Welcome and thank you for considering Sally E. Hansen MS, LIMHP with True North Counseling, LLC for your mental health needs. This document contains important information about our professional services and business policies.

Education, Training, and Experience

Sally E. Hansen is a Licensed Independent Mental Health Practitioner practicing under Nebraska State License Number 1404. My highest degree is a Master of Science in Community Counseling from the University of Nebraska at Omaha in 2009. My areas of specialized training include individual mental health counseling, family counseling, anger management, Parent-Child-Interaction-Therapy and group therapy.

Mental Health Services

While it may not be easy to seek help from a mental health professional, it is hoped that you will be better able to understand your situation and feelings and move toward resolving your difficulties. The therapist, using her knowledge of human development and behavior, will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to explore your own feelings and thoughts and to try new approaches in order for change to occur. You may bring other family members/significant others to a therapy session if you feel it would be helpful or if this is recommended by your therapist.

Appointments

Appointments are made by calling (531)-466-4696, Monday through Friday between the hours of 8:00 A.M. and 8:00 P.M. Please call to cancel or reschedule at least 24 hours in advance, or you will be charged for the missed appointment. Third-party payments will not usually cover or reimburse for missed appointments.

Number of Visits

The number of sessions needed depends on many factors and will be discussed by the therapist. Your initial session will involve an evaluation of your needs and depending on your circumstances, further evaluative sessions may be required. At the end of the evaluation process, the undersigned therapist will be able to provide you with some first impressions of what therapy may include and a treatment plan to follow if both you and the therapist agree to work together in therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with the therapist.

Therapy involves a large commitment of time, money and energy, so you should be very careful about the therapist you select. If you have questions about procedures, feel free to discuss them with the therapist at any time. If you have doubts, your therapist can help you set up a meeting with another mental health professional for a second opinion.

Length of Visits

The initial intake and evaluative session are normally scheduled for 60-120 minutes. Further evaluative sessions may be scheduled as needed for the therapist to accurately assess your needs. All initial paperwork needs to be completed and signed by the identified client or a parent for children under the age of 19 before the start of the session. Once the evaluation process is completed, therapy sessions are 45-55 minutes in length.

Relationship

Your relationship with the therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapist not have any other type of relationship with you. Personal or business relationships undermine the effectiveness of the therapeutic relationship. The therapist cares about helping you but cannot have a social or personal relationship with you.

If the therapist encounters you in a public setting, in order not to reveal your identity, the therapist will not acknowledge your presence unless addressed by you first. Gifts, bartering, and trading services are not appropriate and should not be shared between you and the therapist.

Discussion of Treatment Plan

It is my intention to provide services that will assist you in reaching your goals. Within the first three sessions after the initiation of treatment, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives and my view of the possible outcomes of treatment. Sometimes more than one approach can be helpful in dealing with a certain situation. During therapy, I will draw on various treatment approaches which may include, but are not limited to, narrative therapies, client-centered, psychodynamic, cognitive-behavioral, trauma-focused cognitive-behavioral, Solution-Focused, psycho-education, behavioral approaches and Parent-Child-Interaction-Therapy.

I believe that therapists and their clients are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, my expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining those treatments.

Cancellations

Cancellations must be received at least 24 hours before your scheduled appointment. You are responsible for calling to cancel or reschedule your appointment within this time frame. Please see Office Financial and Billing Agreement for the fees associated with your missed appointment.

Payment for Services

If you are unable or unwilling to pay, services will be terminated, and you will be given referrals to other competent providers. Sally E. Hansen, MS, LIMHP will look to you for full payment of your account, and you will be responsible for payment of all charges. A credit card will be kept on file for co-payments and other fees you wish to pay by credit card.

Insurance

Please inform me if you wish to utilize health insurance to pay for services. I will discuss the procedures for billing your insurance. Although I am happy to assist your efforts to seek insurance reimbursement, I am unable to guarantee whether your insurance will provide payment for the services provided to you. The amount of reimbursement, co-payment and deductible depend on the requirements of your specific insurance plan.

You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions, which then become part of your medical record. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. You are responsible for obtaining prior authorization for treatment from your insurance carrier. Please discuss any questions or concerns that you may have about this with me.

If for some reason you find that you are unable to continue paying for your therapy, please inform me. I will help you to consider other options that may be available to you.

Confidentiality

Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated or permitted by law. 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 treatment facilities; sexual exploitation; AIDS/HIV and other communicable disease infection and possible transmission; court orders; 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, protect, notify, or disclose; sexual exploitation by a mental health professional or member of the clergy; fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; the filing of a complaint with a licensing board or other state or federal regulatory authority; to regulatory authorities in connection with their compliance or investigatory responsibilities; to employees or agents of the practice for operational purposes, to a supervisor if the therapist is under supervision and for treatment consultations with other mental health professional when deemed necessary by the therapist.

FOR FURTHER INFORMATION REVIEW THE NOTICE OF PRIVACY PRACTICES FURNISHED TO YOU BY YOUR THERAPIST IN CONJUNCTION WITH THIS CLIENT INFORMATION AND CONSENT DOCUMENT. By signing the information and consent form below, you are giving your consent to the undersigned therapist to share confidential information with all persons mandated or permitted by law, with the agency that referred you, and the managed care company and/or 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 for any departure from our right of confidentiality that may result.

Duty to Warn

In the event that the undersigned therapist reasonably believes that you are a danger, physically or emotionally, to yourself or another person, by signing this information and consent form below, you specifically consent for the therapist to warn the person in danger and to contact any person in position to prevent harm to yourself or another person, in addition to medical and law enforcement personnel, and the following persons:

NAME TELEPHONE NUMBER

_____

_____

_____

This information is to be provided at your request for use by said persons only to prevent harm to yourself or another person. This authorization shall expire upon the termination of your therapy with the undersigned therapist.

You acknowledge that you have the right to revoke this authorization in writing at any time to the extent the undersigned therapist has not taken action in reliance on this authorization. You further acknowledge that even if you revoke this authorization, the use and disclosure of your protected health information could possibly still be permitted by law as indicated in the copy of the Notice of Privacy Practices of the undersigned therapist that you have received and reviewed.

You acknowledge that you have been advised by the undersigned therapist of the potential of the redisclosure of your protected health information by the authorized recipients and that it may not be protected from unauthorized disclosures as required by the federal Privacy Rule.

You further acknowledge that the treatment provided to you by the undersigned therapist was conditioned on you providing this authorization.

Termination

You acknowledge and authorize that termination of professional services with True North Counseling, LLC when in the opinion of Sally E. Hansen, MS, LIMHP, you are not progressing as a client. Other reasons for termination of professional services can include, but are not limited to, the following:

Client failure to follow agreed-upon therapy plan

Delinquent payment schedules

Failure to keep scheduled appointments or cancel as per agreements

Disrupting the peace of other therapists and clients in the facility

Theft or destruction of property

Having more than three occurrences of a no call/no show scheduled appointment

Making the therapist or other clients uncomfortable due to intimidation or threatening behavior

Contact Information

You consent for the undersigned therapist to communicate with you by mail, e-mail, text, and by phone at the following addresses and phone numbers, and you agree to IMMEDIATELY advise the therapist in the event of any change:

MAILING ADDRESS: _____

TELEPHONE NUMBER: _____

E-MAIL ADDRESS: _____

Risks of Therapy

Therapy is the Greek word for change. You may learn things about yourself that you do not like. Often growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety, or pain. The success of our work together depends on the quality of the efforts on both our parts, and the realization that you are responsible for lifestyle choices and changes that may result from therapy. Specifically, on risk of marital therapy is the possibility of exercising the divorce option.

After-Hours Emergencies

Please know that your therapist at True North Counseling, LLC DOES NOT PROVIDE twenty-four (24) hour crisis or emergency therapy services. Should you experience an emergency necessitating immediate mental health attention, immediately call 911 or if you are able to safely transport yourself, go to the nearest hospital emergency room for assistance.

Contacting Your Therapist

Your therapist is often not immediately available by telephone. The office number 531-466-4696 is answered by voice mail that the therapist will monitor from time to time throughout the day. The therapist will not take calls when with a client. A reasonable effort will be made to return a call on the same day it is received or within 1-2 business days, weekends and holidays excepted. Messages left after hours, on weekends or holidays will normally be returned the next business day. If you are difficult to reach, please inform your therapist of times when you will be available.

E-Mail and Text Messages

The undersigned therapist uses and responds to e-mails only to arrange or modify appointments. Please do not send e-mails related to your treatment or therapy sessions as electronic communications are not completely secure and confidential. Any therapy related questions or issues will not be addressed by the therapist in any electronic communication but will be dealt with during your next therapy session. Any electronic transmissions of information by you are retained in the logs of your service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator of the service provider. You should know that any e-mails received from you and any responses sent will become part of your therapy record.

Social Media

Your therapist does not accept friend or contact requests from current or former clients on any social networking sites. Adding clients as friends or contacts on these sites can compromise confidentiality and privacy of both the therapist and the client. It can blur the boundaries of the professional relationship and are not permitted. Any attempt by a client to surreptitiously gain access to the therapist's personal sites will be cause for termination of therapy.

Therapist's Incapacity or Death

You acknowledge that, in the event the undersigned therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of your file and records. By signing this information and consent form below, you give consent to allowing another licensed mental health professional selected by the undersigned therapist to take possession of your file and records and provide you with copies upon request, or to deliver them to a therapist of your choice. The undersigned therapist will select a successor therapist within a reasonable time and will notify the appointed licensed mental health professional.

Marital or Joint Therapy

If I participate in marital or joint therapy pursuant to which joint sessions are held with the undersigned therapist, I consent for the undersigned therapist to maintain a single case file for all joint sessions and to release all information contained in the file maintained for joint sessions to any participant in the joint session upon request by a participant.

Defamation

By signing this intake and consent form below you agree that you will not make defamatory comments about the undersigned therapist to others or to post defamatory commentary about the therapist on any website or social media site. In the event that defamatory remarks about the therapist are made by you, or others acting in concert with you, you further consent by signing this intake and consent form below to allowing the therapist to use confidential information necessary to rebut or defend against, or prosecute claims for, the defamation.

Psychotherapist-Client Privilege

The information disclosed by you, as well as any records created, is subject to the psychotherapist-client privilege. The psychotherapist-client privilege results from the special relationship between the psychotherapist and client in the eyes of the law. It is akin to the attorney-client privilege. If I receive a subpoena for records, deposition testimony, or testimony in a court of law, I will assert the psychotherapist-client privilege on your behalf until instructed, in writing, to do otherwise by you or your representative. You should be aware that you might be waiving the psychotherapist-client privilege regarding your entire treatment if you make your mental or emotional state an issue in a legal proceeding. You should address any concerns you might have regarding the psychotherapist-client privilege with your attorney.

Patient Litigation

I will not voluntarily participate in any litigation or custody dispute in which you and another individual or entity, are parties. I have a policy of not communicating with patients' attorneys and will generally not write or sign letters, reports, declarations, or affidavits to be used in any patient's legal matter. I will generally not provide records or testimony unless compelled to do so. Should I be ordered by a court of law, to appear as a witness in an action involving you, you agree to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance at the hourly rate of $150.00 per hour.

Consent to Treatment

I, voluntarily, agree to receive (or agree for my child to receive) Mental Health assessment, care, treatment, or services, and authorize the undersigned therapist to provide such assessment, care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care (or my child's care), treatment, or services, and that I may stop such care, treatment, or services that I receive (or my child receives) through the undersigned therapist at any time.

By signing this Client Information and Consent form, I, the undersigned client (or parent), acknowledge that I have read, understood, and agreed to be bound by all the terms, conditions, and information it contains. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Acknowledgment

By signing below, you acknowledge that you have reviewed and fully understand the terms and conditions of this Agreement. Also, you have discussed such terms and conditions with the therapist and have had any questions with regards to its terms and conditions answered to your satisfaction. You, as the client, agree to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy with Sally E. Hansen, MS, LIMHP. Moreover, you, as the client, agree to Sally E. Hansen, psychotherapist, free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

_____ _____

Client/Parent Signature Date

_____ _____

Written name of client Client's Date of Birth

As witnessed by: _____ Date: _____

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