Duluth Psychological Clinic

Dan D'Allaird, PsyD, LP · H, Mitzi Doane, PhD, LP · Corrie Ehrbright, MSW, LICSW · Douglas Heck, PhD, LP · Ryan Jagim, PhD, LP · James Shreffler, PsyD.

CHILD AND ADOLESCENT INTAKE

DATE: _____

NAME: _____

(Last) (First) (MI)

DATE OF BIRTH: _____ AGE: _____ GENDER: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ PREFERRED PHONE: _____

NAME OF SCHOOL: _____ GRADE: _____

REFERRAL SOURCE: _____

LEGAL GUARDIANSHIP: _____ Both parents _____ Single parent _____ Other (name & address):

_____

PARENT: _____ PARENT: _____

ADDRESS: _____ ADDRESS: _____

_____ _____

PHONE 1: _____ PHONE 1: _____

PHONE 2: _____ PHONE 2: _____

SIBLINGS: NAME AGE

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

CHILD'S PRIMARY CARE PHYSICIAN AND LOCATION: _____

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PRIMARY INSURANCE: _____
Phone #: _____ Employer: _____
Identification #: _____ Group #: _____
Name of Insured: _____ Date of Birth: _____

SECONDARY INSURANCE: _____
Phone #: _____ Employer: _____
Identification #: _____ Group #: _____
Name of Insured: _____ Date of Birth: _____

TYPE OF PAYMENT: Private Insurance: _____ MA: _____ Medicare: _____ Cash: _____

Has your child had psychotherapy or psychological testing in the past? Yes _____ No _____

If yes, with whom, where and when?

Clinician	Facility	Approximate Dates

Medical issues for which your child is currently being treated:
_____
_____

Child's current medical specialists (if applicable):
_____

Child's psychiatrist and location (if applicable):
_____

Current medications:

Medication	Dosage	Purpose

List all medical conditions that require a special medical alert (such as diabetes, epilepsy or hemophilia):
_____
_____

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LIMITED CONSENT FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)
BILLING AGREEMENT

Name: _____ DOB: _____

Please initial one of the following:

_____ I give permission to personnel at the Duluth Psychological Clinic (DPC) to provide PHI information, and other information as needed, to my third-party payer and/or primary insured. DPC will send the minimum amount of information that is needed. I understand that I am finically responsible for any and all fees not covered by my third-party payer and/or other responsible parties.

_____ I agree to pay via cash or check the amount due at each session. I understand that I am financially responsible for any and all fees for services provided to me.

PROFESSIONAL CONSULTATION: Each individual who seeks psychological care comes with a unique and complex situation. The Duluth Psychological Clinic's purpose and goal is to provide the most effective and scientifically up-to-date psychological care possible. To accomplish this, each clinician may occasionally consult, as appropriate, with other clinicians within DPC about your situation. Your clinician will protect your identity during these consultations. Specific exchanges of information with relevant people—such as your physician or family member—require a signed release of information.

Please initial one of the following:

_____ I consent to professional consultation within DPC.
_____ I do not consent to professional consultation within DPC.
_____ I wish to discuss professional consultation further with my clinician.

This Agreement is an agreement between you, your clinician, and DPC. You may revoke this Agreement in writing at any time. That revocation will be binding on your clinician unless 1) she/he has already taken action in reliance on it; 2) obligations are imposed on your psychologist by your health insurer to process or substantiate claims made under your policy; 3) you have not satisfied any financial obligations you have incurred. This Agreement will be in effect for one year from the date of singing unless you specifically request that it remain in effect for a shorter amount of time. A photocopy of this Agreement may be treated in the same manner as the original.

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LIMITED CONSENT FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)
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Please initial all that apply:

_____ I have reviewed the DPC Handbook. _____ I wish to receive a copy of the DPC Handbook.
_____ I authorize phone messages: _____cell _____work _____home
_____ I authorize appointment reminders via text messages: _____cell _____work _____home

Signature of client or legal guardian: _____ Date: _____

Clinician:

I have reviewed the DPC Handbook with this client, including the areas of informed consent, confidentiality, and mandated reporting laws.

Clinician signature: _____ Date: _____

I authorize appointment reminders via text messages. _____ (Clinician initials)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of my responsibilities to help you.

Get an electronic or paper copy of your psychological record

- You can ask to see or get an electronic or paper copy of your psychological record and other health information I have about you. Ask me how to do this.
- I will provide a copy or a summary of your health information, usually within 30 days of your request. You may be charged a reasonable, cost-based fee.

Ask me to correct your psychological record

- You can ask me to correct health information about you that you think is incorrect or incomplete. Ask me how to do this.
- I might say "no" to your request, but I'll tell you why in writing within 60 days.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. I will provide you with a paper copy promptly.

Request confidential communications

- You can ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- I will say "yes" to all reasonable requests.

Ask me to limit what I use or share

- You can ask me not to use or share certain health information for treatment, payment, or my operations. I am not required to agree to your request, and I might say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask me not to share that information for the purpose of payment or my operations with your health insurer. I will say "yes" unless a law requires me to share that information.

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NOTICE OF PRIVACY PRACTICES

Get a list of those with whom I've shared information

- You can ask for a list (accounting) of the times I've shared your health information for six years prior to the date you ask, who I shared it with, and why.
- I will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked me to make). I'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Choose someone to act for you

- If you have given someone psychological power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- I will make sure the person has this authority and can act for you before I take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel I have violated your rights by contacting my office using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/
- I will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell me your choices about what I share. If you have a clear preference for how I share your information with your family, close friends, or others involved in your care, talk to me. Tell me what you want me to do, and I will follow your instructions.

If you are not able to tell me your preference, for example if you are unconscious, I may go ahead and share your information if I believe it is in your best interest. I may also share your information when needed to lessen a serious and imminent threat to health or safety.

I will never market or sell your protected health information for any reason.

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NOTICE OF PRIVACY PRACTICES

My Uses and Disclosures

How do I typically use or share your information?
I typically use or share your health information in the following ways:

Treat you
I can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run my practice
I can use and share your health information to run my practice, improve your care, and contact you when necessary.
Example: I use health information about you to manage your treatment and services.

Bill for your services
I can use and share your health information to bill and get payment from health plans or other entities.
Example: I give information about you to your health insurance plan so it will pay for your services.

How else can I use or share your health information?
I am allowed or required to share your information in other ways that contribute to the public good. I have to meet many conditions in the law before I can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Child Abuse
If I know or have reason to believe a child is being neglected or physically or sexually abused, or has been neglected or physically or sexually abused within the preceding three years, I must immediately report the information to the local welfare agency, police or sheriff's department.

Adult and Domestic Abuse
If I have reason to believe that vulnerable adult is being or has been maltreated, or if I have knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, I must immediately report the information to the appropriate agency in this county. I may also report the information to a law enforcement agency.

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A "vulnerable adult" means a person who, regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental or emotional dysfunction: (i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care or supervision; and (ii) because of the dysfunction or infirmity and the need for assistance, the individual has an impaired ability to protect the individual from maltreatment.

Health Oversight Activities
The Minnesota Board of Psychology may subpoena records from me if they are relevant to an investigation it is conducting.

Judicial and Administrative Proceedings
If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law and I must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case.
Serious Threat to Health or Safety

If you communicate a specific, serious threat of physical violence against a specific, clearly identified or identifiable potential victim, I must make reasonable efforts to communicate this threat to the potential victim or to a law enforcement agency. I must also do so if a member of your family or someone who knows you well has reason to believe you are capable of and will carry out the threat. I also may disclose information about you necessary to protect you from a threat to commit suicide.

With Your Signed Written Consent
Records created during, or arising from, psychotherapy care or treatment are afforded a higher level of protection than regular psychological records. For this reason, I will only release records containing protected health information to another person, organization, or legal entity for purposes not otherwise allowed in this Notice upon your signed written consent.

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NOTICE OF PRIVACY PRACTICES

My Responsibilities

- I am required by law to maintain the privacy and security of your protected health information.
- I will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- I must follow the duties and privacy practices described in this notice and give you a copy of it.
- I will not use or share your information other than as described here unless you tell me I can in writing. If you tell me I can, you may change your mind at any time. Let me know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

I can change the terms of this notice, and the changes will apply to all information I have about you. The new notice will be available upon request, in my office, and on my web site.

Your signature below indicates that you have read and received this Notice of Privacy Practices and agree to its terms.

Signed: _____ Date:_____