Healing connections Therapy Center

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

1751 Southcross Drive West
Burnsville, Minnesota 55306

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 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. 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.

Cancellation policy. 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.

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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 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.

8. Parents or caregivers are responsible to supervise the activities of children with respect to use of facilities, material, etc.

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Intake Registration Form

Client Information

Client Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Is it OK to leave a detailed message (Yes/No): _____
Date of Birth: _____ Gender: _____ Email: _____
Emergency Contact: _____ Relationship: _____ Phone: _____

Insurance Information

Bill to: (select one) Self _____ Parent/Guardian _____

Responsible Party

Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Email: _____ Relationship to Client: _____

Insurance

Insurance Company: _____
ID #: _____ Group #: _____

Secondary Insurance

Insurance Company: _____
ID #: _____ Group #: _____

Primary Care Information

Physician Name and Clinic Affiliation: _____
Address: _____ City: _____ Zip: _____
Phone Number: _____

Important Information

The following documents can be found on our website at www.healingconnectionsonline.com. We encourage you to read these documents so that you understand our general policies as well as your rights and responsibilities in receiving services at Healing Connections Therapy Center.

- Welcome Letter
- Client Responsibility statement
- Client Bill of Rights
- Notice of Health Insurance Portability and Accountability Act (HIPAA)

By signing this document, I am agreeing to receive services here and also agree to assign all benefits from insurance or other third-party coverage to Healing Connections Therapy Center or its independent contractors. I also understand that by signing this form I acknowledge that if my insurance carrier 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 of Client or Guardian (if under 18) **Date**

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Name: _____

History						
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						

Do you currently have any other medical problems?

Are your medical problems being treated? If yes, by whom?

Date of most recent physical?

Have you been seen previously by any other mental health provider (Psychiatrist, Psychologist, Social Worker, Counselor, Minister, Chemical Dependency Counselor, etc.)?
Please explain:

Medications

List all medications you are currently taking:

Allergies

List all allergies:

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Name: _____

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
Have you ever been arrested for alcohol or drug related charges: DWI, public intoxication, etc.? Yes No Explain:
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			
Nicotine: include cigarettes, cigars, chew and amount:			

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Reason for seeking therapy

Name: _____

Listed below are possible problems you or your family currently has. Please rate each by circling the number that most closely represents your level of concern. For ratings greater than zero, please explain why you are concerned.

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: _____

11. Legal issues – Is this visit court ordered? Yes _____ No _____

Explain: _____

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Primary Care Physician Consent for the Release of Information

☐ I **CONSENT** to have information sent to my primary care physician: By checking this box, you are consenting to have information shared with your primary care physician. If you are choosing to consent, please fill in the following fields.
☐ I **DECLINE** to have information sent to my primary care physician: By checking this box, you are declining to have information shared with your primary care physician. If you are choosing to decline, please sign at the bottom of the page and do not fill in the following fields.

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/Company: _____

Address: _____City: _____State: _____Zip: _____

Phone# _____ Fax# _____

Information from the medical record maintained from (date range of records requested): _____

The information to be disclosed is: **(check all that apply)**

	History and intake information		Social/ Psychological/ Medical reports		Other (specify)
	Consultation notes/ progress reports		Court or probation records		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)
	Treatment plan, goals, and results		Medications used in treatment		

The purpose of the information release is: **(check all that apply)**

	Diagnosis and evaluation		To facilitate treatment		Treatment planning		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 upon completion of care, 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 re-disclosure by the recipient and may no longer be protected under federal privacy law.

_____ _____

Signature of Client or Guardian (if under 18) Date

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)