1606 30th Ave S * Suite 2 * Moorhead, MN 56560 * 701-566-9965 (phone) * 218-600-5488 (fax)
bethsplacerecovery@gmail.com

Client Intake

Name:_____ Date:_____

Address (street, city, state, zip):_____

_____

Cell #:_____ E-mail: _____

Birthdate:_____ SSN:_____ Sex:_____

Marital Status: Single Married Widowed Divorced Separated Living w/ Partner

Parole Officer:_____

Name Phone Email

Why are you seeking care at this agency: _____

_____

CPS Involvement: Yes No

What is your current charge and in what state did this charge occur: _____

_____

Do you have any priors (if yes, please list): _____

_____

Have you been in treatment before (if so, how many times):_____

_____

Have you had a Rule 25 Assessment done before: _____

_____

Emergency Contact: _____

Name Relationship Phone Number

Referred by: _____

Insurance Provider: _____ ID #:_____

Group #: _____

County Funding/PMI #: _____

Private Pay: _____

CC #:_____

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CLIENT BILL OF RIGHTS AND RESPONSIBILITIES

- Be treated with dignity and respect
- Be treated without regard to physical or mental disability
- Be treated without regard to race, creed, national origin, sexual preference
- Have all information handled confidentially in accord with standards of confidentiality
- Receive notice of federal confidentiality requirements
- Not be subject to physical, emotional, or sexual abuse or harassment by the staff or another client
- Have access to an established client grievance procedure
- Be informed of rights in a language the client can understand
- Be assured of privacy in restroom facilities § Be assured of their rights to freedom of religion
- A client may file a Grievance/Appeal by completing a Grievance/Appeal Form. The grievance shall be reviewed and responded to be administration (and employee to whom the grievance applies) within 48 hours. If the grievance-appeal is not responded to favorably by staff, the client may contact the MN Department of Human Services to act as a mediator.

Clients Responsibility include:

- Attend sessions as scheduled § Be on time for sessions
- Alert counselor or director if they experience concerns regarding their treatment/evaluation
- Be respectful of others
- Respect confidentiality of other clients
- Make an honest effort in involvement in the counseling process
- Pay fee for services in a timely manner

Beth's Place shall protect the fundamental human, civil, constitutional and stature of each client

I HAVE READ (OR HAVE HAD READ TO ME) THE ABOVE INFORMATION; THE ABOVE INFORMATION HAS BEEN EXPLAINED TO ME AND I UNDERSTAND THIS INFORMATION.

_____ Client Name

_____ Client Signature _____ Date

_____ Signature Parent/Guardian _____ Date

CC #: _____

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Client Grief, Conflict, Resolution, and Appeals

Policy:

Each client, family member or legal guardian will have the right to initiate complaints regarding quality of services at Beth's Place. The grievance procedure will be made available to all clients, family members or legal guardians upon request.

Procedure:

Client, family member or legal guardian presents a complaint to the primary counselor or staff member working with the client. If complaint is in regard to staff member working closet with the client and client is uncomfortable addressing complaint with that staff person, the client can then express a complaint to the supervisor of that staff member. the following outlines the process at each level upon expression or filing of complaint:

1) Counselor receives complaint: Counselor will respond to complaint in less than 48 hours. The counselor will assist the client in formulating a formal complaint. If the complaint is in regard to the counselor, the counselor will assist in writing of complaint and then forward complaint to the Owner (Cassie Kasowski) The owner will review and respond to complaint within three business days.

2) If the client still feels the issue has been dealt with unsatisfactory, the owner/counselor will provide the following addresses and telephone numbers to make a formal complaint

Alcohol and Drug Abuse Division
PO Box 64977
St. Paul, MN 55164-0977
Phone: 651-431-2460
Fax: 651-431-7449

Licensing Division
PO Box 64242
St. Paul, MN 55164-0242
Phone: 651-431-6500
Fax: 651-431-7673

Minnesota Board of Behavioral Health & Therapy
2829 University Ave SE, Suite 210
Minneapolis MN 55414
bbht.board@state.mn.us
Phone: (612) 548-2177
Fax: (612) 617-2187

I have read (or have been read to) the above information; The above information has been explained and I understand and consent.

_____ _____
Client Name/Date Signature of Client/Date

CC #: _____

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CLIENT INFORMED CONSENT

Client Name:_____

• I have chosen to receive treatment services from Beth's Place my choice has been voluntary, and I understand that I may terminate therapy at any time.

• I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between my therapist and myself, we will work together in a cooperative manner to resolve my difficulties.

• l understand that during the course of my treatment, material may be discussed which will be upsetting in nature and this may be necessary to help me resolve my problems.

• I understand that records and information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information. Written patient release information is usually required for the transfer of records. However, there are some exceptions where a minimal amount of information may be shared without a patient release and are specified below.

• I understand that I have the right to inspect or copy Protected Health Information (P.H.I) and/o psychotherapy notes unless it is determined this would adversely affect my wellbeing.

• I have received a copy of the basic rights of individuals receiving therapy at Beth's Place. These rights include:

- The right to be informed of the various steps and activities involved in receiving services.
- The right to confidentiality under federal and state laws relating to the receipt of services.
- The right to humane care and protection from harm, abuse, or neglect.
- The right to have treatment options explained and to make an informed decision whether to accept or refuse treatment; any questions I have will be addressed within a reasonable timeframe.
- The right to contact and consult with counsel at my expense.
- The right to select practitioners of my choice at my expense.

• The right to request restrictions on uses and disclosures (e.g. request certain things not be included in a record) except where there is an exception by law.

• I understand that Beth's Place and my insurer may exchange any and all information pertaining to my treatment. payment and/or healthcare operations. Non-clinical information may be released to billing or collection service for the purpose of collecting the payments owed for services rendered.

• I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or vulnerable adults.

• I understand that state and local laws require that my therapist report all cases in which there exists a danger to self and/or others.

CC #: _____

- I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information, including court ordered testimony and rendering of records.
- I understand that general feedback on treatment progress is reported to the parents/guardians of children under 14 years of age.
- I understand that I may be contacted by my insurer to ensure continuity and quality of my treatment and/or after completion of treatment, to assess the outcome of treatment.
- I understand that the following disclosures do not require authorization:
    - To health oversight agency.
    - To avert imminent harm to client or others, as per duty to protect statute.
    - As required by law (e.g. child abuse reporting).
    - Under court order.
    - To HHS, Office of Civil Rights (OCP) to determine compliance with the privacy rule.
    - When defending legal action brought by a client.
- I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in advance on this consent, and that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid.
- Additionally, and in accordance with Federal laws and the State of Minnesota:
    - My clinical records may be released upon written consent of the patient.
    - Records may be released upon a signed, appropriate order from a court of competent jurisdiction.

I HAVE READ (OR HAVE HAD READ TO ME) THE ABOVE INFORMATION REGARDING INFORMED CONSENT; THE ABOVE INFORMATION HAS BEEN EXPLAINED TO ME AND I UNDERSTAND THIS INFORMATION.

Signature of Client	Date
Signature of Parent or Guardian	Date
Witness	Date

CC #: _____

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CONFIDENTIALITY OF CLIENT SUBSTANCE ABUSE RECORDS

Client Name:_____

The confidentiality of client records maintained by Beth's Place is protected by federal laws (42 U.S.C. 290 dd-22) and regulations (42 C.F.R. Part 2). Beth's Place may not say to a person outside of the agency that a client attends substance abuse programming or disclose any information identifying a client as an alcohol or drug abuser. **The following exceptions may apply:**

- The client consents in writing;
- The disclosure is allowed by an acceptable court order;
- The disclosure is made to medical personnel in a medical emergency;
- The disclosure is necessary to report suspected abuse or neglect of a child or vulnerable adult; The disclosure is made to qualified personnel for research, audit or program evaluation;
- The disclosure is made to report a crime on the premises or against agency personnel;
- The disclosure is covered by 42 CFR Part 2.

In addition, clients who meet minimum age requirements (age 16 in Minnesota) are protected by federal laws and information disclosed in counseling sessions will not be provided to parents unless the above exceptions are met.

Violation of the federal laws and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

I HAVE BEEN GIVEN NOTICE OF MY RIGHTS UNDER FEDERAL LAWS AND REGULATIONS REGARDING PROTECTION OF MY SUBSTANCE ABUSE RECORDS.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent or Guardian Date

_____ _____
Witness Date

CC #:_____