twin cities
FAMILY COUNSELING

Tara Palmer, MA, LMFT
Licensed Marriage and Family Therapist, #1443
CLIENT HANDBOOK Updated: 11-27-23

Therapy Process

Therapy may seem very different from other relationships in your life. You are encouraged to speak freely and openly about yourself—much more than you may choose to in other situations. You are invited to bring up concerns relating to various areas of life in order for us to consider their importance to your growth goals. As with most relationships, however, comfort and ease in therapy come with time and opportunities to establish trust.

My job as a therapist is to support you in coming to know yourself, your relationships, and your life more fully in an effort to help you move towards the change you desire. I may do this in a variety of ways—by listening to the story of your present situation or your history; considering the impact of your thoughts, feelings, or behaviors; discussing possible options for new ways of looking at certain situations, and by inviting you to try on new ways of doing things both inside and outside of our sessions.

Specific goals will be created collaboratively in our first few sessions, and successive sessions will be used to help you explore options you may not have previously been aware of regarding thoughts, feelings, and/or behaviors that may move you towards your goals. Our interaction alone does nor guarantee a successful outcome. As a therapist, I can only guide you in the process—the hard work of actually making change happen belongs to you.

After challenging sessions, and times of hard work, you may leave therapy feeling relieved. For example, your depressed mood may lift or you may find new freedom in a release from fear, anger, or anxiety. You may experience improvements in your relationships as you apply new coping mechanisms and problem-solving skills. You may grow in many directions—individually, relationally, in your work or schooling, and in the ability to enjoy your life.

Therapy, however, is a process. Initially, you may feel uncomfortable, even anxious about the changes you desire to make. Sometimes things seem to get worse before they get better.

Those around you may struggle as they see you changing. That is why it is generally best to have both parties present when addressing marital problems, or, the family present when addressing family issues. That said, I will generally address these issues with individuals who feel strongly about not having other parties present, or whose significant other/family are not willing to participate in therapy, provided the individual understands that there is no guarantee that those they are in relation with will change along with them, and if that is the case those relationships may experience greater difficulty as the client changes.

Staying with therapy even during uncomfortable times will have a significant impact on your therapeutic outcome. As your therapist, I will be available to discuss any of your concerns as we progress in our work together.

As previously mentioned, most therapeutic relationships develop with time. If you feel, however, that our relationship is not a good fit, or does not develop within a reasonable time, we may need to explore other options for moving you towards your goals. There are varied approaches to therapy. I tend to focus on the whole person within the context of their current relationships and experiences, while also considering the impact of past influences. I often use experiential exercises in session, inviting clients to try on new ways of thinking or doing things. If you feel my approach or style is not a good fit for you, I encourage you to discuss this openly with me. If we determine that a different approach would be a better fit for you, I will assist you with the transition to another professional.

The duration and frequency of therapy varies from person to person. Some may choose to see me as often as once a week or more for several months, gradually reducing the frequency of visits. Other clients may feel their goals can be met with less frequent appointments. We will establish a schedule that will support your unique goals, and then make adjustments as necessary.

As we near the end of therapy, we will discuss discontinuing therapy, with the understanding that you may choose to return should you feel the need. If you choose to stop therapy at any time, I ask that you agree to meet for at least one session to review our work together.

Fees and Policies
A session is fifty-five (55) minutes unless otherwise agreed upon. Longer sessions will be billed at the same hourly rate as noted below, though often require private payments, as insurance companies rarely reimburse for extended meeting times.

Clients Utilizing Insurance

In-network
The session rate is $175.00. Co-pays, co-insurance, or deductible is due at the time of service; balances remaining after insurance reimbursement is received will be your responsibility.

Out-network
The session rate is $175.00, and is due at the time of each meeting.
This provider agrees to submit to your insurance, allowing you to receive the allowed amount per session returned to you by your insurance company. Should your insurance company reimburse this provider, rather than send reimbursement directly to you, this provider will credit your account or issue you a check in the same amount, depending on the client's preference.

No Insurance
Given the high deductible amounts attached to many policies, increased numbers of people prefer to avoid using their insurance. This option allows you the benefit of not having therapeutic services become a part of your medical record, as well as receiving a reduced fee for the same quality service.

A lesser rate of $145.00 per session will be due at the time of each meeting. This fee reduction is available due to the decreased administrative tasks associated with services.

*Though the services will not be submitted to insurance, a receipt can be issued to you if you hope to submit to an HSA for reimbursement. In this case, a diagnostic code must often be provided.

Forms of Payment
You may use cash, check, debit, or credit card to pay. If the bank returns a check, you will be charged a $30 fee and denied the right to write checks as payment for any future sessions.

In all cases—whether utilizing in-network insurance, out of network insurance or no insurance-- you are personally and fully responsible to Tara Palmer LLC for the payment of services rendered. Insurance claim submission is provided as a courtesy by the therapist and in no way transfers ultimate responsibility for payment away from the client. *If you plan to use health insurance benefits, please be aware that it is your responsibility to inquire about mental health coverage and applicable deductions.* The therapist recommends that this be done before the first meeting so the client is aware of the financial implications from the beginning.

Cancellation Policy
If you need to cancel an appointment for any reason, you must do so at least 48 business hours in advance of your appointment time. You will be charged $120 for missed/failed appointments and for appointments cancelled with less than a 48-hour notice (except in cases of illness, emergency, or severe weather, or by discretion of the therapist). Excessive cancellations or requests for appointment changes are disruptive to the therapeutic process. Should this become a concern, the therapist reserves the right to terminate treatment.

Please note insurance companies do not reimburse for missed sessions, therefore you are responsible for paying the therapist directly the $120 missed session fee prior to your next scheduled visit.

Telephone Contacts and Emergencies

I am available, as time permits, between regular sessions to return calls for such issues as scheduling appointments or answering simple questions. I can be reached at the number provided during my regular office hours, generally 9:00 a.m. to 5:00 p.m. Monday-Thursday. Most often you will receive my voice mail where you can leave a confidential message that I will return as my schedule permits. This voice mail system is available 24 hours a day, however I retrieve messages during business hours only.

If phone calls become frequent and/or require excessive time in the judgment of the therapist, you will be billed in the amount of $145 per hour, rounded up in 15 minute increments. This fee also applies to excessive administrative time such as copying or releasing of records, heavy consultation work, or any other form of contact with third parties that is not directly related to specific therapeutic goals.

PLEASE NOTE:

I provide outpatient services only and thus, am not available in person, by phone or email beyond traditional office hours noted above. **If you are in crisis and need immediate assistance at any time of day or night, please call 911 or go to the nearest emergency room.**

Electronic Contact

"Confidentiality" means that anything that occurs in psychotherapy is not divulged by the therapist to anyone outside the therapeutic relationship. The contents of an intake, assessment or counseling session are considered to be confidential. Electronic communication, while convenient and potentially useful, is not covered within this privilege. If you choose to use email or texting to contact the therapist, you agree to do so knowing this communication is not covered within the therapist-client privilege and is inherently insecure due to risks associated with hacking and other similar activities. Please use electronic communication at your own level of comfort and risk tolerance. The therapist assumes no liability for any exchanges that occur in this manner and offers no guarantee of privacy.

Damage to Property

In the unlikely event that you as a client, or any other person attending sessions with you cause damage to any item in the therapist's office space or to the office space itself, you will be responsible for the cost of repairs or replacement of the item or property damage or destroyed.

Confidentiality/ Therapist-Client Privilege

"Confidentiality" means that anything that occurs in psychotherapy is not divulged by the therapist to anyone outside the therapeutic relationship. The contents of an intake, assessment or counseling session are considered to be confidential. Neither verbal information nor written records about a client can be shared with another party without the written consent of the client or the client's legal guardian. This special protection is known as the "therapist-client privilege." Specifically, "privilege" refers to the client's ability to protect information in a legal proceeding.

It is my policy to not release any information about a client without having a signed release of information form. However, there are specific situations that are exceptions to this rule. The exceptions to confidentiality and the therapist-client privilege are listed below.

Mandated reporting: *Extreme situations that are exceptions to confidentiality and in which the therapist MUST by law file a report with the appropriate social service agencies and legal authorities, as well as notify individuals that may be affected by the situation. All other reasonable means would be exhausted before this option is used, and even then, your cooperation would be encouraged.*

1. If you are a danger to yourself physically, or become incompetent mentally, as determined by the therapist's evaluation.
2. If you disclose an intention or a plan to bring physical harm to others.

3. If you have physically, sexually, or (severely) emotionally harmed or neglected a minor or a dependent/vulnerable adult, or, if a minor or dependent adult is in danger of being abused. This would include parental admitted prenatal exposure to controlled substances that are potentially harmful.
4. If professional misconduct by another health care professional is reported.

Situations in which privilege does not apply or is limited: *Any time you give permission to provide information to another party, there is limited confidentiality. In these cases, and in most of the situations listed above, the therapist can reveal information only to someone who has a need to know, and entire records and/ or irrelevant information may not be disclosed. Whenever information will be shared with other persons, every effort will be made to ensure (but not guarantee) that the receiving person also maintains confidentiality. Situations in which confidentiality may not apply or may be limited are:*

1. If you are being evaluated or treated for a third party (disability, custody, etc.)
2. If you request or give permission for information to be obtained from or provided to a third party (another therapist, a physician, a teacher, an employer, etc.).
3. If the client is a non-emancipated minor, parents or legal guardians have the right to access the minor client's records.
4. If your therapist is being supervised, his/her supervisor may know the details of the case, but the supervisor is also bound by confidentiality.
5. If your therapist is unavailable and temporary coverage is required (emergencies, etc.).
6. When a professional or legal disciplinary meeting is being held regarding another health care professional's actions, related records may be required in order to substantiate disciplinary concerns.
7. When a court order requiring client records has been placed.
8. If you bring a lawsuit against the therapist.
9. In the event of a client's death.
10. In the event of the therapist's disability or death.
11. Electronic Contact- As stated above, electronic communication is inherently risky and, if client chooses to communicate in this manner, they assume all associated risks. Client also acknowledges and accepts that privilege cannot be guaranteed for electronic communications and agrees to hold the therapist harmless for any and all breaches of confidentially that may occur, directly or indirectly, as a result of electronic communication whether initiated by the client or the therapist.

In the case of non-payment of fees for services: In the event that the client does not make payment, or does not respond to notices sent by therapist in an effort to make arrangements for payment, confidentiality may be breeched as necessary to:

1. Turn account over for collections
2. Attempt to collect fees in court.

In addition to the above, special circumstances apply to group, couple, parent-child, and family therapy (any time more than one person is involved in treatment). Simply put, other individuals in the therapy room are not bound by the therapist-client privilege and may choose not to hold information confidentially; the therapist is not responsible for disclosure by these individuals. It is also important to understand that in couple, parent-child, or family therapy, individual secrets about important information may interfere with therapy, and the therapist may encourage you to share this critical information with significant others. In certain instances, it may be difficult to continue therapy if you choose not to reveal important information.

As the client, you have the right to access your records. It is generally best for your therapist to discuss the information contained in them with you or to provide you with a summary for a specific purpose.

If you are not satisfied with services you have received, you are encouraged to speak with your therapist directly by addressing your concerns. If you are still not satisfied, you may file a grievance with the Minnesota Board of Marriage and Family Therapy.

Litigation Limitation

Client agrees that should there be legal proceedings including, but not limited to, divorce, custody evaluations, injuries, and lawsuits, neither client nor your attorney, nor anyone else acting on your behalf will call on this therapist or Tara Palmer LLC to participate in these proceedings, the activities leading up to or occurring after said proceedings. Client specifically agrees that therapist will not be called upon to testify in court or to release therapy records for any reason except when ordered to directly by the court.

*If my involvement is compelled by the court, however, I will be required to respond to your legal interests. You will, then, be charged for my involvement in accordance with the fee structure noted below. All payment for these services must be paid privately in advance of their delivery.

Fee Structure:
*Phone calls (with attorneys, custody evaluators, guardian ad litem, or other involved persons) will take place at the rate of $250 per hour. Shorter calls will be rounded upward in 15 minute increments. For purposes of example only, a 5 minute call would therefore be billed at $62.50.
*Preparation of paperwork will also be billed at a rate of $250 per 60 minutes.
*If required to appear in court on your behalf for any amount of time, a base rate of $2,500 will be paid in advance of the court or mediation date. If applicable, additional fees of $2,500 each must also be paid in advance for all subsequent court or mediation appearances. This fee will cover the therapist's time, potential lost client services revenue, as well as other costs involved in preparing for testimony.
Providers are impacted both in the direct delivery of the services noted above, as well as involvement of legal and professional consultation required to competently function in a legal setting which is outside the scope of our training and expertise. Fees are set to cover non-billable provider costs that are routinely incurred when in the context of being compelled to provide these non-routine services.

Consultation/ Supervision
It is standard practice in the mental health field to consult with other mental health professionals and supervisors to gain additional insight and skills in our work with clients. As I participate in this practice, identifying information will be altered to protect your confidentiality.

Therapist Title/Training
- License # 1443 issued by the Minnesota Board of Marriage and Family Therapy
- Undergraduate work at College of St. Catherine, St. Paul
- Master of Counseling Psychology from St. Mary's University
- Post-Master's Certificate in Marriage and Family Therapy
- Previous involvement with University of Minnesota research study, designed as prevention/intervention program for high risk youth
- Case-Management for youth with Severe Emotional Disturbances
- Facilitator of Social Skill Development groups with early childhood clients utilizing researched based program from Washington State University titled Incredible Year's Program
- Private practice work with individual adults and children, couples, and family groups
- Certificate in Narrative Therapy

CLIENT BILL OF RIGHTS

Consumers of Marriage and Family Therapy Services offered by Marriage and Family Therapists licensed by the State of Minnesota have the right:

1. to expect that a therapist has met the minimal qualification of training and experience required by state law;
2. to examine public records maintained by the Board of Marriage and Family Therapy which contain the credentials of a therapist;
3. to obtain a copy of the code of ethics from the State Register and public Documents Division, Department Administration, 117 University Avenue, Saint Paul, MN 55155;
4. to report complains to the Board of Marriage and Family Therapy, 335 Randolph Avenue, Suite 260; St. Paul, MN 55102
5. to be informed of the cost of professional services before receiving the services;
6. to privacy as defined by rule and law;
7. to be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services;
8. to have access to their records as provided in Minnesota Statutes, section 144.335, subdivision 2; and
9. to be free from exploitation for the benefit of advantage of a therapist (whether emotional, financial, sexual, religious, political, or personal advantage or benefit of the therapist).

Tara Palmer, MA, LMFT
Licensed Marriage and Family Therapist, #1443

CONSENT TO TREATMENT, 2024

I am entering into this therapy contract with full understanding, participation, and consent. I have read the Client Handbook provided by the therapist and understand and agree to its contents. I realize and acknowledge that the therapist cannot guarantee any particular outcome as a result of therapy. I understand that I have a right to a second opinion from another mental health professional at any time and that I may register a legitimate concern with the appropriate person or agency as indicated in the Client Handbook. I also agree to the limits of confidentiality stated in the Client Handbook and understand their meanings and ramifications. Specifically, but not limited to:

_____I understand the confidentiality and security limitations of electronic communication and acknowledge any use of said communication is not covered within the therapist-client privileged communication.
_____I understand Tara Palmer LLC provides outpatient services only; it does not provide 24-hour care and thus cannot insure any availability for immediate crisis intervention that I may require. I understand the direction within this agreement to call 911 or go to the nearest emergency room if I am in crisis and/or need immediate assistance.
_____I am aware that 55 minutes is the industry standard session duration.

_____I agree to the litigation agreement stating that neither I, nor my attorney, nor anyone else acting on my behalf will call on this therapist or Tara Palmer LLC to testify in court or otherwise participate in any legal matter, nor will a disclosure of the therapy records to outside parties be requested. I understand the fee structure (as noted in the handbook) if Tara Palmer is compelled by the courts to act on my behalf in legal matters.

Initial:
_____ I intend to use insurance and agree to take personal financial responsibility for my sessions at the rate of $175 per 55-minute therapy hour.
_____I intend to pay privately for my sessions at the adjusted rate of $145.00 per 55 minute therapy hour.
_____ I agree to pay $120.00 for any missed or failed appointments (for which I have not provided a minimum of 48 hours advance notice). I agree to provide payment in full prior to or at the beginning of my next scheduled visit.

For Blue Cross Blue Shield Insurance Holders Only:

____ I understand that Tara Palmer LLC is an in-network provider and has agreed to accept payment directly from Blue Cross Blue Shield ("BCBS") on my behalf.
____ I agree to pay, at the time of service, any co-pay, co-insurance, or deductible amount Tara Palmer LLC believes will not be covered by BCBS.
____ I understand that if BCBS chooses not to pay a claim for any reason, I am personally responsible for 100% of the charges.
____ I will notify Tara Palmer LLC within one week if I am no longer covered by a BCBS policy.

For Holders of All Other Insurance Policies and Private Pay Clients:

____ I agree to pay Tara Palmer LLC AT THE TIME OF SERVICE for all sessions.

____ I understand that Tara Palmer LLC will submit to my insurance company for services provided to me but that submission of claims is no guarantee of reimbursement (does not apply to private pay).
____ If my insurance company sends payment to Tara Palmer LLC for sessions which I have previously paid, Tara Palmer LLC agrees to provide timely reimbursement to client (does not apply to private pay).

Client acknowledges that there are no other agreements between the parties other than the ones contained within this contract. Any modifications to this contract must be in writing and signed by all parties.

Client (signature):_____Date:_____
(please print name):_____

Parent/guardian (signature):_____Date:_____
(please print name):_____

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FAMILY COUNSELING
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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Understanding Your Mental Health Record Information

A record will be kept of each of your visits. Typically, this record contains an assessment history, current symptoms, diagnosis, treatment, and a plan for future care or treatment. This information serves as a:

a. Basis for planning your care and treatment.
b. Means of communication among any other health professionals who contribute to your care.
c. Legal document describing the care you received.
d. Means by which you or a third-party payer can verify that you actually received the services billed for.
e. Tool to assess the appropriateness and quality of care you received.
f. Tool to improve the quality of health care and achieve better patient outcomes.
g. Tool to document compliance with regulatory, licensing and accreditation standards.

Understanding what is in your health records and how your health information is used helps you to:

a. Ensure its accuracy and completeness.
b. Understand who, what, where, why and how others may access your health information.
c. Make informed decision about authorizing disclosure to others.
d. Better understand the health information rights detailed below.

Your Rights Under the Federal Privacy Standard

You have certain rights with regard to the information contained in your health records. You have the right to:

1. Request restriction on uses and disclosures of your health information for treatment, payment, and health care operations. “Health care operations” consists of activities that are necessary to carry out quality of operations, such as quality assurance and peer review. The right to request restriction does not extend to uses or disclosures permitted or required under §164.502(a)(2)(i) (disclosures to you), §164.510(1) (for facility directories, but note that you have the right to object to such uses), or §164.510 (uses and disclosures not requiring a consent or an authorization). The latter uses and disclosures include, for example, those required by law, like mandatory communicable disease reporting, mandatory reporting of abuse or neglect of children or vulnerable adults, as well as mandatory reporting under the Tarisoff Act describing the duty to warn if safety of self or others is in jeopardy. In those cases, you do not have a right to request restriction. The Consent to use and disclose your individually identifiable health information provides the ability to request restriction. We do not, however, have to agree to the restriction. If we do, however, we will adhere to it unless you request otherwise or we give you advance notice.

2. Ask me to communicate with you by alternate means, if the method of communication is reasonable, we must grant the alternate communication request. Again see the consent form.

3. Obtain a copy of this notice of information practices. Although we have posted a copy in prominent locations throughout the facility and on our website, you have a right to a copy upon request.

4. Inspect and copy your health information upon request. Again, this right is not absolute. You do not have a right of access to the following:

   a. Any information that would cause harm to the client, family member or involved party.
   b. Information compiled in reasonable anticipation of or for use in civil, criminal, or administrative actions or proceedings.
   c. PHI that is subject to the Clinical Laboratory Improvement Amendments of 1988 ("CLIA"), 42 U.S.C. §263a, to the extent that the provision of access to the individual would be prohibited by law.
   d. Information was obtained from someone other than a healthcare provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of information.

5. A summary of any decision to deny access. For these reviewable grounds (see below), another licensed professional must review the decision of the provider denying access within 60 days. If we deny you access, we will explain why and what your rights are, including how to seek review. These "reviewable" grounds for deniable include:

   a. Licensed healthcare professional has determined, in the exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety of the individual or another person.
   b. PHI makes reference to another person (other than a healthcare provider) and a licensed healthcare provider has determined, in the exercise of professional judgment, that the access is reasonably likely to cause substantial harm to such other person.
   c. The request is made by the individual's personal representative and a licensed healthcare professional has determined, in the exercise of professional judgment, that the provider of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person.

   If we grant access, we will tell you what, if anything, you have to do to get access. *We reserve the right to charge a reasonable, cost-based fee for making copies.*

6. Request amendment/correction of your health information. We do not have to grant the request if:

   a. We did not create the record. If, as in the case of a consultation report from another provider, we did not create the record, we cannot know whether it is accurate or not. Thus, in such cases, you must seek amendment/correction from the party creating the record. If they amend or correct the record, we will put the corrected record in our records.
   b. The records are not available to you as discussed immediately above.
   c. The record is accurate and complete.

   If we deny your request for amendment/correction, we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut), and how you can complain. If we grant the request, we will make the correction and distribute the correction to those who need it and those you identify to us that you want to receive the corrected information.

7. Obtain an accounting of "non-routine" uses and disclosures—those other than for treatment, payment, and health care operations. To individuals of protected health information about them. We do not need to provide an accounting for:

   a. The facility directory or to persons involved in the individual's care or other notification purposes as provided in §164.510 (uses and disclosures requiring an opportunity for the individual to agree or to object, including notification to family members, personal representatives, or other persons responsible for the care of the individual, or the individual's location, general condition, or death.

b. National security or intelligence purposes under §164.512(k)(2) (disclosures not requiring consent, authorization, or an opportunity to object, see chapter 16).
c. Correctional institutions or law enforcement officials under §164.512(k)(5) (disclosures not requiring consent, authorization, or an opportunity to object).
d. Those uses and disclosures that occurred before April 14, 2003.

I must provide the accounting within 60 days. The accounting must include:

a. The date of each disclosure.
b. The name and address of the organization or person who received the protected health information.
c. A brief description of the information disclosed.
d. A brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure or, in lieu of such statement, a copy of the written authorization, or a copy of the written request for disclosure. The accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable cost-based fee.

8. Revoke your consent or authorization to use or disclose health information except to the extent that we have already taken action in reliance of the consent or authorization.

Our Responsibilities Under the Federal Privacy Standard

In addition to providing you your rights, as detailed above, the federal privacy standard requires us to:

1. Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.

2. Provide you with this notice, upon request, as to our legal duties and privacy practices with respect to individually identifiable health information we collect and maintain about you, including those who agree to receive the Statement of Information Practices electronically.

3. Abide by the terms of this notice.

4. Train our personnel concerning privacy and confidentiality.

5. Implement a sanction policy to discipline those who breach privacy/confidentiality or our policies with regard thereto.

6. Mitigate (lesson the harm of) any breach of privacy/confidentiality.

WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION WE MAINTAIN. SHOULD WE CHANGE OUR INFORMATION PRACTICES, WE WILL MAIL A REVISED NOTICE TO THE ADDRESS YOU HAVE SUPPLIED US.

We will not use or disclose your health information without your consent or authorization, except as described in this notice or otherwise required by law.

Examples of Disclosures for Treatment, Payment, and Health Operations

If you give us consent, we will use your health information for treatment.

Example: Upon each visit, your therapist will record information in your record to diagnose your condition and determine the best course of treatment for you.

If you give us consent, we will use your health information for payment.

Example: I may send a bill to you or to a third-party payer, such as a health insurer. The information on or accompanying the bill may include information that identifies you, your diagnosis, treatment received, and modality.

If you give us consent, we will use your health information for health operations.
Example: A quality assurance person from your insurance carrier may use information in your health record to assess the care and outcomes in your case and the competence of the caregiver.

Other health operations include:
Business associates*:* We provide some services through contracts with business associates. Examples include certain diagnostic testing, transcribing, billing, and shredding service, psychiatrists, volunteers, and the like. When we use these services, we may disclose your health information to the business associate so that they can perform for services rendered. Other business associates, like office cleaning and computer maintenance for example, do not receive client health information but could come into contact with such information by the nature of the service provided. To protect your health information, however, we require all business associates to appropriately safeguard your information and understand client confidentiality.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition in an emergency situation where 911 is called on site. This information is protected through use of a consent unless in an emergency situation.

Marketing continuity of care: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You have the right to decline such contact.

Workers compensation: We may disclose information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health*:* As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information purposes as required by law or in response to a valid subpoena.

Health oversight agencies and public health authorities: If a member of our work force or a business associate believes in good faith that we have engaged in unlawful conduct or otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or public, they may disclose your health information to health oversight agencies and/or public health authorities, such as the department of health.

The federal Department of Health and Human Services (DHHS): Under the privacy standards, we must disclose your health information to DHHS as necessary for them to determine our compliance with those standards.

Tara Palmer, MA, LMFT
Licensed Marriage and Family Therapist, #1443

Statement of Information Practices
Client Acceptance Form, 2024

The policies that you have just read describe how medical information about you may be used and disclosed and how you can get access to the information. Your understanding of this material is important and any concerns or questions should be addressed immediately.

Your signature below signifies that you have read, understand and accept this information.

_____ _____
Client Signature Date

_____ _____
Parent or Guardian Signature Date

Tara Palmer, MA, LMFT
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INSURANCE INFORMATION 2024

Patient Name_____ Patient DOB_____

Sex: ___M___F
Marital Status: ___Single___Married___Divorced___Widowed___Partnered
Race/ Ethnicity: ___Caucasian___Black/Af. American___Hispanic___Native American
___Alaskan Native ___Asian___Multi-racial___Pacific Islander___Other:_____

Street Address_____

City_____ State_____ Zip_____

Phone #1_____ Phone #2_____
Okay to leave a message on (circle preferences): Phone 1 Phone 2

Emergency Contact Name:_____ Relationship:_____
Emergency Phone:_____

Primary Insurance
Individual Policy ID_____ Group/ Plan ID_____
Name of Policy Holder_____ Relationship_____
Policy Holder Employer_____ Policy Holder DOB_____

Secondary Insurance (if applicable)
Individual Policy ID_____ Group/ Plan ID_____
Name of Policy Holder_____ Relationship_____
Policy Holder Employer_____ Policy Holder DOB_____

Release of Information
I authorize Tara Palmer and all business partners to release billing information which may include name, date, and type of services, diagnostic codes, substance abuse information and treatment plans to my insurance company for the purpose of collecting insurance benefits, authorization of additional sessions, or requirements associated with in-network provider status.

Client:_____ Date:_____
Witness:_____Date:_____

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Recurring Payment Authorization Form, 2024

I _____ authorize Twin Cities Family Counseling to charge the
(full name)
credit card indicated below for all fees for which I am responsible which include, but are not limited to, coinsurance, copayments, appointment no-show charges, fees for failing to provide a minimum of a 24 hour notice for canceled appointments and, if applicable, claims denied by my insurance company.

Billing Street Address _____

City, State, Zip _____

Credit Card Information:

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name _____

Account Number _____

CVV Code (3 digit code on back of card) _____

Expiration Date _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to promptly notify Twin Cities Family Counseling of any changes to my account information. I understand that if my credit card is not authorized for any reason, Twin Cities Family Counseling may attempt to reprocess the charge until it is authorized. I certify that I am an authorized user of this credit card and will not dispute these transactions with my credit card company.

SIGNATURE_____ DATE _____