Date _____ Therapist _____

INFORMATION SHEET

NAME_____
(Last) (First) (MI)

Home #_____ **Work #:**_____ **Cell #:**_____

ADDRESS_____
(# and Street) (City) (County) (Zip)

REFERRED BY:

Self/Family/Friend _____ School _____ Church _____ Professional (Doctor/Clinic) _____
Advertisements _____ Operation De Novo _____ Insurance Co. _____ Police/Courts ____
South Lake Peds. _____

BIRTHDATE _____/_____/_____ **AGE** _____ **SEX** _____ **RACE**(Optional) _____

MARITAL STATUS: Single _____ Married _____ (Spouse's name) _____
Separated _____ Divorced _____ Widow _____ Partner_____

YEARS OF EDUCATION COMPLETED _____

FOR FUNDING PURPOSES, PLEASE INDICATE ANNUAL INCOME LEVEL FOR HOUSEHOLD:

Less than $ 9,800 _____	$20,001-$23,400 _____	$33,601-$40,000 _____	$60,401-67,200 _____
$ 9,801-$13,200 _____	$23,401-$26,800 _____	$40,001-$46,800 _____	Over $67,200 _____
$13,201-$16,600 _____	$26,801-$30,200 _____	$46,801-$53,600 _____	
$16,601-$20,000 _____	$30,201-$33,600 _____	$53,601-$60,400 _____	

NUMBER IN HOUSEHOLD _____ **AGES** _____

IS THIS A SINGLE PARENT HOUSEHOLD? **YES** _____ **NO** _____

EMPLOYMENT STATUS: Full Time _____ Part Time _____ Homemaker _____
Student _____ Unemployed _____ Retired _____

NAME OF EMPLOYER _____

SPOUSE'S EMPLOYER _____

PERSON TO NOTIFY IN AN EMERGENCY: NAME _____
PHONE _____

The information given on this form is true, complete, and correct to the best of my knowledge.

_____
(Client Signature) (Date)

Name:_____ **Date:**_____

____ **I do not have insurance or Medical Assistance.**

Please present insurance ID card to receptionist.

INSURANCE/MEDICAL ASSISTANCE CLIENTS

NAME OF COMPANY_____ PHONE_____

POLICYHOLDER_____ EMPLOYER_____

I.D.#_____ GROUP #_____

I hereby authorize payment directly to RELATE Counseling Center for outpatient mental health benefits for services received by me or my dependents.

_____

Client Signature Date

_____

RELEASE OF MEDICAL INFORMATION

I authorize RELATE Counseling Center to disclose to my insurance company (if Medicaid, to the MN Medical Assistance Program), information concerning the nature and diagnoses, extent, dates, cost and outcome of the services provided to me by this agency, for the purpose of payment of services, billing verification, and evaluation. I understand that my records are protected under state and federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I understand that I may revoke this consent at any time except to the extent that information has been released in good faith or release of information is a condition of parole, probation, or court confinement. In any event, this consent expires automatically when my period of treatment ends and the financial liability for it has been satisfied, or within one year, whichever is earlier. I also understand that if I revoke this consent before any third-party payer or funding source has received data required for billing verification, I will assume full responsibility for the cost of the services provided to me. I understand that failure to pay my bill may result in my name being referred to a collection agency or a conciliation court.

_____

Signature (Relationship if other than client) Date

BILLING INFORMATION

The costs of our services are covered by most health insurance plans, with the exception of certain HMO's. Insurance companies may **not** cover specified services such as treatment of marital, parent-child, or family problems, or treatment of bereavement. In this or any event in which insurance coverage is denied, you will be responsible for payment of fees. We will submit claims for services to your insurance company.

RELATE accepts regular Medical Assistance or Medical Assistance U-Care reimbursement. If you are covered under Medical Assistance or U-Care, please bring in your Identification card at each appointment, so that we can record your ID number and verify your eligibility dates.

If for any reason your insurance coverage, MA coverage, or financial circumstances change, we ask that if possible you notify us 30 days prior to the change in status.

Clients may be billed for appointments that are not kept unless RELATE receives 24-hour advance cancellation of the appointment. Please note that insurance companies do not pay for missed appointments. A $10 fee will be charged for checks returned for non-sufficient funds. RELATE does accept payment via major credit cards.

***Responsible Party* is the party who completes and signs the Intake paperwork for themselves or their child.** If you have an agreement through the courts or other entities, it is up to the Responsible Party to recoup the amount owed to them by the other party.

Insurance clients: I understand that I am fully and directly responsible to RELATE for payment of services rendered, and my obligation to pay is not in any way contingent upon any insurance payments that I may or may not receive. I further understand that RELATE does not accept responsibility for negotiating a settlement of disputed claims. It is agreed and understood that if an account balance should accrue, RELATE has the right to suspend services and that if my account should become delinquent and RELATE forwards my account to a collection agency and /or attorney, I, the responsible party, agree to pay collection costs, attorney fees, interest and court costs.

_____ _____ _____

Client's Signature Date Witness

Self-pay clients: Clients with no insurance may be eligible for an adjusted fee that is based on gross family income and number of dependents. Based on the information provided, my fee with be $_____ per session, **payable in full at each session** (if an account balance should accrue, RELATE has the right to suspend services). Any reduced fee will be in effect for 90 days or until my financial situation changes, and will be reassessed at that time. The maximum allowable number of individual sessions at a reduced fee is twenty per year, after which time the full fee applies. To verify reduced fee eligibility, a copy of my 1040 tax form is required.

I understand that I am fully and directly responsible to RELATE for payment of services rendered. It is agreed and understood that if my account should become delinquent I will no longer be eligible for a reduced fee. If RELATE forwards my delinquent account to a collection agency and/or attorney, I, the responsible party, agree to pay collection costs, attorney fees, interest and court costs.

_____ _____ _____

Client's Signature Date Witness

Relate Counseling Center

Client Name: _____ Date: _____

Parent/guardian name (if signing paperwork for minor): _____

Relationship to client (circle): Parent Guardian Other: _____

Please initial "Yes" or "No" for each of the following statements.

_____ *Yes* _____ *No* I acknowledge that I have read and understand the "Clients Rights and Responsibilities" form given to me by Relate, and have received a copy if I have requested one.

_____ *Yes* _____ *No* I acknowledge that I have been given time to review the "Notice of Privacy Practices," and have received a copy if I have requested one. My initials indicate that I understand that federal regulations require that Relate obtains proof that I have received the information in the Notice. My initials do not indicate that I have read the Notice or agree with its contents.

_____ *Yes* _____ *No* I would like access to the online Patient Portal, which allows me to view the client's account and billing information, and pay my bill. I would like to access the Patient Portal through the following email address (one email address only; please write clearly): _____

_____ *Yes* _____ *No* I agree to have my credit card information saved in Relate's accounting system. I understand that Relate will never charge my credit card without prior approval from me.

_____ *Yes* _____ *No* I authorize the above-named client to use my saved credit card information should they arrive for an appointment without me. They may charge my credit card for the following amount only (co-payment amount): $_____

_____ *Yes* _____ *No* Relate may send me future mailings (newsletters, event invitations, etc.)

_____ *Yes* _____ *No* Relate has permission to contact me regarding appointments, billing, and follow up for services received. I would prefer to be contacted via:

☐ phone ☐ Patient Portal (email)

☐ US Mail ☐ no preference

Intake Date: ____/____/____

FAMILY AND MEDICAL HISTORY: Adult

Name_____ Date of Birth:_____/_____/_____ Age:_____

YOUR PRESENT FAMILY and CURRENT LIVING SITUATION

	Name	Date of Birth	Age
Spouse or Companion:			
Children:			

Home: (check one)

Rent___ Own___ Homeless___ Single Family___ Town Home___ Condominium___ Apartment___

For Self-
List dates of Marriage _____ Separation _____ Divorce/Widow _____ Remarriage _____

For Spouse or Companion-
List dates of Marriage _____ Separation _____ Divorce/Widow _____ Remarriage _____

FAMILY OF ORIGIN

	Name	Date of Birth	Age	If Deceased, Date & Cause
Father:				
Mother:				
Siblings:				

MEDICAL

Your Physician: _____ Phone #: _____

Clinic/Hospital: _____

Address: _____

Please list any medications you are taking, how long, and reason: _____

_____

Please list any current or chronic health problems: _____

_____

Coordination of Care with your Primary Care Physician (PCP)

To ensure more informed, effective, and coordinated treatment of your mental health or chemical health needs, it is often helpful (and sometimes critical) for your Mental Health Provider (MHP) to have direct contact with your medical doctor (PCP). This is especially true if/when you have a medical condition which affects your mental/chemical health or vice versa, or when your PCP is responsible for prescribing psychiatric medications.

If you choose to have your Mental Health Provider contact your PCP, please understand that the initial information released will include diagnosis, general treatment plan, and any medications prescribed by Relate's psychiatrists. After the initial information is sent, there may be additional contact by telephone between providers for the purpose of continued coordination of care, and other pertinent reports (for example, psychiatric or testing reports or chemical health assessment) may be exchanged as deemed necessary. If you choose to authorize such contact between your health providers, you will be asked to sign the attached Release of Information Form, and to provide contact information for your PCP. Please speak with your Mental Health Provider if you have any concerns or questions regarding your choices.

Please select the option below that applies to you.

☐ NO, I do not want any communication with my medical doctor.

☐ I do not have a medical doctor at this time. I understand that I am encouraged to obtain one.

☐ YES, I want you to notify my medical doctor that I am receiving care at RELATE Counseling Center. (Your Mental Health Provider will have you provide your doctor's contact information and sign the attached Release Form to authorize this contact.)

Your signature below confirms that you have been informed of your choices regarding contact with your PCP, and that you have indicated what you want RELATE staff to do regarding this.

NAME (or signature of legal guardian) DATE

RELATE Counseling Center

5125 County Road 101, Suite 300
Minnetonka, MN 55345
Ph: 952-932-7277 Fax: 952-932-9827

AUTHORIZATION FOR RELEASE OF INFORMATION
(A photocopy of the original is acceptable)

Between:	Name	**And:**	Name
			Agency
	Relate Counseling Center		Address
			City / State / Zip
			Phone No. / Fax No.

Client:	Name	DOB
Information to be disclosed:	Please ☐ release ☐ obtain the following information:	

MENTAL HEALTH

- ☐ Diagnostic/Intake Evaluation
- ☐ Progress Notes/Treatment Summary
- ☐ Psychological Testing
- ☐ Medical Records
- ☐ Other (Specify) _____
- ☐ Verbal Communication
- ☐ Juvenile/Adult Court Records
- ☐ Academic Records

CHEMICAL DEPENDENCY

- ☐ Chemical Dependency Evaluation
- ☐ Chemical Dependency Treatment
- ☐ Other (Specify) _____

NOTE: For Chemical Dependency, only the patient (including minors) can sign for release of records

Reason for the Release:

This information is being obtained/released for the purpose of:

- ☐ Assessment and treatment planning
- ☐ Coordination of services
- ☐ Other (Specify) _____

Authorization and Revocation

I understand that (my) (my child's) records are protected under State and Federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time, verbally or in writing, and that in any event this consent expires automatically 365 days after signing or at termination of services. I understand that any information used by RELATE is limited to staff whose work assignments reasonably require access to my data within the purposes specified in the services provided. Information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA.

Date: _____

_____
(Signature of client, parent, or guardian)

_____
(Relationship if other than client)

_____
(Witness)

RELATE Counseling Center
5125 County Road 101, Suite 300
Minnetonka, Minnesota 55345
Ph: (952)-932-7277
Fax: (952)-932-9827

Statement of Understanding: Use of E-mail (electronic mail)

I acknowledge and understand the following issues related to the use of electronic mail (e-mail):

1. I understand that e-mail is not a form of therapy or counseling, particularly involving issues of an urgent nature. E-mail is just another means of communicating along the lines of telephones, cell phones, texting etc..

2. Relate Counseling Center makes no guarantee of a response within a certain time frame. If you send an e mail to your therapist it may be minutes or hours or days before he/she returns your e mail. Therefore, again, nothing of an urgent nature should ever be sent via e-mail.

3. E-mail is not encrypted, and therefore is not as confidential as mail sent through the United States Post Office or telephone communication. By signing this form you are letting us know that you are aware of this potential for compromised confidentiality.

4. I understand that it is possible for e-mail to be intercepted and read without mine or the sender's knowledge. That is, anyone with access to my computer may accidentally or purposefully read e-mail intended for me and not them.

5. Relate Counseling Center bears no responsibility for possible loss of privacy or confidentiality by anything communicated through e-mail. I am requesting this means of communication as it seems it will benefit me and my communication with my therapist.

My signature below represents that I accept the risk of loss of privacy of confidential information associated with communication by e-mail.

_____ Date:_____
Signature

_____
Email address

RIGHTS AND RESPONSIBILITIES

Client Rights
As a client of RELATE, you have the right to know the professional qualifications of the therapist to whom you are assigned.

You have the right to discuss with your therapist possible outcomes and side effects of any treatment you receive (including prescribed medications), and an estimate of the predicted length, cost, goals, and outcome of treatment, as well as alternative options to that treatment.

You are expected to be on time for appointments, to participate actively in the therapy process, and to give feedback to your therapist about your progress in therapy.

You have the right to ask your therapist about any results or interpretations of psychological testing that you complete here.

MINORS: If you are a minor (under 18 years of age), you have the right to request, in writing, that information in your records not be shown to your parents or guardians. You will need to state what information you don't want shown to them and why you are requesting this. If RELATE agrees that it would not be in your best interest for your parents or guardians to be given this information, it will not be shown to or shared with them.

Client Financial Responsibilities
It is your responsibility to understand what services are covered under your insurance or other third party payor. If you have questions, we will be happy to give you the information your insurance company has **quoted**, however insurance companies do not guarantee payment over the phone. Coverage is determined at the time a claim is submitted.

It is your responsibility to inform the billing office or your therapist immediately if anything changes with your insurance or with your financial situation. **Failure to provide insurance/financial information, or other requested financial information, make agreed upon payments and/or not showing up for your scheduled appointments could result in RELATE terminating services and giving you options to other mental health providers outside of our agency.**

It is your responsibility to make your payment at the time of your appointment(s).

You are expected to give **at least 48 hours advance notice if you must cancel your appointment or a fee will be charged**. This fee is **not** billable to insurance, and is the clients' responsibility. Multiple missed appointments could result in termination of services.

Staff Rights/Responsibilities
Your therapist will be available for calls during business hours. In case of emergency, he or she can be contacted through RELATE's answering service by calling our regular number.

Your therapist has the right to refuse a form of treatment that you may request if he/she believes it is not in your best interest, or if some other conflict of interest exists.

Your therapist has the right to terminate treatment with you, and make appropriate referrals to other resources, if he/she judges that you are not benefiting from treatment here.

Your therapist has a responsibility to be ethical in provision of your professional services, to be on time for appointments, to follow Center procedures, and to refer you to another therapist if he/she cannot provide services you require.

NOTICE OF

PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***PLEASE REVIEW IT CAREFULLY.***

OUR DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for health care is considered "Protected Health Information" (PHI). We are required to extend certain protections to your PHI, and to give you this Notice about our privacy practices that explains how, when and why we may use or disclose your PHI. Except in specified circumstances, we must use or disclose only the minimum necessary PHI to accomplish the intended purpose of the use or disclosure.

We are required to follow privacy policies described in this Notice though we reserve the right to change our privacy practices and the terms of this Notice at any time. You may request a copy of the new Notice from our main office or your therapist.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We use and disclose Personal Health Information for a variety of reasons. We have a limited right to use and/or disclose your PHI for purposes of treatment, payment and for our health care operations. For uses beyond that, we must have your written authorization.

USES AND DISCLOSURES RELATING TO TREATMENT, PAYMENT, OR Health Care Operations

Generally, we may use or disclose your PHI as follows:

For treatment: We may disclose your PHI to doctors, and other health care personnel who are involved in providing your health care. For example, your PHI may be shared among clinical staff in consultation meetings. Your PHI may also be shared with outside entities performing ancillary services relating to your treatment, such as lab work.

To obtain payment: We may use/disclose your PHI in order to bill and collect payment for your health care services. For example, we may release portions of your PHI to the Medicaid program, state or county referral agencies, and/or a private insurer to get paid for services we delivered to you.

For health care operations: We may use/disclose your PHI in the course of operating our facility. For example ,we may use your PHI in evaluating the quality of services provided, disclose your PHI to our accountant or attorney for audit purposes, or to our computer programmer for similar services.

Appointment reminders: Unless you provide us with alternative instructions, we may send appointment reminders and other similar materials to your home.

Fundraising activities: We may use certain limited information such as name, address, etc. to contact you to raise money for RELATE.

USES AND DISCLOSURES OF PHI REQUIRING AUTHORIZATION

For uses and disclosures beyond treatment, payment and operation purposes, we are required to have your written authorization, unless the use or disclosure falls within one of the exceptions described below. Authorizations can be revoked at any time to stop further uses/disclosures except to the extent that we have already undertaken an action in reliance upon your authorization.

USES AND DISCLOSURES OF PHI NOT REQUIRING CONSENT OR AUTHORIZATION

The law provides that we may use/disclose your PHI from mental health records without consent or authorization in the following circumstances:

When required by law: We may disclose PHI when a law requires that we report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose PHI to authorities that monitor compliance with these privacy requirements.

For public health activities: We may disclose PHI when we are required to collect information about disease or injury, or to report vital statistics to the public health authority.

For health oversight activities: We may disclose PHI to a health oversight agency for activities authorized by law. Examples of oversight activities include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Relating to decedents: We may disclose PHI related to a death to coroners, medical examiners or funeral directors and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.

For research purposes: By performing research, we learn new or better ways to diagnose and treat illness. RELATE will not use or disclose your health information to external researchers unless you authorize the disclosure in writing.

To avert serious threat to health or safety: In order to avoid serious threat to health or safety, we may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lesson the threat of harm.

For specific government functions: We may disclose PHHI to authorized federal officials so that may provide protection to the President, or authorized persons or foreign heads of state or conduct special investigations.

Workers' Compensation: If you are being treated for a work-related injury or condition, we may release PHI about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Military and Veterans: If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

Law Enforcement: We may release Phi if asked to do so by a law enforcement official:

- In response to a court order;
- About the victim of a crime if, under certain limited circumstances, we are able to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- In other situations as required by law.

Lawsuits and disputes: If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful processes by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

USES AND DISCLOSURES REQUIRING YOU TO HAVE AN OPPORTUNITY TO OBJECT

In the following situation, we may disclose a limited amount of your PHI if we inform you about the disclosure in advance and you do not object, as long as the disclosure is not otherwise prohibited by law.

To families, friends or others involved in your care: We may share with these people information directly related to their involvement in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights relating to your protected health information:

To request restrictions on uses/disclosures: You have the right to ask that we limit how we use or disclose your PHI. We will consider your request, but are not legally bound to agree to the restriction. To the extent that we do agree to any restrictions on our use/disclosure of you PHI, we will put the agreement in writing and abide by it except in emergency situations. We cannot agree to limit uses/disclosures that are required by law.

To choose how we contact you: You have the right to ask that we send your information to an alternate address or by an alternative means. We must agree to your request as long as it is reasonable easy for us to do.

To inspect and request a copy of your PHI: Unless your access to your recodes is restricted for clear and documented treatment reasons, you have a right to see your PHI upon your written request. We will respond to your request within 30 days. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed, depending on your circumstances. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.

To request amendment of your PHI: If you believe that PHI we have about you is incorrect or incomplete, you may request in writing that we correct or add to the record. We will respond within 60 days of receiving your request. We may deny the request if we determine that the PHI is (1) correct and complete; (2) not created by us and/or not part of our records, or (3) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended or linked to your PHI. If we approve the request for amendment, we will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

To find out what disclosures have been made: You have a rights to receive a list of when, to whom, for what purpose, and what content of your PHI has been released other than instances of disclosure: for treatment, payment, and operations; to you, your family; or pursuant to your written authorization. The list also will not include any disclosures made for national security purposes, to law enforcement officials, or correctional facilities, or disclosures made before April 2003. We will respond to your written request for such a list within 60 days of receiving it. Your request can relate to disclosure going back as far as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

YOU HAVE THE RIGHT TO RECEIVE THIS NOTICE

You have the right to receive a copy of this Notice upon request.

HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you believe your privacy rights have been violated, or you disagree with a decision we made about access to your Protected Health Information (PHI), you may file a complaint with the Contact Person(s) listed below. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue SW, Washington D.C., 20201 or call 1-800-696-6775. We will take no retaliatory action against you if you if you make such complaints.

CONTACT PERSON FOR INFORMATION OR TO SUBMIT A COMPLAINT

If you have any questions about this notice or any complaint about our privacy practices, please contact:

RELATE Counseling Center:
Phone #: 952-932-7277

Or:

Commissioner, State of Minnesota
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155
651-296-3971

Effective Date:
This notice is effective on April 14, 2003.