FamilyAttachment
COUNSELING CENTER

Confidential Client Information Sheet

Date: _____

Name: _____

Home Phone: _____

Other Phone: _____

Street Address: _____

City, State, Zip: _____

Social Security: _____ DOB: _____

Referral Source: _____

If you would like to receive appointment reminders via text or e-mail, please check the appropriate box below and provide your contact information.

I consent to receive appointment reminders via:

☐ Text at this number _____

☐ E-mail at this address_____

In the unlikely event of an emergency, please specify a contact person.

Name: _____

Home Phone: _____

Other Phone: _____

Street Address: _____

City, State, Zip: _____

FamilyAttachment

COUNSELING CENTER

Client Insurance Information

Client Name: _____ Male Female

Please circle last name

Address: _____

Date of Birth: _____

Home Telephone: _____ Work Telephone: _____

Primary Insurance: _____

Name of insured: _____ Date of Birth: _____
(if other than client)
Insurance Address: _____

Insurance Phone: _____

ID and Group #: _____

Secondary Insurance: _____

Name of insured: _____
(if other than client)
Insurance Address: _____

Insurance Phone: _____

ID and Group #: _____

Authorization to Bill Insurance

I understand that full payment of all charges is my responsibility. I authorize Family Attachment and Counseling Center to bill my insurance company for all appropriate charges. I understand that any applicable co-payment and deductible are due at the time services are rendered. I authorize my insurance company to make payment of medical benefits to Family Attachment and Counseling Center for appropriate services.

_____ _____

Authorized Signature Date

FamilyAttachment

COUNSELING CENTER

Consent for Treatment

By signing below, you are stating that you have read and understood all documents have been given and that you have had your questions answered to your satisfaction.

I accept, understand and agree to abide by the contents and terms of the documents given me and further, consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.

Name of patient (please print)_____ Date of Birth_____

_____ _____

Client Signature Date

_____ _____ _____

Guardian Signature (for minor) Relationship to patient Date

Family Attachment and Counseling Center
Acknowledgement of Receipt of New Client Information

I acknowledge that I have received the Client Bill of Rights; Office Policies (including the Appointment Charging and Complaint Policies, Office Hours and Policy on Confidentiality of Records), and the Minnesota Notice of Policies and Practices related to protect the Privacy of Health Information Form.

_____ _____

Client Name Date

_____

Client Signature

_____

Guardian Signature (for minors only)

OFFICE POLICIES

1. The current maximum hourly rate charge for non-intensive therapy is $165.00 per 50 minute session or part thereof. See current price list for rates. Current charge for intensive therapy is $575.00 per day. Payment is due at each appointment, unless other arrangements are agreed upon prior to starting treatment. Psychological testing and reports incur an additional charge.
2. Clients are encouraged to keep all appointments. 24 HOUR ADVANCE NOTICE IS REQUIRED TO AVOID A CHARGE FOR THE SESSION. If cancellation is made less than 24 hours in advance, or if an appointment is not kept, you will be billed for the missed session and it will be recorded in your file.
3. You, as a client, have certain rights. A copy of the "Client Bill of Rights" was given to you separate from this document. Please read and discuss any questions you may have with your therapist. You have the right to discuss any concern regarding your treatment or general office issues with your therapist and, if you are still dissatisfied, with the therapist's supervisor and/or the clinic director.
4. Family Attachment and Counseling Center does not provide 24 hour emergency services. Normal business hours are 9 am to 4 pm Monday to Friday, and our voice mail system is available 24 hours per day. If you have a crisis situation, you can contact Crisis Connection at 612-379-6363.
5. Your therapist may dictate progress notes that contain information about you and your sessions. These notes will be transcribed by a third party and placed in your medical record. The purpose of progress notes are to document treatment.
6. The Family Attachment and Counseling Center does not recommend sending protected health information and other private material via e-mail due to security risks. If you initiate an e-mail communication, our therapists will respond if it is clinically appropriate to do so. However, we are not responsible for any violation of your privacy by a third party when responding to client initiated e-mails.

Your signature below indicates that you have read this agreement and agree to its terms.

Signature: _____ Date: _____

Family Attachment and Counseling Center
General Consent Agreement and Office Policies

This document informs you of our office policies. Your signature constitutes your consent to these policies. This document will remain in effect for one year from the date of your signature, unless you specifically request that it remain in effect for a shorter time. This agreement, or any part of the agreement, can be revoked by you in writing at any time except to the extent that the Family Attachment Center (FACC) has relied on the document prior to your revocation.

PROTECTED HEALTH INFORMATION

Treatment at FACC may require that we maintain information about your health. The use and disclosure of this information is protected by state and federal law, and we will safeguard this information in line with those requirements. This information may be used and disclosed to carry out treatment, payment and health care operations. You have the right to request in writing restrictions on the use and disclosure of this information for treatment, payment and health care operations. If FACC agrees to the restrictions, they shall be binding on FACC. Additional information describing our policies for the use and disclosure of protected health information is contained in the Minnesota Notice Form also provided to you, which you may review prior to signing this agreement. The Notice Form also contains additional information about your rights as a patient. Should any of the terms of the Notice Form change you will be provided with a revised form at your next scheduled appointment.

CONFIDENTIALITY OF RECORDS

Any information you discuss in therapy is classified as "private" under Minnesota law and will be used to help you assess your problem, to determine counseling goals, and to provide the services you need. State statutes and ethical standards for psychologists require that relevant information be released if any of the following events or circumstances occurs:

- Records are subpoenaed by the courts.
- There is the suspicion of neglect or abuse of a child or vulnerable adult.
- If there is a potential for suicide, homicide or threat of imminent, serious harm to another individual.
- Client identifies a psychologist or another counseling professional, and discloses that he or she has had sexual contact with a client or former client, during or within two years of the termination of therapy.
- Client is a minor, parents have access to records. Minor clients can request, in writing, that particular information not be disclosed to parents. Such a request should be discussed with the therapist.

In addition, to facilitate continuity of care, confidential client information may be shared as follows:

- Whereas a client is involved in more than one mode of counseling or therapy at FACC—for example, group, individual, marriage and family couples, children, etc.—those providing care are allowed to consult with, refer to, cooperate with and mutually share information to the extent needed to serve the best interests of the clients.
- Meetings for supervision, including appropriate professional consultation, are regularly scheduled at FACC. Again, those providing care are allowed to consult with, refer to, cooperate with, and mutually share information to the extent needed to serve the best interests of the clients.
- Session notes may be dictated and transcribed at the therapist's discretion.

FAMILY ATTACHMENT CENTER MINNESOTA NOTICE FORM

Notice of Policies and Practices to Protect the Privacy of Health Information

This notice describes how mental health and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- *"Treatment, Payment, and Health Care Operations"*
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another therapist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my clinic, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my clinic, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I know or have reason to believe a child is being neglected or physically or sexually abused, or has been neglected or physically or sexually abused within the preceding three years, I must immediately report the information to the local welfare agency, police or sheriff's department.
- **Adult and Domestic Abuse:** If I have reason to believe that a vulnerable adult is being or has been maltreated, or if I have knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, I must immediately report the information to the appropriate agency in this county. I may also report the information to a law enforcement agency.

  "*Vulnerable adult*" means a person who, regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:

  (i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and

  (ii) because of the dysfunction or infirmity and the need for assistance, the individual has an impaired ability to protect the individual from maltreatment.

- **Health Oversight Activities:** The Minnesota State Board with oversight responsibility for my license (e.g., Board of Psychology or Board of Marriage and Family Therapy) may subpoena records from me if they are relevant to an investigation it is conducting.
- **Judicial and Administrative Proceedings**: If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law and I must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case.
- **Serious Threat to Health or Safety**: If you communicate a specific, serious threat of physical violence against a specific, clearly identified or identifiable potential victim, I must make reasonable efforts to communicate this threat to the potential victim or to a law enforcement agency. I must also do so if a member of your family or someone who knows you well has reason to believe you are capable of and will carry out the threat. I also may disclose information about you necessary to protect you from a threat to commit suicide.
- **Worker's Compensation**: If you file a worker's compensation claim, a release of information from me to your employer, insurer, the Department of Labor and Industry or you will not need your prior approval.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI (and psychotherapy notes) in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide a copy either in person or by mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Todd Nichols. If you believe that your privacy rights have been violated and wish to file a complaint with my office, you may send your written complaint to Todd Nichols, 18322C Minnetonka Blvd. Deephaven, MN 55391 or todd@familyattachment.com.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by delivery at your next scheduled appointment.

BILL OF RIGHTS OF CLIENTS

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

a. to expect that a psychologist has met the minimal qualifications of training and experience required by the state law;

b. to examine public records maintained by the Board of Psychology which contain the credentials of a psychologist;

c. to obtain a copy of the rules of conduct from the State Register and Public Documents Division of the Department of Administration, 117 University Avenue, St. Paul, MN 55155;

d. to report complaints to the Board of Psychology, 2700 University Avenue West, Room 101, St Paul, 55114-1095;

e. to be informed of the cost of professional services before receiving the services;

f. to privacy as defined by rule and law;

g. to be free from being the object of discrimination on the basis of race, religion, gender or other unlawful category while receiving psychological services;

h. to have access to their records as provided in subpart 1a and Minnesota Statutes, section 144.335, subdivision 2; and

i. to be free from exploitation for the benefit or advantage of the psychologist.