Bridges and Pathways Counseling Services
Twin Cities

Signature/Client Consent Form

Client Name ____

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating you have fully read and understand the information below.

CLIENT/THERAPIST RELATIONSHIP: You and your therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

AVAILABLE SERVICES: Bridges and Pathways Counseling Services offers a wide array of counseling services, including individual, family, couples, and group services. We are staffed by skilled and experienced licensed marriage and family therapist, licensed clinical social workers, and doctors of psychology. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is our intent to convey the policies and procedures used in our practice, and we will be pleased to discuss any questions or concerns you may have.

RISKS AND BENEFITS: Psychotherapy is a way of talking through your problems in order to begin resolving them. You will need to take an active part in psychotherapy by working on and thinking about the issues you share with your therapist. Psychotherapy has been shown to have many benefits. However, there are no guaranteed results, and at times you may experience uncomfortable feelings. Your work in psychotherapy may lead to feeling less distress, better relationships and solutions to problems.

COUNSELING: We provide counseling designed to address many of the issues our clients are dealing with. Your first visit will be an assessment session in which you and your therapist will determine your concerns and, if both agree that your therapist can meet your therapeutic needs, develop a plan of treatment. Your treatment plan is an active and flexible plan that you and your therapist will review and revise as appropriate.

If you desire to use your medical insurance to cover therapy, your therapist is required by insurance to administer a diagnostic assessment with you the first session so that it can be determined if you are eligible for a diagnosis. Insurance companies require a mental health diagnosis before reimbursing for a therapy session.

The goal of psychotherapy is to provide the most effective therapeutic experience available to you. If at any time you feel that you and your current therapist are not a good fit, please discuss this matter with your therapist to determine if transferring to a more suitable therapist is right for you. If you and your therapist decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs.

Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. Our services are designed to provide our clients an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

EMERGENCIES: If an emergency arises after hours or on a weekend, you may Google: ***Mobile Crisis Mental Health Services,*** and locate the emergency mental health service in your county. If you are experiencing

a life-threatening emergency, call 911 or go to your nearest emergency room. You may leave a message with your therapist, who will call you back as soon as possible.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent sessions may be available if determined appropriate by your therapist. **If you must cancel or reschedule your appointment, we ask that you call your therapist at least 24 hours in advance. This will free your appointment time for another client. There is a charge for a late cancellation. Please consult with your therapist about the fee for late cancellations.**

FEE SCHEDULE: Please consult your medical insurance company about your insurance coverage. As an independent contractor, each therapist will set his/her own fees. Each therapist will have their own fees for writing reports, phone calls, and legal proceedings. If you need to make arrangements for paying your fees, please talk with your therapist.

PAYMENT/INSURANCE FILING: Payment of fees, including any required co-pays, is expected at the time of each appointment. We request that payment be made before your session begins. If you are using insurance benefits, Bridges and Pathways Counseling Services will file insurance claims for you, and we will honor any contractual agreements with managed health care companies that have specific reimbursement restrictions and claim requirements. If you are not using insurance, we expect full payment at the time of service, and we will provide you with a statement for services rendered. Outstanding balances of 90 days will be sent to a bill collecting service.

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of the undersigned therapist, it will be necessary to assign my case to another therapist and for that therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

EMERGENCY AUTHORIZATIONS
In the event that my therapist may have an emergency and my therapist is unable to contact me directly,
I authorize the therapists and staff members at Bridges and Pathways Counseling Services access to my contact information so that I can be contacted regarding the status of my therapist and my appointments.

May contact me by phone ___yes ___no
Phone numbers(s): ____
May contact me by letter ___ yes ___ no

DUTY TO WARN/DUTY TO PROTECT: If my therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my therapist to contact the/any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Print Name(s):	Telephone Number(s):
________________________________	______________________
________________________________	______________________

CONFIDENTIALITY: Bridges and Pathways Counseling Services follows all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Please see our Notice of Privacy Practices.

Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law or as described below. Possible exceptions to confidentiality include, but are not limited to, the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose; fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the licensing or certifying board.

Email and Other Electronic Method Contact:
Also, the confidentiality, security and privacy of information transmitted by email or text messages over the Internet cannot be assured because no one can guarantee the absolute security of the Internet. We prefer not to initiate a conversation with you by means of email or text messages and the best means of preserving the confidentiality, privacy and security of your information is to refrain from using email and text messages to communicate with us. Your transmission of email or text messages to us after you sign this form constitutes your (a) acknowledgment of such lack of guaranty of confidentiality, privacy and security, (b) consent that we may receive your messages and rely and act on them on your behalf and respond to such messages by the same means and (c) waiver, release and hold harmless of us regarding any claim you may have against us for our receipt of and reply to your messages and any interception or disclosure of your messages by an unauthorized third party.

Cellular Phone Contact Policy – By providing us with a telephone number for a cellular phone or other wireless device, you are expressly consenting to receiving communications – including but not limited to prerecorded or artificial voice message calls, text messages, and calls made by an automatic telephone dialing system – from us and our affiliates and agents at that number. This express consent applies to each telephone number that you provide to us now or in the future and permits such calls regardless of their purpose. Calls and messages may incur access fees from your cellular provider.

Consent to Receive Automated or Prerecorded Communication:
By my signature below. I indicate my consent to receive automated and/or prerecorded phone calls and text messages from (Provider) or its business associates, regarding my account or health care, on my residential phone line and/or cellular phone. I understand that if I do not wish to receive such automated and/or prerecorded phone calls and text messages, I may indicate such preferences here:

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If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time.
NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, your therapist will not render services to your child until the therapist has received and reviewed a copy of the most recent applicable court order.

I have reviewed this document and I have received the opportunity to ask my therapist questions about it.

I hereby authorize the release of necessary medical information to my insurance company for insurance reimbursement purposes.

I further authorize the release of the minimum amount of my personal health information necessary to the billing service utilized by Bridges and Pathways: Billerbee Services.

I hereby instruct my insurance company to pay directly to Bridges and Pathways or directly to my therapist all benefits allowable and payable under my policy.

I understand that I/we are responsible for as well as guarantee payment of all charges and any unpaid balances not covered by my/our medical insurance.

____ ____
Signature – Client/Parent Date

____ ____
Signature – Spouse or Partner (If spouse/partner will be involved in therapy) Date

____ ______________________ Copy provided:___
Therapist Date

Revised November 2021