Adult Data Form

Date_____ Who Referred you to S. N. Hinrichs, LLC?_____

Individual Counseling

Name (First, MI, Last) _____

DOB_____ Gender (circle one) Male Female

Address_____ Email_____

City_____ State_____ Zip_____

Home Phone_____ Mobile Phone_____ Other_____

May we identify ourselves by using the clinic name? (Circle one) Yes No

If no, how should we identify ourselves_____?

May we leave a message? (Circle one) Yes No

If you would like to receive appointment reminders, please circle one or both – Text/Email

Marital Status (circle one) Never Married Married Separated Divorced Widowed Other

Employment Status (circle one) Employed Student Other

Employer

Name_____ City_____

Emergency Contact

Name_____ Phone_____

Relationship_____

Treatment

To best coordinate your care, may we contact your primary Physician (Circle one) Yes No

Do you have a Psychiatrist? (Circle One) Yes No

To best coordinate your care, may we contact your primary Psychiatrist (Circle one) Yes No

Have you worked or are you working with any other mental health professionals? (Circle one) Yes No

Would you like us to contact this professional regarding your counseling session? (circle one) Yes No

If you answer YES to any of the above, please complete the form titled "**Release of information Consent Form**."

Consent for Treatment and Agreement to Terms

I. Consent for Treatment

By signing below, you are giving informed consent for treatment. By signing below, you are also stating that you have received, read, and understand the *Client information and Office Policy* Statement and agree to its terms, unless otherwise stated in writing.

I give my consent for treatment with S. N. Hinrichs, LLC and its associated professional staff to include evaluation, psychotherapy, and involvement in the treatment planning process. I understand that the client may decline at any time specific treatment recommendations.

II. Billing/Cancellations

I authorize S. N. Hinrichs, LLC to release the information necessary to Great Lakes Medical Billing, to process any applicable medical insurance claim for services provided by S. N. Hinrichs, LLC. I understand S. N. Hinrichs, LLC will release copies of my medical records and information as to the nature of treatment as requested by the insurance company.

I understand that I will be charged for late cancellations or failed appointments (less than 24 hours). There will be a charge of $100.00, which is not covered by any insurance. You may leave a message or cancel 24 hours a day.

III. **HIPAA/Notice of Privacy Practices/Limits of Confidentiality Statement**

By signing below, you are stating that you have received, read, and understand the HIPAA/Limits of Confidentiality and agree to its terms, unless otherwise stated in writing.

I hereby acknowledge that I have received and have been given an opportunity to ready a copy of S. N. Hinrichs, LLC's Notice of Privacy Practices. I understand that I can contact S. N. Hinrichs, LLC if I have any questions regarding the Notice of my privacy rights.

Client Signature (or parent/guardian if minor) _____ Date _____

Spouse's Signature (For marital counseling) _____ __ Date_____

Name of minor being treated (If applicable) _____ Date _____

Payment Contract for Services

Name(s) of client(s) receiving services _____

Person responsible for payment (if different) _____

Federal Truth in Lending Disclosure Statement

Clients With Insurance Coverage

Some Insurance companies have incorporated your Social Security number as a part of your ID number. Please check your card to see if this is required and fill in your full ID number here**.**

Insurance Carrier	
Full ID Number	
Group Number	

Deductible amount: $_____

Co-payment: % or $_____

We suggest you confirm your benefit and eligibility with your insurance company. Your insurance company may not pay for services that they consider to be not effective, not medically or therapeutically necessary, or ineligible. You are responsible for any amount not covered by insurance. It is your responsibility to know if the therapist is accepted by your insurance.

Client <u>WITHOUT</u> Insurance Coverage

I (we) agree to pay S. N. Hinrichs, LLC a rate of $_____ per session.

All Clients: Please read and sign below

Payments and co-payments are due at the time of service. Any amount due on the client's account will be issued a statement showing the balance. Statement charges are due within 15 days. There may be an interest surcharge posted to overdue accounts which will be included on the statement.

I authorize S. N. Hinrichs, LLC to disclose case records (diagnosis, case notes, psychological reports, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment directly to S. N. Hinrichs, LLC. I understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I understand that I may revoke this consent at any time by providing written notice, and after one year this consent expires.

By signing below, I agree that I have received, read, and agree to the conditions of this form including the **Federal Truth in Lending Disclosure Statement** for Professional Services.

_____ _____

Signature of person responsible for payment **Date**

Consent for Transmission of Protected Health Information

By Non-Secure Means

I, _____ **AUTHORIZE**: Sheri Hinrichs,MA, LP_____

(Name of client) 600 W 78th St Ste 220_____

Chanhassen, MN 55317_____

TO TRANSMIT THE FOLLOWING PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

- o Information related to the scheduling of meetings or other appointments.
- o Information related to billing and payment.
- o Completed forms, including forms that may contain sensitive, confidential information.
- o Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment.
- o My health record, in part or in whole, or summaries of material from my health record.
- o Other information. Describe: _____

BY THE FOLLOWING NON-SECURE MEDIA:

- o Unsecured email.
- o SMS text message (i.e. traditional text messaging) or other type of "text message"
- o Other media. Describe: _____

TERMINATION

- o This authorization will terminate _____ days after the date listed below.

OR

- o This authorization will terminate upon completion of treatment.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

(Signature of client)_____ **Date** _____

Credit Card Recurring Payment Authorization Form

For your convenience, you may schedule your payment to be automatically charged to your credit card. If you are interested, please complete and sign this form to get started**.**

How do Recurring Payments Work?
You authorize regularly scheduled charges to your Visa, Mastercard, American Express, or Discover card. You will be charged each visit the total amount due. A receipt will be emailed to you and the charge will appear on your credit card statement. You agree that no prior notification will be provided.

Please complete the information below:

I (full name) _____ authorize S. N. Hinrichs, LLC to charge my credit card indicated below for $_____ dollars each visit. I understand that I will not receive advance notice of the charge and agree to pay for all charges as outlined in the card member agreement.

Billing Address_____

City _____ **State** _____ **Zip** _____

Phone # _____ **Email for receipt** _____

Account Type (circle one): Visa MasterCard Amex Discover

Cardholder Name _____

Account Number _____

Expiration Date_____

CW (3 digit number on back of Visa/MC, 4 digits on front of AMEX)
_____

Signature _____ **Date** _____

I authorize S. N. Hinrichs, LLC to charge the credit card indicated in this authorization form according to the terms outlined above. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user or this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

Client Information and Office Policy Statement

Appointments

Welcome to S. N. Hinrichs LLC. This is an opportunity to acquaint you with the information relevant to treatment, confidentiality, and office policies. S. N. Hinrichs LLC will offer you courteous and professional treatment by a competent, caring counselor. Making appointments, determining financial commitments, urgent requests, and resolution of your concerns will be handled in a timely manner, with confidentiality, courtesy, and respect. Your counselor will answer any questions you have regarding any of these policies.

Office Information

Fee Policy

You are responsible for determining benefits, costs, and co-payments as they pertain to your treatment. Any amount that your insurance company will not be paying is due from you at the time services are rendered. If there are any problems with meeting the financial obligations, please speak with Sheri Hinrichs, MA, LP. You are responsible for providing this office with copies of your insurance card (s) or any changes in your insurance coverage. Failure to do so may result in a denial of your claim, and you may become liable for any charges. Payment is due at the time of the session unless other arrangements have been made. The standard rate is $225 for a diagnostic session and between $160 and $200 depending on session length for all other individual appointments.

Cancellations

If you cannot make an appointment, please notify the office at least 24 hours in advance. For late cancellations (less than 24 hours prior to appointment time) or failed appointments ("no shows"), there will be a charge of $100.00, which is not covered by insurance. You may leave a voicemail or email to cancel 24 hrs a day.

After hours

If you are suicidal or need to be hospitalized due to a crisis situation, you may contact the 24 hour crisis line at 952-442-7601(Carver County) 612-379-6363 (Hennepin County Crisis Connection). If your situation requires immediate attention, you may be referred to the nearest emergency room. Otherwise, please call 9-1-1.

Client Rights

Freedom from Abuse

S. N. Hinrichs, LLC offers dependable treatment of all clients and strictly follows the Vulnerable Adults Protection Act as described in its respective statute, section 626.557, subdivision 2D. This requirement is a protection from assault, sexual exploitation, and criminal sexual conduct.

Other Rights

You have the right to respectful care as it relates to your family's ethnic, social, religious, and psychological well-being. Our responsibility is to provide your family with those services that best meet your needs in a professional and ethical manner. You have the right to seek an outside opinion from another agency and an explanation for any referral recommendations made.

Other Responsibilities

You have a responsibility to give your counselor the information needed in order to care for you. You also have the right to participate in the planning of your mental health care, and it is expected that you will follow the treatment plan and instructions needed in order to care for you.

Additional Information

S. N. Hinrichs Therapist

Sheri Hinrichs is licensed with the State of Minnesota as an LP (Licensed Psychologist).

Treatment Process

You and your therapist will work together to identify treatment options and goals. The length of treatment will vary according to individual needs and will be discussed throughout the course of your care. You are encouraged to talk as openly as possible about the problems you are experiencing so that your clinician may better assist you in treatment planning. You have the right to refuse treatment.

Clinic Responsibilities

S. N. Hinrichs, LLC is responsible for providing you with quality professional services. This includes treating you with respect, maintaining your confidentiality, and informing you about your condition/diagnosis and treatment options. Information about treatment options will include potential benefits and risks associated with those options. In order to meet these responsibilities, your clinician may consult with other clinicians (which would be discussed with you).

Confidentiality

Your therapist takes seriously the responsibility to hold in confidence what you discuss with him/her. Information about clients and their families is protected and confidential. Written permission is required to required to release any information to another agency. Exceptions to this policy only occur under certain circumstances. These are discussed in more detail on the HIPAA/Terms and Limits of Confidentiality form included in the introductory packet.

Request for Paperwork

There are times when you may need paperwork completed by the Clinician. There is a fee for filling out forms and reports. The fees vary according to the document(s) needed. Paperwork and forms can take up to 10 business days to be completed. Please deliver each paperwork request to this office as early as possible.

Record Keeping

Clinical information is maintained describing your current condition, treatment, progress, dates, notes, etc. Your records will not be released without your written consent or otherwise noted in the HIPAA/Limits of Confidentiality form in the introductory packet. Confidential records are locked/secured and kept on site.

Your Satisfaction is Important to Us

Please feel free to raise any concerns with your counselor at any time.