6901 S Lyncrest Place Ste 105
Sioux Falls, SD 57108
605-335-1516

INFORMED CONSENT

This document contains important information about the professional services and business policies of WellSpring Therapy Center. Please read it carefully and ask any questions you might have. Once you sign this, it will constitute your therapy agreement with WellSpring Therapy Center.

Psychotherapy

Psychotherapy is a cooperative effort between the client and the therapist. Your therapist may be trained in a variety of therapies including brief therapy, solution focused therapy, cognitive behavioral therapy, EMDR, and other therapies. Your therapist will decide which type of therapy is best for you. Psychotherapy has been proven to have significant benefits for people who are willing to be active participants in the process of change. Being an active participant may mean that you engage in problem solving, explore new ideas and feelings, and practice new skills. You may, at times, find your work in therapy to be both challenging and rewarding mentally, emotionally, and even physically as you engage in the process of change. We encourage you to ask questions and offer ideas regarding your treatment. If at any time you wish to terminate therapy, please discuss it openly with your therapist.

Appointments

Therapy sessions vary in duration and frequency according to your needs. Typically, a session will last 45-50 minutes. Once you have scheduled an appointment you must provide 24-hour notice of cancellation. If you fail to provide this 24 hour notice you will be billed the full fee for the missed appointment. Your insurance will not be billed for your missed session. We understand that emergencies do arise and we encourage you to inform us of those situations. We invite discussion of any misunderstandings that may occur about appointments.

We can send you an appointment reminder by email. The appointment reminder will include only the date and time of you appointment and your service provider name. We will not encrypt the messages. Health care information sent by regular e-mail could be lost, delayed, intercepted, delivered to the wrong address, or arrive incomplete or corrupted. If you understand these risks and would like to receive an appointment reminder by email, we need you to confirm you accept responsibility for these risks, and will not hold us responsible for any event that occurs after we send the message. Initial _________

Confidentiality

In general, the law protects the confidentiality between a client and the therapist. However, there are the following exceptions:

1) The client authorizes the release of information with a signature.
2) The therapist is ordered by the court to release information.
3) The client presents a physical danger to self or others.
4) There is evidence or reasonable suspicion of child/elder abuse and/or neglect.

Minors seen in individual session are not legally entitled to confidentiality; rather, their parents have this right. However, unless the minor feels that he/she has some privacy in speaking with their therapist, the benefits of therapy may be lost. Therefore, it will be necessary for you, your child, and the therapist to work out an arrangement in which your child feels that privacy is being respected, while at the same time you have access to critical information. This will be a verbal agreement between the three parties.

You should be aware that most insurance agreements require you to authorize your therapist to provide a diagnosis, and sometimes additional clinical information such as a treatment plan. When an insurance company requests an entire record we obtain written permission from the client prior to releasing this information.

Contacting Your Therapist

When your therapist is unavailable, please leave a message. We will make every effort to return your call on the same day with the exception of weekends and holidays. If it is an emergency and you cannot wait for us to return your call, you should do one of the following:

1) Call your psychiatrist or medical doctor.
2) Dial 911 for emergency medical attention.
3) Go to the nearest emergency room.

Fees, Billing and Payment

WellSpring Therapy Center is committed to providing the best therapy for our clients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. The fees for services will be discussed in your first session. In some situations where clients have no insurance and limited financial resources payment arrangements can be made with the therapist.

Many insurance companies provide some coverage for mental health treatment. However, you, and not your insurance company, are responsible for the full payment of your bill. Therefore, it is very important that you find out exactly what your policy covers. You can do that by referring to your policy handbook, or by calling the 800 number on your insurance card.

You are expected to pay your co-pay or co-insurance on the day of service. You may also have a deductible which is determined by your insurance company. Forms of payment accepted are cash, check and credit card. Discrepancies between what you pay and what your insurance company says you owe will be reconciled as soon as we receive notification from your insurance company.

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. Interest will accrue at the rate of 1.25%/month (15% annual) on the unpaid balance after 90 days from the initial billing date. If your bill is delinquent and suitable arrangements for payment have not been agreed to, WellSpring Therapy Center has 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.

Contract

Please take the opportunity to discuss any and all questions and concerns you have regarding this contract with your therapist. A copy of this agreement will be kept in your clinical record. You will also be provided a copy for your personal records.

My signature below indicates that I have read the information in this document and agree to abide by its terms during my professional relationship with my therapist.

Signature of Client: ____ Date: ________________
(parent if client is minor)

Signature of Therapist: ____ Date: _________________

Effective 7/1/2018 the fees for therapy at Wellspring Therapy Center are as follows:

Service	Fee
Initial Intake	$200
30 minute session	$85
45 minute session	$120
60 minute session	$170

These rates are in line with insurance payouts and usual and customary rates in the area.

Co-pay and Co-insurance amounts are determined by your insurance company and due on the date of service.

I acknowledge receipt of this fee schedule and have been given opportunity to discuss it with my therapist.

____ ____________________
Name Date

____ ____________________
Therapist Date

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Therapist Date