PATIENT INFORMATION SHEET

Date_____/_____/_____

NAME OF CLIENT(s)

_____/___/_____
Client #1 (Last) (First) (MI) DOB

_____/____/_____
Client #2 (Last) (First) (MI) DOB

_____/____/_____
Client #3 (Last) (First) (MI) DOB

Please provide additional family members on page 2, if necessary

ADDRESS_____
(Street)

_____
(City) (Zip)

_____
(Email/s)

Please list telephone numbers and check boxes next to the phone number(s) below where Lisa Nielsen-Karatz has your permission to leave a message with identifying information from her practice. If necessary, voicemail messages may include the name of this private practice for purpose of appointment reminders, etc.

Home # ( )_____ Name/Cell # ( )_____

Work # ( )_____ Name/Cell # ( )_____

Will you accept appointment reminders by email, if necessary? Yes ( ) or No ( ), if yes list preferred email for appointment reminders:_____

Will you accept appointment reminders by text message, if necessary? Yes ( ) or No ( ), if yes list preferred cell number for reminder text:_____

REFERRED BY (circle one): Self - Family Member - Friend - School - Insurance Co - Website or Other Source/Name?_____

MARITAL STATUS: (circle one) Single – Separated – Married – Divorced – Widowed

RACE/CULTUREAL CONSIDERATIONS: _____

_____

_____

EMPLOYMENT STATUS OF PATIENT:

Full Time____ Part Time____ Stay-at-home Parent____ Student____ Unemployed____ Retired____

Client #1/NAME OF EMPLOYER _____

Full Time____ Part Time____ Stay-at-home Parent____ Student____ Unemployed____ Retired____

Client #2 NAME OF EMPLOYER_____

NAMES OF RELEVANT FAMILY MEMBERS	AGES	RELATIONSHIP

PERSON TO NOTIFY IN CASE OF AN EMERGENCY:

Name	Telephone Number

INSURANCE INFORMATION:
Check here if the patient does not have insurance ( )

Insurance Name/Type_____

Name of ins. Company:_____ Phone _____

Policy holder's name_____ Employer Name_____

Date of birth of policy holder_____ Subscriber ID #_____

Group #_____

I hereby authorize payment directly to Lisa Nielsen-Karatz, MSW, LICSW for outpatient mental health benefits for services received by me or my dependents.

The information given on this form is true, complete, and correct to the best of my knowledge.

_____
Print Patient Name Date

_____
Patient Signature (or parent/guardian if minor patient) Date

Release of Medical Information:

I authorize Lisa Nielsen-Karatz, MSW, LICSW to disclose to my insurance company (if Medicaid, to the MN Medical Assistance Program), information concerning the nature and diagnoses, extent, dates, cost, and outcome of the services provided to me, for the purpose of payment of services, billing verification, and evaluation. I understand that my records are protected under state and federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I understand that I may revoke this consent at any time except to the extent that information has been released in good faith or release of information is a condition of parole, probation, or court confinement. In any event, this consent expires automatically when my period of treatment ends and the financial liability for it has been satisfied, or within one year, whichever is earlier. I also understand that if I revoke this consent before any third-party payer or funding source has received data required for billing verification, I will assume full responsibility for the cost of the services provided to me. I understand that failure to pay my bill may result in my name being referred to a collection agency or a conciliation court.

Patient Name_____

_____
If Minor Patient, Print Name of Parent/Guardian) Date

_____
Patient Signature (or parent/guardian if minor patient) Date

Relationship if other than patient's signature_____

Symptom Checklist

Please check if you have experienced any of the following symptoms/behaviors within the past month.

__Depressed mood __Loss of interest or pleasure in activities __Feelings of hopelessness __Feelings of worthlessness __Fatigue or low energy level __Social withdrawal __Crying more than usual __Feeling anxious or worried __Fears __Trouble making decisions __Irritable __Family problems __Problems with spouse or significant other __Problems at work __Trouble with memory __Difficulty concentrating __Feeling lonely __Suicidal thoughts __Thoughts of death __Trouble falling asleep or staying asleep __Decreased need for sleep __Sleeping more than usual or too much __Grief/Loss __Worries about health __Depressed mood __Loss of interest or pleasure in activities __Feelings of hopelessness __Feelings of worthlessness	__Fatigue or low energy level __Social withdrawal __Shortness of breath __Compulsion to do things __Intrusive thoughts __Disturbing thoughts __Compulsion to do certain behaviors __Outburst(s) of anger __Thoughts of harming others __Fear of losing control __Uncontrolled eating __Concerns about eating __Increase in appetite __Decrease in appetite __Weight loss /Weight gain __Thoughts that are hard to ignore __Out of character behavior (e.g., buying sprees) __Fear of doing something embarrassing in public __Panic attack(s) __Sexual concerns __Excessive guilt __Concerns about alcohol or drug use __Financial problems __Legal concerns __Other (explain):_____ _____ _____

Presenting Concerns or Problems

Please answer the following questions in as much details as you would like to share.

List the reasons for seeking help by listing the most urgent reasons at the top of your list.

1) _____

_____

2) _____

3) _____

Describe your past experiences with therapy and diagnosis:

Family dynamics important to consider for the therapist:

Please include any further information about yourself and/or your family that would be helpful to know:

PATIENT AGREEMENT

TREATMENT PHILOSOPHY

As your therapist, I believe in providing goal-directed treatment. This means that a treatment goal or several goals are established after a thorough assessment. All treatment is then planned with the goal in mind and progress is made toward accomplishment of that goal in a time-efficient manner. If you ever have any questions about the nature of the treatment or anything else about your care, please don't hesitate to ask.

CONFIDENTIALITY
All information between Lisa Nielsen-Karatz, MSW, LICSW and the patient is held strictly confidential unless:
1. The patient authorizes release of information with his/her signature.
2. The patient presents a physical danger to self.
3. The patient presents a danger to others.
4. Child/elder abuse/neglect is suspected.
In the latter two cases, Lisa Nielsen-Karatz is required by law to inform potential victims and legal authorities so that protective measures can be taken.

FINANCIAL TERMS
Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed for you, and Lisa Nielsen-Karatz, MSW, LICSW will be paid directly by the carrier, unless you have a deductible, then you must pay the therapy fee directly to Lisa Nielsen-Karatz. You will be responsible for any applicable deductibles and co-payments. Co- payments must be paid at the time services are rendered. If you are not eligible for insurance reimbursement at the time services are rendered, you are responsible for the full private payment rate or agreed upon fee. There is a straight fee for any additional services outside the therapy session, such as your request for documentation, paperwork, court preparation and court fees. The fee for time is calculated in 15-minute increments according to the full private pay rate ($155) and the court fee is a daily rate of $450, per each day needed in court, regardless of the number of hours per day. If your account becomes delinquent and Lisa Nielsen-Karatz forwards your account to a collection agency and/or attorney, you agree to pay collection costs, attorney fees, interest, and court costs. The balance of fees not paid by the insurance company within 90 days of claim submission will be billed to the patient (parent/guardian if the patient is a minor). Additionally, a $25.00 fee will be charged for checks returned for non-sufficient funds.

CANCELLED/MISSED APPOINTMENTS
A scheduled appointment means the time is reserved only for you. If an appointment is missed, or cancelled with less than 48 hours notice, you will be billed $50.00 for the missed session. Your health plan does not cover payment for missed appointments; therefore, you will be responsible for the $55.00 no-show/late cancellation fee. Please discuss with provider, if you have any questions.

EMERGENCY PROCEDURES
If you need to contact me, leave a message on my phone, and your call will be returned 24-48 hours. If an emergency situation arises, state that your call is an emergency. If you deem your situation to be a life or death situation, immediately call 911 or go to the nearest emergency room.

RELEASE OF INFORMATION
I authorize the release of information regarding my care to my health insurance plan for the payment of claims, certifications/case management decisions, and other purposes related to the administration of benefits for my health care plan.

CONSENT FOR TREATMENT
I further authorize and request that Lisa Nielsen-Karatz, MSW, LICSW carry out mental health evaluations, treatments, and/or diagnostic assessments, which now or during the course of my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that, while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.
I understand and agree to all of the above information.

Print Name of Patient _____ Date_____

If Minor Patient, Print Name of Parent/Guardian)_____

Patient (or if Minor, Parent/Guardian) Signature_____

HIPAA 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.

If you have any questions about this notice, please contact Lisa Nielsen-Karatz, LICSW at 612-234-7162.

Please note that this notice is required by Federal law, and the information it contains is mandated by that law. If you have any questions about how your Protected Health Information (PHI) is used, please contact me.

I. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH lNFORMATION (PHI) I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it on my website as noted at the beginning of this document. You can also request a copy of this Notice from me, or you can view a copy of it on my website as noted at the beginning of this document.

II. HOW I MAY USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior authorization; for others, however, I do not.

Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent . I can use and disclose your PHI without your consent for the following reasons:

1. For treatment. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if you're being treated by a psychiatrist, I can disclose your PHI to your psychiatrist in order to coordinate your care. However, it is my practice to only do so if you have directly authorized me in writing, unless a threat to your safety is involved.

2. To obtain payment for treatment . I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

3.For health care operations. I can disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to our accountants, attorneys, consultants, and others to make sure I am complying with applicable laws.

4. Other disclosures. I may also disclose your PHI to others without your consent in certain situations. For example, your consent is not required if you need emergency treatment, as long as I try to get your consent

after treatment is rendered, or if I try to get your consent, but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Uses and Disclosures Do Not Require Your Consent . I can use and disclose your PHI without your consent or authorization for the following reasons:
1. When disclosure is required by federal, state or Iocal law; judicial or administrative proceedings; or, law enforcement . For example, I may make a disclosure to applicable officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.
2. For public health activities. For example, I may have to report information about you to the county coroner.
3. For health oversight activities. For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
4.To avoid harm. In order to avoid a serious threat to you or another person, I may disclose PHI to law enforcement personnel or persons able to prevent or lessen such harm.
5. For specific government functions. I may disclose PHI of military personnel and veterans in certain situations. And I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
6. For workers' compensation purposes. I may provide PHI in order to comply with workers' compensation laws.
7. Appointment reminders and health related benefits or services. I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.
C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.
Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.
D. Other Uses and Disclosures Require Your Prior Written Authorization . There are specific disclosures that would require your authorization, but that this practice does not do. These include disclosing your PHI for marketing purposes (marketing of services other than those of Families Counseling), sale of PHI to third parties, and fundraising purposes.
In these, or any other situation not described in sections III A, B, and C above, I will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.
III. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI. You have the following rights with respect to your PHI:
A. The Right to Request Limits on Uses and Disclosures of Your PHI . You have the right to ask that I limit how I use and disclose your PHI. I am not required to agree to your request unless you are asking me to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid me “out-of-pocket” in full. If I agree, I will comply with your request unless the information is needed to provide you with emergency treatment. You may not limit the uses and disclosures that I am legally required or allowed to make.
Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that I not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and I will honor that request.
B. The Right to Choose How I Send PHI to You . You have the right to ask that I send information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail) I must agree to your request so long as I can easily provide the PHI to you in the format you requested.

C. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to you within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance. If you request copies of your PHI, I will charge you not more than $.25 for each page. In my practice, I keep "treatment notes" which are a regular part of your PHI. I do not keep what are called "psychotherapy notes", which are a separate sort of record and are generally not accessible to clients.

D. The Right to Correct or Update Your PHI . If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

E. The Right to Get This Notice by E-Mail . You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

F. Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the following agencies. State of Minnesota Department of Health and Human Services at (651)282.5600. Board of Social Work at (612)617.2100 (LGSW, LICSW). You may also send a written complaint to the federal civil rights office at: US Department of Health and Human Services, Office for Civil Rights, Region V, 233 N. Michigan Avenue, Suite 240, Chicago, IL 60601.

VI. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on November 1st, 2019. The latest version was effective on the date noted at the beginning of this document.

Please sign to indicate that you received a copy of this document:

Print Name of Patient _____ Date_____

If Minor Patient, Print Name of Parent/Guardian)_____

Patient (or if Minor, Parent/Guardian) Signature_____

Thank you very much for taking the time to share this personal information. It will greatly help me in your assessment and treatment process. If there is anything else you would like to add, please feel free to include below or discuss during our meeting.