Registration Form

Minnesota Center For Psychology, LLC

DX Code ______________

Date ______________ Therapist ______________

Patient Information

Patient Name (Print) ______________ Last Name ______________ First Name ______________ Initial ______________ Date of Birth ______________

Street Address ______________ Cell/Home Phone ______________

City ______________ State ______________ ZIP ______________ Work Phone ______________

Soc. Sec. # ______________ Emergency Contact ______________ Emergency Phone ______________

Sex: ☐ Female ☐ Male Age ______________ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Other

Employer ______________ Occupation ______________

Referred by ______________ May we acknowledge this referral? ______________

Primary Insurance

Primary Insurance Company ______________ Phone ______________

Ins Claims Address ______________ City ______________ State ______________ Zip ______________

Policy / Member ID ______________ Group/Account # ______________

Policy Holder Information: (if the patient is not the employee/policy holder)

Name ______________ Last name ______________ First Name ______________ Initial ______________ Date of Birth ______________

Address ______________ City ______________ State ______________ Zip ______________ Relationship ______________

Soc. Sec# ______________ Employer ______________

Secondary Insurance

Secondary Insurance Company ______________ Phone ______________

Ins Claims Address ______________ City ______________ State ______________ Zip ______________

Policy / Member ID ______________ Group/Account # ______________

Policy Holder Information: (if the patient is not the employee/policy holder)

Name ______________ Last name ______________ First Name ______________ Initial ______________ Date of Birth ______________

Address ______________ City ______________ State ______________ Zip ______________ Relationship ______________

Soc. Sec# ______________ Employer ______________

Responsible Party

(Where should the patient's portion of the bill be sent, if not to the patient?)

Name ______________ Relationship ______________

Address ______________ Phone ______________

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance 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 insurance. I hereby authorize the healthcare provider 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 insurance submissions.

______________ Responsible Party Signature ______________ Relationship ______________ Date

MINNESOTA CENTER FOR PSYCHOLOGY, LLC
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.

The law requires us to protect the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to this health information. We are required to follow the terms of the Notice that is currently in effect. This Notice outlines our legal obligations regarding your health information and is effective as of February 2, 2010. We reserve the right to change the terms of this Notice and to make the new terms effective for all health information we possess. If this Notice is changed, we will post the revised Notice on our website and in our office, and we will give you a revised Notice upon request.

How We May Use or Disclose Your Health Information

The law allows us to use or disclose your health information for the following purposes:

1. *For Treatment.* We may use or disclose your health information to provide you with medical treatment or services. For example, a mental health practitioner may review your medical record and release medical information for a consultation or referral. We will get your written consent prior to making disclosures outside our practice for treatment purposes, except in emergency circumstances when it is not possible to get your consent.
2. *For Payment.* We may use and disclose your health information to receive payment for treatment that you receive. For example, we may send a bill to your health insurance company that describes the services we provided to you. We will get your written consent prior to making disclosures for payment purposes.
3. *For Health Care Operations.* We may use and disclose your health information for the operation of our practice. For example, we may share information with our staff or employees for training purposes or to assess the quality of care provided in our practice. We will get your written consent before making disclosures to others outside our practice for health care operations purposes.
4. *Communication with Family and Friends Involved in Your Care or Paying Your Bills.* If you are able to make your own health care decisions, we will ask your permission before sharing medical information about you. If you are unable to make health care decisions, our health care practitioners may disclose relevant information if they believe that doing so is in your best interests.
5. *Appointment Reminders.* We may use your information to send you reminders about future appointments.
6. *Notification.* We may disclose your health information to notify a family member, a personal representative, or other persons responsible for your care about your location or general condition.
7. *Public Health Agencies.* We may use or disclose your health information for public health activities such as assisting public health authorities in preventing or tracking disease. We may be permitted and/or required by law to report neglect, child abuse, or abuse of a vulnerable adult.
8. *Health and Safety.* Your health information may be disclosed to avert a serious threat to health or safety of you or any other person. Any disclosure would be only to someone able to help prevent the threat. Minnesota law imposes a duty to warn on certain mental health care providers if a person has communicated a specific, serious threat of physical violence against a specific person.
9. *Law Enforcement.* We will only release your medical information to law enforcement officials in response to a valid court order, a grand jury subpoena, or warrant, or with your written consent. We may release non-medical information about you to law enforcement if we are asked by law enforcement for the information, or as may be required by law. In addition, we may release non-medical information about you if you are suspected of committing a crime on the practice's premises.
10. *Research.* We may use and disclose your information for research purposes, either with your written authorization or otherwise consistent with applicable law. Minnesota law may require consent before your information can be released to an outside researcher. We will make a good faith effort to obtain your consent or refusal, as required by law, prior to releasing any identifiable information about you to outside researchers.
11. *Health Oversight.* We may disclose your information to a health oversight agency for activities authorized by law, including audits and investigations, in order for the government to monitor health care programs and compliance with laws. Minnesota law requires that patient-identifying information be removed from most disclosures for these purposes, unless you have provided us with written consent.
12. *Lawsuits/Disputes.* If you are involved in a lawsuit or dispute, we may disclose information about you in response to a court order, a grand jury subpoena, a warrant, with your written consent, or as otherwise required by law.
13. *National Security, Intelligence, and Protective Services for the President and Others.* We will release medical information about you to authorized federal officials for intelligence, counter-intelligence, national security

activities, and protective services for the President or other authorized persons or foreign heads of state only as required by law or with your written consent.

14. *Decedents.* Health information may be disclosed to funeral directors, coroners, or medical examiners in the case of certain types of death for the purpose of identifying a deceased person, determining a cause of death or other purpose, in accordance with applicable law.
15. *Workers' Compensation.* Your information may be used or disclosed in order to comply with laws and regulations related to Worker's Compensation. Minnesota law permits disclosure of your information to the parties involved in the claim, without specific written consent, if the information is related to a workers' compensation claim.
16. *Business Associates.* We may disclose your information to a business associate to perform functions on our behalf, if the business associate has signed an agreement to protect the confidentiality of the information.
17. *As Required by Law.* We may use and disclose your health information as otherwise required by law.

Other uses and disclosures will be made only with your written authorization, which you may revoke, except to the extent we have already acted upon the authorization. We are required to retain records of care provided to you.

Your Rights Regarding Your Health Information

You have the following rights with respect to your health information. If you would like to exercise any of these rights or if you have questions regarding your rights, please contact:

Privacy Officer
Minnesota Center for Psychology
Phone: (651) 644-4100

1. *You have the right to request that we limit our uses and disclosures of your health information.* Requests must be in writing, and you must tell us what information you wish to limit; whether you want to limit our use, our disclosure, or both; and to whom you want the limits to apply. If you pay out-of-pocket in full for an item or service, then you may request that we not disclose information pertaining solely to such item or service to your health plan for purposes of payment or health care operations. We are required to agree with such a request. However, we are not required to agree to any other request.
2. *You have the right to request that we communicate with you through alternative means or locations.* We will respect any reasonable requests. Requests must be in writing, and you must specify how and where you wish to be contacted. We may require you to provide information about how payment will be handled.
3. *You have the right to review and obtain a copy of your health information.* We may charge you a fee for the cost of providing you with such a copy. Requests must be in writing. If we maintain your health information in an electronic health record, you have the right to receive a copy of your health information in electronic form. You may also direct us to provide such electronic health information directly to an entity or person clearly and specifically designated by you in writing. We may deny your request in limited circumstances, such as if the disclosure will be harmful to your health. In such cases, we may supply the information to a third party who may release the information to you. You may have a denial reviewed by another health care professional chosen by the practice, and we will comply with the outcome of that review.
4. *You have the right to request that we amend your health information.* Requests must be in writing, and we may deny your request if it does not include a reason to support the request. We may also deny a request if you ask us to amend information that: was not created by us; is not part of the medical information kept by us; is not information you would be permitted to inspect and copy; or is already accurate and complete.
5. You have the right to obtain an accounting of disclosures of your health information, except disclosures: for treatment, payment, or health care operations; authorized by you; for national security or intelligence; or to correctional institutions and law enforcement with custody of you. Requests must be in writing and may not go back more than six years. You may receive one free accounting in any 12-month period; we will charge you for additional requests.
6. You have the right to receive a paper copy of this Notice.

Complaints

You may complain to us if you think we have violated your privacy rights. You will not be retaliated against for bringing a complaint. Direct complaints to:

Minnesota Center for Psychology
2324 University Avenue, Suite 120
St. Paul, Minnesota 55114
Phone: (651) 644-4100

You can also file a complaint with the Department of Health and Human Services, Office for Civil Rights.

PATIENT RIGHTS AND RESPONSIBILITIES

Our commitment is to provide quality mental health services to all individuals without regard to race, color, religion, national origin, gender, age, sexual orientation, or disability.

Patients have the right to:

- be treated with courtesy and respect
- appropriate medical and personal care based on individual needs
- receive full information from the potential treating professional about that professional's knowledge, experience, credentials
- be informed about diagnoses and the options available for treatment interventions and effectiveness and risks of the recommended treatment
- have the information they disclose to their mental health provider kept confidential within the limits of state and federal law
- participate meaningfully in the planning, implementation and termination or referral of their treatment and if whey wish, to include a family member or other chosen representative in planning their care
- be cared for with reasonable regularity and continuity of staff assignment as far as facility policy allows
- freedom from maltreatment
- refuse treatment or participation in experimental research
- discuss concerns or questions about the mental health services they receive with their provider
- know costs of treatment services
- confidential treatment of their personal and medical records and may approve or refuse their release to any individual outside the facility within the limits of state and federal law
- a prompt and reasonable response to their questions and requests
- consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being

Minnesota Patients' Bill of Rights

Legislative Intent

It is the intent of the Legislature and the purpose of this statement to promote the interests and well-being of the patients of health care facilities. No health care facility may require a patient to waive these rights as a condition of admission to the facility. Any guardian or conservator of a patient or, in the absence of a guardian or conservator, an interested person, may seek enforcement of these rights on behalf of a patient. An interested person may also seek enforcement of these rights on behalf of a patient who has a guardian or conservator through administrative agencies or in probate court or county court having jurisdiction over guardianships and conservatorships. Pending the outcome of an enforcement proceeding the health care facility may, in good faith, comply with the instructions of a guardian or conservator. It is the intent of this section that every patient's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed and that the facility shall encourage and assist in the fullest possible exercise of these rights.

Definitions

For the purposes of this statement, "patient" means a person who is admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental health of that person. "Patient" also means a minor who is admitted to a residential program as defined in Section 7, Laws of Minnesota 1986, Chapter 326. For purposes of this statement, "patient" also means any person who is receiving mental health treatment on an out-patient basis or in a community support program or other community-based program.

Public Policy Declaration

It is declared to be the public policy of this state that the interests of each patient be protected by a declaration of a patient's bill of rights which shall include but not be limited to the rights specified in this statement.

1. Information about Rights
Patients shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in Section 7, the written statement shall also describe the right of a person 16 years old or older to request release as provided in Section 253B.04, Subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments, and those who speak a language other than English. Current facilities policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and Section 626.557, relating to vulnerable adults.

2. Courteous Treatment
Patients 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.

3. Appropriate Health Care
Patients shall have the right to appropriate medical and personal care based on individual needs. This right is limited where the service is not reimbursable by public or private resources.

4. Physician's Identity
Patients shall have or be given, in writing, the name, business address, telephone number, and specialty, of 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 patient's care record, the information shall be given to the patient's guardian or other person designated by the patient as his or her representative.

5. Relationship with Other Health Services
Patients who receive services from an outside provider are entitled, upon request, to be told the identity of the provider. Information shall include the name of the outside provider, the address, and a description of the service which may be rendered. In cases where it is medically inadvisable, as documented by the attending physician in a patient's care record, the information shall be given to the patient's guardian or other person designated by the patient as his or her representative.

6. Information about Treatment
Patients shall be given by their physicians 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 patients can reasonably be expected to understand. Patients 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 physician in a patient's medical record, the information shall be given to the patient's guardian or other person designated by the patient as his or her representative. Individuals have the right to refuse this information.

Every patient suffering from any form of breast cancer shall be fully informed, prior to or at the time of admission and during her stay, of all alternative effective methods of treatment of which the treating physician is knowledgeable, including surgical, radiological, or chemotherapeutic treatments or combinations of treatments and the risks associated with each of those methods.

7. Participation in Planning Treatment

Notification of Family Members:

(a) Patients 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 patient cannot be present, a family member or other representative chosen by the patient may be included in such conferences. A chosen representative may include a doula of the patient's choice.

(b) If a patient who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the patient as the person to contact in an emergency that the patient has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the patient has an effective advance directive to the contrary or knows the patient has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the patient has executed an advance directive relative to the patient's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the patient;
(2) examining the medical records of the patient in the possession of the facility; (3) inquiring of any emergency contact or family member contacted whether the patient has executed an advance directive and whether the patient has a physician to whom the patient normally goes for care; and
(4) inquiring of the physician to whom the patient normally goes for care, if known, whether the patient has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to the patient for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the patient and the medical records of the patient in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the patient has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility is not liable to the patient for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

8. Continuity of Care
Patients shall have the right to be cared for with reasonable regularity and continuity of staff assignment as far as facility policy allows.

9. Right to Refuse Care
Competent patients shall have the right to refuse treatment based on the information required in Right No. 6. In cases where a patient is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the patient's medical record.

10. Experimental Research
Written, informed consent must be obtained prior to patient's participation in experimental research. Patients have the right to refuse participation. Both consent and refusal shall be documented in the individual care record.

11. Freedom from Maltreatment
Patients 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 patient shall also be free from nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a patients' physician for a specified and limited period of time, and only when necessary to protect the patient from self-injury or injury to others.

12. Treatment Privacy
Patients 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. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient safety or assistance.

13. Confidentiality of Records
Patients shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility. Copies of records and written information from the records shall be made available in accordance with this subdivision and Section 144.335. This right does not apply to complaint investigations and inspections by the department of health, where required by third party payment contracts, or where otherwise provided by law.

14. Disclosure of Services Available
Patients shall be informed, prior to or at the time of admission and during their stay, of services which are included in the facility's basic per diem or daily room rate and that other services are available at additional charges. Facilities shall make every effort to assist patients in obtaining information regarding whether the Medicare or Medical Assistance program will pay for any or all of the aforementioned services. 15. Responsive Service Patients shall have the right to a prompt and reasonable response to their questions and requests. 16. Personal Privacy Patients shall have the right to every consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being.

17. Grievances
Patients shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients and citizens. Patients 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. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, Section 307 (a)(12) shall be posted in a conspicuous place.

Every acute care in-patient facility, every residential program as defined in Section 7, and every facility employing more than two people that provides out-patient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision-maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in Section 7 which are hospital-based primary treatment programs, and outpatient surgery centers with Section 144.691 and compliance by health maintenance organizations with Section 62D.11 is deemed to be in compliance with the requirement for a written internal grievance procedure.

18. Communication Privacy
Patients may associate and communicate privately with persons of their choice and enter and, except as provided by the Minnesota Commitment Act, leave the facility as they choose. Patients shall have access, at their expense, to writing instruments, stationery, and postage. Personal mail shall be sent without interference and received unopened unless medically or programmatically contraindicated and documented by the physician in the medical record. There shall be access to a

telephone where patients can make and receive calls as well as speak privately. Facilities which are unable to provide a private area shall make reasonable arrangements to accommodate the privacy of patients' calls. This right is limited where medically inadvisable, as documented by the attending physician in a patient's care record. Where programmatically limited by a facility abuse prevention plan pursuant to the Vulnerable Adults Protection Act, Section 626.557, Subdivision 14, Paragraph (b), this right shall also be limited accordingly.

19. Personal Property
Patients may retain and use their personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients, and unless medically or programmatically contraindicated for documented medical, safely, or programmatic reasons. The facility may, but is not required to, provide compensation for or replacement of lost or stolen items.

20. Services for the Facility
Patients shall not perform labor or services for the facility unless those activities are included for therapeutic purposes and appropriately goal-related in their individual medical record.

21. Protection and Advocacy Services
Patients shall have the right of reasonable access at reasonable times to any available rights protection services and advocacy services so that the patient 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 patient and a representative of the rights protection service or advocacy service.

22. Right to Communication Disclosure and Right to Associate
Upon admission to a facility, where federal law prohibits unauthorized disclosure of patient identifying information to callers and visitors, the patient, or the legal guardian or conservator of the patient, shall be given the opportunity to authorize disclosure of the patient's presence in the facility to callers and visitors who may seek to communicate with the patient. To the extent possible, the legal guardian or conservator of the patient shall consider the opinions of the patient regarding the disclosure of the patient's presence in the facility.

The patient has the right to visitation by an individual the patient has appointed as the patient's health care agent under chapter 145C and the right to visitation and health care decision making by an individual designated by the patient under paragraph 22.

Upon admission to a facility, the patient or the legal guardian or conservator of the patient, must be given the opportunity to designate a person who is not related who will have the status of the patient's next of kin with respect to visitation and making a health care decision. A designation must be included in the patient's health record. With respect to making a health care decision, a health care directive or appointment of a health care agent under chapter 145C prevails over a designation made under this paragraph. The unrelated person may also be identified as such by the patient or by the patient's family.

ADDITIONAL RIGHTS IN RESIDENTIAL PROGRAMS THAT PROVIDE TREATMENT TO CHEMICALLY DEPENDENT OR MENTALLY ILL MINORS OR IN FACILITIES PROVIDING SERVICES FOR EMOTIONALLY DISTURBED MINORS ON A 24-HOUR BASIS:

23. Isolation and Restraints
A minor patient who has been admitted to a residential program as defined in Section 7 has the right to be free from physical restraint and isolation except in emergency situations involving likelihood that the patient will physically harm the patient's self or others. These procedures may not be used for disciplinary purposes, to enforce program rules, or for the convenience of staff. Isolation or restraint may be used only upon the prior authorization of a physician, psychiatrist, or licensed consulting psychologist, only when less restrictive measures are ineffective or not feasible and only for the shortest time necessary.

24. Treatment Plan
A minor patient who has been admitted to a residential program as defined in Section 7 has the right to a written treatment plan that describes in behavioral terms the case problems, the precise goals of the plan, and the procedures that will be utilized to minimize the length of time that the minor requires inpatient treatment. The plan shall also state goals for release to a less restrictive facility and follow-up treatment measures and services, if appropriate. To the degree possible, the minor patient and his or her parents or guardian shall be involved in the development of the treatment and discharge plan.

Inquiries or complaints regarding medical treatment or the Patients' Bill of Rights may be directed to:

Minnesota Board of Psychology
2829 University Ave SE #320
Minneapolis, MN 55414
Tel: (612) 617-2230

Minnesota Board of Social Work
2829 University Ave SE #340
Minneapolis, MN 55414
Tel: (612) 617-2100
Fax: (612) 617-2103

Minnesota Board of Behavioral Health & Therapy
2829 University Ave SE #210
Minneapolis, MN 55414
Tel: (612) 548-2177
Fax: (612) 617-2187

Minnesota Board of Marriage and Family Therapy
2829 University Ave SE #400
Minneapolis, MN 55414
Tel: (612) 617-2220
Fax: (612) 617-2221

Minnesota Board of Medical Practice
2829 University Avenue SE #500
Minneapolis, MN 55414
Tel: (612) 617-2130
Fax: (612) 617-2166

Office of Health Facility Complaints
P.O. Box 64970
St. Paul, MN 55164-0970
Tel: (651) 201-4201
(800) 369-7994

Inquiries regarding access to care or possible premature discharge may be directed to: Ombudsman for Long-Term Care
PO Box 64971
St. Paul, MN 55164-0971
Tel. (800) 657-3591 or
(651) 431-2555 (metro)

Text provided by the Minnesota Hospital and Healthcare Partnership. Translation financed by the Minnesota Department of Health. For more information on this translation, contact the Minnesota Department of Health at (651) 201-3701.

Group Availability:

Please mark any times below that you know you will **NOT** be able to attend group.

	Morning (9am-12pm)	Afternoon (12-3pm)	Evening (5-8pm)
Monday	☐	☐	☐
Tuesday	☐	☐	☐
Wednesday	☐	☐	☐
Thursday	☐	☐	☐
Friday	☐	☐	N/A
Saturday	☐	N/A	N/A

**Please note: this does not guarantee that DBT will be recommended as the best treatment for you and does not guarantee that a spot in a specific group will be available.

MCP

MINNESOTA
CENTER FOR
PSYCHOLOGY

ADULT CONSENT (A)

I voluntarily give permission to clinicians at Minnesota Center for Psychology to evaluate, administer diagnostic testing, develop a treatment plan, provide treatment, and maintain documentation in accordance with the law. I understand that the practice of psychotherapy is not an exact science and I acknowledge that no guarantees have been made to me as the result of assessment or treatment in this facility.

____
Patient Full Legal Name (printed)

________________________________ __________________
Patient Signature Date

________________________________ __________________
Parent/Guardian/Legal Representative Name (if applicable) Legal Relationship

________________________________ __________________
Parent/Guardian/Legal Representative Signature (if applicable) Date

MCP

MINNESOTA
CENTER FOR
PSYCHOLOGY

Dialectical Behavior Therapy (DBT) Program
Diagnostic Assessment Consent Form

Please read the following carefully and sign below, indicating that you have read, understand, and agree to the terms of the DBT Diagnostic Assessment Appointment:

1. This appointment is for a diagnostic assessment, to determine whether or not DBT services are clinically recommended at this time. This is not a "Consent for Treatment" agreement. This DBT assessment does not establish a therapeutic relationship with the assessment clinician or any other clinician at MCP.

2. **If DBT is not recommended**, you will receive recommendations from the assessment clinician. Neither MCP, nor the assessment clinician is responsible for obtaining other services for you if DBT is not recommended.

3. **If DBT is recommended,** you will be placed in the appropriate group by the assessment clinician or intake coordinator according to your symptoms, insurance coverage, and personal schedule. MCP can not guarantee that you will be able to see an individual DBT clinician from MCP. If an individual DBT clinician is not available at MCP, your group leader will give recommendations for adherent DBT providers in the area.

4. You are responsible for any charges not covered by your insurance (co-payments, co-insurance, deductible, etc.) If you receive a bill for services, payment is expected within 30 days. If you are unable to pay the amount in full by 30 days, you must set up a payment agreement with your clinician(s). In the event that there is an unpaid balance or you do not adhere to the payment agreement, after 90 days, your account may be sent to collections.

5. Please arrive at your assessment appointment 10 minutes prior to the appointment time with all required paperwork complete. Proof of insurance is required at all appointments at MCP. If you do not follow these guidelines, you may not be able to see the assessment clinician at your scheduled appointment time.

6. If you need to cancel the assessment appointment, please do so at least 24 hours prior to the appointment time to avoid a possible charge.

____
Patient Full Legal Name (printed)

______________________________ ______________
Patient Signature Date

______________________________ ______________
Parent/Guardian/Legal Representative Name (if applicable) Legal Relationship

______________________________ ______________
Parent/Guardian/Legal Representative Signature (if applicable) Date

MCP

MINNESOTA
CENTER FOR
PSYCHOLOGY

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH OPERATIONS

I understand that as part of my/my child's healthcare, Minnesota Center for Psychology, LLC creates and maintains a paper and/or electronic record describing my/my child's health history, symptoms, assessment and test results, diagnoses, treatment, discharge information, and any plans for future care. I understand that this information serves as:

- A basis for documenting and planning patient care and treatment
- A means of communication and coordination among the healthcare professionals who contribute to a patient's care
- A source of information for billing purposes if a patient is using medical insurance
- A means by which a third-party payer can verify that services were actually provided
- A tool for routine healthcare operations

I have received a Notice of Privacy Practices that provides a more complete description of information uses and disclosure.

I understand that I may revoke this consent in writing, except to the extent that action has already been taken. I also understand that by declining the terms of this consent or revoking this consent, this organization may refuse to treat me/my child as permitted by section 164.506 of the Codes of Federal Regulations.

I further understand that Minnesota Center for Psychology, LLC reserves the right to change their Notice of Privacy Policy Practices. Should Minnesota Center for Psychology, LLC change their notice, a revised copy will be available in the office and will be posted at the front desk and on the organization's website.

I understand that as part of this organization's treatment, payment, and/or healthcare operations, it may become necessary to disclose my/my child's protected health information to another entity. I consent to such disclosure for these permitted uses, including disclosures via fax.

By signing below, I indicate that I have read, understand, and accept the terms of this consent.

____
Patient Name (printed)

____________________________________ ____________________
Patient Signature Date

____________________________________ ____________________
Parent/Guardian/Legal Representative Name (if applicable) Legal Relationship

____________________________________ ____________________
Parent/Guardian/Legal Representative Signature (if applicable) Date

MCP

MINNESOTA
CENTER FOR
PSYCHOLOGY

AGREEMENT ON SERVICES WHICH MAY NOT BE COVERED BY INSURANCE

My provider may bill the insurance company as a courtesy to me, and I may subsequently receive notice from the insurance company that all or part of these charges is considered by them to be "uncovered services" (deductibles, co-payments, co-insurance, etc.).

However, I understand and acknowledge in advance that I am seeking these services knowing that they may not be covered. I agree to cover the full cost, less any insurance payment. I know that these or similar services may be covered by my insurance company, or covered at a higher rate, if I use providers within my network. I understand that it is my responsibility to know my insurance plan and that I am responsible for knowing what and how much my insurance carrier will cover.

I agree to notify the clinic immediately if my insurance changes or is terminated. I will also update the clinic immediately regarding any changes of address or telephone number.

I understand that I am expected to attend all scheduled appointments or cancel them with 24-hour notice. If I do not do this, I understand that I may be charged a "no show" or "late cancel" fee (the fee does not apply to MA, Medicare clients).

____
Patient Name (printed)

______________________________ ______________________________
Patient Signature Date

FIREARMS POLICY

I understand that Minnesota Center for Psychology, LLC (MCP) bans guns in these premises. I agree that I will not bring a gun into 2324 University Ave., Suite 120, St. Paul, MN 55114.

____
Patient Name (printed)

______________________________ ______________________________
Patient Signature Date

MCP

MINNESOTA
CENTER FOR
PSYCHOLOGY

AGREEMENT FOR COLLABORATIVE SERVICES WITH YOUR PRIMARY CARE PHYSICIAN

In an effort to provide collaborative services with your/your child's Primary Care Provider, we request consent to use and disclose information with your/your child's current Primary Care Provider. Please check one of the following boxes and sign below. If you agree to allow communication, you will be provided with a release of information to complete.

□ I agree to allow communication between my/my child's primary care and mental health providers.

□ I do not agree to allow communication between my/my child's primary care and mental health providers.

□ I do not/My child does not have a primary care provider.

____
Patient Name (printed)

______________________________ ______________
Patient Signature Date

______________________________ ______________
Parent/Guardian/Legal Representative Name (if applicable) Legal Relationship

______________________________ ______________
Parent/Guardian/Legal Representative Signature (if applicable) Date

MINNESOTA CENTER FOR PSYCHOLOGY

Midtown Commons ▪ 2324 University Ave. W. ▪ Suite 120 ▪ St. Paul, MN 55114

Phone: 651.644.4100 ▪ Fax: 651.644.4885

MCP

MINNESOTA
CENTER FOR
PSYCHOLOGY

Communicable Disease/Parasitic Infestation Policy

Minnesota Center for Psychology (MCP) does not permit clients to attend individual or group appointments if they are currently experiencing a communicable disease or parasitic infestation. The purpose of this policy is to protect the health and safety of our clients, providers and employees.

If, during the course of treatment at MCP, you are diagnosed with, or suspected of having a communicable disease or parasitic infestation, you must notify your therapist immediately. **Clients will not be permitted to return to the clinic until they can provide proof from a medical professional that you are no longer contagious, or proof that you/your home are free from parasites.**

Communicable diseases include, but are not limited to, measles, mumps, rubella, chicken pox, shingles, influenza, viral hepatitis-A (infectious hepatitis), leprosy, meningitis, Severe Acute Respiratory Syndrome (SARS) and active tuberculosis. MCP may choose to broaden this definition within its best interest and in accordance with information received through the Centers for Disease Control and Prevention (CDC). Parasites include, but are not limited to, head lice, body lice, bed bugs, fleas, ticks and mites (scabies).

By signing this policy, you are attesting that you do not currently have a communicable disease or parasitic infestation. You also agree that if, at any time during the course of your treatment at MCP, you are diagnosed with, or suspected of having a communicable disease or parasitic infestation, you will disclose this information to MCP/your therapist immediately.

____
Patient Name (printed)

____________________________________ ____________________
Patient Signature Date

____________________________________ ____________________
Parent/Guardian/Legal Representative Name (if applicable) Legal Relationship

____________________________________ ____________________
Legal Representative Signature (if applicable) Date

MINNESOTA CENTER FOR PSYCHOLOGY
Midtown Commons • 2324 University Ave. W. • Suite 120 • St. Paul, MN 55114
Phone: 651.644.4100 • Fax: 651.644.4885

Please complete the attached release forms for any/all of the providers/contacts listed below:

Required:	Emergency Contact Primary Care Provider
Optional:	Psychiatrist Case Manager Individual Therapist Other (i.e. spouse, involved family member, child's social worker, parole officer, etc.)

Additional release forms can be provided upon request. Please see the front desk if you have any questions.

MINNESOTA CENTER FOR PSYCHOLOGY, LLC
AUTHORIZATION TO DISCLOSE INFORMATION

Client Full Name: ____________________ Other Names Used (if applicable): ____________________

Date of Birth: ____________________ **Phone Number:** ____________________

I Authorize: Minnesota Center for Psychology
2324 University Ave W, Suite 120
St. Paul, Minnesota 55114
Phone: (651)644-4100
Fax: (651)644-4885

To release information to and receive information from:

Name/Agency: ____________________ Phone: ____________

Address: ____________________ Fax: ____________

____

Check **One**:
- □ Primary Physician
- □ Psychiatrist/Therapist
- □ Emergency Contact
- □ Other ____________

Information which may be released includes (check all that apply):
- □ **ALL**
- □ Phone Contact
- □ Diagnostic Assessments/Self Reports
- □ Psychological Tests
- □ Medication Information
- □ Functional Assessments
- □ Other ____________________
- □ Discharge Summaries
- □ Treatment Plans and Reviews
- □ Crisis Plans
- □ Clinical Notes/Records
- □ Billing/Insurance Information
- □ Emergency Only

All records pertaining to psychiatric/mental health, chemical dependency, and/or HIV/AIDS will be released unless indicated here: **DO NOT release** records regarding: □Mental Health □Chemical Dependency □HIV/AIDS

This information may be released for the purposes of:
- □ **Planning or continuing my care and treatment**
- □ Determining eligibility for insurance benefits
- □ Other (specify)____________________
- □ Determining eligibility for Social Security benefits
- □ Billing
- □ Emergency Only

Dates of information to be released: □ ALL □ Other ____________

Your signature on this form indicates that you know what information will be given and what it will be used for. This authorization also states that you know who will receive this information and that this information is private. A detailed description of the potential uses and disclosures of protected health information can be found in our *Notice of Privacy Practices.* You have the right to review our most updated copy of these practices before signing this consent. Your care and treatment are not dependent on your signing of this release. You acknowledge that information disclosed as a result of this authorization may be redisclosed by the recipient and no longer be subject to federal healthcare privacy protections.
Revocation Clauses: I understand that I may revoke my authorization by written notice. My authorization will expire one year from the date signed if I do not revoke my consent earlier.
Date of Expiration (not to exceed one year):

____________________ ____________ ____________________
Client Signature **Date** SSN (voluntary)

____________________ ____________ ____________________
Parent/Guardian Signature (if applicable) Date Relationship to client

A photocopy of this release is as valid as the original

MINNESOTA CENTER FOR PSYCHOLOGY, LLC
AUTHORIZATION TO DISCLOSE INFORMATION

Client Full Name: ____________________ Other Names Used (if applicable): ____________________

Date of Birth: ____________________ **Phone Number:** ____________________

I Authorize: Minnesota Center for Psychology
2324 University Ave W, Suite 120
St. Paul, Minnesota 55114
Phone: (651)644-4100
Fax: (651)644-4885

To release information to and receive information from:

Name/Agency: ____________________ Phone: ____________

Address: ____________________ Fax: ____________

____

Check **One**:
- □ Primary Physician
- □ Psychiatrist/Therapist
- □ Emergency Contact
- □ Other ____________

Information which may be released includes (check all that apply):

- □ **ALL**
- □ Phone Contact
- □ Diagnostic Assessments/Self Reports
- □ Psychological Tests
- □ Medication Information
- □ Functional Assessments
- □ Other ____________
- □ Discharge Summaries
- □ Treatment Plans and Reviews
- □ Crisis Plans
- □ Clinical Notes/Records
- □ Billing/Insurance Information
- □ Emergency Only

All records pertaining to psychiatric/mental health, chemical dependency, and/or HIV/AIDS will be released unless indicated here: **DO NOT release** records regarding: □Mental Health □Chemical Dependency □HIV/AIDS

This information may be released for the purposes of:

- □ **Planning or continuing my care and treatment**
- □ Determining eligibility for insurance benefits
- □ Other (specify) ____________________
- □ Determining eligibility for Social Security benefits
- □ Billing
- □ Emergency Only

Dates of information to be released: □ ALL □ Other ____________

Your signature on this form indicates that you know what information will be given and what it will be used for. This authorization also states that you know who will receive this information and that this information is private. A detailed description of the potential uses and disclosures of protected health information can be found in our *Notice of Privacy Practices*. You have the right to review our most updated copy of these practices before signing this consent. Your care and treatment are not dependent on your signing of this release. You acknowledge that information disclosed as a result of this authorization may be redisclosed by the recipient and no longer be subject to federal healthcare privacy protections.

Revocation Clauses: I understand that I may revoke my authorization by written notice. My authorization will expire one year from the date signed if I do not revoke my consent earlier.

Date of Expiration (not to exceed one year):

____________________ ____________ ____________________

Client Signature **Date** SSN (voluntary)

____________________ ____________ ____________________

Parent/Guardian Signature (if applicable) Date Relationship to client

A photocopy of this release is as valid as the original

MINNESOTA CENTER FOR PSYCHOLOGY, LLC
AUTHORIZATION TO DISCLOSE INFORMATION

Client Full Name: ____________________ Other Names Used (if applicable): ____________________

Date of Birth: ____________________ **Phone Number:** ____________________

I Authorize: Minnesota Center for Psychology
2324 University Ave W, Suite 120
St. Paul, Minnesota 55114
Phone: (651)644-4100
Fax: (651)644-4885

To release information to and receive information from:

Name/Agency: ____________________ Phone: __________

Address: ____________________ Fax: __________

____

Check **One**:
- □ Primary Physician
- □ Psychiatrist/Therapist
- □ Emergency Contact
- □ Other __________

Information which may be released includes (check all that apply):

- □ **ALL**
- □ Phone Contact
- □ Diagnostic Assessments/Self Reports
- □ Psychological Tests
- □ Medication Information
- □ Functional Assessments
- □ Other __________
- □ Discharge Summaries
- □ Treatment Plans and Reviews
- □ Crisis Plans
- □ Clinical Notes/Records
- □ Billing/Insurance Information
- □ Emergency Only

All records pertaining to psychiatric/mental health, chemical dependency, and/or HIV/AIDS will be released unless indicated here: **DO NOT release** records regarding: □Mental Health □Chemical Dependency □HIV/AIDS

This information may be released for the purposes of:

- □ **Planning or continuing my care and treatment**
- □ Determining eligibility for insurance benefits
- □ Other (specify) __________
- □ Determining eligibility for Social Security benefits
- □ Billing
- □ Emergency Only

Dates of information to be released: □ ALL □ Other __________

Your signature on this form indicates that you know what information will be given and what it will be used for. This authorization also states that you know who will receive this information and that this information is private. A detailed description of the potential uses and disclosures of protected health information can be found in our *Notice of Privacy Practices*. You have the right to review our most updated copy of these practices before signing this consent. Your care and treatment are not dependent on your signing of this release. You acknowledge that information disclosed as a result of this authorization may be redisclosed by the recipient and no longer be subject to federal healthcare privacy protections.

Revocation Clauses: I understand that I may revoke my authorization by written notice. My authorization will expire one year from the date signed if I do not revoke my consent earlier.

Date of Expiration (not to exceed one year):

____________________ __________ __________

Client Signature **Date** SSN (voluntary)

____________________ __________ __________

Parent/Guardian Signature (if applicable) Date Relationship to client

A photocopy of this release is as valid as the original

ADULT SELF-REPORT FORM

(Part of Adult Standard Diagnostic Assessment)

Minnesota Center for Psychology, LLC
2324 University Ave West, Suite 120
Saint Paul, MN 55114
Phone:651-644-4100 • Fax:651-644-4885

Please answer all of the following questions to the best of your knowledge. This form *must be completed* before the start time of your assessment appointment, or the appointment may have to be re-scheduled.

Date:	**Form Completed By:** **Relationship to the Client:** ☐**Self** ☐**Other**________________

REFERRAL INFORMATION

Who referred you to our clinic? / How did you learn about MCP?

TYPE(S) OF SERVICES REQUESTED:

Please check all that apply.

☐ Psychological Testing ☐ Individual Therapy ☐ Couples/Marriage Counseling ☐ Family Therapy
☐ Group Therapy ☐ DBT Therapy ☐ Other: ______________

PATIENT INFORMATION

Last Name	**First Name**	**Middle Name**

Date of Birth	**Age**	**Gender**	**Transportation to Therapy**

Street Address	**City, State**	**Zip Code**

Check appropriate box for address:

☐ House ☐ Apartment ☐ Residential Facility (Specify:______________________) ☐ Homeless

Home Phone Number	**Work Phone Number**	**Cellular Phone Number**
OK to leave detailed message? ☐ Yes ☐ No	**OK to leave detailed message?** ☐ Yes ☐ No	**OK to leave detailed message?** ☐ Yes ☐ No

Emergency Contact Person *release must be signed, or we can not contact/communicate with your emergency contact	**Contact's Phone Number**	**Emergency contact's relationship to you:**

Do you have medication allergies? ☐ **Yes** ☐ **No** **If yes, what medication/s?** ________________________ ________________________	**Do you have substance or food allergies?** ☐ **Yes** ☐ **No** **If yes, what substance/s?** ________________________ ________________________

What community resources, if any, do you currently utilize? (support groups, social services, school-based services, etc.)

Race (check all that apply):
☐ American Indian/Alaska Native Tribe:__________________
☐ Asian (☐ Chinese ☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other________)
☐ Black/African American (☐ Ethiopian ☐ Somali ☐ Other__________________)
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other __________________

Ethnicity:
☐ Hispanic/Latino/a ☐ Not Hispanic/Latino/a

Primary Language: ☐ English ☐ Other:	**Other Languages Spoken:**

Guardianship Status:
☐ Own Guardian
☐ Have Legal Guardian (Name): __________________
☐ Have Financial Conservator (Name): __________________
☐ Other __________________

Religion:

Cultural Considerations for Treatment:

Marital Status (check all that apply):
☐ Single without partner
☐ Unmarried with partner/in relationship (Length of time in relationship__________________)
☐ Married (How long?__________________)
☐ Separated (How long?__________________)
☐ Divorced (How long?__________________)
☐ Widowed (How long?__________________)
☐ Other (How long?__________________)

Gender Identity:
☐ Male ☐ Female ☐ Trans Male/Trans Man ☐ Trans Female/Trans Woman
☐ Gender Queer/Gender Non-Conforming ☐ Different Identity ____________

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other: __________________

Do you have children? ☐ Yes ☐ No Ages/Names ______ ______ ______	Do you have legal custody of your children? ☐ No ☐ Full ☐ Joint ☐ N/A	Number of children living with you:	Number of adults living with you:
		Do any of your children have special needs? ☐ Yes ☐ No	

Client's Current Household

	Name	Relationship	Age	Hx of Mental Illness? ("Y" if yes)	Hx of significant medical illness? ("Y" if yes)	Hx of substance abuse? ("Y" if yes)	Hx of physical abuse? ("Y" if yes)	Hx of sexual abuse? ("Y" if yes)
1.								
2.								
3.								
4.								
5.								
6.								
7.								

Current Employment Status:
☐Not working/not looking for work ☐Not working- looking for work ☐ Employed (☐ FT ☐ PT)

Current Employer:	Position:	Length of time at job:	Avg. # of hours worked per week:

Previous Employer(s)	Position(s) Held:	Length of time at job:
______	______	______
______	______	______
______	______	______

Current Education Status: ☐ No educational/vocational ☐ Working on GED ☐ Attending vocational school ☐ Attending college	Average hours of school per week:

Education (highest completed):
☐ Did not graduate HS* ☐ High School/GED ☐ Some college ☐ Some graduate
☐ Highest grade level completed ______ ☐ Vocational ☐ College degree ☐ Graduate degree

Do you Volunteer? ☐ Yes ☐ No **If Yes, average number of hours per month:**

Who manages your finances? (income, budgeting, etc)

How do you support yourself financially?

Are you able to find financial resources to support yourself/your family?

REASONS FOR WANTING SERVICES

Please check all that apply.

☐ ADHD	☐ Grief/Loss/Death	☐ Parenting Issues	☐ Sexual Abuse/Trauma
☐ Issues with Alcohol	☐ Health Problems	☐ Phobia(s)	☐ Sexuality Concerns
☐ Anxiety	☐ Hearing Voices	☐ Physical Abuse	☐ Sleep Problems
☐ Body Image/Weight Issues	☐ Help Finding Resources	☐ Physical Pain	☐ Stress
☐ Binging and/or Overeating	☐ HIV/AIDS	☐ Problems with Anger	☐ Suicidal Thoughts
☐ Bipolar Depression/Mania	☐ Hyperactivity	☐ Psychiatric Hospitalization	☐ Suicide Attempt
☐ Issues from Childhood	☐ Inattention	☐ Purging (throwing up)	☐ Trauma
☐ Children Removed	☐ Learning Problems	☐ Relationship Concerns	Other:
☐ Depression	☐ Legal Problems	☐ Restricting Food	☐
☐ Domestic Abuse	☐ Memory Problems	☐ Sadness	☐
☐ Eating Disorder	☐ Mood Swings	☐ Schizophrenia	☐
☐ Issues with Drugs	☐ Obsessions	☐ Low Self-Esteem	☐
☐ Fetal Alcohol Syndrome	☐ Panic Attack	☐ Self-Harm	☐

FAMILY MEDICAL/PSYCHOLOGICAL HISTORY

YOUR HISTORY:

Please check all that apply.

☐ Alcohol/Drug Abuse	☐ Depression	☐ High Blood Pressure	☐ Physical Abuse
☐ Allergies	☐ Diabetes	☐ HIV/AIDS	☐ Physical Pain
☐ Alzheimer's	☐ Domestic Abuse	☐ Hyperactivity	☐ Psychiatric Hospitalization
☐ Anxiety	☐ Eating Disorder	☐ Inattention	☐ Schizophrenia
☐ Autism	☐ Epilepsy/Seizures	☐ Learning Problems	☐ Sexual Abuse
☐ Bedwetting	☐ Fetal Alcohol Syndrome	☐ Legal Problems	☐ Stomachaches
☐ Blood Clot/Stroke	☐ Was/Is in Foster Care	☐ Manic/Bipolar Disorder	☐ Suicide/Attempt
☐ Borderline Personality Dis.	☐ Headaches	☐ Mental Retardation	☐ Surgery/ies
☐ Cancer	☐ Heart Attack/Disease	☐ Panic Attacks	☐ Tuberculosis
☐ Other (please specify):			

Please describe any issues checked above:

YOUR MOTHER AND MOTHER'S SIDE OF FAMILY:

☐ Check here if history is unknown.

☐ Alcohol/Drug Abuse	☐ Depression	☐ High Blood Pressure	☐ Physical Abuse
☐ Allergies	☐ Diabetes	☐ HIV/AIDS	☐ Physical Pain
☐ Alzheimer's	☐ Domestic Abuse	☐ Hyperactivity	☐ Psychiatric Hospitalization
☐ Anxiety	☐ Eating Disorder	☐ Inattention	☐ Schizophrenia
☐ Autism	☐ Epilepsy/Seizures	☐ Learning Problems	☐ Sexual Abuse
☐ Bedwetting	☐ Fetal Alcohol Syndrome	☐ Legal Problems	☐ Stomachaches
☐ Blood Clot/Stroke	☐ Was/Is in Foster Care	☐ Manic/Bipolar Disorder	☐ Suicide/Attempt
☐ Borderline Personality Disorder	☐ Headaches	☐ Mental Retardation	☐ Surgery(ies)
☐ Cancer	☐ Heart Attack/Disease	☐ Panic Attacks	☐ Tuberculosis

YOUR FATHER AND FATHER'S SIDE OF FAMILY: ☐ Check here if history is unknown.			
☐ Alcohol/Drug Abuse	☐ Depression	☐ High Blood Pressure	☐ Physical Abuse
☐ Allergies	☐ Diabetes	☐ HIV/AIDS	☐ Physical Pain
☐ Alzheimer's	☐ Domestic Abuse	☐ Hyperactivity	☐ Psychiatric Hospitalization
☐ Anxiety	☐ Eating Disorder	☐ Inattention	☐ Schizophrenia
☐ Autism	☐ Epilepsy/Seizures	☐ Learning Problems	☐ Sexual Abuse
☐ Bedwetting	☐ Fetal Alcohol Syndrome	☐ Legal Problems	☐ Stomachaches
☐ Blood Clot/Stroke	☐ Was/Is in Foster Care	☐ Manic/Bipolar Disorder	☐ Suicide/Attempt
☐ Borderline Personality Disorder	☐ Headaches	☐ Mental Retardation	☐ Surgery/ies
☐ Cancer	☐ Heart Attack/Disease	☐ Panic Attacks	☐ Tuberculosis

YOUR SIBLINGS (if applicable): ☐ Check here if history is unknown.			
☐ Alcohol/Drug Abuse	☐ Depression	☐ High Blood Pressure	☐ Physical Abuse
☐ Allergies	☐ Diabetes	☐ HIV/AIDS	☐ Physical Pain
☐ Alzheimer's	☐ Domestic Abuse	☐ Hyperactivity	☐ Psychiatric Hospitalization
☐ Anxiety	☐ Eating Disorder	☐ Inattention	☐ Schizophrenia
☐ Autism	☐ Epilepsy/Seizures	☐ Learning Problems	☐ Sexual Abuse
☐ Bedwetting	☐ Fetal Alcohol Syndrome	☐ Legal Problems	☐ Stomachaches
☐ Blood Clot/Stroke	☐ Was/Is in Foster Care	☐ Manic/Bipolar Disorder	☐ Suicide/Attempt
☐ Borderline Personality Disorder	☐ Headaches	☐ Mental Retardation	☐ Surgery/ies
☐ Cancer	☐ Heart Attack/Disease	☐ Panic Attacks	☐ Tuberculosis

YOUR CHILDREN (if applicable): ☐ Check here if history is unknown.			
☐ Alcohol/Drug Abuse	☐ Depression	☐ High Blood Pressure	☐ Physical Abuse
☐ Allergies	☐ Diabetes	☐ HIV/AIDS	☐ Physical Pain
☐ Alzheimer's	☐ Domestic Abuse	☐ Hyperactivity	☐ Psychiatric Hospitalization
☐ Anxiety	☐ Eating Disorder	☐ Inattention	☐ Schizophrenia
☐ Autism	☐ Epilepsy/Seizures	☐ Learning Problems	☐ Sexual Abuse
☐ Bedwetting	☐ Fetal Alcohol Syndrome	☐ Legal Problems	☐ Stomachaches
☐ Blood Clot/Stroke	☐ Was/Is in Foster Care	☐ Manic/Bipolar Disorder	☐ Suicide/Attempt
☐ Borderline Personality Disorder	☐ Headaches	☐ Mental Retardation	☐ Surgery/ies
☐ Cancer	☐ Heart Attack/Disease	☐ Panic Attacks	☐ Tuberculosis

YOUR CURRENT MEDICATIONS
(list more on separate page if necessary)

Prescribed by:

Current Medication	For What Condition?	Dose	Frequency	Date Started	Side Effects/Comments
1)					
2)					
3)					
4)					
5)					
6)					
7)					
8)					
9)					
10)					

YOUR PAST MEDICATIONS
(list more on separate page if necessary)

Past Medication	For What Condition?	Past Medication	For What Condition?
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

DRUG/ALCOHOL USE/ABUSE
Please check the appropriate boxes.

CAGE-AID Drug and Alcohol Screening
Within the past year:

Have you ever felt you ought to cut down on your drinking or drug use?	☐Yes	☐No
Have people annoyed you by criticizing your drinking or drug use?	☐Yes	☐No
Have you ever felt bad or guilty about your drinking or drug use?	☐Yes	☐No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐Yes	☐No

Alcohol	☐ Never Used	☐ Currently Use	☐ Used in Past
Sedatives	☐ Never Used	☐ Currently Use	☐ Used in Past
Crack Cocaine	☐ Never Used	☐ Currently Use	☐ Used in Past
Cocaine	☐ Never Used	☐ Currently Use	☐ Used in Past
Hallucinogens (i.e., LSD)	☐ Never Used	☐ Currently Use	☐ Used in Past
Heroin	☐ Never Used	☐ Currently Use	☐ Used in Past
Inhalants	☐ Never Used	☐ Currently Use	☐ Used in Past
Marijuana	☐ Never Used	☐ Currently Use	☐ Used in Past
Methadone	☐ Never Used	☐ Currently Use	☐ Used in Past
Opiates	☐ Never Used	☐ Currently Use	☐ Used in Past
Prescription Drugs	☐ Never Used	☐ Currently Use	☐ Used in Past
PCP	☐ Never Used	☐ Currently Use	☐ Used in Past
Club Drugs	☐ Never Used	☐ Currently Use	☐ Used in Past
Stimulants (i.e., methamphetamine)	☐ Never Used	☐ Currently Use	☐ Used in Past
Other:__________		☐ Currently Use	☐ Used in Past
Other:__________		☐ Currently Use	☐ Used in Past

ADDITIONAL QUESTIONS:

☐ Yes ☐ No	Do you smoke? *If yes, how many cigarettes per day: ______________________
☐ Yes ☐ No	Do you drink caffeine? *If yes, how often and how much: ______________________
☐ Yes ☐ No	Have you ever received help for a drug or alcohol problem? (treatment program, AA/NA)
☐ Yes ☐ No	In the last 6 months, have you been in inpatient or residential treatment for substance abuse?
☐ Yes ☐ No	Would you like help now for a drug or alcohol problem?
☐ Yes ☐ No	Have you received other mental health services before? *If YES: How long? ___________________ Age at first MH Service: _________
☐ Yes ☐ No	Have you been hospitalized for a mental issue? *If YES: When?______________________ # of times in the last year? _________
☐ Yes ☐ No	In the last 6 months, have you been admitted to a hospital for a self-harm injury? *If YES, please list dates:______________________
☐ Yes ☐ No	In the last 6 months, have you gone to the emergency room for behavioral issues? *If YES, please list number of times:_________________
☐ Yes ☐ No	In the last 6 months, have you been in a residential crisis stabilization program? *If YES, please list dates/ # of times:________________________________
☐ Yes ☐ No	Would you like to discuss problems related to a rape or sexual abuse?
☐ Yes ☐ No	Would you like to discuss problems related to physical and/or emotional abuse?
☐ Yes ☐ No	Are you now or have you ever been in a relationship where you have been physically hurt or threatened?
☐ Yes ☐ No	Would you like to discuss problems related to childhood neglect?
☐ Yes ☐ No	Did you receive special education services in school?
☐ Yes ☐ No	Have you ever been in the military? If Yes: ☐☐No Combat ☐☐Combat Zone
☐ Yes ☐ No	Have you ever been arrested or in trouble with the law?
☐ Yes ☐ No	Have you been incarcerated in the last six months? (How long?_______________)
☐ Yes ☐ No	Are you currently on probation?
☐ Yes ☐ No	Has your mental health treatment been court ordered?
☐ Yes ☐ No	Have you been homeless within the last 6 months? *If YES, please list how long/ # of occurrences:_____________________________
☐ Yes ☐ No	Are there spiritual issues that you would like to discuss that would be important in counseling?
☐ Yes ☐ No	Are there cultural issues that you would like to discuss that would be important in counseling?
☐ Yes ☐ No	Do you have an infectious disease? Specify:_________________________

Are you currently receiving any of the following services from another provider?		
☐ARMHS (Adult Rehabilitative Mental Health Services)	☐Day Treatment	☐Medication Management
☐ACT (Assertive Community Treatment)	☐DBT (other provider)	☐Partial Hospitalization
☐CSP (Community Support Program services)	☐ Housing with Supportive Services	☐Peer Support Services
☐ICRS (Intensive Community Recovery Services)		☐Rule 79 Case Management
☐IRTS (Intensive Residential Treatment Services)	☐Crisis Residential	☐State-Operated Inpatient Supported Employment
☐Crisis Assess, Intervention or Stabilization	☐Other Therapy	

YOUR CURRENT PROVIDER(S) AND PROFESSIONAL(S)

PRIMARY CARE PHYSICIAN	PSYCHIATRIST	CASE MANAGER
Name	Name	Name
Agency/Address	Agency/Address	Agency/Address
Phone	Phone	Phone
Fax	Fax	Fax
Length of time services received:	Length of time services received:	Length of time services received:
PSYCHOLOGIST	**PROBATION OFFICER**	**OTHER**
Name	Name	Name
Agency/Address	Agency/Address	Agency/Address
Phone	Phone	Phone
Fax	Fax	Fax
Length of time services received:	Length of time services received:	Length of time services received:
OTHER	**OTHER**	**OTHER**
Name	Name	Name
Agency/Address	Agency/Address	Agency/Address
Phone	Phone	Phone
Fax	Fax	Fax
Length of time services received:	Length of time services received:	Length of time services received:

PAST PROVIDERS AND PROFESSIONALS (Include Psychologists, Psychiatrists, Social Workers, etc)

TYPE OF PROVIDER:	TYPE OF PROVIDER:	TYPE OF PROVIDER:
Name	Name	Name
Agency/Address	Agency/Address	Agency/Address
Phone	Phone	Phone
Fax	Fax	Fax
When services were received:	When services were received:	When services were received:

Do you feel that your mental health symptoms are affecting the following areas?		
Relationship with significant other	□ Yes □ No	If Yes, How?
Relationship with family	□ Yes □ No	If Yes, How?
Friendships/Peer Relationships	□ Yes □ No	If Yes, How?
Job/School Performance	□ Yes □ No	If Yes, How?
Hobbies/Interests	□ Yes □ No	If Yes, How?
Physical/Dental Health	□ Yes □ No	If Yes, How?
Activities of Daily Living	□ Yes □ No	If Yes, How?
Finances	□ Yes □ No	If Yes, How?
Housing	□ Yes □ No	If Yes, How?
Transportation	□ Yes □ No	If Yes, How?
Drug/Alcohol Use	□ Yes □ No	If Yes, How?
Other:	□ Yes □ No	If Yes, How?
Notes:		

WHODAS 2.0 12-Item version, self-administered

(Required by MN Dept. of Human Services as of 10/1/2014)

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

In the past 30 days, how much difficulty did you have in:						
S1	Standing for long periods such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
S2	Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or cannot do
S3	Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do
S4	How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do
S5	How much have you been emotionally affected by your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do
S6	Concentrating on doing something for 10 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
S7	Walking a long distance such as a kilometer (or equivalent)?	None	Mild	Moderate	Severe	Extreme or cannot do
S8	Washing your whole body?	None	Mild	Moderate	Severe	Extreme or cannot do
S9	Getting dressed?	None	Mild	Moderate	Severe	Extreme or cannot do
S10	Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme or cannot do
S11	Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme or cannot do
S12	Your day-to-day work?	None	Mild	Moderate	Severe	Extreme or cannot do

H1	Overall, in the past 30 days, how many days were these difficulties present?	**Record number of days ____**
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities of work because of any health condition?	**Record number of days ____**
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	**Record number of days ____**

I certify that I have answered these questions to the best of my knowledge.

______________________________ Date ______________________________

Patient Signature

CLINICIAN NOTES (clarifications, follow up to additional questions, follow up on any safety items endorsed):

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CAGE-AID Score _____/4

Recommendations:

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______________________________ ______________________________

Clinician **Date**

______________________________ ______________________________

Cosignatory **Date**