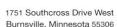


PHONE: 952-892-7690





WELCOME LETTER

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 solutionfocused, 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, or for the purpose of consultation or supervision). If there is a clear intention to do serious harm to your self 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. Your use of any social media websites (ex. Facebook, YouTube) governed by our facility is at your own risk. We do not encourage you to reveal your identity on any of these sites.

<u>Cancellation policy.</u> Cancellations or changes of appointments must be made at least 24 hours in advance to avoid charges. If you fail to notify us 24 hours in advance, you will be charged \$60.00 for each missed or late cancelled appointment. Exceptions may be made for emergencies and other extenuating circumstances. Please note that insurance companies do not pay for missed or cancelled appointments. You can make appointment changes by calling 952-892-7690 and pressing "0" for the office staff or enter your provider's extension. If it is after hours, please leave a message.

Fees. Full payment or co-payment, if covered by insurance, is expected at the beginning of your session. It is your responsibility to know what insurance benefits you have. Receiving information regarding your insurance coverage does not guarantee payment. You are responsible for covering the cost of the deductible, co-payment, and/or co-insurance, including any charges that are not covered by your insurance company. Our office staff is available 8:00-4:30 Monday-Thursday and 8:00-3:00 on Friday.

Independent Contractors: Many of the providers at Healing Connections Therapy Center are affiliated independent mental health professionals engaged in private practice who share a name, office space and certain business expenses. Should your therapist or nurse practitioner be an independent contractor, he or she assumes sole responsibility for providing clinical services.

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 outside therapy professionals and uses a multidisciplinary DBT team for consultation. When discussing clients in these forums, confidentiality is protected.

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

Collections/Returned checks. 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 charged to your account. A fee of \$35.00 will be charged to your account for each returned check.



PHONE: 952-892-7690 FAX: 952-898-4930

Burnsville, Minnesota 55306



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.
- Fulfill contracted behavior.
- Be honest with your therapist concerning your thoughts and feelings about your therapy and treatment.
- 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.
- Keep current in paying your fees including but not limited to deductibles, co-payments, co-insurance payments, etc. You are required to pay your co-payment and/or fee for service fees at the beginning of each session. Deductibles and co-insurance fees are often billed after insurance processes the claim and will be billed to you. Payments must be made within 30 days of receiving a statement in order to keep your account current.
- 7. Inform those involved in the treatment plan about any changes to physical health, insurance plan, or ability to pay for contracted services.
- Parents or caregivers are responsible to supervise the activities of children with respect to use of facilities, material, etc.



1751 Southcross Drive West Burnsville, Minnesota 55306



Intake Registration Form

Client Information Client Name: Address: Phone: Date of Birth: Emergency Contact:	City: Is it OK to leave a	State: Zip: detailed message (Yes/No): _Email: D:Phone:
	Insurance Informa	ition
Bill to: (select one) Self Responsible Party		
Name:	City	Date of Birth:
Phone:Email:	Oity	Date of Birth: Zip: Relationship to Client:
Insurance		
Insurance Company:		
		Group #:
Secondary Insurance		
Insurance Company:ID #:		Group #:
Primary Care Information	ition:	Zip:
Important Information		
	our general policies as well as	connectionsonline.com. We encourage you to read your rights and responsibilities in receiving services HIPAA)
By signing this document, I am agreeing other third-party coverage to Healing Co by signing this form I acknowledge that it	to receive services here and nnections Therapy Center or in f my insurance carrier does no nformation necessary to proc	also agree to assign all benefits from insurance or ts independent contractors. I also understand that t cover certain services, I will pay for them in full. I cess any claim for services provided by Healing

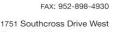


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History								
Issue	Pre	sent	Pá	Past 1				
	Yes	No	Yes	No	Yes	No		
Stroke								
Anemia								
Asthma								
Cancer								
Seizures								
Diabetes								
Hepatitis								
Hypertension								
Migraines								
Chronic pain								
Tuberculosis								
Liver damage								
Chronic fatigue								
Eating disorder								
Cardiac problems								
Thyroid problems								
Urinary tract problems								
Persistent flu-like symptoms								
Communicable diseases								
Do you currently have any other in Are your medical problems being	·							
Date of most recent physical?								
Have you been seen previously by Counselor, Minister, Chemical Dep Please explain:	any other menta endency Counse	ll health provid elor, etc.)?	er (Psychiatris	t, Psychologist	, Social Worke	r,		
		Medication	าร					
List all medications you are curre	ntly taking:							
		Allergies	.					



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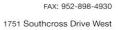
1751 Southcross Drive West Burnsville, Minnesota 55306



Nicotine: include cigarettes, cigars, chew and amount:

N	2	m	Δ	•
	ч		·	=

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 fre	quently							
Do you sometimes drink more than you had planned? Yes No									
Have family and friends ever expressed concern about your drinking Yes No	or drug use?								
Have you ever been arrested for alcohol or drug related charges: Drug Yes No Explain:	WI, public intoxi	cation, etc.?							
Have you ever been treated for drinking or drug problems or gone to AA, NA, etc.? Yes No Explain:									
Have you ever had episodes where you were unable to remember periods of time when you were drinking? Yes No Explain:									
Have you ever overdosed? Yes No Explain:									
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									
Caffiene: Coffee, tea, energy drinks, soda									
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									



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Reason for seeking therapy

1. Thoughts of suicide	(Low) 0	1	2	3	4	5	6	7	8	9	10	(High)
Explain:												
2. Depression	(Low) 0	1	2	3	4	5	6	7	8	9	10	(High)
Explain:												
3. Grief/Loss	(Low) 0	1	2	3	4	5	6	7	8	9	10	(High)
Explain:												
4. Alcohol/drug abuse	(Low) 0	1	2	3	4	5	6	7	8	9	10	(High)
Explain:												
5. Family/relationship issues	(Low) 0	1	2	3	4	5	6	7	8	9	10	(High)
Explain:												
6. Worry/Anxiety	(Low) 0	1	2	3	4	5	6	7	8	9	10	(High)
Explain:												
7. Verbal abuse/behavior	(Low) 0	1	2	3	4	5	6	7	8	9	10	(High)
Explain:												
8. Sexual abuse/behavior	(Low) 0	1	2	3	4	5	6	7	8	9	10	(High)
Explain:												
9. Physical abuse/behavior	(Low) 0	1	2	3	4	5	6	7	8	9	10	(High)
Explain:												
10. Other problems/behavior	(Low) 0	1	2	3	4	5	6	7	8	9	10	(High)
Explain:												



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1751 Southcross Drive West Burnsville, Minnesota 55306

Primary Care Physician Consent for the Release of Information

	I CONSENT to have i	nforma	tion sent to my p	orima	ry ca	re physi	ician:					
By ch	ecking this box, you are cons	senting to	o have information s	shared	with y	our prima	ary care p	hysicia	an. If you ar	re		
choos	ing to consent, please fill in t	the follow	ving fields.									
	I DECLINE to have in	formati	on sent to my pr	imary	/ care	e physic	ian:					
By ch	ecking this box, you are decl	ining to h	nave information sha	ared w	ith you	ur primary	care phy	/sician	. If you are	choosing		
to dec	cline, please sign at the botto	m of the	page and do not fill	in the	follow	ing fields						
	uthorizes Healing Connected below concerning:	tions Th	nerapy Center and	l its pr	ovide	ers to use	e and dis	close	the specifi	c health inf	ormation	
Client:						Da	ate of Bir	th:				
This w	ill authorize Healing Conn	ections	Therapy Center a	and its	provi	iders to r	elease t	o/obta	ain from:			
Name/	Company:										_	
Addres	ss:		City:				Sta	te:	Zip:		_	
Phone	#		Fax# _									
Informa	ation from the medical record	maintair	ned from (date rang	e of re	cords	requeste	d):					
The info	rmation to be disclosed is: (chec	k all that	apply)			1						
	History and intake information		Social/ Psychologica reports	al/ Medi	ical		Other (specify)					
	Consultation notes/ progress reports		Court or probation re	ecords			Chemical dependency abu			otected by Federal and		
	Treatment plan, goals, and results		Medications used in	treatme	ent		State regulations 42 CFR Part 2 and ORS 430.399(5), 179.505)					
The pur	pose of the information release is	s: (check	all that apply)									
	Diagnosis and evaluation	To	o facilitate treatment		Trea	tment plan	ning		Other			
entity t author refuse may re	requesting the Authorizat o disclose information to rization; (2) You have the rito sign this authorization; evoke this consent at an etion of care, this conse	me: (1) light to it and (4) y time a	I cannot deny my nspect a copy of t I must provide yo and that upon fu	servic the pro ou with	ces or otecte n a co ent of	treatme ed inform ppy of the f the abo	nt to you ation to signed ove state	if you be use autho ed pu	refuse to ed or disclo rization at y rposes(s)	make this so psed; (3) Your reques	signed ou may	
does not the dis	ning this authorization, you ot have the same obligation sclosure of the information and health information and	ons to p n specifi	rotect privacy request above may car	uired rry wit	of hea th it th	alth care ne potent	practitio	ners	under state	and federa	al law.	
which '	ay request that I require the recipient agrees to lime the need recipient refuses	it its use	e and disclosure o	of your	r infor	mation a	as specifi	ied by	the confid	entiality ag	reement.	
	reviewed the Authorizatio ization may be subject to											
Cianatur	o of Client or Guardian (if under	10\										

Consent for Telehealth:

I understand that I need to be a resident of Minnesota and be in the state of Minnesota at the time of the session in order to receive telehealth services through Healing Connections Therapy Center.

Benefits

Tele-health services may improve my access to behavioral health services when either myself or my provider are unable to meet face-to-face.

Risk

Telehealth services are not the same as meeting with my provider face-to-face and certain information may not be able to be assessed by my provider via telehealth. I understand there could be technical problems including video quality, audio quality or Internet connectivity.

Confidentiality

I understand that the software being used to provide tele-health meets the recommended standard to protect the privacy and security of tele-health sessions. However, Healing Connections Therapy Center cannot guarantee the total protection against hacking or tapping into the tele-health session by an outsider.

Rights

I understand I have the right to withdraw or withhold my consent at any time to tele-health without affecting my right to care in the future or withdrawal from programming I am otherwise entitled to.

The laws that protect confidentiality of my medical information also apply to telehealth. As such I understand that information disclosed by me during the course of my treatment via tele-health is generally confidential. Limits to this confidentiality includes mandatory reporting of abuse of children or vulnerable adults, expressed threats of violence towards a known victim or when the client's emotional or mental state presents a danger to their personal safety, or as court ordered. I have the right to be informed by my provider if any other professional can see or hear part of our session.

Responsibilities:

- I will not record any of the telehealth sessions and I understand my provider will not record any of our telehealth sessions.
- I will notify my provider if any other person can hear or see part of our session before the beginning of our session.
- I understand that I am responsible for the configuration and understanding of any electronic equipment or devices I may use for telehealth.
- I understand that I will be using my own equipment to communicate with my provider and not equipment owned by another person or entity. I am aware that if I use my employer's computer or devices all information exchanged may be considered by the courts to belong to my employer and thus compromise my confidentiality and privacy.
- I hereby consent to engage in telehealth with Healing Connections Therapy Center as part of my mental health evaluation and treatment. I understand that telehealth includes the practice of health care delivery diagnosis, education and treatment using interactive audio and video communications. I have read and understand the information provided above regarding telehealth and agree to receive telehealth services from Healing Connections Therapy Center.

Client Name		
Client Signature	Date	
Parent or Guardian Signature (if required)		