep a log of Ascend's transactions with the system for various purposes, including maintaining the integrity of the records and allowing for security audits. These transactions are kept for an indefinite period of time by Valant Medical Solutions, Inc. (they have yet to archive but would likely keep records for 7 years if they did according to communication between Ascend and Valant in 2015), for 6 years by Navicure (2 years in a format accessible to clients), and 5 years by Microsoft.

I understand Ascend Family Institute stores my health record electronically in compliance with various state and federal laws and that I can opt out of having my record stored electronically but that doing so may prevent me from being able to use my health insurance to pay for services. I understand my electronic health record will contain a patient portal and that I should

use that (or my provider's private voicemail) as a primary means of communicating with my provider if necessary outside of session.

Lastly, at times, Ascend may need to store paper records that are part of your medical record or otherwise associated with your medical file that contain your PHI. In these situations, Ascend has file cabinets that are locked to store these kinds of paper records. The keys to these filing cabinets are stored inside a locked punch button key box that requires a staff member to enter a digital code to open.

Ascend maintains records for 10 years past the final date of service for adults and 10 years past the 18th birthday for minors.

TELEHEALTH SERVICES

I consent to engaging in telehealth with Ascend Family Institute and my provider, specifically, as a part of the therapy process and my treatment goals. I understand that telehealth psychotherapy may include mental health evaluation, assessment, consultation, treatment planning, and therapy. Telehealth will occur primarily through interactive audio, video, telephone and/ or other audio/video communications.

Technology: I understand that I will need to download an application and/or software to use this platform. I also need to have a broadband Internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services. I understand I a need to take precautions on my end to ensure privacy in the setting I choose to engage in telehealth appointments. I further understand my provider will be providing me a link to a secure platform within Doxy.me to engage in services and my provider will ensure HIPAA compliance and security from the location they are engaging in services.

I also understand that in case of technology failure, I may contact my provider via phone to coordinate alternative methods of treatment.

I understand that using the Telemedicine platform allows access to mental health services that might not otherwise be available to me due to my mental health, and/or my physical, resource, or geographic limitations.

Scheduling: I understand that scheduling is conducted through my provider and is based on my provider's normal clinic hours. Telemedicine appointments are considered outpatient services and not intended as a substitute for emergency or crisis services. Crisis or mental health emergencies should be directed to the local county crisis line or by dialing 911.

I understand I have the following rights with respect to telehealth:

1. I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.

2. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, all the limitations to confidentiality previously reviewed in our Informed Consent remains true for telehealth services. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

3. I understand that there are risks and consequences from telehealth including but not limited to, the possibility, despite reasonable efforts on the part Ascend Family Institute that: the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons.

4. In addition, I understand that telehealth based services and care may not be as complete as in-person services. I understand that if my therapist believes I would be better served by other interventions I will be referred to a mental health professional who can provide those services in my area. I also understand that there are potential risks and benefits associated with any form of mental health treatment, and that despite my efforts and efforts of my therapist, my condition may not improve, or may have the potential to get worse.

5. I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured. I understand that the use of Doxy.me, and audio/video systems are not 100% secure and may have issues with wifi issues with these communication systems. Signing this form shows an awareness of these issues and a decision by this client to use these systems for telehealth services. I will not hold Ascend Family Institute or its staff liable for gathering or use of client information by these service providers.

6. I understand I have the right to access my personal information and copies of case notes. I have read and understand the information provided above. I have discussed these points with my therapist, and all of my questions regarding the above matters have been answered to my approval.

7. By signing this document I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer based psychotherapy services. If I am in crisis or in an emergency I should immediately call 911 or go to the nearest hospital or crisis facility. By signing this document I understand that emergency situation may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if I am in a life threatening or emergency situation, and/or if I am abusing drugs or alcohol and are not safe. By signing this document, I acknowledge I have been told that if I feel suicidal I am to call 911, local county crisis agencies or the National Suicide Hotline at 1-800-784-2433.

COMMUNICATIONS POLICY

I understand that, in most circumstances, Ascend upholds the following communication expectations and commitments:

- Administrative staff are available during most business hours to handle scheduling and billing questions as well as general questions about services provided. The best way to get such questions answered is to call the main number at 763.244.4900. We request that you channel administrative questions to administrative staff rather to your provider.

- For confidential questions, each therapist has a voicemail box that can be reached by calling 763.244.4900. Therapists try to get back to those who leave messages within 48 hours. However, most of our therapists are part time and may not receive messages for a few days. Please feel free to contact the main number and speak to administrative staff if you have left a message and not received a response.
- I understand my electronic health record will contain a patient portal and that I should use that (or my provider's private voicemail) as a primary means of communicating with my provider if necessary outside of session. Therapeutic exchanges are preferably handled via the secure client portal in Valant and cannot be handled outside of that via any electronic means without the consent below being completed. Due to time constraints, providers may not respond to any messages throughout the week that are not critical in nature and may respond to your concerns during your next scheduled session.
- In a crisis or emergency, appropriate communication methods will be utilized to promote safety in a way that poses the least amount of risk to client confidentiality.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I understand that Ascend's electronic health record, Valant, includes a patient portal where I can download copies of relevant forms and communicate back and forth with my provider in a secure environment. I also understand that it is Ascend's preference that I use this feature to communicate with my provider, especially when I am sharing highly-sensitive or private clinical information about myself.

I understand that if I deem it useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication, I need to be informed that these methods, in their typical form, are not confidential means of communication. If I use these methods to communicate with Ascend, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in my home or other environments who can access my phone, computer, or other devices that I use to read and write messages
- My employer, if I use my work email to communicate with Ascend
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

I consent to allow Ascend to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

C1-P/G1: _____ C2-P/G2: _____ Information related to the scheduling of meetings or other appointments

C1-P/G1: _____ C2-P/G2: _____ Information related to billing and payment

C1-P/G1: _____ C2-P/G2: _____ Completed forms, including forms that may contain sensitive, confidential information

C1-P/G1: _____ C2-P/G2: _____ Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment

C1-P/G1: _____ C2-P/G2: _____ My health record, in part or in whole, or summaries of material from my health record

C1-P/G1: _____ C2-P/G2: _____ Other information. Describe: _____

C1-P/G1: _____ C2-P/G2: _____ All of the above

BY THE FOLLOWING NON-SECURE MEDIA:

C1-P/G1: _____ C2-P/G2: _____ Unsecured email.

C1-P/G1: _____ C2-P/G2: _____ SMS text message (i.e. traditional text messaging) or other type of "text message."

C1-P/G1: _____ C2-P/G2: _____ I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that complete security of unencrypted email cannot be guaranteed. I understand and accept these risks, including but not limited to the possibility the email could be intercepted, the ability for an employer to save and read emails on a company server, the possibility of others logging in an email account and viewing the content, information that was deleted being saved in a computer's operating system, typos leading to messages being sent to unintended recipients, and/or email being used a means of spreading computer viruses. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time. I also understand that Ascend Family Institute has secure messaging available via my patient portal in Valant, their electronic medical record software. Even still, I authorize Ascend Family Institute, LLC communicate with me via unsecured email and SMS text messaging as described above for the purposes described above (scheduling, billing, sending forms or records, communicating about clinical information). I also understand that I incur the risk involved in transmitting clinical information through non-secure electronic means and that this authorization will terminate 60 days after I have been discharged from care by Ascend Family Institute. I understand this authorization to communicate by nonsecure means stays in effect until I cancel it in writing. **I also understand email is not an appropriate means of communicating about any emergency information and that Ascend's phone (763.244.4900), crisis connection, crisis hotlines, and 911 should be used instead depending on the level of emergency.**

The email address I would like to use for nonsecure communication with Ascend Family Institute, LLC is:

C1-P/G1: _____ C2-P/G2: _____

I understand it is my responsibility to update this email address with Ascend Family Institute if I would prefer an alternate address be used to communicate with me electronically.

I understand that email correspondence to and from Ascend Family Institute, LLC becomes a part of my permanent medical record.

AUDIO/VIDEO RECORDING

To protect the privacy of all clients in the office, absolutely no audio or video recording by clients is allowed, whether overt or in secret, on any device, including a smart phone. If Ascend Family Institute, LLC video or audio records in the office, the client is informed first.

ACCESS TO MEDICAL RECORDS

The laws and standards of our profession require that we keep Protected Health Information about you in your Clinical Record. Unless your provider believes viewing your record could be harmful to you or another person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.

EMERGENCY PROCEDURE

In the event of a life-threatening emergency, call 911. If I have another crisis that cannot wait I am aware I can call the Crisis Connection at 612-379-6363.

My signature on this AGREEMENT FOR PSYCHOTHERAPY SERVICES/INFORMED CONSENT means I have reviewed, understand, and consent to everything above and indicates my consent to participate in psychotherapy at Ascend Family Institute, LLC.

CONTACT INFORMATION AND CHANGES TO PERSONAL INFORMATION

It is your responsibility to inform Ascend as soon as possible regarding any changes to your personal or contact information that would affect our ability to contact you, secure payment from you, or bill your correct insurance.

Ascend Family Institute, LLC may leave information on my voicemail or answering machine at these numbers:

Client 1: Home: _____ Cell: _____ Work: _____
Please share: Scheduling information Medical information Billing Information

Client 2: Home: _____ Cell: _____ Work: _____
Please share: Scheduling information Medical information Billing Information

Client 1 Signature: _____ Date: _____

Client 1 Printed Name: _____

Client 2 Signature: _____ Date: _____

Client 2 Printed Name: _____

Parent/Guardian 1 Signature: _____ Date: _____

Parent/Guardian 1 Printed Name: _____

Parent/Guardian 2 Signature: _____ Date: _____

Parent/Guardian 2 Printed Name: _____

Provider Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Provider Signature: _____ Date: _____