

Dear Client;

Thank you for this opportunity to work with you. The following are some of the necessary details. Your intake will be held at Healing Connections Therapy Center located at 1751 Southcross Drive W. Burnsville, MN. Please allow ½ hour to fill out these forms if you are doing so in our office. Please bring your insurance card, a list of all medications and dosages, and the name address, phone and fax of your primary care physician, and psychiatrist, and therapist if you are seeing any of these providers.

Directions are:

From I-35W and County Road 42, go across County 42 south on Buckhill Road, which parallels the freeway on the west side. When you get to the stop light at Southcross Drive (1 long block), turn right and go about ¾ mile. Earley Lake Office Park is on the southwest corner of Southcross Drive and County Road 5. Continue through the intersection of Southcross and County Road 5 to the Early Lake Office Park Driveway and turn left. Our office is in the 2unit building to the right of the driveway.

From I-35E and County Road 42 take a right turn on to County Rd. 42 and go to the intersection of County Rd 42 and Buckhill Rd, which is the second stop light. Take a left turn on Buckhill Road and go south to the next intersection, which is Southcross Drive. Turn right and go about ¾ mile. Earley Lake Office Park is on the southwest corner of Southcross Drive and County Road 5. Continue through the intersection of Southcross and County Road 5 to the Early Lake Office Park Driveway and turn left. Our office is in the 2unit building to the right of the driveway.

Additional information:

- Please complete the enclosed forms and bring to your intake.
- Along with the forms please bring your insurance card and copay if using insurance
- A list of all medications and dosages
- The names, addresses, phone numbers, and fax numbers of your primary care physician, psychiatrist, and any other mental health provider that you are presently or have recently seen.

If you are not using insurance the cost is \$175 per hour for intakes and \$130 per hour for therapy sessions. For medication management the cost is \$190 for intake sessions. Other services including medication management vary in price and can be discussed with your clinician. Full payment or co-payment expected at the beginning of the session. Note: if you have Medica/UBH, Value Options, or many other kinds of insurance, you will need to call the authorization number on the back of your card before the session in order to have it authorized. Failure to prior authorize services with your insurance company may result in your incurring the full cost of the first and other sessions.

If you need to change or cancel the appointment, or have further questions, we can be reached at (952) 892-7690.

Sincere regards,

Healing Connections Therapy Center Staff

WELCOME! The most important goal of psychological services is to help you feel and do better in your life. As a client, you can help with your treatment by keeping the following information in mind. At Healing Connections we use solution-focused, goal-directed approaches for a wide variety of problems, from crises in daily living to ongoing mental health issues. It is especially important that you keep in close contact with family or supportive friends during a crisis and that you assume responsibility for helping yourself. If you are dissatisfied with your progress in therapy or with any services provided, please discuss this openly.

Confidentiality. 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, as required by law, e.g., 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 yourself or to another person, information will be shared in an attempt to prevent harm from occurring. Information regarding services provided to minor children can be given to parents on request as a matter of state law. If a minor child is seen, issues regarding confidentiality will be discussed with the parents. Insurance providers often require more detailed information about your situation prior to approval of continued treatment or payment for treatment. If you wish to know the informational requirements of your insurance company, please ask.

Office Hours and cancellation policy. Standard therapy sessions are 50 minutes in length. While this can be somewhat flexible, the time frame will be maintained as much as possible to help all involved. Also this is a courtesy to others that may be waiting. Office hours vary and include some evening hours. Therapy time is valuable to all involved. Cancellations or changes of appointments must be made at least 24 hours in advance or you will be charged one half of your session fee the first missed session and full fees thereafter, unless other arrangements are made. Exceptions are for sudden illness or accidents. This is standard practice and is intended in part to preserve the time for those who may need it. Please note that insurance companies do not pay for failed or canceled appointments. Please ask any questions you have about this policy. You can make appointment changes by calling the office and leaving a message.

Fees, Phone Calls, and Reports. Fees are \$175 per fifty-minute hour for intake and diagnostic assessments, \$130 for therapy, consultation, or training whether in the office or by telephone. Intensive Life Skills Day Program rates are \$300 per session and Life Skills Group Therapy sessions are \$150 per session. For medication management the fees are \$190 for intake and \$100 for a half hour medication management session or \$150 for a therapy and medication management session. These services are provided by our nurse practitioner and can be scheduled with her directly. Full payment (or co-payment if covered by insurance and the deductible has been satisfied) is expected at the beginning of the hour. Phone calls, letters, and reports to facilitate scheduling, information sharing, etc. and requiring up to 10 minutes of time are free of charge. After 10 minutes, you are billed at a prorated \$130 per hour rate. Scheduling paid telephone sessions is welcome when a situation is particularly urgent or because of travel or geographical difficulties. These services may not be covered by insurance. It is your responsibility to discuss this with your insurance provider and your therapist.

Consultation and Supervision. To provide you with the best possible service, we engage in ongoing supervision and consultation with other mental health professionals. Healing Connections Therapy Center contracts with Karen Hilgers, Ph.D., L.P. for supervision and also uses a multidisciplinary DBT team for consultation. In addition we contract with Gary Schoener MEq. LP for ethical consultation and training. When discussing clients in these forums, confidentiality is protected.

Insurance and Bookkeeping. Healing Connections Therapy Center retains the insurance billing and bookkeeping services of Mary Fahrenkamp at Advanced Billing Services. Please call her directly at (952-461-4351) if you have questions about these areas.

Crisis Situations. Depending on the nature of the crisis situation, you can call the office at (952) 892-7690 during business hours, or (612-852-2221) after hours, or 911 for life-threatening emergencies. If necessary, discuss back-up systems for when your therapist is unavailable.

Collections. In the event of non payment of accounts due, Healing Connections reserves the right to seek payment through use of a collection agency or through other legal means. The cost of collection may be added to your bill. Return check fees of \$35 are added to your bill.

I understand and agree to abide by the policies stated above. I give my consent for services, to include evaluation, psychotherapy, testing (if indicated) and involvement in the treatment planning process.

Client Signature

Date

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES (HIPPA)

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

Introduction

Healing Connections Therapy Center is committed to treating you and using protected health information about you responsibly. This Notice of Health Information Privacy Practices describes the personal information I collect, and how and when I use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 15, 2003 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Healing Connections Therapy Center a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which I can assess and continually work to improve the services rendered and the outcomes achieved.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Healing Connections Therapy Center, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Initial and Date

Name: _____

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES (2)

Responsibilities of My Practice

Healing Connections Therapy Center., is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to my legal duties and privacy practices with respect to information I collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if I am unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

I reserve the right to change my practices and to make the new provisions effective for all protected health information I maintain. Should my information practices change, I will give you in person, or mail a revised notice to the address you've supplied me.

I will not use or disclose your health information without your authorization, except as described in this notice. I will also discontinue to use or disclose your health information after I have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions, would like additional information, or believe your privacy rights have been violated, you can contact the Office for Civil Rights. There will be no retaliation for filing a complaint. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

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

Name _____ Birthdate _____

Signature _____ Date _____

Registration and History

Date: _____

| Client Identification Data | | | | | | |
|--|---------------|--------------------|-----------------|---|-----------------|------------|
| Name (Last) | (First) | (M) | Age | Birthdate | Sex | |
| Address | | | (City) | (State) | (Zip) | |
| Social Security # | | Home Phone | | Work Phone | | |
| Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed | | | | Religion | | |
| Education (Highest Grade Completed) | | College Degrees | | Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Employer | | Occupation | | How long employed? | | |
| Family History | | | | | | |
| Family Members | Age | Emotional Problems | | Living? | | Occupation |
| | | Yes | No | Yes | No | |
| Spouse's Name | | | | | | |
| Mother's Name | | | | | | |
| Father's Name | | | | | | |
| Stepmother's Name (if applicable) | | | | | | |
| Stepfather's Name (if applicable) | | | | | | |
| Other significant person responsible for raising you | | | | | | |
| Number of children of person completing form | Age of oldest | | Age of youngest | | Number deceased | |
| Number of brothers and sisters | Age of oldest | | Age of youngest | | Number deceased | |
| Number of other persons living in current household | Relationship | | | | | |
| Notify in case of emergency (Name, relationship, phone number for contact) | | | | | | |
| Name: | | | | | | |
| Address: | | | | Home Phone | | |

Registration and History

Page 2

Name: _____

| Health Data | | | |
|-----------------------------------|----------|--------|-------------|
| Your Physician (Full Name): _____ | | | |
| Address (Clinic Name) | (Street) | (City) | (State/Zip) |

Do you have any current medical problems? Please describe and include any infectious diseases: _____

Are your medical problems being treated? ____ If yes, by whom? _____ Date of most recent physical _____

What medications are you now currently taking? _____

Have you ever had a drug allergy or sensitivity? ____ To what drug? _____

Have you ever seen any of the following for help with a problem? Please circle:

Psychiatrist Psychologist Social Worker Counselor Minister Chemical Dependency Counselor

For What? _____ When? _____

Previous psychiatric or chemical dependency hospitalization? ____ Yes ____ No

If yes, where? _____ When? _____

| Chemical Use Information |
|--------------------------|
|--------------------------|

Do you drink alcoholic beverages? ____ Yes ____ No If yes what do you drink ____ Beer ____ Wine ____ Hard liquor

How often do you drink? ____ Daily ____ 3-5 times weekly ____ 1-2 times weekly ____ Less frequently

Do you sometimes drink more than you had planned? ____ Yes ____ No

Have family and friends ever expressed concern about your drinking or drug use? ____ Yes ____ No

Which: _____
Have you ever been arrested for alcohol or drug related charges: DWI, public intoxication etc.? ____ Yes ____ No

Have you ever been treated for drinking or drug problems or gone to AA, NA etc? ____ Yes ____ No

Have you ever had episodes where you were unable to remember periods when you were drinking? ____ Yes ____ No

Have you ever overdosed? ____ Yes ____ No

| What has been your experience with the following? | Uses currently | Used in past | Never used |
|--|----------------|--------------|------------|
| Tranquilizers: Valium, Librium, Tranxene, Azene, Miltown, Equanil, Xanax, | | | |
| Pain Pills/Narcotics: Darvon, Codeine, Percodan, Demerol, Dilaudid, Heroin | | | |
| Stimulants: Amphetamines, Speed, Dexedrine, Ritalin, White Crosses, Zip, Cocaine and its derivatives ie, crack, crank | | | |
| Sleeping Pills/Soporifics: Doriden, Placidyl, Dalmane, Seconal, Tuinal, Nembutal, Amytal, Phenobarbital, Noctec, Somnos | | | |
| Hallucinogens: Marijuana, Hashish, THC, LSD, Mescaline, Psilocybin, MDA, PCP, Angel Dust, Mushrooms | | | |
| Volatiles: Aerosols, Paint thinner, Glue, Lacquer, Amyl or Butyl, Nitrate "Poppers", Gasoline | | | |
| Nicotine: include cigarettes, cigars, chew and amount: | | | |

Name: _____

Reason for seeking therapy

Directions: Please answer the following questions from your personal perspective.

1. Who referred you to Healing Connections Therapy Center? _____

2. What is the crisis or problem that brought you here? _____

Problem List

Listed below are possible problems you or your family currently has. Please rate each by your degree of concern by circling the issue, rating it, and indicating why you are concerned.

1. Suicide potential or depression? (Low) 1 2 3 4 5 6 7 8 9 10 (High) Why?

2. Alcohol/drug abuse? (Low) 1 2 3 4 5 6 7 8 9 10 (High) Why?

3. Family/relationship problems? (Low) 1 2 3 4 5 6 7 8 9 10 (High) Why?

4. Worry/Anxiety? (Low) 1 2 3 4 5 6 7 8 9 10 (High) Why?

5. Verbal abuse/behavior? (Low) 1 2 3 4 5 6 7 8 9 10 (High) Why?

6. Sexual abuse/behavior? (Low) 1 2 3 4 5 6 7 8 9 10 (High) Why?

7. Physical abuse/behavior? (Low) 1 2 3 4 5 6 7 8 9 10 (High) Why?

8. Other problem/behavior? (Low) 1 2 3 4 5 6 7 8 9 10 (High) Explain:

| | |
|-----------|-------|
| Date | _____ |
| Diagnoses | _____ |
| | _____ |

Insurance Intake

Client Information

Client Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Gender: _____ Date Of Birth: _____ Social Security# _____

Marital Status: _____ Employer: _____

Insurance

Insurance Company: _____

Phone number: _____

Address: _____ City: _____ State: _____ Zip: _____

ID# _____ Policy# _____ Group# _____

Co-pay amt: _____ per visit. Deductible Yes No Amount: _____ Effective Date: _____

Prior Authorization or Referral name and phone: _____

Policy Holder Information

Insured Person _____

Address _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Relation to Client: _____ Employer: _____

Secondary Insurance

Insurance Company Information

Company: _____

Address: _____ City: _____ State: _____ Zip: _____

ID# _____ Policy# _____ Group# _____ Phone _____

I assign all benefits from insurance or other third-party coverage to Healing Connections Therapy Center or its independent contractors. I understand that by signing this form I acknowledge that if my insurance carrier or HMO/PPO does not cover certain services, I will pay for them in full. I authorize the release of any medical information necessary to process any claim for services provided by Healing Connections Therapy Center or its independent contractors. A photocopy of this authorization may be honored.

Signature: _____ **Date:** _____

I have been informed that Healing Connections Therapy Center consists of affiliated independent mental health professionals engaged in private practice who share a name, office space and certain business expenses. I understand that my therapist will assume sole responsibility for providing clinical services.

Client Signature

Date

Medical History

| Client Name: | | | | | | |
|------------------------------|---------|----|------|----|-----------|----|
| Issue | Present | | Past | | Treatment | |
| | Yes | No | Yes | No | Yes | no |
| Stroke | | | | | | |
| Anemia | | | | | | |
| Asthma | | | | | | |
| Cancer | | | | | | |
| Seizures | | | | | | |
| Diabetes | | | | | | |
| Hepatitis | | | | | | |
| Hypertension | | | | | | |
| Migraines | | | | | | |
| Chronic pain | | | | | | |
| Tuberculosis | | | | | | |
| Liver damage | | | | | | |
| Chronic fatigue | | | | | | |
| Eating disorder | | | | | | |
| Cardiac problems | | | | | | |
| Thyroid problems | | | | | | |
| Urinary tract problems | | | | | | |
| Persistent flu-like symptoms | | | | | | |
| Communicable diseases | | | | | | |
| Allergies: food | | | | | | |
| What foods: | | | | | | |
| Allergies: drug | | | | | | |
| What drugs: | | | | | | |

 Client Signature

 Date

At Healing Connections, we have a strong commitment to your holistic health. For that reason it is important to have a close working relationship with your physician, psychiatrist, or other health care provider.

We are asking for your permission to communicate with your health care providers. We find that we can serve you best if your other providers are aware of mental health and substance abuse concerns which often impact health and well-being. Please complete the attached release to enable us to communicate with them about your care.

We will be happy to answer any of your questions or respond to your concerns regarding this matter.

Some insurance companies, request that a copy of your intake information be sent to your primary care physician. It is your right to either agree or disagree to this request. If you would not like information sent to your primary care physician's office, please indicate below.

| | | | |
|---|--|------|--|
| I refuse to have information sent to my primary care physician: | | | |
| Signature: | | Date | |

| | | | |
|---|--|------|--|
| I refuse to have information sent to other treating clinicians: | | | |
| Signature: | | Date | |

Releases must be signed for each person who will be contacted.

Please read the following carefully:

In order to provide good continuity of care, we are asking for your consent to release information to the following providers:

- Your primary care physician
 - Your mental health medication provider. This person might be your primary care physician, a psychiatrist, or a nurse practitioner or clinical nurse specialist
 - Your individual therapist, if you have one outside this clinic
1. **Please fill out a Release of Information for each of the above providers or sign the refusal form indicating that you do not want information released.**
 2. **Fill out the Release of Information form completely with the provider's name, address, phone number and fax number if you know it.**
 3. **Initial each pertinent box, and sign at the bottom of the form.**

If you have questions about the Release of Information form, ask your therapist during the intake.

Consent for the Release of Information

This authorizes Healing Connections Therapy Center and its providers to use and disclose the specific health information described below concerning:

Client: _____ Date of Birth: _____

This will authorize Healing Connections Therapy Center and its providers to release to/obtain from
Name _____

Address _____

Phone # _____

Fax# _____

Information from the medical record maintained from (dates): _____

The information to be disclosed is: (please initial)

| | | | | | |
|--------------------------|--------------------------------------|--------------------------|--|--------------------------|--|
| <input type="checkbox"/> | History and intake information | <input type="checkbox"/> | Social/ Psychological/ Medical reports | <input type="checkbox"/> | Other (specify) |
| <input type="checkbox"/> | Consultation notes/ progress reports | <input type="checkbox"/> | Court or probation records | <input type="checkbox"/> | Chemical dependency abuse or diagnosis, history and treatment (protected by Federal and State regulations 42 CFR Part 2 and ORS 430.399(5), 179.505) |
| <input type="checkbox"/> | Treatment plan, goals, and results | <input type="checkbox"/> | Medications used in treatment | <input type="checkbox"/> | |

The purpose of the information release is: (please initial)

| | | | | | | | |
|--------------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------|--------------------------|-------|
| <input type="checkbox"/> | Diagnosis and evaluation | <input type="checkbox"/> | To facilitate treatment | <input type="checkbox"/> | Treatment planning | <input type="checkbox"/> | Other |
|--------------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------|--------------------------|-------|

If I am requesting the Authorization from you for my use and disclosure or to allow another health care professional or entity to disclose information to me: (1) I cannot deny my services or treatment to you if you refuse to make this signed authorization; (2) You have the right to inspect a copy of the protected information to be used or disclosed; (3) You may refuse to sign this authorization; and (4) I must provide you with a copy of the signed authorization at your request. You may revoke this consent at any time and that upon fulfillment of the above stated purposes(s) or within one year, this consent will automatically expire without express revocation.

By signing this authorization, you may be directing me to disclose your health information to a person or organization that does not have the same obligations to protect privacy required of health care practitioners under state and federal law. The disclosure of the information specified above may carry with it the potential for unauthorized disclosure of your protected health information and loss of protection under state and federal law.

You may request that I require the recipient of your protected health information to sign a Confidentiality Agreement in which the recipient agrees to limit its use and disclosure of your information as specified by the confidentiality agreement. If the intended recipient refuses to sign the confidentiality agreement you request, I will not release the information.

I have reviewed the Authorization and I understand it. I understand that the information used or disclosed under this Authorization may be subject to redisclosure by the recipient and may no longer be protected under federal privacy law.

Signature of Client

Date

Signature of parent or guardian or witness

Date

Consent for the Release of Information

This authorizes Healing Connections Therapy Center and its providers to use and disclose the specific health information described below concerning:

Client: _____ Date of Birth: _____

This will authorize Healing Connections Therapy Center and its providers to release to/obtain from
Name _____

Address _____

Phone # _____

Fax# _____

Information from the medical record maintained from (dates): _____

The information to be disclosed is: (please initial)

| | | | | | |
|--------------------------|--------------------------------------|--------------------------|--|--------------------------|--|
| <input type="checkbox"/> | History and intake information | <input type="checkbox"/> | Social/ Psychological/ Medical reports | <input type="checkbox"/> | Other (specify) |
| <input type="checkbox"/> | Consultation notes/ progress reports | <input type="checkbox"/> | Court or probation records | <input type="checkbox"/> | Chemical dependency abuse or diagnosis, history and treatment (protected by Federal and State regulations 42 CFR Part 2 and ORS 430.399(5), 179.505) |
| <input type="checkbox"/> | Treatment plan, goals, and results | <input type="checkbox"/> | Medications used in treatment | <input type="checkbox"/> | |

The purpose of the information release is: (please initial)

| | | | | | | | |
|--------------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------|--------------------------|-------|
| <input type="checkbox"/> | Diagnosis and evaluation | <input type="checkbox"/> | To facilitate treatment | <input type="checkbox"/> | Treatment planning | <input type="checkbox"/> | Other |
|--------------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------|--------------------------|-------|

If I am requesting the Authorization from you for my use and disclosure or to allow another health care professional or entity to disclose information to me: (1) I cannot deny my services or treatment to you if you refuse to make this signed authorization; (2) You have the right to inspect a copy of the protected information to be used or disclosed; (3) You may refuse to sign this authorization; and (4) I must provide you with a copy of the signed authorization at your request. You may revoke this consent at any time and that upon fulfillment of the above stated purposes(s) or within one year, this consent will automatically expire without express revocation.

By signing this authorization, you may be directing me to disclose your health information to a person or organization that does not have the same obligations to protect privacy required of health care practitioners under state and federal law. The disclosure of the information specified above may carry with it the potential for unauthorized disclosure of your protected health information and loss of protection under state and federal law.

You may request that I require the recipient of your protected health information to sign a Confidentiality Agreement in which the recipient agrees to limit its use and disclosure of your information as specified by the confidentiality agreement. If the intended recipient refuses to sign the confidentiality agreement you request, I will not release the information.

I have reviewed the Authorization and I understand it. I understand that the information used or disclosed under this Authorization may be subject to redisclosure by the recipient and may no longer be protected under federal privacy law.

Signature of Client

Date

Signature of parent or guardian or witness

Date

Consent for the Release of Information

This authorizes Healing Connections Therapy Center and its providers to use and disclose the specific health information described below concerning:

Client: _____ Date of Birth: _____

This will authorize Healing Connections Therapy Center and its providers to release to/obtain from
Name _____

Address _____

Phone # _____

Fax# _____

Information from the medical record maintained from (dates): _____

The information to be disclosed is: (please initial)

| | | | | | |
|--------------------------|--------------------------------------|--------------------------|--|--------------------------|--|
| <input type="checkbox"/> | History and intake information | <input type="checkbox"/> | Social/ Psychological/ Medical reports | <input type="checkbox"/> | Other (specify) |
| <input type="checkbox"/> | Consultation notes/ progress reports | <input type="checkbox"/> | Court or probation records | <input type="checkbox"/> | Chemical dependency abuse or diagnosis, history and treatment (protected by Federal and State regulations 42 CFR Part 2 and ORS 430.399(5), 179.505) |
| <input type="checkbox"/> | Treatment plan, goals, and results | <input type="checkbox"/> | Medications used in treatment | <input type="checkbox"/> | |

The purpose of the information release is: (please initial)

| | | | | | | | |
|--------------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------|--------------------------|-------|
| <input type="checkbox"/> | Diagnosis and evaluation | <input type="checkbox"/> | To facilitate treatment | <input type="checkbox"/> | Treatment planning | <input type="checkbox"/> | Other |
|--------------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------|--------------------------|-------|

If I am requesting the Authorization from you for my use and disclosure or to allow another health care professional or entity to disclose information to me: (1) I cannot deny my services or treatment to you if you refuse to make this signed authorization; (2) You have the right to inspect a copy of the protected information to be used or disclosed; (3) You may refuse to sign this authorization; and (4) I must provide you with a copy of the signed authorization at your request. You may revoke this consent at any time and that upon fulfillment of the above stated purposes(s) or within one year, this consent will automatically expire without express revocation.

By signing this authorization, you may be directing me to disclose your health information to a person or organization that does not have the same obligations to protect privacy required of health care practitioners under state and federal law. The disclosure of the information specified above may carry with it the potential for unauthorized disclosure of your protected health information and loss of protection under state and federal law.

You may request that I require the recipient of your protected health information to sign a Confidentiality Agreement in which the recipient agrees to limit its use and disclosure of your information as specified by the confidentiality agreement. If the intended recipient refuses to sign the confidentiality agreement you request, I will not release the information.

I have reviewed the Authorization and I understand it. I understand that the information used or disclosed under this Authorization may be subject to redisclosure by the recipient and may no longer be protected under federal privacy law.

Signature of Client

Date

Signature of parent or guardian or witness

Date

Consent for the Release of Information

This authorizes Healing Connections Therapy Center and its providers to use and disclose the specific health information described below concerning:

Client: _____ Date of Birth: _____

This will authorize Healing Connections Therapy Center and its providers to release to/obtain from
Name _____

Address _____

Phone # _____

Fax# _____

Information from the medical record maintained from (dates): _____

The information to be disclosed is: (please initial)

| | | | | | |
|--------------------------|--------------------------------------|--------------------------|--|--------------------------|--|
| <input type="checkbox"/> | History and intake information | <input type="checkbox"/> | Social/ Psychological/ Medical reports | <input type="checkbox"/> | Other (specify) |
| <input type="checkbox"/> | Consultation notes/ progress reports | <input type="checkbox"/> | Court or probation records | <input type="checkbox"/> | Chemical dependency abuse or diagnosis, history and treatment (protected by Federal and State regulations 42 CFR Part 2 and ORS 430.399(5), 179.505) |
| <input type="checkbox"/> | Treatment plan, goals, and results | <input type="checkbox"/> | Medications used in treatment | <input type="checkbox"/> | |

The purpose of the information release is: (please initial)

| | | | | | | | |
|--------------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------|--------------------------|-------|
| <input type="checkbox"/> | Diagnosis and evaluation | <input type="checkbox"/> | To facilitate treatment | <input type="checkbox"/> | Treatment planning | <input type="checkbox"/> | Other |
|--------------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------|--------------------------|-------|

If I am requesting the Authorization from you for my use and disclosure or to allow another health care professional or entity to disclose information to me: (1) I cannot deny my services or treatment to you if you refuse to make this signed authorization; (2) You have the right to inspect a copy of the protected information to be used or disclosed; (3) You may refuse to sign this authorization; and (4) I must provide you with a copy of the signed authorization at your request. You may revoke this consent at any time and that upon fulfillment of the above stated purposes(s) or within one year, this consent will automatically expire without express revocation.

By signing this authorization, you may be directing me to disclose your health information to a person or organization that does not have the same obligations to protect privacy required of health care practitioners under state and federal law. The disclosure of the information specified above may carry with it the potential for unauthorized disclosure of your protected health information and loss of protection under state and federal law.

You may request that I require the recipient of your protected health information to sign a Confidentiality Agreement in which the recipient agrees to limit its use and disclosure of your information as specified by the confidentiality agreement. If the intended recipient refuses to sign the confidentiality agreement you request, I will not release the information.

I have reviewed the Authorization and I understand it. I understand that the information used or disclosed under this Authorization may be subject to redisclosure by the recipient and may no longer be protected under federal privacy law.

Signature of Client

Date

Signature of parent or guardian or witness

Date

Client Bill of Rights

Consumers of services offered by practitioners licensed by the State of Minnesota have the right:

1. to expect that the practitioner has met the minimal qualifications of training and experience required by state law.
2. to examine the public records maintained by the Board which contain the credentials of the practitioner.
3. to obtain a copy of the rules of conduct from the appropriate Board i.e.. the Board of Psychology, Board of Nursing.
- 4.
5. to report complaints to the practitioner, and if not satisfactorily resolved, to file a complaint with the appropriate Minnesota Board.
6. to be informed of the cost of professional services before receiving the services.
7. to privacy as defined by rule and law. This means that no information will be released from the facility in which the practitioner works without the client's informed, written consent, except for the following:
 - a. The practitioner is required by law to report instances of abuse or neglect of a child or a vulnerable adult.
 - b. The practitioner is required by law and professional codes of ethics to notify proper persons and/or authorities if the practitioner believes there is a danger to a client or another identified person.
 - c. The practitioner is required to report admitted prenatal exposure to harmful controlled substances.
 - d. In the event of a client's death, the spouse or parents of the deceased have a right to access the client's records.
 - e. The practitioner must produce records or testimony in response to a Court Order and potentially to a subpoena.
 - f. Parents or legal guardians of a non-emancipated minor client have the right to access their child's records.
 - g. Case discussions with other staff through case management, consultation, testing, and treatment are confidential and are to be conducted as such by all staff.
8. to be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving psychological services.
9. to respectful, considerate, appropriate, ethical and professional treatment.
10. to see information in his/her record upon request.
11. to be informed of diagnosis, involved in the formulation of the treatment plan, the periodic review of plans and progress, and the formulation of the discharge plan.
12. to be informed of treatment options, expected outcome of treatment, expected length of treatment, and cost in language that he/she can understand, and to have the right to refuse treatment and the consequences of that decision.
13. to discuss needs, wants, concerns, and suggestions with the practitioner.
14. to be advised as quickly as possible if a scheduled appointment time cannot be kept due to illness or emergency.

_____ Initial and Date

Client Responsibilities

Each client has the responsibility to:

1. Refrain from physical (and other) abuse of self, others, and property. Clients are responsible for repair or replacement of any property they damage in the facility.
2. Devote reasonable energy and time to therapy work. Therapy is generally "hard (emotional) work." For progress to occur, we recommend making your therapy a high priority in your personal life. Your therapist may regularly assign homework that is intended to help you learn about yourself, and doing your homework is expected to expedite your therapy and decrease your costs.
3. Fulfill contracted behavior.
4. Be honest with your therapist concerning your thoughts and feelings about your therapy and treatment.
5. Keep appointments as made. Your appointment time is reserved for you. Therefore, you will be charged for the appointment unless you give at least 24 hours advance notice. Exceptions may be made for emergencies and other extenuating circumstances.
6. Keep current in paying your fees (deductibles, co-payments, fee-for-service payments). You are required to pay your fee at the beginning of each session. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that occurred prior to the first visit to my office), session fees credited toward the deductible will be collected at the time of the session until the deductible payment is verified by the insurance company or third-party provider. Verification can be made through my billing coordinator, who will contact your insurance company to check your benefit status upon request.
7. Inform those involved in the treatment plan about any changes to physical health, insurance plan, or ability to pay for contracted services.
8. Parents or caregivers are responsible to supervise the activities of children with respect to use of facilities, material, etc.

I have read and understand my rights and responsibilities as noted above.

Signature

Date

