MAPLE GROVE COUNSELING CENTER, P.A.
13700 83rd Way North Suite 205 Maple Grove, MN 55369

CLIENT DATA SHEET

Cell Phone (___)_____

Name (Last, First, MI) _____ Home Phone (___)_____

Ok to leave a message on Cell (Y/N)_____

Street _____ Ok to leave a message on Home (Y/N)_____

City _____State _____Zip _____Date of Birth_____

Marital Status:

___ Divorced ___Married ___Widowed

___ Legally Separated ___Single ___Other _____

Student Full-Time _____ Student Part-Time _____

Employed Full-Time _____ Employed Part-Time _____

Not Employed _____

Retired _____ If Checked, Date of Retirement _____

Employer Name _____ Work Phone (___)_____

Occupation _____OK to call or leave a message at work? (Y/N)_____

Referring Provider _____

Insurance Name/Address _____

_____

Insurance Phone # (___)_____ ID# _____

Group/Plan Name _____Group # _____

Coverage for Outpatient Psychotherapy: Limits/Deductibles _____

_____

Person to call in case of Emergency _____

Home # (___)_____ Cell Phone # (___)_____Other # (___)_____

PLEASE COMPLETE (May use "same or see above" if you are primary insured.)

Insured Name (Last, First, MI) _____Home Phone (___)_____

Insured Address _____Cell Phone (___)_____

City _____State _____ Zip _____ Date of Birth _____

Relationship to Insured (Spouse, Child, Other) _____

Employer Name _____

Occupation _____Work Phone (___)_____OK to call work? (Y/N)_____

MAPLE GROVE COUNSELING CENTER, P.A.
MEDICAL INSURANCE BENEFITS (MENTAL HEALTH COVERAGE)

Medical insurance benefits are frequently used to help cover the costs of mental health care. Getting complete and accurate information prior to starting therapy is important. Please complete the following medical benefits questions and give this form to your therapist.

Please note: When you call the member service number on the back of your insurance card, ask your insurance representative to give you information on your **outpatient mental health benefits** for yourself, or for the designated client. The insurance representative will ask for the name of the person starting therapy, their date of birth, the primary insured person (who has the insurance through an employer, etc.) and the ID number (or Social Security Number) of the person seeking therapy. If there is more than one insurance covering the client, please identify which insurance is **primary**, and which insurance is secondary. Be sure to let your therapist know if there is double insurance coverage.

Write down all of the outpatient mental health benefits information, including the name of the insurance representative who gave the information to you and the date this was received. Ask the following benefit questions which pertain to outpatient mental health (some may not apply to your specific plan):

Client's Name _____ Member's Name _____

Representative's Name _____Telephone Number _____

Effective date of your insurance plan _____Date Received _____

Is Maple Grove Counseling Center an in-network provider for your specific plan? _____
(Maple Grove Counseling Center is a provider for most insurances.)

Do you have a deductible? _____If so, how much has been met thus far? _____

Do you have an office visit co-pay? _____If so, how much is the co-pay? _____

Do you have a co-insurance? _____If so, what is the percentage you would owe? _____

Is an authorization needed prior to your therapy? _____If yes, write down the authorization number given to you _____and the effective date of this authorization _____, along with the expiration date _____

Do you have a maximum number of office visits available to you in a benefit year? _____
If so, how many? _____Which month does your benefit year start? _____

Do you have an out-of-pocket maximum amount paid for medical expenses per year, at which point your insurance pays 100% of the allowed claims? _____If so, what is the maximum amount you would pay?_____

MAPLE GROVE COUNSELING CENTER, P.A.
MEDICAL INSURANCE BENEFITS (MENTAL HEALTH COVERAGE)

By my signature below, I authorize payment of medical benefits to Maple Grove Counseling Center, P.A., for services rendered to me and/or my dependents.

In addition, I authorize the release of any medical information to the insurance company which would be necessary to process medical claims for outpatient mental health services. This would include Diagnostic Codes and dates of therapy services rendered.

I understand that I am financially responsible to Maple Grove Counseling Center, P.A. for the charges not covered by my insurance. I understand that the benefits quoted by my insurer are only an estimate, and not a guarantee of payment. If I am not covered by my insurance, I will pay for services at the time that they are provided, unless other arrangements are made with my therapist.

Client (print name) _____ Date _____

Client Signature _____

Please have your insurance card with you and it is available for your therapist to copy at your first appointment. Thank you.

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL

MAPLE GROVE COUNSELING CENTER, P.A.
CLIENT RIGHTS AND RESPONSIBILITIES

The purpose of this policy is to provide you with information on your rights and responsibilities at Maple Grove Counseling Center. We are committed to providing quality professional services to all of our clients and, in order to do so, we need your informed participation. Should you have any questions regarding this policy please discuss them with your therapist.

CLIENT RIGHTS Each client has the right to receive the best care possible without the violation of his or her rights. These rights shall include:

1) The right to considerate, appropriate and professional treatment.

2) The right to know the professional qualifications of your therapist and the therapy costs before receiving those services.

3) The right to be informed, within a reasonable period of time, if your appointment must be cancelled or rescheduled.

4) The right to see information in your case file, including complete, current and understandable information concerning diagnosis, treatment plans, expected outcome of therapy and expected length of treatment.

5) The right to a timely and reasonable response to your request for case file information.

6) The right to be involved in the formulation of the treatment plan, in periodic review of the plan and in the formulation of the discharge plan.

7) The right to privacy regarding information in your case file. All information is considered confidential and cannot be released without your written consent, except under rare legal circumstances. Further information about your privacy rights, (Notice of Privacy Practices or NPP), will be given to you at your first appointment.

8) The right to receive psychological services free of discrimination on the basis of race, religion, gender, or any other legally protected category.

9) The right to be free from exploitation for the benefit or advantage of the therapist.

10) The right to examine public records of the MN Licensing Board which governs the credentials of your therapist, and the right to report complaints to the appropriate MN Licensing Board, e.g., the Board of Licensed Psychologists or the Board of Licensed Social Workers.

MAPLE GROVE COUNSELING CENTER, P.A.
CLIENT RIGHTS AND RESPONSIBILITIES

NEW CLIENT RESPONSIBILITIES As a client, you have a responsibility to yourself and to your therapist to be an active partner in your therapy process. To promote this partnership, please keep in mind these expectations:

1) Devote reasonable energy and time to therapy work, which is usually not an easy process.
1.
2) Be honest with your therapist concerning your thoughts and feelings about your progress and about the therapy process.

3) Keep scheduled appointments. Your therapy time is reserved for you, and you will be charged for that time unless you give your therapist at least a 24-hour notice. Messages can be left on your therapist's confidential voice mail at any time, day or night. Telephone consultations over 15 minutes may be billed to you by your therapist.

4) Keep current in paying your therapy co-payments (set by your insurer) or private pay fees. These will be due at the time of service, unless other arrangements have been made with your therapist. Billings for co-insurances and unpaid balances with be sent to your home address monthly. Please inform your therapist if you do not want billings sent directly to you, for confidentiality purposes. Maple Grove Counseling Center accepts personal checks, cash, all major credit cards, debit cards, and Health Savings Account (HSA) cards.

5) Inform your therapist, and other medical providers, of changes that may be occurring in your emotional or physical health. For example, please report your response to any new medications, including possible side-effects.

6) Refrain from physical or other types of abuse of yourself, of others, or of property. The therapy process can only work within an environment which is "safe" for all concerned.

EMERGENCY PROCEDURES

If you are feeling suicidal or in a crisis, it is important that you seek help immediately. If you are unable to reach your therapist at the office, or through our after-hours emergency **Answering Service (952-936-2342)**, please call or text **988 the 24-hour crisis line.**

If this is a life-threatening emergency, go to your nearest hospital emergency room.

I have read and understand the Client Rights and Responsibilities and the Emergency Procedures which have been described above.

Client signature_____ Date_____

MAPLE GROVE COUNSELING CENTER, P.A.
NOTICE OF PRIVACY PRACTICES

NOTICE OF PRIVACY PRACTICES – SHORT VERSION
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.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information. Federal laws also mandate privacy of health information. These laws are complicated, but we must provide you with important information. This pamphlet is a shorter version of the full, legally required Notice of Privacy Practices (NPP) which is located on our office bulletin board. Please refer to the full Notice for more information. You can receive a copy of the privacy practice notice. A copy of the full version is also available upon your request.
We will use the information about your health to provide you with **treatment**, to arrange payment for our services or for **health care operations**. After you have read this NPP, we will ask you to sign a **Consent Form** to let us share your information. Any questions you may have will be answered as completely as possible. We need your signed consent in order to provide treatment.

If you or your therapist want to disclose (send, share, release) your health information for any other purpose, we will discuss this with you and ask you to sign an Authorization to allow this. Of course, we will keep your health information private, but there are times when the laws require us to use or share it such as:

1. When there is a serious threat to the health and safety of yourself, another individual, or the public. We will only share information with a person or organization who is able to help prevent or reduce the threat.

2. Some lawsuits and legal or court proceedings.

3. If a law enforcement official requires this information a criminal matter.

4. For Worker's Compensation and similar benefit programs.

MAPLE GROVE COUNSELOR CENTER, P.A.
YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home, but not at work, to schedule or cancel an appointment. We will do our best to comply with your wishes.

2. You have the right to ask us to limit what we tell certain individuals involved in your care or the payment for your care, such as family members. We will maintain your privacy unless we are mandated to report abuse or legal issues or there is an emergency situation.

3. You have the right to look at the health information we have about you such as your medical and billing records. You may request a copy of your medical record. Please contact our Privacy Officer to arrange how to review or get copies of your medical records (see below). Billing records can be obtained by calling our billing manager, Karen Deusenbery at Electronic Billing Management (ph: 763-434-4959). An itemized monthly billing statement will be sent to you as part of our routine treatment process. Please let us know if you want this billing statement sent to an address other than your home.

4. If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. Please indicate why this change is necessary.

5. You have the right to a copy of this notice. If we change this NPP, we will post it on our office bulletin board in the waiting area, as well as on our website at: http://www.maplegrovecounselingcenter.com. You can get a copy of this, or the full version of the NPP, from our Privacy Officer at any time.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer, and with the Secretary of the Department of Health and Human Service. All complaints must be in writing. Filing a complaint will not change the health and care we provide to you in any way.

If you have questions regarding this Privacy Notice or our health information privacy policies, please contact our Privacy Officer, Ardith Messicci, RN, MA, Licensed Psychologist (Owner, MGCC). She can be reached at 763-494-8699 or by fax at 763-494-8797.

MAPLE GROVE COUNSELOR CENTER, P.A.
CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, _____ and Maple Grove Counseling Center, PA. If the client is a minor, please indicate his or her name here _____ and the word "you" in this consent will mean your child. When we assess, diagnose, treat or refer you, we will be collecting what the law calls **Protected Health Information (PHI)** about you. We need this information to identify what treatment is best for you, to provide treatment to you and to arrange payment for treatment (e.g., sending claims for insurance benefits). A **separate** and **specific** Release of Information will need to be signed by you prior to sending your protected health information to other medical providers (for coordination of care) or to any other agency. This further protects your health information.

By signing this form, you are agreeing to let us use your health information at our office as described above. The Notice of Privacy Practices explains, in more detail, your rights and how we can use and share your information. **Please read the Privacy Notice before you sign this Consent form.**

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. We will do our best to comply with your wishes.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we may not be able to treat you. For example, as licensed professionals, we are required to keep medical records of your treatment and insurers require billing information.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

Since the Notice of Privacy Practices is mandated by Federal Law (the Health Insurance Portability and Accountability Act or HIPAA) it is possible that future changes will be made in its contents. Should we make changes, you can get an updated copy of this Notice from our Office, on our website, or by calling our Privacy Officer at 763-494-8699.

_____ _____
Signature of client or personal representative Date

_____ _____
Printed name of client or personal representative Relationship to the client

_____ **Copy given to the client, parent or personal representative.**