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 10 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. 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.

4. A Diagnostic Assessment* will be conducted at the first appointment and will last from 1-2 hours. Please plan accordingly.
   * Includes history and symptoms, clinical assessment of problems and options, clinical diagnosis, treatment goals and plans, staffing and consultation as needed, and charted documentation and review of the above.

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 services 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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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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CHILD INTAKE FORM
Please fill out if client is a child age 17 or under.
Please complete the following paperwork to the best of your knowledge.

Identifying Information

Name of child _____ Age _____ Date of Birth _____
Race: White ___, Black ___. Hispanic ___, Native American ___, Asian ___, Other ___, Religion_____, Sex: M F
Present Address: _____ City: _____ State: ____ Zip: _____
County of residence: _____ Home phone: _____ Other phone: _____
Name of person completing form (if different than child): _____
What is your relationship to child? _____
Who referred child to NHCFS: _____ Social Security Number: _____

Present Placement Information

Child currently lives:
____ at home with family
____ at a relatives' home (name and relationship of custodial adults in this home):
_____
____ in a foster home (name of foster parents): _____
____ in a group home or residential facility (name of facility): _____
____ other (please explain): _____

- Length of time child has been at current placement: _____
- Who has current legal custody of child? _____

Members living in same household as child:

Name	Age	Occupation	Relationship to Child

- Is there now, or has there been in the last 5 years, an Order For Protection or Restraining Order in place from any state on a member of this household? No ___, Yes ___ (please explain) _____
_____
- Is there any current or pending legal actions against any member of the household (including the child)? No ___, Yes ___ (please explain) _____
- Has there been mental health services involved with child before? No ___, Yes ___ (please explain)
_____
- Is the County Social Services involved with this child or family? No ___, Yes ___ (how?)
_____

Please attach copy of CHIPS Petition, Court Order or OFP if applicable

Present Interventions/Services Being Provided to the Family	
Case Manager/Social Worker:	Children's Mental Health Worker:
Outpatient Mental Health Agency:	Outpatient Mental Health Provider:
C.D. Treatment Agency:	C.D. Treatment Provider:
Probation Agency:	Probation Officer:
Psychiatric Service Agency:	Psychiatric Service Provider:
Current Foster Home:	Other Service Providers:

Medical Information

Child's Physician's Name and/or Clinic: _____

- Are there any physical or medical problems we should be aware of? No ____, Yes ____ (please explain)
  _____
  _____
- Is the child currently taking any medication? No ___, Yes ____(please state the medication and dosage)
  _____
  _____
- Has there been any history of head trauma, seizures or loss of consciousness? No_____, Yes_____ (please explain) _____
  _____

Problem Description

- Please describe the problems that bring the child to NHCFS at this time:
  _____
  _____
- How long has the problem or pattern existed?
  _____
  _____
- Under what conditions does the problem or pattern usually get worse?
  _____
  _____
- Under what conditions does the problem or pattern usually improve?
  _____
  _____
- What would you like to see change by coming here?
  _____
  _____

Developmental History

Pregnancy, Labor and Delivery

- Duration of Pregnancy _____
- Did the mother smoke during this time? No ____, Yes _____ (if yes, how much per day?)_____
- Was there any drinking or drug use by mother during this time? No ____, Yes ____ (please describe fully)_____
- Were there any complications during pregnancy (i.e., illness, injuries, hospitalization, etc.)? No _____, Yes _____ (please describe) _____
  _____
- Any complications during labor/delivery (i.e., premature, lack of oxygen, injuries to mother or child, incubator care, infections, etc.?) No ____, Yes ____ (please explain) _____

Infancy – Toddler Period (Birth to 2 years of age)

- Primary caregiver(s) during this time: _____
- Any changes in, or separations from, primary caregivers lasting more than 2 weeks? No____, Yes ____ (please explain) _____
- Were there any physical or emotional difficulties for either the child or the primary caregivers during this time? No____, Yes ____ (please explain)_____

Early Childhood (3 to 5 years of age)

- Primary Caregiver(s) during this time: _____
- Were there any physical or emotional difficulties for either the child or the primary caregivers during this time? No ____, Yes ____ (please explain) _____
- Any changes in, or separations from, primary caregivers lasting more than 2 weeks? No____, Yes ____ (please explain) _____
- Were there any physical or emotional difficulties for either the child or the primary caregivers during this time? No____, Yes ____ (please explain) _____
  _____

<u>Developmental Millstones</u>

Please fill in when the following milestones took place.

Behavior	Age Began	Comments
Walking		
Talking		
Toilet Trained		

Please rate your opinion of the child's development (compared to others the same age) in the following areas:

	Below Average	Average	Above Average
Social			
Physical			
Language			
Intellectual			
Emotional			

- For each type of development that you rated above as *below average*, please describe current areas of concern. Be specific.
  _____
  _____
- List the child's three greatest strengths:
  1._____
  2._____
  3._____
- List the child's three greatest weaknesses or areas needing improvement:
  1._____
  2._____
  3._____
- List the child's main difficulties in school and/or daycare:
  1._____
  2._____
  3._____

- List the child's main difficulties at home:
  1._____
  2._____
  3._____
- Briefly describe the child's friendships: _____
  _____
  _____
- Briefly describe the child's hobbies and interests: _____
  _____
  _____
- Describe how the child is disciplined: _____
  _____
  _____
- For what reasons is the child disciplined: _____
  _____
  _____
- Briefly describe the child's way of expressing the following emotions or behaviors:
  1. Anger: _____
  2. Happiness: _____
  3. Sadness: _____
  4. Anxiety: _____

School History

Please list all the schools the child has attended

			Level of Achievement				
Name of School	**City/State**	**Grade(s) Attended**	**Very Poor**	**Poor**	**Average**	**Good**	**Very Good**

- Has the child ever repeated a grade? No ____, Yes ____ (Which?) _____

Have there been any learning disabilities in the child in the past? No ___, Yes ___ (please describe)

_____
_____

Current School Information

- Present school and grade: _____

Class placement: _____ Mainstream; _____ Special Class (where) _____

Teacher or Advisors' name: _____ IEP in place? No____, Yes ____

Please rate the child in school on the following:

	Very Poor	**Poor**	**Average**	**Good**	**Very Good**
Writing Skills					
Arithmetic Skills					
Reading Skills					
Attendance					
Behavior Management					
Work Completion					
Social Interaction					

Family History

- Biological Mother's Name: _____ Lives with Child? No_____ Yes _____
- Current Age ____ Age at time pregnant with client ____ Highest grade completed in school _____
- Has the mother or any of the mother's blood relative's experienced problems similar to those currently experienced by the child? No _____, Yes _____ (please explain)_____
- Biological Father's Name: _____ Lives with Child? No _____ Yes _____
- Current Age ____ Age at time of birth of child ____ Highest grade completed in school _____
- Has the father or any of the father's blood relative's experienced problems similar to those currently experienced by the child? No _____, Yes _____ (please explain) _____

Marital

- Are the biological parents of the child: ___ Married; ____ Separated; ____Divorced; ____ Living together; ____ Never were together; ____ Widowed; ____ Other (please explain) _____
- Are the biological parents now remarried or living with a Significant Other? No___, Yes ____ (please explain) _____
  Are there any custody issues? (please explain)_____
- Please describe any abuse, chemical dependency or legal difficulties in the child's immediate relatives. _____

Current Symptoms

Please rate the child on the following as occurring now or in the recent past:

Symptom	Frequently	Sometimes	Rarely	Never
Fails to give close attention to details or makes careless mistakes				
Has difficulty sustaining attention in tasks or play activities				
Doesn't seem to listen when spoken to directly				
Doesn't follow through on instructions and fails to finish tasks				
Has difficulty organizing tasks and activities				
Avoids, dislikes or is reluctant to engage in tasks that require sustained effort				
Loses things necessary for tasks or activities				
Is easily distracted by external stimuli				
Is forgetful in daily activities				
Fidgets with hands or feet or squirms in seat				
Leaves seat in situations in which remaining seated is expected				
Runs about or climbs excessively in situations in which it is inappropriate				
Has difficulty playing or engaging in leisure activities quietly				
Is "on the go" or acts as if "driven by a motor"				
Talks excessively				
Blurts out answers before the questions have been completed				
Has difficulty awaiting turn				
Interrupts or intrudes on others (e.g., butts into conversations or games)				

Symptom	Frequently	Sometimes	Rarely	Never
Loses temper				
Argues with adults				
Actively defies or refuses to comply with adults' requests or rules				
Deliberately annoys people				
Blames others for his or her mistakes or misbehavior				
Is touchy or easily annoyed by others				

Is angry or resentful				
Is spiteful or vindictive				

Symptom	Frequently	Sometimes	Rarely	Never
Bullies, threatens or intimidates others				
Initiates physical fights				
Has used a weapon that can cause serious physical harm to others				
Has been physically cruel to people				
Has been physically cruel to animals				
Has stolen while confronting a victim				
Has forced someone into sexual activity				
Has deliberately engaged in fire setting with intention of causing serious damage				
Has deliberately destroyed others' property (other than by fire setting)				
Has broken into someone else's house, building or cars				
Has stolen valuable items without confronting a victim (i.e., shoplifting)				
Stays out at night despite parental prohibitions				
Has run away from home overnight or longer				
Is truant from school				

Symptom	Frequently	Sometimes	Rarely	Never
Depressed or irritable mood most of the day				
Markedly diminished interest or pleasure in all or nearly all activities				
Weight loss when not dieting, or weight gain, or increase or decrease in appetite				
Insomnia (not sleeping) or Hypersomia (sleeping too much)				
Overly agitated or slowed down in movements				
Fatigue or loss of energy				
Feelings of worthlessness or excessive or inappropriate guilt				
Diminished ability to think or concentrate, or indecisiveness				
Recurrent thoughts of death (not just fear of dying)				
Suicide thoughts without a plan for committing suicide				
Suicide attempts or planning of suicide				

Symptom	Frequently	Sometimes	Rarely	Never
Has experienced traumatic event(s)				
Has recurrent and intrusive distressing memories of traumatic event(s)				
Does repetitive play with themes or aspect of the traumatic event(s)				
Recurrent distressing dreams (with or without recognizable content)				
Acts or feels as if the traumatic event were recurring				
Psychological distress at internal or external reminders of the traumatic event(s)				
Physical reacting to internal or external reminder of the traumatic event(s)				
Tries to avoid thoughts, feelings or conversations associated with the event(s)				
Tries to avoid activities, places or people that arouse memories of the event(s)				
Inability to recall important aspects of the trauma(s)				
Markedly diminished interest of participation in significant activities				

Feeling of detachment or estrangement from others				
Restricted range of affect (i.e., unable to have loving feelings)				
Sense of foreshortened future				
Difficulty falling or staying asleep				
Irritability or outbursts of anger				
Difficulty concentrating				
Hypervigilance				
Exaggerated startle response				

Symptom	Frequently	Sometimes	Rarely	Never
Excessive distress when separation from home or loved ones is anticipated				
Excessive worry about losing, or harm happening to, a loved one				
Excessive worry that some bad event will lead to separation from loved ones				
Reluctance of refusal to go to school or elsewhere because of fear of separation				
Excessive fear to be alone at home or elsewhere without loved ones				
Reluctance or refusal to go to sleep without being near loved ones				
Nightmares involving themes of separation				
Complaints of physical symptoms when separation occurs or is anticipated				

Substance use resulting in a failure to fulfill major obligations at school or work				
Substance use in situations in which it is physically hazardous (i.e., driving)				
Substance use related to legal problems				
Substance use despite recurring social or interpersonal problems caused by use				

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 (Primary)
Carrier _____
Subscriber Name: _____
Subscriber DOB: _____
Subscriber Address: _____
Employer _____
Group # _____
Policy # _____

____ Insurance (Secondary)
Carrier _____
Subscriber Name: _____
Subscriber DOB: _____
Subscriber Address: _____
Employer _____
Group # _____
Policy # _____

____ Medical Assistance
MA # _____

____ 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, Inc. 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 (Tennessen 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 Statues, 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)