Adult Intake

1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Address: _____ Apt./Unit #: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

Gender:
○ Male ○ Female ○ Other

Marital Status:
○ Single ○ Married ○ Domestic Partner ○ Separated ○ Divorced ○ Widowed

Race (optional): _____

Referred by:
○ Self/Family/Friend ○ Professional (Doctor/Clinic) ○ Advertisement/Internet ○ Insurance Company ○ Police/Courts/Attorney

Person to Notify in Emergency: (name and phone) _____ Emergency Contact Phone Number: _____

Primary Insurance Carrier: _____

Identification Number: _____ Group Number: _____ Customer Service Phone Number: _____

Policy Holder: _____ Policy Holder Date of Birth: _____

Secondary Insurance Carrier: _____

Identification Number: _____ Group Number: _____ Customer Service Phone Number: _____

Policy Holder: _____ Policy Holder Date of Birth: _____

RELATE accepts commercial insurance as well as Medicare, Medical Assistance and Pre-paid Medical Assistance Program insurance plans. Please bring your insurance cards to each appointment, so we may record your ID number and verify your eligibility information.

The cost 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.

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

Clients may be billed $50 for appointments that are not kept unless RELATE receives 24-hour advance cancellation of appointment. Please note that insurance companies do not pay for missed appointments.

Cost of Services before insurance coverage:

Intake Appointment/Diagnostic Assessment (90791): $180

45 minute Individual/Family Therapy Session (90834): $120

Family Therapy-Without Adolescent Client present (90846): $120

Interactive/Play Therapy (add-on 90785): $15

Please contact Relate's Billing Department for questions on fees for additional services.

Responsible Party is the party who completes and signs the intake and consent forms 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.

Consent to bill Insurance:

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

RELATE
COUNSELING CENTER

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 outcomes 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.

Client Signature

Date

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 purposes.

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 illnesses. 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 lessen the threat of harm.

For specific government functions: We may disclose PHI to authorized federal officials so they 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 unable 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 process 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 restriction on our use/disclosure of your 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 alternative address or by an alternative means. We must agree to your request as long as it is reasonably easy for us to do so.

To inspect and request a copy of your PHI: Unless your access to your records 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 your 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 link 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 right 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 as far back 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 a 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 make such complaints.

Contact Person for Information or to Submit a Complaint

If you have 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

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 24 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.

Please initial each of the following statements:

I acknowledge that I have read and understand the "Clients Rights and Responsibilities" form above. _____

I acknowledge that I have been given time to review the "Notice of Privacy Practices" above. 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. _____

I agree to have my credit card information saved in RELATE's Merchant Services account. I understand that RELATE will never charge my card without prior approval from me. (not required) _____

Client Signature Date

_____ _____