

Assessment and Counseling Services



210 Beltrami Avenue Northwest, Bemidji, MN 56601

Tel. (218)751-0282 Fax (218)751-0870

APPOINTMENT INFORMATION

1. Please arrive approximately 15 minutes prior to your scheduled appointment time with your completed intake paperwork. This will allow time for necessary information to be obtained/updated prior to your appointment.
2. If the appointment is for a minor, a parent or legal guardian must accompany the child. Please complete all admission forms **keeping the client in mind**.
3. In addition to the time necessary for the evaluation, testing may be required. Testing will take two hours or more. Please bring your eyeglasses if needed for reading.
4. If you are court-ordered for an evaluation, testing or treatment, we must have a copy of the court order no later than the first appointment.
5. If you have insurance, please bring this information with you.
6. *Social Security numbers are needed on all clients.*
7. Please be aware that our staff are mandated reporters. We are required by law to report all suspected cases of child physical or sexual abuse within a period of the last three years.
8. Please have releases completely filled out dated and signed for:
 - Social Services
 - Probation Contact
 - School
 - Mental Health Services
 - Primary Physician
9. Follow up appointments will be made as recommended by the North Homes Children and Family Services mental health licensed professional. Please be aware that in the event of **two** consecutive failed appointments, the file will be closed and rescheduling will no longer be allowed.

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NORTH HOMES
Children and Family Services

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Acknowledgement of Receipt of: _____ **Minnesota Notice of Privacy Practice**
(Client initial on the line.) _____ **Client Bill of Rights**
_____ **Rules and Exemptions of Confidentiality**

Name of Individual (client):

Date:

Client's or Legal Representative's Name (Please Print):

Client's or Legal Representative's Signature:

Capacity or Authority or Legal Representative (if applicable)*:

Signature of NHCFS Employee:

* May be requested to provide verification or representative status

FOR OFFICE USE ONLY

We made the following efforts to obtain written acknowledgement of receipt of the Notice of Privacy Practices:

However, acknowledgement could not be obtained because:

- Individual refused to sign Communication barriers prohibited obtaining the acknowledgement
 An emergency situation prevented us from obtaining acknowledgement Other (Please specify)

Consent for Mental Health Treatment

Name of Individual (client):

A problem and goal-specific individual treatment plan will be developed between the therapist and the client named above. The treatment plan will be reviewed with the client and updated every 90 days. The potential risks of receiving mental health assessment and therapy services include the possibility that an individual will not agree with the findings of the assessment, the possibility that an individual will experience discomfort or anxiety as difficult feelings and or experiences are disclosed, and the possibility that no benefit will result from therapy. The potential benefits of receiving mental health and therapy services include the possibility that an individual will experience symptom relief, improved self-knowledge, and improved personal functioning in important life areas.

I, the above named individual or individual's parent/guardian have read and understand the "Consent to Mental Health Treatment". I do hereby consent and give my permission for the provision of mental health services through North Homes Children and Family Services and/or by designated mental health practitioners under the supervision of North Homes Children and Family Services mental health services licensed personnel.

The signature for consent for Mental Health Treatment is effective for one year from the date of signing.

Client's Legal Representative Signature:	Date:
M.H. Practitioner Signature:	Date:

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Name of Client _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ SSN _____

Date of Birth _____ Age _____ County of Residence _____

Employer _____ Occupation _____

Do you have any special difficulty with reading or writing? _____

Name of person completing form (if different from above) _____

Referral Source _____

Circle one answer:

Employment: (1) Full time (2) Part time (3) Unemployed (4) Student (5) Retired

Marital Status: (1) Never married (2) Divorced (3) Widowed (4) Married (5) Separated

Education: 1 2 3 4 5 6 7 8 9 10 11 12 GED _____ College/Vocational _____

Race: (1) White (2) Black (3) Native American
(4) Hispanic (5) Asian/Pacific (6) Mixed _____

Gender: (M) Male (F) Female

Client lives: (1) Alone (2) With relatives (3) With non-related

Client lives in: (1) Shelter/Homeless (2) Private residence (3) Other residential Setting
(4) Correctional Facility (5) Other institutional setting (6) Other

Have you received counseling or mental health services in the past? Yes _____ No _____ If yes, where? _____

Have you received services for alcohol and/or other drug problems in the past? Yes _____ No _____

If yes, where? _____

Physician's Name: _____

List any medical problems: _____

Are you currently taking any medication? Yes _____ No _____ If yes, please list:

Med: _____ Dosage _____ Med: _____ Dosage _____

Med: _____ Dosage _____ Med: _____ Dosage _____

Med: _____ Dosage _____ Med: _____ Dosage _____

Med: _____ Dosage _____ Med: _____ Dosage _____

Are you a Veteran? Yes _____ No _____ If yes, D/C? _____

Is the reason you are wishing to be seen at North Homes Children and Family Services military related?
Yes _____ No _____

Family members living in the same household:

Name	Age	Relationship	M/F	Employer	Phone
------	-----	--------------	-----	----------	-------

Name	Age	Relationship	M/F	Employer	Phone
------	-----	--------------	-----	----------	-------

Name	Age	Relationship	M/F	Employer	Phone
------	-----	--------------	-----	----------	-------

Name	Age	Relationship	M/F	Employer	Phone
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Name	Age	Relationship	M/F	Employer	Phone
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Name	Age	Relationship	M/F	Employer	Phone
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Are there any custody issues? Yes _____ No _____ explain: _____

Is there currently an Order for Protection (OFP) or Harassment Order in place from any state on a member of your household? Yes _____ No _____

Has there been on OFP, or harassment Order from any state placed on a member of your household in the past five years? Yes _____ No _____

Order for protections and restraining order policy (Please read and sign):

In order to ensure the safety of our clients and clinicians, it is mandatory that we be informed and provided copies of any current or future Order of Protection and/or Restraining Orders concerning our clients. We are further bound to comply with any existing OFP's and Restraining Orders. I understand and will comply with the North Homes Children and Family Services policy concerning restraining orders.

Signature of Client (or Client Guardian)

Date

Checklist of Concerns

Client Name: _____ Date: _____

Please mark all of the items below that apply to you. Circle the one that is most important.

- | | |
|--|--------------------------------------|
| (1) ___ Marital/family problems | (12) ___ Abuse/assault victim |
| (2) ___ Social/interpersonal (not family) problems | (13) ___ Sexual abuse/rape victim |
| (3) ___ Coping with daily roles | (14) ___ Child behavior problems |
| (4) ___ Medical/physical symptoms | (15) ___ Major mental illness |
| (5) ___ Depression | (16) ___ Psychiatric medication |
| (6) ___ Attempt, threat, danger of suicide | (17) ___ Perpetrator of sexual abuse |
| (7) ___ Alcohol/Drugs | (18) ___ Anger management |
| (8) ___ Court evaluation referral | (19) ___ Gambling |
| (9) ___ Program entrance evaluation | (20) ___ Stress |
| (10) ___ Eating Disorder | (21) ___ ADD/ADHD |
| (11) ___ Anxiety | (22) ___ Other |

Please continue checking all items that apply to you:

- | | |
|--|--|
| ___ Aggression, violence | ___ Headaches, other kinds of pain |
| ___ Career concerns, goals, and choices | ___ Inferiority feelings |
| ___ Childhood issues (your own childhood) | ___ Impulsiveness, loss of control, outbursts |
| ___ Children, child management, child care, parenting | ___ Irresponsibility |
| ___ Concentration | ___ Judgment problems, risk taking |
| ___ Compulsions (actions that are repeated) | ___ Legal matters, charges, suits |
| ___ Custody of children | ___ Loneliness |
| ___ Decision making, indecision, putting off decisions | ___ Memory problems |
| ___ Delusions | ___ Menstrual problems, PMS, Menopause |
| ___ Dependence | ___ Mood Swings |
| ___ Emptiness | ___ Motivation, laziness |
| ___ Failure | ___ Nervousness, tension |
| ___ Fatigue, tiredness, low energy | ___ Obsessions (thoughts are repeated) |
| ___ Fears, phobias | ___ Overly sensitive to rejection |
| ___ Financial or money problems | ___ Panic or anxiety attacks |
| ___ Work problems, workaholic, can't keep a job | ___ Perfectionism |
| ___ Grieving, mourning, deaths, losses, divorce | ___ Pessimism |
| ___ Guilt | ___ Procrastination, work inhibitions |
| ___ Relationship problems | ___ School problems |
| ___ Self-centeredness | ___ Self Esteem |
| ___ Self-neglect, poor self care | ___ Sexual issues: dysfunction, conflicts,
desire differences |
| ___ Shyness, oversensitivity to criticism | ___ Sleep problems: too much, too little,
insomnia, nightmare, wakening |
| ___ Smoking and tobacco use | ___ Suspiciousness |
| ___ Thought disorganization and/or confusion | ___ Threats, violence |
| ___ Weight and diet issues | ___ Withdrawal, isolation |
| ___ Recreation/hobbies | ___ Other concerns or issues _____ |

Describe what change in your life you are seeking by coming to North Homes Children and Family Services

Diagnostic Assessment – Physical Assessment Questionnaire

When was your last physical examination? _____

Do you have any medical problems that might interfere with your receiving services here at North Homes Children and Family Services?

___ Yes ___ No If yes, please explain: _____

Have you experienced a recent weight loss or weight gain? ___ Yes ___ No If yes, please explain:

Have you experienced any serious head injury, trauma or loss of consciousness? ___ Yes ___ No

If yes, please explain: _____

Have you required urgent care or emergency room attention during the last year? ___ Yes ___ No

If yes, please explain: _____

Have you experienced any of the following within the last six months?

	<u>YES</u>	<u>NO</u>
Asthma.....	___	___
Epilepsy.....	___	___
Diabetes.....	___	___
Chest Pain.....	___	___
Shortness of Breath.....	___	___
Seizures.....	___	___
Tremors or shakes.....	___	___
Frequent sore throats.....	___	___
Stomach Pain.....	___	___
Sexually Transmitted Diseases.....	___	___
Frequent diarrhea.....	___	___
Ringing in ears	___	___
Heart Problems.....	___	___
Hepatitis.....	___	___
Tuberculosis.....	___	___

If other medical problems exist, please explain: _____

Do you have any allergies? Yes ___ No ___ If yes, please identify: _____

=====

Office use only:

Comments: _____

Physical examination recommended ___ Not recommended ___

Reviewed by Assessment Staff

Medical Consultant's Signature

ACCEPTANCE OF FINANCIAL RESPONSIBILITY

Client Name: _____ DOB _____ CASE: _____

PLEASE INDICATE HOW THE SERVICES REQUESTED ARE TO BE PAID:

_____ **Bill insurance carrier or other as indicated:**
(Charges for the services requested are to be billed to the following sources)

_____ Insurance Carrier _____
(Primary) Subscriber Name: _____
Subscriber DOB: _____
Subscriber Address: _____

Employer _____
Group # _____
Policy # _____

_____ Insurance Carrier _____
(Secondary) Subscriber Name: _____
Subscriber DOB: _____
Subscriber Address: _____

Employer _____
Group # _____
Policy # _____

_____ Medical MA # _____
Assistance

_____ Consolidated
Date of Funding Assessment/Assessors Name _____

_____ Private Pay

A Diagnostic Assessment is billed at a rate of \$175.00 per hour (based on a 2-2.5 hour session) and individual/family therapy services are billed at a rate of \$125.00 per hour. Psychological testing rates will vary depending on what type(s) of testing is conducted.

I understand that if coverage has lapsed, if the services requested are not covered by the plan, if the plan caps have been exceeded, or if services are denied by the carrier but I wish to have them anyway, **that I will be responsible for the payment.** I also agree to any self-pay amounts indicated by the carrier contract. I authorize North Homes Children and Family Services to furnish information to the payment sources concerning my illness and treatments and hereby assign to North Homes Children and Family Services all payments and services rendered to my dependents or myself. This authorization shall remain in effect until otherwise cancelled by policy holder or representative. I understand that my insurance carrier or other third party payer may inform the "subscriber" of any services billed to that payer. In the event of non-payment, the bill will be sent to collections. North Homes Children and Family Services reserves the right to decline services or to require cash payments if a previous billing arrangement has not been honored.

Client or guardian

Date

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Minnesota Provider Notice of Privacy Practices

EFFECTIVE DATE OF THIS NOTICE: 04-14-03

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

Our Pledge And Legal Duty To Protect Health Information About You.

The privacy of your health information is important to us. We are required by federal and state laws to protect the privacy of your health information. We must give you notice of our legal duties and privacy practices concerning your health information, including:

- We must protect information that we have created or received about your past, present, or future health condition, health care we provide to you, or payment for your health care.
- We must notify you about how we protect your health information.
- We must explain how, when and why we use or disclose your health information.
- We may only use or disclose your health information as we have described in this Notice.
- We must abide by the terms of this Notice.

We are required to abide by the terms of this Notice. We reserve the right to change the terms of this Notice and to make new Notice provisions effective for all health information that we maintain. We will post a revised Notice in our offices and make copies available to you upon request.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

There are a number of purposes for which it may be necessary for us to use or disclose your health information. For some of these purposes, we are required to obtain your consent. In other specific instances, we may be required to obtain your individual authorization. And in a limited number of circumstances, we will be authorized by Law to disclose your health information without your consent or authorization. Following is a description of these uses and disclosures.

A. Uses and Disclosures of Your Health Information for Purposes of Treatment, Payment and Health Care Operations.

- **Health Care Treatment.** We may use or disclose health information about you to provide and manage your health care. This may include communicating with other health care providers regarding your treatment and coordinating and managing the delivery of health services with others. For example, we may use or disclose health information about you when you need a prescription, lab work, an x-ray, or other health care services.
- **Appointment Reminders and Other Contacts.** We may use your health information to contact you with reminders about your appointments, alternative treatments you may want to consider, or other of our services that may be of interest to you.
- **Payment.** We may use or disclose your health information to bill and collect payment for the treatment and services provided to you. For example: A bill may be sent to you or a third party payer. The information on, or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.
- **Health Care Operations.** We may use or disclose health information about you to allow us to perform business functions. For example, we may use your health information to help us train new staff and conduct quality improvement activities. We may also disclose your information to consultants and other business associates who help us with these functions (for example, billing, computer support and transcription services).
- **Fundraising.** As part of our health care operations, we may use or disclose your demographic information and dates of treatment to contact you to raise money for our organization.

Minnesota Patient Consent for Disclosures.

For some of the disclosures of health information described above, we are required by Minnesota Laws to obtain a written consent from you, unless the disclosure is authorized by Law.

B. Uses and Disclosures of Your Health Information that Require Your Opportunity to Agree or Object.

In the following instances we will provide you with the opportunity to agree or object to our use or disclosure of your health information:

- **Facility Directory.** We may use or disclose your name, location in the facility, general condition, and religious affiliation for facility directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.
- **Persons Involved in Your Care.** We may, using our best judgment, disclose to a family member, other relative, close personal friend or any other person identified by you, health information relevant to that person's involvement in your care or payment related to your care.
- **Notification to Others.** We may, in some instances, disclose health information about you to a family member, a personal representative, or another person responsible for your care, in order to notify such person about your current location or general condition.

C. Uses and Disclosures Authorized by Law.

Under certain circumstances we are authorized by Law to use or disclose your health information without obtaining a consent or authorization from you. These may include when the use or disclosure is:

- **Required by Law.** We will disclose your health information when such disclosure is required by federal, state or local laws.
- **Necessary for public health activities.** For example, when reporting to public health authorities the exposure to certain communicable diseases or risks of contracting or spreading a disease or condition.
- **Related to victims of abuse and neglect.** For example, when reporting suspected victims of abuse or neglect.
- **For health oversight activities.** For example, when disclosing health information to a state or federal health oversight agency so that they can appropriately monitor the health care system.
- **For judicial and administrative proceedings.** For example, when responding to a request for health information contained in a court order.
- **For law enforcement purposes.** For example, when complying with laws that require the reporting of certain types of wounds or injuries.
- **To avert a serious threat to health or safety.** For example, when disclosing health information that will help prevent a serious threat to the health or safety of you or another person of the public.
- **Related to specialized government functions.** For example, we may disclose health information about you if it relates to military and veterans' activities or national security.
- **Related to Workers' Compensation.** For example, when reporting health information to entities that provide benefits for work-related injuries and illness.
- **Related to correctional institutions.** And in other custody situations.

D. Uses and Disclosures of Your Health Information that Require Your Authorization.

Other uses and disclosures of your health information not covered in this Notice will be made only with your written authorization. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect.

YOUR INDIVIDUAL RIGHTS

A. Right to Access and Copy Your Health Information.

You have the right to access and receive a copy or a summary of your health information contained in clinical, billing and other records that we maintain and use to make decisions about you. We ask that your request be made in writing. We may charge a reasonable fee. There might be limited situations in which we may deny your request. Under these situations, we will respond to you in writing, stating why we cannot grant your request and describing your rights to request a review of our denial.

B. Right to Request an Amendment of Your Health Information.

You have the right to request amendments to the health information about you that we maintain and use to make decisions about you. We ask that your request be made in writing and must explain, in as much detail as possible, your reason(s) for the amendment and, when appropriate, provide supporting documentation. Under limited circumstances we may deny your request. If we deny your request, we will respond to you in writing stating the reasons for the denial. You may file a statement of disagreement with us. You may also ask that any future disclosures of the health information under dispute include your requested amendment and our denial to your request.

C. Right to Request Restrictions on Uses and Disclosures of Your Health Information.

You have the right to request that we restrict our use or disclosure of your health information. We ask that your request be made in writing. We are not required to agree to your request for a restriction, and we will notify you of our decision. However, if we do agree, we will comply with our agreement, unless there is an emergency or we are otherwise required to use or disclose the information.

D. Right to Request Confidential Communications.

Periodically, we will contact you by phone, email, postcard reminders, or other means to the location identified in our records with appointment reminders, results of tests or other health information about you. You have the right to request that we communicate with you in a specific way or at a specific location. For example, you may request that we contact you at your work address or phone number or by email. We ask that your request be made in writing. While we are not required to agree with your request, we will make efforts to accommodate reasonable requests.

E. Right to Request and Accounting of Disclosures of Health Information.

You have the right to request a listing of certain disclosures we have made of your health information. We ask

that your request be made in writing. You may ask for disclosures made up to six (6) years before the date of your request (not including disclosures made prior to April 14, 2003). We will provide you one accounting in any 12-month period free of charge.

F. Right to Receive a Copy of This Notice.

You have the right to request and receive a paper copy of this Notice at any time.

If you have any questions about these rights or to exercise any of them please contact our Privacy Office listed below.

Rules and Exemptions of Confidentiality and Data Privacy

The policy of North Homes Children and Family Services regarding the provision of psychological services is to keep all personal information private within the guidelines of federal and state law. The only individuals who will ordinarily have access to client information and records are those whose job responsibilities involve peer consultation, clinical supervision, transcription, record maintenance, utilization review, quality assurance/improvement, and working with third party payers. Personal information provided by clients is used for the purposes of determining treatment needs, developing treatment plans, coordinating client care with other professionals and communicating with third party payers.

There are some situations that qualify as exemptions to rules of confidentiality and data privacy (Tennessee Notice). They are:

- If a client threatens to harm him/herself and the therapist believes there is an imminent risk of the client actually doing so, the therapist is required by law to notify public authorities in order to maintain the individual's safety and to help the individual obtain proper treatment.
- If a client threatens to harm someone else and the therapist determines there is an imminent risk of the client actually doing so, the therapist is required by law to inform the intended victim and public authorities in order to try to maintain other's personal safety.
- If a client who is under the age of 18 years discloses information that the therapist determines needs to be reported to parents, guardians of public authorities in order to effectively intervene or to otherwise maintain the individual's well being, the therapist will do so.
- If a client discloses information concerning the physical or sexual abuse of a minor or vulnerable adult, either by the client or by another individual, the therapist is required by law to report such information to the appropriate governmental or human service agency/authority.
- If a client discloses information concerning the unethical conduct of another therapist, the treating therapist is required by law to disclose such information to the proper authorities.

If the client is required by law or court order to receive evaluation or treatment, resulting clinical information will be disclosed to the appropriate agencies and/or authorities in order to fulfill the order and/or to accomplish/maintain coordination of care.

If a subpoena or court order requests the disclosure of personal or clinical information, the physician/therapist is required by law to provide such information in either written or verbal format.

Client Bill of Rights

Clients receiving psychological services in the state of Minnesota, have the following rights:

- To expect the treating therapist has met the minimum qualifications of training and experience required by law.
- To examine public records maintained by accrediting boards and agencies regarding the credentials of the therapist.
- To obtain a copy of the rules of conduct from the State Register and Public Documents Division, Department of Administration, 117 University Avenue, St. Paul, MN, 55155.
- To report complaints to the Minnesota Board of Psychology, 2700 University Avenue West, St. Paul, MN, 55114-1095.
- To be informed of the cost of professional services before receiving services.
- To privacy, within established rules and exemptions of confidentiality and data privacy.
- To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving psychiatric and/or psychological services.
- To be free from harassment or exploitation for the benefit or advantage of the physician or psychologist.
- To have access to your records as provided in Minnesota Statutes, Sec. 144.335, sub. Division 2.
- To participate in the development of your individual plan of treatment and to have the plan reviewed and updated, at minimum, every 90 days.
- To receive the least restrictive level of treatment necessary to effectively treat your condition.

QUESTIONS OR COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact our Privacy Office. If you are concerned that your privacy rights have been violated, you may file a complaint with our Privacy Office. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Office Contact Information

Laurie A. Meyer
Privacy Officer

North Homes Children and Family Services

1880 River Road
Grand Rapids, MN 55744

218-322-4108 (phone)
218-327-1871 (fax)
1-888-430-3055 (toll free)