

Name		Phone #		ID #	
Address		Legal Sex	Legal Sex	Date of Birth	
City/State/Zip		Gender	Gender	SS# or PMI#	
Legal Guardian	Self	Relationship	Self	Phone #	NA
Emergency Contact		Relationship		Phone #	

1st Insurance	Choose an item.	Member #		Group #	
2nd Insurance	None	Member #	NR	Group #	NR
Service Start Date		Client Status	Choose an item.	Reservation	[13] Not on Reservation
		County	Choose an item.	Tribe	[13] Not Enrolled

The following information is provided to familiarize the Client with Spectrum Care LLC's (The Company) policies and help the Client to best understand his/her rights as a client. If the Client has any questions about any aspect of the Client's professional relationship with the provider or about the specifics of these policies, please review them with the provider. If Client finds no adequate resolution with the provider, please contact The Company at 651-330-6223.

Client Bill of Rights

Minnesota law establishes a variety of legal rights for individuals undergoing a course of treatment with The Company. They are described in the accompanying Minnesota Patients' Bill of Rights. In addition to those rights, Client also has the right:

1. To expect that a therapist has met the minimal qualifications of training and experience required by state law.
2. To examine public records which contain the credentials of a therapist.
3. To report complaints to the professional's relevant board:

MN Board of Marriage and Family Therapy	MN Board of Social Work	MN Board of Behavioral Health & Therapy
335 Randolph Ave. #260	335 Randolph Ave. #245	335 Randolph Ave. #290
St. Paul, MN 55102	Saint Paul MN 55102	St. Paul, MN 55102
612-617-2220	612-617-2100	651-201-2756
mft.board@state.mn.us	social.work@state.mn.us	bbht.board@state.mn.us
https://mn.gov/boards/marriage-and-family/	https://mn.gov/boards/social-work/	https://mn.gov/boards/behavioral-health/

4. To privacy as defined by rule and law (further described under HIPAA Notice and Privacy Practices & Consent to Disclose).
5. To be free from being the object of discrimination based on race, religion, gender, or other unlawful categories while receiving services.
6. To have access to Client's records as provided in Minnesota Statutes, section 144.292.
7. To be free from exploitation for the benefit or advantage of a therapist.

Other Client Rights and Responsibilities:

1. The Client has the right to refuse to provide information. (If Client do not provide the needed information, Client may not be eligible for the services for which Client are applying/receiving).
2. The Client has the right to refuse treatment or terminate services at any time (unless prohibited by law or court order).
3. The Client has the right to ask for a referral to a different provider or to seek services through another company for any reason.
4. The Client has the right to information about the cost of services, Client's diagnosis, treatment alternatives, recommended treatments, and estimated length/outcome of services.
5. The Client has the right to a non-technical description and explanation of assessment results.
6. The client has the right to know the intended recipients of Client's Protected Health information (PHI) and to withdraw consent to the release of Client's PHI (If Client do not give consent to release needed information, Client may not be eligible for the services for which Client are applying/receiving).
7. The Client has the right to assert these rights without retaliation.
8. The Client is responsible for participating in determining Client's own treatment plan and to make sure that Client understands it to Client's satisfaction.

The Client acknowledge that any service provided by The Company may be terminated at any time if it is determined that the provider's objectivity and/or effectiveness is impaired, or if Client are unlikely to benefit from continued professional services with The Company. If services are terminated, The Company will offer to make a recommendation to Client for other appropriate mental health services.

Acknowledgement of Receipt of Notice of HIPAA Privacy Practices & Consent to Disclosure of Protected Health Information

This notice describes how medical information about the client may be used and disclosed and how clients can get access to this information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about the Client. The notice contains patient's rights section describing Client's rights under the law. The Client has the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, clients may obtain a revised copy by contacting our office at 651-330-6223.

The Client has the right to request that we restrict how protected information about the Client is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, the Client consent to our use and disclosure of protected health information about Client for treatment, payment and health care operations. The Client also consents to our use and disclosure of protected health information for other purposes authorized under Health Insurance Portability and Accountability Act of 1996 and the corresponding regulations ("HIPPA"), including but not limited to:

- information about victims-of abuse, neglect or domestic violence;
- for judicial and administrative proceedings;
- for law enforcement purposes;
- for public health activities;
- for health oversight activities;
- information about decedents;
- for cadaver organ, eye or tissue donation purposes;
- for certain limited research purposes;
- to avert a serious threat to health or safety;
- for specialized government functions; and
- that relate to workers' compensation programs.

The Client has the right to revoke the Consent in writing, signed by the Client. However, such a revocation shall not affect any disclosures we have already made in reliance on the Client's prior Consent. The Company provides this form to comply with HIPAA and the Minnesota Health Records Act.

Client understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations and other purposes as provided under HIPAA, including to the Clinic's Business Associates as defined under HIPAA.
- The Company has a Notice of Privacy Practices, and the Client has the opportunity to review this notice.
- The Company reserves the right to change the Notice of Privacy Practices.
- The Client has the right to request restrictions to the uses of their information, but The Company does not have to agree to those restrictions.
- The Client may revoke this Consent in writing at any time and full disclosures will then cease.
- The Company may condition receipt of treatment upon the execution of this consent.
- This Consent lasts for one year or until: _____

I have received a copy of the Notice of Privacy Practices and, by signing at the bottom of this form, hereby consent to the use and disclosure of my protected health information as provided therein.

Complaint Procedures:

To file a complaint there are two main procedures available to every client.

1. Provide a written complaint to The Company
 - a. Clients are to submit a signed written report citing all relevant information about their complaint, and any potential outcomes the Client would request to address the complaint. The Client may also report the complaint and requested outcomes to staff who then would create this written document to be signed by the Client.
 - b. Once received all written complaints are immediately given to the owner, Sacad Guled, and clinical supervisor who is responsible for addressing all complaints given to The Company.
 - c. Within 10 business days The Company will provide to the client a written acknowledgement stating:
 - i. The name and contact information of the person responsible for handling the complaint
 - ii. The expected timeline for investigating and determining an outcome for the complaint, generally within 30 days from receipt of the complaint unless otherwise noted.
2. Provide a complaint to the MN Office of Ombudsman for Mental Health and Developmental Disabilities
 - a. Clients may file online - <https://mn.gov/omhdd/client-services/how-to-file-a-complaint.jsp>
 - b. Clients may contact a Regional Ombudsman for the county where the client is located. This can be found by using the regional map or the Regional Ombudsman via the county list.
 - i. Call the OMHDD: 651-757-1800 or 1-800-657-3506.
 - ii. Email the OMHDD: ombudsman.mhdd@state.mn.us
 - iii. Fax the OMHDD: 651-797-1950
 - c. Clients may send a letter by US postal mail:
 - i. The MN Office of Ombudsman for Mental Health and Developmental Disabilities
 - ii. 121 7th Place East
 - iii. Suite 420 Metro Square Building
 - iv. St. Paul, Minnesota 55101-2117

Emergency Procedures:

1. The Company provides ARMHS by appointment only.
2. The Company and its staff DO NOT provide crisis intervention services.
3. In case of emergency The Company recommends calling one of the following numbers for crisis intervention services:
 - a. National Resources
 - i. Police and Emergency Services: 911
 - ii. Suicide and Crisis Emergencies: 988

Website: SpectrumCareLLCMN.com
E-mail: SpectrumCareLLC@GMail.com

Phone: 651-330-6223
Fax: 651-400-6204

- iii. Crisis Text Line: Text "home" to 741741
- iv. MN Domestic Abuse and Violence Hotline: 1-866-223-1111, or Text 612-399-9995
- b. County Specific Resources:
 - i. Anoka County Crisis Line: 763-755-3801
 - ii. Benton County Crisis Line: 320-253-5555
 - iii. Carver County Crisis Line: 952-442-7601
 - iv. Dakota County Crisis Line: 952-891-7171
 - v. Hennepin County Adult Crisis Line: 612-596-1223
 - vi. Hennepin County Child Crisis Line: 612-348-2233
 - vii. McLeod County Crisis Program: 320-864-2713
 - viii. Meeker County Crisis Line: 1-800-432-8781
 - ix. Mower County Crisis Line: 1-844-274-7472
 - x. Ramsey County Crisis Line: 651-266-7900
 - xi. Rice County Crisis Line: 1-877-399-3040
 - xii. Scott County Crisis Line: 952-818-3702
 - xiii. Sherburne County Crisis Line: 1-800-635-8008
 - xiv. Sibley County Crisis Line: 1-877-399-3040
 - xv. Stearns County Crisis Line: 1-800-635-8008
 - xvi. Washington County Crisis Line: 651-275-7400
 - xvii. Wright County Crisis Line: 1-800-635-8008

COVID-19 Assumption of Risks

While the COVID-19 pandemic continues, Client can choose between in person and tele-medicine services, with the awareness that there are pluses and minuses to both types of services, including that Client's preferred provider may not be available for in-person therapy and that the quality of remote services may not be the same as in-person services. If Client decides that Client's situation is better serviced by in-person services, Client assumes the risk of receiving services in person during the COVID-19 pandemic, which includes potential exposure to COVID-19 and any damages from the illness, even when staff are using reasonable precautions to guard against infection.

Telemedicine Consent

For Client's convenience, health, and safety, The Company offers telemedicine. Telemedicine includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of Protected Health Information (PHI), and education using synchronous or asynchronous audio, video, or data communications. However, it is important to understand that telemedicine is different than traditional in person services and comes with unique risks regarding Client's PHI.

Prior to utilizing Telemedicine with The Company, the Client has read, understand, and acknowledges that:

1. Telemedicine is not the same as a face-to-face visit since Client will not be in the same room as Client's healthcare practitioner, and that telemedicine services and care may not be as effective as face-to-face services.
2. The Company will assess the appropriateness of telemedicine for the services Client have requested it for, and if it is determined that Client would be better served by receiving different services, such as face-to-face services, recommendations for treatment and treatment providers or facilities will be provided to Client.
3. At any time in place of telemedicine Client may seek face-to-face consultation with a health care provider.
4. It may be required that Client provide identifying information or copies of identifying documents such as a State ID at the request of Client's healthcare practitioner before any health services are provided via telemedicine.
5. There are risks of incomplete or ineffective consultation because of the technology utilized, and that if any of these risks occur, the consultation may terminate. The risks may include but are not limited to:
 - a. Failure, interruption, or disconnection of the audio/video connection
 - b. Audio or video that is not clear enough to meet the needs of the consultation

- c. Access to the consultation through the interactive connection by electronic tampering.
6. If Client are unable to connect with the telemedicine or phone call platform or are disconnected during a session due to a technological breakdown, try to reconnect within 5 minutes. If reconnection is not possible, contact Client's practitioner at the number they have provided. If that is not possible, then The Company can be reached at the following phone number: 651-330-6223.
7. The Company may use and respond to e-mail and text messages only to arrange or modify appointments if Client have provided consent for them below.
8. Email and text messaging are not secure forms of communication. The Client agrees not to send PHI or other information related to Client's treatment through e-mail or text messages and acknowledge that any health-related questions or issues will not be addressed by The Company in any other electronic communication but will be address during the Client's next health session.

Privacy and risk with Telemedicine:

1. The Company utilizes several policies and procedures to protect Client's privacy and security, and all electronic communications between Client and healthcare practitioner will be transmitted using reasonable measures to ensure confidentiality, but limitations exist whenever conducting services over electronic communications.
2. The risks and consequences of telemedicine include, but are not limited to:
 - a. Interrupted or distorted transmission of data or information due to technical failures;
 - b. access or interception of protected health information by unauthorized persons; and/or
 - c. any electronic transmissions of information are retained in the logs of service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the service providers. I acknowledge that any electronic communication, e-mails, or any communications sent via social media, online, or The Company's website are not secure, and I assume the risks of the insecure transmission.
3. In the event that other professionals are called in by Client's healthcare practitioner either for health consult or technical support (e.g. to operate or fix audio/video equipment) during Client's session, are bound to maintain confidentiality of any PHI disclosed.
4. Any individuals invited at Client's discretion are not bound by any confidentiality agreements, and Client's confidentiality may be waived.

Other Electronic Communication:

For Client's convenience, The Company utilizes several methods of communication, including voice mail, text messaging, e-mail, and fax. These methods are specifically for the purposes of scheduling and communicating with other non-PHI. Any health-related questions or issues will not be addressed by The Company in these forms of electronic communication but will be addressed during Client's next health session. For a better understanding of how to safely utilize these other forms of electronic communication, please see the non-exhaustive list of their risks below:

1. Voice Mail, Text Messages, E-mail, and Faxes are not secure forms of communication, and any information in them may be obtained and/or reviewed by people other than the intended recipient due to user error, or by a 3rd party by error or for malicious purposes.
2. PHI information contained in Voice Mail, Text Messages, E-mail, Faxes may also be forwarded/broadcast to 3rd parties due to user error, or by a 3rd party by error or for malicious purposes.
3. Voice Mail, Text Messages, E-mail, and Faxes may leave backup copies on servers and user terminals that are not accessible to be deleted by the sender, recipient/client, or any one party.
4. Voice Mail, Text Messages, E-mail, and Faxes may no longer be considered part of a client's medical record, and therefore be open to discovery during legal inquiries.
5. Voice Mail, Text Messages, E-mail, and Faxes can be an A-synchronous form of communication and should not be relied on for urgent messages that need to be acted on immediately.
6. Digital information is easily altered or falsified and may be subject to technological failures.

After reviewing the provided information and risks for both telemedicine and other electronic communications, and acknowledging that there may be other risks not listed when using telemedicine or other electronic communication, by signing this document, I acknowledge that:

Website: SpectrumCareLLCMN.com
E-mail: SpectrumCareLLC@GMail.com

Phone: 651-330-6223
Fax: 651-400-6204

- I authorize The Company to provide telemedicine and communicate with me via the means indicated above.
- I have a right to revoke this authorization at any time by sending written notification to The Company. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.
- I release The Company, its employees, agents, and assigns from any and all liability which may arise from this telemedicine consultation, the use of interactive video or audio connections, or from the taking or authorized use of any images or audio obtained.
- I understand the limitations inherent in ensuring client confidentiality of information transmitted in telemedicine and agree to waive my privilege of confidentiality with respect to any confidential information that may be accessed by an unauthorized third party despite the reasonable efforts of The Company to arrange a secure line of communication
- I understand that The Company cannot prevent the re-disclosure of information transmitted as a result of this authorization and that it may not be subject to privacy rule protections; therefore, The Company is released from any and all liability resulting from user error and/or re-disclosure by 3rd party sources.
- I agree that neither I nor my healthcare practitioner will record any part of my sessions unless The Company and I mutually agree in writing that the health session may be recorded.
- I further acknowledge that The Company objects to my recording any portion of my sessions without The Company's written consent.
- I expressly agree that audio and video recordings used for security or legal and documentation purposes are not part of my health records and are therefore not protected by confidentiality or any other provisions under this agreement.
- The Company has provided Client a satisfactory explanation of all technology that will be used, how to use it, and risks associated with its use.
- I have read this form and/or have had it read to me and explained in a language that I can understand.

Payments and Health Insurance:

1. The Company's Fees for Service (unless otherwise negotiated):
 - a. Fees for services are usually covered by insurance, county contract, private pay, or a combination of these options. Private pay and Co-pay/co-insurance is due at the time of service. Cash, credit cards and personal checks are accepted. If the therapeutic service is provided under an agreement with a government or other agency, there may be no cost directly to the Client from The Company. Please be advised that in certain circumstances the government or other agency may charge the Client for the services provided by The Company.
 - b. Many insurance plans cover outpatient mental health services. It is Client's responsibility to check with Client's insurance carrier for specific information regarding Client's coverage. Please be aware that authorization for treatment by Client's insurance carrier does not ensure payment to a provider. If Client's insurance carrier refuses payment for any reason, Client are responsible for Client's bill.
2. All payments should be made to The Company at the time of services.
3. When Client makes an appointment, The Company holds that time for Client. The Client is responsible for keeping the appointment or notifying the Client's provider at least 24 hours advance notice of any cancelation and/or rescheduling.
4. For individuals covered by commercial insurance (and other individuals as permitted by law), missed appointments or late cancels/late rescheduling (cancellations/late rescheduling with less than 24 hours of notice) will result in a charge for the session. These charges are not covered by Client's insurance company.
5. Please leave all messages for business concerns, including cancellations with Client's provider. If Client are unable to get a hold of Client's provider, Client can call 612-810-6216 to leave a message. If Client leaves a voice message, staff will return Client's call within 48 business hours.
6. The Company is a provider for several major insurance companies. Because health insurance policies vary, the Client is responsible for verifying the Client's benefits with the Client's insurance company.
7. The Company will submit claims to the Client's insurance company and receive payment directly from the insurance company.
8. Client is agreeing to pay copays and/or deductibles at the time of service and understands that the Client is financially responsible for payment of any services provided that are not covered by Client's insurance, including but not limited to: deductibles, co-payments, co-insurance, late-cancellation, and/or late rescheduling. Payments can be made out to The Company.

ARMHS Specific Transportation Waiver

ARMHS is a service that is provided in the community, and therefore Client may decide to utilize various means of transportation including public and private transport. Transportation is NOT an ARMHS service, and Client assumes all of the risks of any transportation Client arranges while in an ARMHS session with The Company staff member, including getting to Client's destination safely. Under no circumstances shall The Company be liable for damages from any transportation Client utilize during the provision of ARMHS by The Company while out in the community. If the Client receives transportation from a staff member of The Company, the staff member is doing so on their own will and not at The Company's direction.

By signing this document, the Client is acknowledging that the Client understands, agree too, and have received a copy of The Company's policies for the Client Rights, Notice of HIPAA of Privacy Practices, Telemedicine Consent, Electronic Communication Consent, Emergency Procedures, Payments and Health Insurance, Transportation Waiver, and COVID-19 Assumption of Risks.

By signing at the bottom of this form, I hereby acknowledge, agree, and consent to the policies contained herein as identified by my initials below.

Please initial for all permissions given:

	Verbal	Client Rights
	Verbal	Notice of HIPAA Privacy Practices
	Verbal	Telemedicine Consent
	Verbal	Electronic Communication Consent
	Verbal	Emergency Procedures
	Verbal	COVID-19 Assumption of Risk
	Verbal	Payments and Health Insurance
	Verbal	ARMHS Specific Transportation Waiver

This authorization expires one year from the date of the client/legal guardian's signature, unless explicitly documented here:

Alternate Expiration Date	NA
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Client/Legal Guardian		Signature		Date	
<input type="checkbox"/> Client/LG provided verbal authorization to the witness					
<input type="checkbox"/> Client/LG refused/unable to sign – Explain:					
Witness		Signature		Date	