CLIENT #____________

TO BE COMPLETED BY THERAPIST

THERAPIST CODE: ____________
DSM IV CODE: ____________
DATE OF 1ST APPT: ____________
❑ New Client ❑ Returning/Existing Client
High Deductible Plan Required ____Yes

CONFIDENTIAL PERSONAL DATA

CLIENT INFORMATION (PLEASE PRINT CLEARLY)

NAME:____ **GENDER:** ❑ Male ❑ Female
FULL FIRST MIDDLE INITIAL LAST

DOB: ____/____/_______ **AGE:** ___________ **GUARDIAN:** ______________________

ADDRESS: STREET ______________________________ CITY________________

STATE ___________ ZIP____________ COUNTY ____________________

PRIMARY PHONE: (______)______________________ **Can MPR leave a message:** ❑ YES ❑ NO

CELL PHONE: (______)______________________ **Can MPR leave a message:** ❑ YES ❑ NO

E-MAIL ADDRESS: ______________________ **Can MPR send a message:** ❑ YES ❑ NO

MARITAL STATUS: ❑S ❑M ❑Sep ❑Div ❑W **STUDENT:** ❑Full time ❑Part time ❑Not a student

EMERGENCY CONTACT NAME: ____________________ **PHONE:** ____________________

CLIENT'S RELATIONSHIP TO EMERGENCY CONTACT: ______________________________

INSURANCE INFORMATION

NAME OF INSURANCE COMPANY:______________________ **ID NUMBER:** ____________

GROUP NUMBER: ____________________ **EFFECTIVE DATE:** ____________________

CUSTOMER SERVICE NUMBER: (on back of Insurance Card) (_____)____________________

NAME OF POLICY HOLDER: ____________________ **POLICY HOLDER DATE OF BIRTH:**__________

CLIENT'S RELATIONSHIP TO POLICY HOLDER: ______________________________

GUARANTOR

(For Children under the age of 18 the Guarantor is the person responsible for the account)

GUARANTOR NAME: ______________________ **GUARANTOR DOB:** ____/____/_______

GUARANTOR ADDRESS: STREET ________________ CITY____________ STATE ________

APPOINTMENT REMINDERS

MPR provides the opportunity for you to sign up to receive appointment reminders. Appointment reminders can be sent to you in the form of a text message, e-mail, or phone call. You can request to receive appointment reminders below. Appointment reminders from MPR are provided as a courtesy. However, if for some reason you sign up to receive an appointment reminder and you do not receive an appointment reminder, you are always responsible to be aware of your appointment time.

How Would you like to Receive Appointment Reminders? Select Just One Option

❑ **E-mail** ______________________________ **(Provide E-Mail Address)**
❑ **Phone Message** ________________________ **(Provide Phone Number)**
❑ **Text Message** _________________________ **(Provide Phone Number)**

CLIENT INFORMATION

The purpose of this form is to provide you with information about the processes and procedures at Minnesota Psychological Resources (MPR) as well as your rights at MPR. We are committed to providing quality professional services to all clients. To do so, we need your informed participation. Please feel free to discuss any questions you may have with your therapist.

1. The information which is requested about you is used to determine your eligibility for services, to evaluate your needs and to develop a plan to address those needs.

2. It is necessary to keep records on all services provided to you. The records must include diagnosis, treatment plans, and specific treatment given.

3. As a client of this Center, you have a right to privacy and a right to see your records. You have a right to a copy of your records (There is a charge for this service). Your therapist can make a clinical decision to deny you access to part or all of your private records if it is determined that your psychological and/or physical well-being or that of another person would be jeopardized.

4. You have the right to challenge your records and to insert your own explanation about that which you object to in your records.

5. You have the right to appeal the content of your records. To file an appeal, you can contact your therapist, the Director of Minnesota Psychological Resources, or you can write directly to the Department of Human Services, Licensing Division, Human Services Building, 444 Lafayette Road North, St. Paul, Minnesota, 55155.

6. If you are a minor, your parents or legal guardians have the right to request access to information related to your assessment and treatment at MPR. You are encouraged to discuss your concerns related to this with your therapist.

7. Your MPR records are kept confidential and ONLY with your written authorization can your records be released to another person or agency EXCEPT when such release is specifically required by law.

8. It is required by law for therapists to disclose confidential information in some specific situations to prevent harm from occurring (for example, child abuse, injury to yourself or others, etc.). In some circumstances a court might be able to obtain your records or subpoena your therapist.

9. E-mail and telephone communications with MPR are not encrypted. When communicating with MPR by phone or e-mail it is important that you know and understand that phone and e-mail communications are not encrypted.

10. You have the right to know the specifics of your treatment plan including treatment options and possible treatment side effects. You also have the right to discuss the outcomes of your treatment.

11. You have the right to know the professional qualifications of your therapist. You are encouraged to ask your therapist about his/her professional background and training.

12. You have the right to request corrective action be taken if your rights are violated. You may present your concern or complaint to your therapist or to the Director of MPR. You may also file a complaint if your concern is not resolved in a satisfactory manner by writing the Department of Human Services, Licensing Division, Human Services Building, 444 Lafayette Road North, St. Paul, Minnesota, 55155.

13. You have a right to a copy of the *Minnesota Psychological Resources Notice of Privacy Practices* brochure which describes how mental health information about you may be used and disclosed, and how you can get access to this information.

A copy of the Minnesota Psychological Resources Notice of Privacy Practices brochure has been provided or made available to me. _______ Please Initial

Again, if you have any questions regarding the information in this form, please direct your questions to your therapist.

________________________________ Client Signature

________________________ Date

Responsibility For Account - Assignment of Benefits - Billing Insurance

Client Name: ____ DOB: ________________

Client Agreement, Authorization, Consent and Release

1. It is agreed that my insurance is to be billed for all services provided by Minnesota Psychological Resources (MPR) as long as my insurance is in effect and the insurance limits have not been exceeded. I understand that I will pay the deductible, co-pay and/or co-insurance required by my insurance company. It is also agreed that I will make the payments at the time of the therapy session.
2. I authorize MPR to send my bills for my medical care and treatment to my insurance company, other payor, and/or Medicare or Medicaid for payment, to the extent my insurance company, other payor, and/or Medicare or Medicaid is required to pay the bill under the terms of my insurance policy or by law.
3. I request that my insurance company, other payor, and/or Medicare or Medicaid pay MPR for the services provided in my treatment.
4. I consent to the release of my medical record by MPR to my insurance company, other payor, and/or Medicare or Medicaid (and organizations working on their behalf) if necessary in order for my bills to be paid.
5. I agree to pay for any charges not covered by my insurance.
6. I understand that MPR will charge interest on unpaid balances 30 days after the date of service and I accept responsibility to pay interest charges.
7. I understand that the information my insurance company provides to me or MPR is NOT A GUARANTEE of the benefits provided or paid by my insurance company. Therefore, I accept full responsibility for all charges for services provided by MPR.
8. I understand that psychological testing fees involve an additional charge and are not included in the charge for the therapy sessions.
9. I understand that clinic appointments must be cancelled at least one business day and 24 hours prior to the scheduled appointment time to avoid a late cancellation charge.
10. I understand that in the event that MPR has been unable to collect payment for services, MPR has the right and will turn my account over to a collection agency.
11. I understand that there is a $20 charge for NSF checks or any other checks that are returned to MPR.

Release of Records for Mental Health Care as Required by Law:

____ INITIAL TO INDICATE UNDERSTANDING. A copy of my records may be sent:

- Health care providers directly involved with my care.
- State, Federal and accrediting bodies for required reporting and/or surveys for compliance.

NOTE: Records are not automatically sent to your referring physician. They must be requested.

Privacy Policy:

____ INITIAL TO INDICATE THE FOLLOWING:

- I have been offered MPR's Notice of Privacy Practices

Cancellation & No Show Policies:

____ INITIAL TO INDICATE UNDERSTANDING:

- Cancellations of appointments must be made at least 24 hours in advance (one business day).
- Failure to cancel an appointment with 24 hour notice or failure to come to a scheduled appointment WILL RESULT IN A NO SHOW FEE WHICH CANNOT BE BILLED TO YOUR INSURANCE COMPANY.

I authorize payment of medical benefits to Minnesota Psychological Resources (MPR). I recognize MPR cannot guarantee payment of charges by any particular insurance company and I am ultimately responsible for the entire bill including deductibles and co-payments. When applicable, I also request payment of government benefits to MPR, which accepts assignment.

By signing this form, I consent to authorize my medical or mental health provider to assess and treat me. I understand that my provider is available to explain the purpose of the treatment, and that I have the right to refuse the recommended treatment. I understand I have the right to revoke this consent, in writing, at any time except where MPR has already made disclosures in reliance on this consent.

______________________________ Client Signature

______________________________ (If a minor, Parent/Guardian's signature)

______________________________ MPR Representative Signature

______________________________ Date

Minnesota Psychological Resources

Appointment Cancellation Policy

Because of the significant demand for mental health care in Minnesota as well as the importance of client responsibility in the counseling treatment relationship, Minnesota Psychological Resources (MPR) requires at least **24 hours advance notice for all appointment cancellations**. Failure to provide 24 hours notice for a cancellation or failure to attend a scheduled appointment **will result in a No Show Fee** which cannot be billed to your insurance company. This fee is $60.00 for the first missed appointment and $100.00 for each additional missed appointment. Questions regarding this clinic policy should be directed to your therapist or psychiatrist.

MPR provides the opportunity for you to sign up to receive appointment reminders. Appointment reminders can be sent to you in the form of a text message, e-mail, or phone call. You can request to receive appointment reminders with the MPR support staff. Appointment reminders from MPR are provided as a courtesy. However, if for some reason you sign up to receive an appointment reminder and you do not receive an appointment reminder, **you are always responsible to be aware of your appointment time**.

By signing below, I acknowledge that I have read and understand the above policy.

____
Client Name (please print)

____
Client Signature

____
Date

PATIENT HEALTH QUESTIONNAIRE

Name: ______________________________________ Date: ____________

Over the *last 2 weeks,* how often have you been bothered by any of the following problems?
Use "✓" to indicate your answer

		Not at all	Several days	More than half of the days	Nearly every day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed or hopeless	0	1	2	3
3.	Trouble falling asleep or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.	Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

\+ +

TOTAL:

10.	If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ______ Somewhat difficult ______ Very difficult ______ Extremely difficult ______

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls8@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at http://www.pfizer.com. Copyright © 1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.

NAME: ______________________________ DATE: ____/_____/_____

DO YOU SMOKE? YES ____ NO _____

DO YOU USE TOBACCO PRODUCTS? YES ____ NO _____

DO YOU WANT TO STOP SMOKING OR USING TOBACCO PRODUCTS? YES ____ NO _____

WOULD YOU LIKE INFORMATION OR ASSISTANCE IN STOPPING SMOKING OR USING TOBACCO PRODUCTS? YES ____ NO _____

If you smoke, please answer the following six (6) questions.

For each statement, circle the most appropriate number that best describes you.

1. How many cigarettes do you smoke per day?
   a) 10 or less
   b) 11-20
   c) 21-30
   d) 31 or more

2. How soon after you wake up do you smoke your first cigarette?
   a) 0-5 min
   b) 30 min
   c) 31-60 min
   d) After 60 min

3. Do you find it difficult to refrain from smoking in places where smoking is NOT allowed (e.g. hospitals, government offices, cinemas, libraries etc)?
   a) Yes
   b) No

4. Do you smoke more during the first hours after waking than during the rest of the day?
   a) Yes
   b) No

5. Which cigarette would you be the most unwilling to give up
   a) First in the morning
   b) Any of the others

6. Do you smoke even when you are very ill?
   a) Yes
   b) No

____

Minnesota Psychological Resources

Psychiatry Communication with Primary Care Provider

TO:

PCP Provider: ______________________

Address: ______________________

____

Phone: ______________________

Fax: ______________________

FROM (MPR Psychiatrist):

William G. Nelson, M.D.
12805 Highway 55, Suite 211
Plymouth, MN 55441
fax. 763-559-2118

It is our desire to inform primary care providers when their patients are receiving psychiatric services at Minnesota Psychological Resources.

This is for your information. There is no need to reply unless you deem it helpful or appropriate.

Regarding:

Patient Name: ______________________ DOB: ______________________

Parents/Legal Guardian: ______________________

Date of initial assessment: ______________________ Next appointment: ______________________

Client Information:

☐ See attached Initial Intake Evaluation

Diagnosis: ______________________

____

Medications: ______________________

____

____

Please call if further information would be helpful.

Sincerely,

William G. Nelson, MD, Psychiatrist

AUTHORIZATION TO DISCLOSE THE ABOVE INFORMATION

To the party receiving this information:

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations 42 CFR Part 2 prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2.

Patient's Signature ______________________ Date: ______________________

Parent/Guardian Signature: ______________________ Date: ______________________

MINNESOTA PSYCHOLOGICAL RESOURCES

❑ 12805 Hwy 55, Suite 211
Plymouth, MN 55441
763-550-9005 phone
763-559-2118 fax

❑ 4325 Woodman St., PO Box 413
Pequot Lakes, MN 56472-0413
218-568-4500 phone
218-568-8944 fax

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name____Client ID # ____________________________

Previous Names_____________________________________ SS#_______-______-__________ DOB____/____/_____

Phone Numbers (Home)___________________(Work)______________________(Other)_____________________

❑ **This authorizes Minnesota Psychological Resources to request information from:**
(and/or)
❑ **This authorizes Minnesota Psychological Resources to release records to:**

Name/Organization____

Street Address____

City____State_______________Zip______________________

Please release the following information (check all that apply):

❑ Admission Summary
❑ Discharge Summary
❑ History and Physical Exam
❑ Consultation Reports
❑ Hospital /Clinic Notes
❑ Treatment Summary
❑ Diagnosis
❑ Psychological Testing- Raw Data
❑ Psychological Testing- Interpretation
❑ Other (specify)_________________
____

For the following date(s) of treatment or condition: ____
(specify dates of treatment or condition)

This information release is being requested for the following purpose:

❑ Diagnosis & Evaluation
❑ Continued care by another provider
❑ Treatment Coordination & Planning
❑ Insurance claim purposes
❑ Personal use
❑ Other______________________

- All records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by a checkmark here: _________
  Please indicate any restrictions. (Specify)____
- I understand I may revoke this authorization by written request at any time to the address checked at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will automatically expire one year from the date of my signature, unless a different expiration date is specified here: ________________. The expiration period noted here may exceed one year only in certain situations as specified by law.
- I understand there may be a retrieval and copy charge assigned with the release.
- I understand that once information is released pursuant to this authorization, Minnesota Psychological Resources can not prevent the re-disclosure of the information to another third party.
- I understand this authorization must be filled out completely and signed in order to be considered valid. A copy that has not been altered will be considered as valid as an original.
- Minnesota Psychological Resources will not condition treatment on my signing this authorization.

______________________________	______________________________	____________________
Signature of Patient/Authorized Person (If authorized person is signing, please also print name)	**Authorized Person's Authority to Sign** (Parent, Guardian, Power of Attorney, etc.)	**Date**

Reason patient is unable to sign: ❑ Minor ❑ Deceased ❑ Other: ______________________________________