ALPHA ELEMENT COUNSELING
Treatment Agreement

Crisis Situations. Steps to take during a crisis will depend upon the nature of the crisis. You may call your individual therapist during normal business hours and then the Crisis Connection at 612-379-6363 after business hours, weekends and holidays. When immediate service is required for life threatening situations, please call 911 or go to the emergency department at the closest hospital.

Confidentiality. Please understand that what you say is CONFIDENTIAL and will be discussed with other people only with your written permission (except in medical emergencies, under a court order, or as required by law, i.e. mandatory child abuse reporting, and vulnerable adult abuse reporting or for the purpose of consultation or supervision). If there is a clear intention to do serious harm to self or to another person, information will be shared in an attempt to prevent harm from occurring. If a minor child is seen, issues regarding confidentiality will be discussed with the parents.

Emails and text messages do not provide sufficient confidentiality. You may put things in writing to us, and request that we do the same for you, however we cannot guarantee that our security will never be breached.

Name: ____

Email Address: ____

Phone: ____

Address: ____

____

Client Signature: ____

The next is not a legal exception to your confidentiality. However it is a policy you should be aware of if you are in COUPLES or PARTNER THERAPY with us: If you or your partner have some individual sessions as a part of couples therapy whatever you say in those individual sessions will be considered to be a part of couples therapy and can and probably will be discussed in our joint sessions.

Record-keeping, Requests from Third Parties for Records, Testifying Regarding Records, and Related Costs. Our records are confidential and may not be used as evidence for litigation purposes. This includes all assessments, questionnaires, evaluations, and testing. If you are involved in litigation, you or your non-health care advisors may not subpoena our documents or use as evidence in any proceeding any communication or documents related to the therapy process. Be advised that if we are somehow compelled to release documents, you as a client acknowledge and grant the right for us to give identical documents to the opposing party. If we are forced to further document or respond to information requests, meet with your representatives, or testify in court our fees are $400/hour, portal to portal, plus all expenses, half day minimum, paid in advance. Agreement to this provision is required to receive therapy services from us, and is acknowledged by your signature at the end of this document.

Note: Therapy ends when a subpoena arrives. We will attempt to legally resist a subpoena request to give your confidential records to legal counsel. We prefer to send directly to the Judge. Therapy summarization documents for legal purposes require written client release and cost $250 per request. I understand and agree to abide by the policies stated above.

Client Signature ______________________________________ ________________________

Date ______________________________________

Parent Signature ______________________________________ ________________________

Health Information Privacy Practices. I have received the Health Information Privacy Practices notice and I have been provided an opportunity to review it.

Name____

Signature____Date_______________

Private Practice of Ingrid Serck-Hanssen, MBA, MS, LPCC
Client Information Form

General Information

Name: ____

Date:_______________

Address: ____

City/State: __________________________ Zip:_________

Home/Cell Phone: _____________________________________

Work Phone: ___________________________________

Email Address: _____________________________________

Is it OK to leave you a VM on your home / cell phone? ____ At work? ____
Is it OK to communicate with you via email? _____
Best time to reach you? __________________________

DOB:___________ Gender: M______F______T_______Ethnicity: _______________

Employment: ____________________________________ Level of Education: ________

Referred by:
____

What concerns brought you to seek counseling?

____

____

Have you addressed these concerns in the past?

____

____

What would you like to accomplish in therapy now?

____

____

Medical Information

Would you describe your physical health as (circle one):

Excellent Good Average Poor

Describe your current diet, exercise, spiritual practices, meditative activities and chronic health problems:

____

____

____

____

Please check all the symptoms you are currently experiencing:

___ Depression ___ Weight Changes ___ Difficulty Concentrating

___ Panic Attacks ___ Perfectionism ___ Difficulty Sleeping

___ Body aches/pains ___ Nightmares ___ Anxious / Tense

___ Lonely / Isolated ___ Suicidal ___ Inferiority Feelings

___ Hearing Voices ___ Low Energy ___ Confusion

___ Rage ___ Feelings of Hopelessness

Health Care Provider: ______________________

Date of you last physical exam: ______________

Please circle previous mental health providers

Therapy Hospitalization Other

Please list current involvement with other mental health providers: ____________________

____

Current Medications: ____

____

Family and Significant Relationship Information

List parents, siblings, and or other significant members in your household growing up:

Name	Gender	Current Age	Relationship

How was it like for you to grow up in your family?

List members in your current household:

Name **Gender** **Current Age** **Relationship**

____

____

____

____

____

Substance use history:

Check if appropriate	**You**		**Family Member**		**Spouse / Partner**	
	Past	Present	Past	Present	Past	Present
Substance and/or alcohol abuse						
Neglect/abuse/family violence						
Sexual assult						
Emotional abuse						
Chronic physical pain						

Describe your current support network:

Is there any additional information that can be helpful to share with me?

ALPHA ELEMENT COUNSELING

Counseling and Financial Agreement

Thank you for trusting Ingrid Serck-Hanssen, MBA, MS, LPCC with your health care needs. Ingrid Serck-Hanssen, MBA, MS, LPCC is committed to your treatment being successful. Ingrid Serck-Hanssen, MBA, MS, LPCC is a fee for service provider. Please understand that payment of your bill is considered part of your treatment. Please see below the financial policy, which you must read, agree to, and sign prior to any treatment.

Each appointment is typically scheduled for 60 minutes. The fee for the intake session in the event it extends to two hours, is $180.00. Individual sessions are at a rate of $120.00 per 60 minutes and couples or family therapy sessions are at a rate of $160.00 per 60 minute sessions. Missed appointment or late cancellations (notice less than 24 hours in advance) will result in a one-half charge the first time and a full charge a second time and thereafter. Payment for missed appointment or late cancellations will need to be collected prior to the onset of your next appointment.

Payment methods include cash, checks, Visa and Mastercard.

Some of your counseling cost might be covered by your out of network benefit programs. Please check with your insurance company. If you have a Health Savings Account (HSA) coverage, this may be used to pay for some or all of your counseling services. By signing this agreement, you agree to assume the responsibility to collect from your HSA or network benefit program.

My signature below indicates that I have read and understand the above policies and agree to accept responsibility for the charges that I incur. My signature also authorizes permission of treatment to myself or my minor child.

Print Client or Parent/Guardian: ________________________________

Signature: _____________________________Date: ________________

MENTAL HEALTH CLIENT BILL OF RIGHTS

All mental health practitioners, other than those providing services in a facility or program licensed by the commissioner of health or the commissioner of human services, shall provide to each client prior to providing treatment a written copy of the mental health client bill of rights. A copy must also be posted in a prominent location in the office of the mental health practitioner. Reasonable accommodations shall be made for those clients who cannot read or who have communication impairments and those who do not read or speak English.

"THE STATE OF MINNESOTA HAS NOT ADOPTED UNIFORM EDUCATIONAL AND TRAINING STANDARDS FOR ALL MENTAL HEALTH PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATION PURPOSES ONLY."

a) You, the client, have the right to file a complaint with the Office of Mental Health Practice, Minnesota Department of Health, 121 East 7th Place, Suite 400, P.O. Box 64975, St. Paul, MN, 55164-0975, or call 651-282-5621;
b) You, the client, have the right to also file a complaint with the Minnesota Board of Behavioral Health and Therapy, 2829 University Avenue S.E., Suite 210, Minneapolis, MN 55414, or call 612-217-2178 or email **bbht.board@state.mn.us**.
c) You, the client, will be informed of the cost of professional services before receiving the service;
d) You, the client, have a right to reasonable notice of changes in services;
e) You, the client, have a right to know my theoretical approach in working with clients;
f) You, the client, have a right to access any information concerning the practitioner's assessment and recommended course of treatment, including the expected duration of treatment;
g) You, the client, may expect courteous treatment and will be free from verbal, physical, or sexual abuse by the practitioner;
h) Your records and transactions with the practitioner are confidential, unless release of these records is authorized in writing by the client, or otherwise provided by law;
i) You, the client, have a right to be allowed access to records and written information from records;
j) There may be other services available to you in the community. You may call First Call for Help 651-291-0211;
k) You, the client, may refuse services or treatment provided by the practitioner;
l) You, the client, may assert your rights without retaliation.

ACKNOWLEDGMENT BY CLIENT. I, the client, by signing below acknowledge that I have received the Client Bill of Rights.

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CLIENT DATE