INTAKE DEMOGRAPHIC PACKET

FORM COMPLETED BY	DATE COMPLETED

CLIENT

LAST NAME		FIRST NAME		MIDDLE INITIAL
MAIDEN NAME	DATE OF BIRTH	AGE	GENDER	SOCIAL SECURITY
HOME ADDRESS				
CITY	ZIP CODE	COUNTY		
HOME PHONE ☐ Preferred	CELL PHONE ☐ Preferred	WORK PHONE ☐ Preferred		
MARITAL STATUS	COUNTRY OF ORIGIN	PRIMARY LANGUAGE ☐ Decline to specify		
RACE ☐ Decline to specify	ETHNICITY ☐ Decline to specify			

GUARANTOR OF ACCOUNT

WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT

☐ Please check this box if the guarantor of account is the same as the person listed above- you may skip this section

☐ Please check this box is the guarantor of account is someone other than listed above- please fill out the person responsible for account below

PERSON RESPONSIBLE FOR THE ACCOUNT

LAST NAME	FIRST NAME	MIDDLE INITIAL
RELATIONSHIP TO PATIENT	DATE OF BIRTH	PRIMARY PHONE NUMBER
HOME ADDRESS		
CITY	ZIP CODE	COUNTY
SOCIAL SECUIRTY NUMBER		

PATIENT GUARDIAN

If you are your own guardian, please skip this section

☐ Please check this box if you have a guardian, please fill out the section below

☐ Please check this box if you have a Power of Attorney (POA), please fill out the section below

LAST NAME	FIRST NAME	MIDDLE INITIAL
RELATIONSHIP TO PATIENT	DATE OF BIRTH	PRIMARY PHONE NUMBER
HOME ADDRESS		
CITY	ZIP CODE	COUNTY

OUR CLINIC WILL NEED A COPY GUARDIAN/ POWER OF ATTORNEY PAPERWORK BEFORE TREATMENT CAN BEGIN

☐ Paperwork will be mailed ☐ Paperwork is attached ☐ Paperwork will be uploaded via our website at www.npamn.com

INSURANCE INFORMATION

PRIMARY INSURANCE

NAME OF INSURANCE		INSURED NAME
INSURED DATE OF BIRTH	RELATIONSHIP TO PATIENT	INSURED SOCIAL SECURITY NUMBER
ID NUMBER		GROUP NUMBER

SECONDARY INSURANCE

NAME OF INSURANCE		INSURED NAME
INSURED DATE OF BIRTH	RELATIONSHIP TO PATIENT	INSURED SOCIAL SECURITY NUMBER
ID NUMBER		GROUP NUMBER

EMERGENCY CONTACT

☐ In the event of an emergency, I authorize Northern Psychiatric Associates to contact the following individals

EMERGENCY CONTACT #1

LAST NAME	FIRST NAME	MIDDLE INITIAL
RELATIONSHIP TO PATIENT	PHONE NUMBER	

EMERGENCY CONTACT #2

LAST NAME	FIRST NAME	MIDDLE INITIAL
RELATIONSHIP TO PATIENT	PHONE NUMBER	

APPOINTEES

These are individuals you allow Northern Psychiatric Assoicates to share your information with regarding your appointments (i.e. making/ scheduling/ reminder calls)

☐ I authorize Northern Psychaitric Associates to share appointment infomation with the following individuals

LAST NAME	FIRST NAME	MIDDLE INITIAL
RELATIONSHIP TO PATIENT	PHONE NUMBER	
LAST NAME	FIRST NAME	MIDDLE INITIAL
RELATIONSHIP TO PATIENT	PHONE NUMBER	
LAST NAME	FIRST NAME	MIDDLE INITIAL
RELATIONSHIP TO PATIENT	PHONE NUMBER	

Northern PSYCHIATRIC ASSOCIATES

ADULT THERAPY QUESTIONNAIRE

FORM COMPLETED BY	DATE COMPLETED

CLIENT NAME	DATE OF BIRTH

The information gathered in this intake form is used to facilitate the intake process and will be reviewed with you. Please answer the following to the best of your ability and comfort.

PLEASE CHECK ALL THAT APPLY TO YOU

☐ Anxiety/ Worry	☐ Thoughts of Suicide	☐ Grief/ Death of a Loved One	☐ Behavior Problems
☐ Relationship Difficulties	☐ Trauma	☐ Employment Problems	☐ Pain Management
☐ Depression	☐ Irritability/ Anger	☐ Attention/ Concentration	☐ Eating Disorder
☐ Skin Picking	☐ Hair Pulling	☐ Getting Stuck on Certain Ideas or Thoughts	☐ Substance Abuse
☐ Tics	☐ Sleep Problems	☐ Doing Things a Certain Way/ Repeatedly to decrease anxiety	
☐ Major Life Trauma/ Event	☐ Psychosis	☐ Reduced Functioning in Important Areas of Life	
☐ Social Anxiety	☐ Gambling	☐ Obessions/ Compulsions	

☐ Other:

PLEASE CHECK ANY FACTORS RELEVANT TO YOUR HISTORY

☐ Abandonment	☐ Severe Car Accident	☐ Emotional Abuse	☐ Verbal Abuse	☐ Sexual Abuse
☐ Significant Loss/ Death of a Family Member		☐ Serious Medical Condition		
☐ Neglect	☐ Physical Abuse	☐ Seperation/ Divorce		☐ Witness to Violence

☐ Other:

GIVEN THE LIST OF CATEGORIES BELOW, HOW MUCH STRESS IS EACH CURRENTLY CAUSING YOU?

	NONE	MILD STRESS	MODERATE STRESS	SEVERE STRESS
FAMILY	☐	☐	☐	☐
FRIENDS	☐	☐	☐	☐
RELATIONSHIPS	☐	☐	☐	☐
EDUCATIONAL	☐	☐	☐	☐
ECONOMIC	☐	☐	☐	☐
OCCUPATIONAL	☐	☐	☐	☐
HOUSING	☐	☐	☐	☐
LEGAL	☐	☐	☐	☐
HEALTH	☐	☐	☐	☐

MEDICAL

CURRENT HEALTH CONCERNS

PAST HEALTH CONCERNS

DEVELOPMENT

ADOPTION

AT WHAT AGE:	ADOPTED FROM:

DURING YOUR PREGNANCY/ BIRTH, DID YOU HAVE ANY PROBLEMS WITH THE FOLLOWING:

☐ Exposure to druges or alcohol ☐ Problems with Delivery
☐ A difficult Pregnancy ☐ None of these ☐ Not Sure
☐ Other:

DID YOU HAVE ANY COMPLICATIONS AFTER YOUR BIRTH? (i.e. premature birth, jaundice, breathing difficulties)

DID YOU HAVE ANY DELAYS OR DIFFICULTIES IN REACHING THE FOLLOWING DEVELOPMENTAL MILESTONES?

☐ Walking ☐ Talking ☐ Toilet Training ☐ Sleeping Alone ☐ Being Away from Parents
☐ Making Friends ☐ None of These ☐ Not Sure
☐ Other:

WHICH OPTIONS BELOW BEST DESCRIBE YOUR CHILDHOOD HOME ATMOSPHERE?

☐ Normal ☐ Supportive ☐ Parental Fighting ☐ Parental Violence
☐ Financial Difficulties ☐ Frequent Moving
☐ Other:

MENTAL HEALTH HISTORY

PLEASE NOTE IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING:

☐ Psychiatric Hospitalization ☐ Residential Treatment ☐ Day Treatment ☐ Outpatient Treatment (therapy or pyschiatry)
☐ Taken Any Medications for Psychiatric Treatment ☐ Have Any Family Members With a History of Psychiatric Illness

SUBSTANCE HISTORY

HAVE YOU EVER HAD ANY PROBLEMS WITH ALCOHOL OR RECREATIONAL DRUG USE?

☐ YES ☐ NO

CHECK ANY THAT APPLY

☐ Alcohol ☐ Heroin ☐ Synthetic Drugs ☐ Cannabis ☐ Prescription Medications
☐ Cocaine/ Crack ☐ Methamphetamine ☐ Other

IF SO, HAVE YOU RECEIVED ANY TREATMENT FOR SUBSTANCE ABUSE?

☐ YES ☐ NO

SOCIAL HISTORY

EDUCATIONAL HISTORY

LAST SCHOOL ATTENDED	HIGHEST GRADE COMPLETED

DID YOU HAVE ANY DIFFICULTIES IN SCHOOL?

WHICH OPTIONS BELOW BEST DESCRIBES YOUR SOCIAL SITUATION?

☐ Supportive Social Network ☐ Few Friends ☐ Substance-use Based Friends ☐ No Friends
☐ Family Conflict ☐ Distant From Family Origin
☐ Other

INVOLVEMENT WITH SOCIAL SERVICES

☐ YES ☐ NO

SOCIAL WORKER NAME	**COUNTY**

SUPPORTIVE FAMILY RELATIONSHIPS

SUPPORTIVE FRIENDSHIP RELATIONSHIPS

RELIGIOUS/ CHURCH AFFILIATIONS

OTHER

EMPLOYMENT

☐ Employed Full-Time ☐ Employed Part-Time ☐ Disabled ☐ Student ☐ Unemployed
☐ Other

WHAT ARE YOUR GOALS FOR THERAPY?

PSYCHOLOGY
CONSENT AND INFORMATION FORM

FORM COMPLETED BY	DATE COMPLETED

CLIENT NAME	DATE OF BIRTH

Thank you for choosing Northern Psychiatric for your care. It is important for you to read each item carefully ***and initial*** in the space provided to the left of each item. By initialing you are indicating you have read and understand the content of each item. If you have any questions about the items below, please discuss with your provider at your appointment.

GENERAL	
INITIAL	I am consenting to be evaluated to undergo possible treatment for my mental illness. I may also be recommended to participate in other forms of mental health care treatment.
INITIAL	NPA does not offer after- hours services. If you have a concern, please call our clinic. Your message will be addressed within one business day.
INITIAL	If you have an emergency, such as severe suicidal thoughts, or thoughts to hurt someone else you should call 911, go to your local urgent care, or go to the emergency room. **IF YOU ARE IN NEED OF EMERGENCY CARE, PLEASE CALL:** **CRISIS LINE AT 218.828.HELP (4357)** **THE GRACE UNIT AT ST. JOSEPH'S MEDICAL CENTER AT 218.828.7437** **911 OR THE NEAREST EMERGENCY ROOM**

APPOINTMENT SCHEDULING AND CANCELATIONS	
INITIAL	Appointments canceled without a 24-hour notice may be assessed a fee up to $40.00.
INITIAL	If you miss 3 appointments in a 12-month period with your psychologist, we will refer you elsewhere.

FORMS	
INITIAL	**Our providers require an appointment to complete any forms.** Any forms needing completion should be dropped off at the front desk. Your provider will review the forms and notify staff how long to schedule your forms appointment for. Any forms completed outside of an office visit will be assessed a fee, requiring prepayment.

PSYCHOLOGICAL TESTING	
INITIAL	If your insurance plan will not cover the cost for psychological, or other testing, you will be responsible for all costs incurred.

BILLING AND INSURANCE	
INITIAL	You are responsible for understanding your insurance coverage.
INITIAL	Co-pays are due at the time of check-in.
INITIAL	We collect $50 at time of service for health insurance plans that have a deductible until the deductible has been met.
INITIAL	Your insurance will be charged for services received. You are responsible for all patient balances due to co-pays, co-insurances, deductibles, tax, billing charges, late or no show charges, psychological testing, emergency transportation, etc.
INITIAL	You will receive a monthly statement from our clinic for the remaining balance after your insurance pays the claim. Payment will be expected within 30 days of receipt.

By signing below I am attesting that I have read, understand and agree to the above policies. This signature is legally binding.

Client/ Guardian Print (if client under 18) _____ Relationship to Client _____

Client/ Guardian Signature (if client under 18) _____ Date _____

CLIENT ACKNOWLEGEMENT FORM

FORM COMPLETED BY	DATE COMPLETED

CLIENT NAME	DATE OF BIRTH

NOTICE OF PRIVACY PRACTICES

INITIAL	I affirm that I have been offered a copy of Northern Psychiatric Associates Notice of Privacy Practices and am aware that I may request a copy at any time, or view/download it on the Northern Psychiatric Associates website at www.npamn.com.

INFORMED CONSENT TO TREATMENT

INITIAL	I affirm that I have been offered a copy of Northern Psychiatric Associates Informed Consent to Treatment including fee information and am aware that I may request a copy at any time, or view/download it on the Northern Psychiatric Associates website at www.npamn.com.

APPOINTMENT CONFIRMATION (PLEASE CHECK ALL BOXES THAT APPLY)

INITIAL

I affirm that I have been offered a copy of Northern Psychiatric Associates Communication for Appointment Reminders and am aware that I may request a copy at any time, or view/download it on the Northern Psychiatric Associates website at www.npamn.com.

I agree to have Northern Psychiatric Associates use the following methods for appointment reminders and cancellations

☐ CALL and ☐ LEAVE MESSAGE	**PHONE NUMBER**	**NAME**
☐ TEXT	**PHONE NUMBER**	**NAME**
☐ EMAIL	**EMAIL ADDRESS**	

TELEHEALTH AGREEMENT

INITIAL	I affirm that I have read, understood, and agree to the terms of Nothern Psychiatric Associates Teleheath Consent Form, and am aware that I may request a copy at any time, or view/download it on the Northern Psychiatric Associates website at www.npamn.com.

COORDINATION OF CARE

INITIAL

Our Philosophy of Care includes being aware of how a person's mind and body affect how they are feeling. We consider it to be good care to coordinate between mental health providers and physical health providers who are treating you.

Please indicate your preference for this coordination of care below

☐ I give permission for Northern Psychiatric Associates staff to contact my physician for the purpose of coordinating my care

NAME OF CLINIC	NAME OF PHYSICIAN

☐ I DO NOT want my physician contacted

☐ I have no physician that I am seeing

ASSIGNMENT and RELEASE

INITIAL	I, the undersigned, certify that I (or my dependent) have payer coverage and assign directly to Northern Psychiatric Associates all payer benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by payer. I hereby authorize Northern Psychiatric Associates to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all payer submissions.

USE OF TECHNOLOGY	
	Clinicians do not engage in the use of social media with clients including "friending".
	Being a friend on social media implies a personal relationship that does not exist between a clinician and a patient. Accordingly, clinicians will not "friend" you on social media. If you would like to be a friend of Northern Psychiatric Associates, please pursue that with our company Facebook, Instagram or Twitter pages.
INITIAL	***Email addresses provided by Northern Psychiatric Associates are not confidential or secure. Your use of email to communicate care with us indicates your acceptance of this limitation.***

PATIENT PORTAL		
	We have a patient portal available through our electronic health record for you to be able to access certain information in your file. Please provide us with your email address below so we can initiate your patient portal.	
INITIAL	☐ YES, initiate the set up of my patient portal ☐ I DO NOT wish to initiate the set up of my patient portal at this time	**EMAIL ADDRESS**

By signing below I am attesting that I have read, understand and agree to the above policies. This signature is legally binding.

Client/ Guardian Print (if client under 18)

Relationship to Client

Client/ Guardian Signature (if client under 18)

Date

NOTICE OF PRIVACY PRACTICES

Northern Psychiatric Associates (NPA) is required to protect the privacy and security of your Protected Health Information (PHI). We are required by the Health Insurance Portability and Accountability Act (HIPAA) as well as the Minnesota Department of Health to provide you with a notice of our legal duties and privacy practices with respect to PHI. The terms *we, our,* and *us* refer to NPA, and the terms *you* and *your* refer to our clients.

WHAT IS THIS NOTICE?

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

Federal and state privacy and medical records laws protect your rights as a client of NPA. This notice applies to your current contact with NPA and all future contacts, whether the contact is in person, by telephone, or by mail.

NOTICE INFORMATION

This Notice of Privacy Practices describes how we may use and disclose your PHI to carry out treatment, payment, and health care operations and for other purposes that are specified by law.

We reserve the right to change this Notice. The changes will apply for PHI we already have about you and PHI we receive about you in the future. We will provide an updated Notice to you when you request one. We will also post the most current Notice at our clinic and online at www.npamn.com.

PROTECTED HEALTH INFORMATION

Protected Health Information (PHI) is:

1. Information about your mental or physical health, related health care services, or payment for health care services.
2. Information that is provided by you, created by us, or shared with us by related organizations.
3. Information that identifies you or could be used to identify you, such as demographic information, address and phone number, social security number, age, date of birth, dependents, and health history.

HOW NPA PROTECTS YOUR PHI

Except as described in this Notice or specified by law, we will not use or disclose your PHI. We will use reasonable efforts to request, use, and disclose the minimum amount of PHI necessary.

Whenever possible, we will de-identify or encrypt your personal information so that you cannot be personally identified. We have put physical, electronic, and procedural safeguards in place to protect your PHI and comply with federal and state laws.

YOUR RIGHTS

You have the following rights with respect to your PHI

OBTAIN A COPY OF THIS NOTICE.

You may obtain a copy of this Notice at any time. Even if you have agreed to receive the Notice electronically, you are still entitled to a paper copy.

REQUEST RESTRICTIONS.

You may ask us not to use or disclose any part of your PHI. Your request must be in writing and include what restriction(s) you want and to whom you want the restriction(s) to apply. This includes the right to restrict disclosures of PHI to Health Insurance companies when the services provided are paid for in full out of pocket. Any request to restrict specific disclosures to individuals or entities must be made in writing. We will review and grant reasonable requests, with respect to and within the limits of state and federal law. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

INSPECT AND COPY.

You have the right to inspect and get a copy of your PHI. You must put your request in writing. You can ask to see or copy an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information within a reasonable time

If you ask to see or receive a copy of your record for purposes of reviewing current medical care, we may not charge you a fee. *Minn. Stat. § 144.292 subd. 6.*

If you request copies of your patient records of past medical care, or for certain appeals, we may charge you specified fees *Minn. Stat. § 144.292 subd. 6.* We do have the right to deny your request to inspect and copy. If you are denied access, you may ask us to review the denial.

REQUEST AMENDMENT.

If you feel that your PHI is incomplete or incorrect, you may ask us to amend it. You may ask for an amendment. Your request must be in writing, and you must include a reason that supports your request.

In certain cases, we may deny your request but we'll tell you why in writing within 60 days. If we deny your request for amendment, you have the right to submit a statement of disagreement with our decision to be placed on file with your records.

RECEIVE A LIST OF DISCLOSURES.

You have the right to receive a list of the disclosures (an accounting) that we have made on your PHI on or after **May 12, 2015**.

The list will not include disclosures that we are not required to track, such as disclosures for the purposes of treatment, payment, or health care operations; disclosures which you have authorized us to make; disclosures made directly to you or to friends or family members involved in your care; or disclosures for notification purposes.

Your right to receive a list of disclosures may also be subject to other exceptions, restrictions, and limitations.

Your request for an accounting must be made in writing and state the time period for which you would like us to list the disclosures. We will not include disclosures made more that six years prior to the date of your request, or disclosures made prior to May 12, 2015.

You will not be charged for the first disclosure list that you request, but you may be charged for additional lists provided with the same 12-month period as the first.

REQUEST CONFIDENTIAL COMMUNICATION.

You may ask us to communicate with you using alternative means or alternative locations. For example, you may ask us to contact you about medical records only in writing or at a different address than the one in your file. Your request must be made in writing and state You do not have to tell us why you are making the request, but we may require you to make special arrangements for payment or other communications.

We will review and grant reasonable requests, with respect to and within the limits of state and federal law.

SPECIAL RULES FOR PSYCHOTHERAPY NOTES.

Only psychotherapy notes collected by a psychotherapist during a counseling session are considered PHI. If those notes are kept separate from a client's medical records, HIPAA requires that they be treated with higher standards or protection than other PHI.

It is not NPA's practice to keep psychotherapy notes as defined by HIPAA, or to keep any client notes separate from the client's file.

NOTIFICATION.

You have a right to be notified if your PHI is impermissibly released or disclosed due to a breach including theft, loss, or other form of disclosure.

NPA will attempt to contact all affected individuals in the event of a breach at their last known address or contact number.

SALE AND MARKETING OF PHI.

NPA may not sell your PHI without your written authorization for any reason. NPA does not presently sell PHI of any of our patients for any reason. If this changes in the future, you will be notified in writing and be given the chance to opt out. We will never share your information unless you give us written permission.

WHEN NPA MAY USE AND DISCLOSE PHI

Common reasons for use and disclosures of PHI are found below.

TREAMENT.

To provide, coordinate, or manage health care and related services for you to make sure you are receiving appropriate and effective care.

For example, we may contact you to provide appointment reminders, information about treatment alternatives, or to refer you to other health-related benefits and services that may be of interest to you. Or we might contact another health care provider or third party to share information or consult with them about the services we are providing to you.

Minnesota Law requires consent for disclosure of treatment, payment, or operations information Minn. Stat. § 144.293 subd. 2 except to

other providers within related health care entities when necessary for the current treatment of the patient Minn. Stat. § 144.293 subd. 5.

PAYMENT.
To obtain payment or reimbursement for services provided to you. For example, we may need to disclose PHI to determine eligibility for treatment or claims payment, only if we obtain your consent. Minn. Stat. § 144.293, subd. 2 and 5.

If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

HEALTH CARE OPERATIONS.
To assist in carrying out administrative, financial, legal, and quality improvement activities necessary to run our business and to support the core functions of treatment and payment. We are required to obtain your consent before we release your health records to other providers for their own health care operations. Minn. Stat.§ 144.293, subd. 2 and 5.

BUSINESS ASSOCIATES.
Our business associates perform some health care administration and operation activities for us. Examples of our business associates include our billing service and claims administrators. We may disclose PHI to our business associates so that they can perform the job we have asked them to do.

We require our business associates to sign agreements that limit how they use and disclose PHI. In addition, business associates are required by law to comply with all HIPAA regulations and requirements regarding the use and protection of your PHI.

HEALTH PLAN SPONSOR.
We may disclose PHI to a group health plan administrator, which may, in turn, disclose such PHI to the group health plan sponsor, solely for purposes of administering benefits provided by NPA.

INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE.
We may disclose your PHI to a family member, other relative, close friend, or any person you identify, who is, based on your judgment, believed to be involved in your care or in payment related to your care.

TO IMPROVE YOUR CARE.
NPA may seek and acquire information from other healthcare systems using EpicAccess or other electronic means unless explicitly prohibited.

AS REQUIRED BY LAW.
We must disclose PHI about you when required to do so by state and federal law, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law Minn. Stat. § 144.293 subd. 2.

Less common reasons for use and diclosure of PHI are found below.

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

LEGAL PROCEEDINGS.
We may disclose PHI for a judicial or administrative proceeding in response to a court order, written notice, or protective order. NPA will not release PHI pursuant to a subpoena without a properly completed release of information authorizing NPA to do so.

TO AVERT SERIOUS THREAT TO PUBLIC HEALTH AND SAFETY.
We may disclose PHI to avoid a serious and imminent threat to your health or safety or to the health or safety of others.

MILITARY OR NATIONAL SECUIRTY AND INTELLIGENCE ACTIVITIES.
We may disclose PHI to armed forces personnel under certain circumstances and to authorized federal officials for national security and intelligence activities, including protective services for the President and other Heads of State with your consent, unless required by law. Minn. Stat. § 144.293, subd. 2.

TO PROVIDE REMINDERS AND BENEFITS INFORMATION TO YOU.
Disclosures may be used to verify your eligibility for health care and enrollment in various health plans and to assist us in coordinating benefits for those who have other health insurance or eligibility for government benefit programs.

WORKER'S COMPENSATION.
We may disclose PHI to comply with worker's compensation laws and other similarly legally established programs.

PUBLIC HEALTH.
We may disclose PHI to a public health authority that is permitted by law to receive the information for public health activities. This disclosure might be necessary to prevent or control disease, injury, or disability.

ABUSE OR NEGLECT.
We may make disclosures to government authorities or social service agencies as required by law in the reporting of abuse, neglect, or domestic violence.

TO GOVERNMENT AGENCIES FOR COMPLIANCE PURPOSES.
We may use or disclose PHI to the Secretary of Health and Human Services to assist with a complaint investigation or compliance review.

CORRECTIONAL FACILITY.
We may use or disclose PHI, as authorized by law, if you are an inmate of a correctional facility.

LAW ENFORCEMENT.
We may disclose PHI to law enforcement officials for the purpose of identifying or locating a suspect, witness, or missing person, or to provide information about victims of crimes or with a law enforcement officials with your consent, unless required by law Minn. Stat. § 144.293, subd. 2.

MEDICAL EXAMINER OR CORONER.
We can share health information with a coroner and medical examiner when an individual dies. We need consent to share information with a funeral director Minn. Stat. § 390.11 subd. 7 (a).

YOUR WRITTEN PERMISSION

We are required to get your written permission (authorization) before using or disclosing your PHI for purposes other than those provided above, or as otherwise permitted or required by law. If you do not want to authorize a specific request for disclosure, you may refuse to do so without fear of reprisal.

YOU MAY WITHDRAW YOUR PERMISSION

If you do provide your written authorization and then later want to withdraw it, you may do so in writing at any time. As soon as we receive your written revocation, we will stop using or disclosing the PHI specified in your original authorization, except to the extent that we have already used it based on your written permission.

YOU MAY FILE A COMPLAINT.
If you believe your privacy rights have been violated, you can file a complaint with NPA at:

HIPAA Compliance Officer
Northern Psychiatric Assoicates
7115 Forthun Road, Suite 105
Baxter, MN 56425
Phone: 218.454.0090
Email: info@npamn.com

Or with the United States Department of Health and Human Services at:

U.S. Department of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1.800.368.1019, 800.537.7697 (TDD)

Complaint forms available at http://www.hhs.gov/ocr/office/file/index.html

Filing a complaint will in no way affect the care or services you receive from NPA

DATA PRIVACY

WHY DO WE ASK FOR INFORMATION?
We ask for information from you to determine what service or help you need, develop a service plan with you, and give you the services you want.

The information may also be used to determine your charges for services or for collection of payment from insurance companies or other

payment sources.

DO YOU HAVE TO GIVE INFORMATION TO US?
There is no law that says you must give us any information. However, if you choose to not give us some information, it can limit our ability to serve you well.

WHAT WILL HAPPEN IF YOU DO NOT ANSWER THE QUESTIONS WE ASK?
If you are here because of a court order, and you refuse to provide information, that refusal may be communicated to the court.

Without certain information, we may not be able to tell who should pay for your services.

WHAT PRIVACY RIGHTS DO MINORS HAVE?
If you are under 18, you may request that information about you be kept from your parents. You must give us your request in writing, describe the information, and tell us why you don't want your parents to see it.

If, after reviewing your request, NPA staff believe that giving information to your parents is not in your best interest, we will not share the information.
If NPA staff believe this information could be safely shared with your parents, we will inform you of that decision.

If you are at least 16 or meet other conditions as noted in law Minn. Stat. § 144.343, subd. 1, Minn. Stat. § 144.342, Minn. Stat. § 144.341 you may ask for mental health services without the consent of your parents, but you may have to pay for the services if you do not want your parents to know Minn. Stat. § 144.347.

CONTACT US

Northern Psychiartic Assoicates
7115 Forthun Road, Suite 105
Baxter, MN 56425
Phone: 218.454.0090
Fax: 218.454.0091
Email: info@npamn.com

MINNESOTA PATIENT BILL OF RIGHTS
(MENTAL HEALTH)

COURTEOUS TREATMENT.
Clients have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.

APPROPRIATE HEALTH CARE.
Clients shall have the right to appropriate medical and personal care based on individual needs.

PHYSICIAN'S IDENTITY.
Clients shall have or be given, in writing, the name, business address, telephone number, and specialty, if any, of the physician responsible for coordination of their care. In cases where it is medically inadvisable, as documented by the attending physician in a client's care record, the information shall be given to the client's guardian or other person designated by the client as a representative.

INFORMATION ABOUT TREATMENT.
Clients shall be given, by their providers, complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information shall be in terms and language the Clients can reasonably be expected to understand.
Clients may be accompanied by a family member or other chosen representative, or both. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending provider in a client's medical record, the information shall be given to the client's guardian or other person designated by the client as a representative. Individuals have the right to refuse this information.

PARTICIPATION IN PLANNING TREATMENT; NOTIFICATION OF FAMILY MEMBERS.
Clients shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative, or both. In the event that the client cannot be present, a family member or other representative chosen by the client may be included in such conferences.

CONTINUITY OF CARE.
Clients shall have the right to be cared for with reasonable regularity and continuity of staff assignment as far as facility policy allows.

RIGHT TO REFUSE CARE.
Competent clients shall have the right to refuse treatment based on the information required about treatment, and to terminate services at any time, except as otherwise provided by law or court order.

FREEDOM FROM MALTREATMENT.
Clients shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every client shall also be free from nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a client's physician for a specified and limited period of time.

TREATMENT PRIVACY.
Clients shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly.

CONFIDENTIALITY OF RECORDS.
Clients shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility.
If we believe it is in your best interest, we may also share your information when needed to lessen a serious and imminent threat to health or safety.

RESPONSIVE SERVICE.
Clients shall have the right to a prompt and reasonable response to their questions and requests.

PROTECTION AND ADVOCACY SERVICES.
Clients shall have the right of reasonable access at reasonable times to any available rights protection services and advocacy services so that the Clients may receive assistance in understanding, exercising, and protecting the rights described in this section and in other law. This right shall include the opportunity for private communication between the clients and a representative of the rights protection service or advocacy service.

NON-DISCRIMINATION.
Client have the right to be free from being the object of unlawful discrimination without regard to race, color, nation of origin, language, religion, political beliefs, sex, marital status, age, sexual orientation, gender identity, or disability, including AIDS, AIDS-related complex, or status as HIV positive.

ADDITIONAL RIGHTS:

Examine public data on your provider maintained by their board;
Be informed of the provider's license status, education, training, and experience
To have access to your records as provided in Minnesota Statutes, sections 144.291 to 144.298; Minnesota Statutes, sections 144.291 to 144.298
To be informed of the cost of professional services before receiving the services To know the intended recipients of psychological assessment results;
To withdraw consent to release assessment results, unless that right is prohibited by law or court order or is waived by prior written agreement;
To a nontechnical description of assessment procedures
To a nontechnical explanation and interpretation of assessment results, unless that right is prohibited by law or court order or is waived by prior written agreement.

GRIEVANCES.
Clients shall be encouraged and assisted, throughout their course of treatment, to understand and exercise their rights as clients and citizens. Clients may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge.

If you believe that Northern Psychiatric Associates has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:
Northern Psychiatric Associates
ATTN: Quality Assurance
7115 Forthun Road, Suite 105
Baxter, MN 56425
Phone: 218.454.0090
Email: info@npamn.com

INFORMED CONSENT TO TREATMENT

This *Informed Consent* is not intended to be *all inclusive* for aspects of your behavioral health treatment. It is only intended to provide some useful information before deciding to engage in behavioral health treatment.

INFORMED CONSENT

Your behavioral health provider will give you a clear recommendation for treatment interventions proposed.

Your behavioral health provider will give you a clear recommendation of the types of treatments, such as individual counseling/therapy, group counseling/therapy, family/couples counseling/therapy, addictions counseling, skills services (for children or adults), and/or psychiatric services. Times, dates, and session length will be discussed with you by your provider.

Your behavioral health provider may make diagnostic and treatment recommendations with which you do not agree (e.g. modality of treatment, duration of treatment, frequency of visits, etc.)

Your provider cannot guarantee results (e.g., less depressed, improved marital satisfaction, etc.) of behavioral health services. However, your behavioral health provider will discuss with you reasons, goals, and objectives for continuing/discontinuing mental health treatment. It is important to periodically review with you how services are going and to discuss any changes or questions you may have.

There may be some risks in participating in mental health or substance use services, including, but not limited to: addressing painful emotional experiences and/or feelings; being challenged or confronted on a particular issue; re- uniting with family members; or being inconvenienced due to costs/fees of counseling. You can discuss any unforeseen risks vs. benefits with your provider at any time. In the case of psychiatric care, medications, side effects, and alternative treatments will be discussed.

You have the right to an interpreter (sign or language) if necessary.

For crisis services call the National Suicide Prevention line at 1-800-273-8255, Crisis Text Line at 741741; in the Twin Cities metro area, call **CRISIS (274747) from a cell phone. Your provider will discuss with you how to access this service. For life threatening emergencies, please call 911.

If you have a grievance with your behavioral health provider, you are encouraged to first attempt to communicate this directly to them. In the event that your grievance is not satisfactorily resolved, you may ask to speak with a supervisor and /or you may complete a customer complaint/grievance form.

If you wish to file a grievance you may speak with the supervisor of the person you have a complaint about or the Clinic Manager at 218.454.0090, in addition you have the right to file a complaint with a licensing board.

While you are agreeing to undergo behavioral health treatment you may end treatment at any time.

For children of divorced or separated parents, if there is disagreement between the parents this must be discussed at the first session. The parent requesting or arranging services, must have the legal right to authorize care and treatment of the child, and will be responsible for payment. Documentation of legal agreements may be required. Our services billed as a medical services are focused on treating the presenting mental or substance use issues and not focused on assessing parenting capacity or documenting disputes between parents.

The complete Patient Bill of Rights is posted at every office or available on our website at www.npamn.com.

You have the right to know the fees for services provided.

FEES FOR SERVICES

If you would like a fee schedule of services please go ask the reception area for a listing.

FINANCIAL POLICIES

The fee to you will depend on whether and which insurance you have and any copays or deductibles associated. As a courtesy, we may verify your insurance benefits, however, any quoted benefits are not guaranteed. It is your responsibility to call your insurance carrier regarding the specifics of your coverage such as copays, deductibles, number of visits and covered services as well as to keep current of any changes in your benefits during course of treatment. It is required you inform us of any insurance change you become aware of. The balance incurred is your personal responsibility whether your insurance company pays or not. Coverage amounts vary from policy to policy. Understand that your insurance policy is a contract between you and your insurance company. Our office will NOT be held responsible in the event your insurance company denies ANY claim. You may choose to pay at the time of service or be billed for any outstanding balance on a monthly basis upon request of an acceptable payment plan.

Your account must remain current in order to provide services. Your account may be turned over to a collection agency if not paid in a timely manner. Should your account go to collections, the balance must be reviewed by Northern Psychiatric Associates or paid in full before any additional appointments can be scheduled

SILDING FEE SCALE

Sliding fee scale is offered for those uninsured. To be eligible for reduced fees, a completed application for sliding fee scale along with verification of income including previous year tax statement, paystubs, or bank statements is required, along with applying for Medical Assistance/MN Care. Reevaluation of income or application status is completed annually. Clients utilizing sliding fee scale are required to inform Northern Psychiatric Associates of any changes of income.

CANCELED OR MISSED APPOINTMENTS

Please make every effort to keep your scheduled appointment. If you must miss, please call to notify us as soon as possible in order to make the time available for someone else who may need it.

A ***$40.00 fee*** will be charged for any late cancellation (within 24 hours of the appointment) or no show after the first missed appointment.

As it is your responsibility to attend scheduled appointments, we reserve the right to terminate services if three or more appointments are missed due to late cancellations or no shows in a 12-month period.

COMMUNICATION FOR APPOINTMENT REMINDERS

IN CASE OF A MEDICAL EMERGENCY, DO NOT USE EMAIL OR TEXT. CALL 911.

TEXT

Northern Psychiatric Associates offers clients the opportunity to receive text reminders in place of phone reminders. This provides the guidelines regarding text reminders. Northern Psychiatric Associates uses a secure encrypted server to send information to you that offers a level of security. We do not offer that same security when you send texts back to Northern Psychiatric Associates. Once a text is on your phone it is your responsibility who may have access to that text.

TEXT USE

Consenting is for Northern Psychiatric Associates to send clients texts which are secure. **Clients agree to notify Northern Psychiatric Associates immediately if the text number changes.**

DO NOT USE TEXT FOR

Sending information back about appointments or any other communication.
THIS IS A ONE-WAY TEXT ONLY. PLEASE DO NOT RESPOND TO THIS TEXT.
PLEASE CALL 218.454.0090 for any changes to an appointment.

CONTENT OF THE MESSAGE

Text messages sent to your phone will only reflect a meeting date, time, and the name of the individual you are scheduled to meet. This will be for all appointments at Northern Psychiatric Associates

ENDING TEXT REMINDERS

You may discontinue using Text as a means of appointment reminders by replying ***"STOP"*** to your appointment text reminder, calling, or sending a letter to Northern Psychiatric Associates indicating you no longer wish to continue receiving text reminders. Please send the letter to Text Reminders, Northern Psychiatric Associates, 7115 Forthun Road; Ste 105 Baxter, MN 56425.

COSTS

Northern Psychiatric Associates provides this free of charge; however, standard text messaging rates from your cell phone provider apply.

EMAIL

Northern Psychiatric Associates offers clients the opportunity to receive email reminders in place of phone reminders. This provides the guidelines regarding email reminders. Once an email is sent it is your responsibility who may have access to that email.

EMAIL USE

Consenting is for Northern Psychiatric Associates to send clients emails with appointment information. **Clients agree to notify Northern Psychiatric Associates immediately if the email address changes.**

DO NOT USE EMAIL FOR

Sending information back about appointments or any other communication. **THIS IS A ONE-WAY EMAIL ONLY. PLEASE DO NOT RESPOND TO THIS EMAIL. PLEASE CALL 218.454.0090 for any changes to an appointment.**

CONTENT OF THE MESSAGE

Email messages sent to you will only reflect a meeting date, time, and the name of the individual you are scheduled to meet. This will be for all appointments at Northern Psychiatric.

ENDING EMAIL REMINDERS

You may discontinue using EMAIL as a means of appointment reminders by replying ***"STOP"*** to your appointment reminder, calling, or sending a letter to Northern Psychiatric Associates indicating you no longer wish to continue receiving email reminders. Please send the letter to Email Reminders, Northern Psychiatric Associates, 7115 Forthun Road; Ste 105 Baxter, MN 56425.

TELEHEALTH CONSENT FORM

CONSENT TO PARTICIPATE IN A TELEMEDICINE APPOINTMENT

I understand that my health care provider wishes me to engage in a telemedicine consultation using Zoom.

My health care provider has explained to me how the Zoom video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

I understand there are potential risks to this technology including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the Zoom video conferencing connections are not adequate for the situation.

I understand that if others are present during the consultation other than my health care provider, they will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following:

(1) omit specific details of my medical history/physical examination that are personally sensitive to me
(2) ask non-medical personnel to leave the telemedicine examination room
(3) to terminate the consultation at any time.

I have had the alternatives to a telemedicine consultation explained to me and am choosing to participate in a Zoom telemedicine consultation.

In an emergency, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner, and that the specialist's responsibility will conclude upon the termination of the Zoom video conference connection.

I have had a direct conversation with my health care provider during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered, and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

BY INITIALING THE CLIENT ACKNOWLEGEMENT FORM, I CERTIFY:

That I have read or had this form read/ and or had this form explained to me.

That I fully understand its contents including the risks and benefits of the procedure(s).

That I have been given ample opportunity to ask questions, and that any questions have been answered to my satisfaction.

Financial Policy

Financial Terms	
INITIAL	Copays are due at time of service. Part of our contract with your insurance company is agreeing to collect your copay, just like your contract with your insurance company states that you owe a copay.
INITIAL	We collect $50 at time of service for health insurance plans that have a deductible, until the deductible has been met.
INITIAL	Collection of payment- we require a credit card on file to schedule services. The card on file will be used to collect any copays and/or deductibles that are due at time of service. We will not charge this card for past due balances unless agreed on by both parties (i.e.: a payment plan is set up, or an automatic payment form has been signed).
INITIAL	Past Due Balances if your balance is over 61 days past due, half of the amount past due will be required to schedule future appointments. If you are unable to pay the past due balance, please contact our billing department at 218.454.4085.
INITIAL	Self-Pay (non-insured**) c**lients are required to pay the full amount due for services at time of service. A card will need to be kept on file for charging at time of service.
INITIAL	Payment Plans are available to those who qualify. Payment plans will be set for 6 months to ensure the amount being paid is sufficient to pay off your bil. While on a payment plan you will be required to still pay your copay/deductible amount at time of service.
INITIAL	Sliding Fee Scale is available to those who qualify. The sliding fee scale application and verification paperwork must be turned in to see if you are eligible. If approved, the discount will be reflected on your next date of service and will be valid for 12 months.

Payment for Services

We require a credit card on file to schedule. As stated above, this credit card will *only be used for collection of copays/deductible amounts due at time of service* . The card on file will not be charged for payment of balances past due unless otherwise instructed to do so by

Please see the Page 2 for credit card consent and Page 3 for credit card information. As all credit card numbers must be encrypted into our system, page number 3 will be shred upon entry of data to our system.

If you have any questions on the above or to get set up with a payment plan, please contact our billing department via phone at 218.454.4085 or email at billing@npamn.com. Voicemails and emails will be returned within one business day.

Financial Policy - Credit Card Consent Form

After reading page 1 of the financial policy, please fill out the below, authorizing Northern Psychiatric Associates to charge your credit card on file for any copays/ deductible amounts due at time of service.

Credit Card Consent Form

Initial

I affirm that I have been offered a copy of Northern Psychiatric Associates Financial Policy and am aware that I may request a copy at any time, or view/download it on the Northern Psychiatric Associates website at www.npamn.com.

Initial

I authorize **Northern Psychiatric Associates** to keep my signature-on-file beginning on today's date and ending one year from today's date and to charge my card for any appointment copays/deductibles due on the dates of service.

Initial

I authorize **Northern Psychiatric Associates** to email my authorization receipt to: _____

_____

Client MRN

_____

Last 4 Digits of card to be put on file

_____

Cardholder Name

_____

Cardholder Relationship to Client

_____

Cardholder Signature

_____

Today's Date

Financial Policy - Credit Card Consent Form

After filling out page two (2), please enter your credit card information below.

The information gathered on this page will be shred once we have entered in your credit card information to our encrypted Electronic Health Record.

HelloSign is a HIPAA compliant, secured platform but we understand that you may not want your credit card number down. Please either fill out the below or select one of the check boxes. *This is required prior to scheduling

☐ Check this box if you prefer for us to give you a call to get credit card information.

☐ Check this box if you prefer to bring your credit card into the clinic to be put on file

Credit Card Information

_____
Client Name

_____
Cardholders Name

_____
Card Number

_____
Cardholders Phone Number

_____
Expiration Date

_____
Card Security Code
(3 numbers on the back of the card or for AMEX the 4 numbers on the upper right-hand side of the front of the card

_____
Date

_____
Zip Code

_____
Cardholder Signature

_____
Cardholder Relationship to Client