Admission Form

PORT Group Homes

Date: _____

Name:_____ _____ _____
Last First Middle Date of birth Social Security number

Admitted by order of : _____of _____ on _____
(Social Worker, Probation Officer, Judge) (County) (Date)

Picture Taken: ☐

Placement Status:(Circle one) 72 Hr Detention Short Term Services 30-Day Program Other:_____

Detention/Hold

Have the parents been notified? Yes - No

By Whom _____ Time: _____

Officer/s Involved: _____ Agency: _____

Reason(s) for placement/offense:_____

Person transporting: _____of_____
(Name) (Agency)

Relationship:_____ Signature:_____
(Person Transporting/Placing)

Referring County: _____ Referring Agency: _____

Agency Address: _____
City State Zip

Probation Officer: _____ Phone #: _____

Agent/Social Worker: _____ Phone #: _____

Medical/Emergency Contact Information

In An Emergency Contact: _____ Relationship: _____

Address:_____ Phone: _____
City State Zip

Alt. Emergency Contact: _____ Relationship: _____

Address:_____ Phone: _____
City State Zip

Family Information Custodial Parent(s) / Guardian(s):

Name:_____

Phone #: _____ Work #_____ Cell# _____

Name:_____

Phone #: _____ Work #_____ Cell# _____

Home Address: _____

Admission Form PORT Group Homes

Non-Custodial Parent(s) / Significant Others /Guardian(s):

Name_____ Relationship to child_____

Name_____ Relationship to child_____

Name_____ Relationship to child_____

Name_____ Relationship to child_____

Sibling Information

Name: _____ Age: _____ Brother/Sister - Full/Half/Step

Name: _____ Age: _____ Brother/Sister - Full/Half/Step

Name: _____ Age: _____ Brother/Sister - Full/Half/Step

Name: _____ Age: _____ Brother/Sister - Full/Half/Step

Additional Comments/Observations:

_____

_____

This section will be completed by PORT Staff during intake

Resident Money and Valuables Verification/Inventory

I (do) (do not) have money or valuables in my belongings.

I have $ _____ in my belongings. (Staff should immediately secure this money in a locked area and issue a receipt per SOP policy).

Please list any documents (i.e. I.D., SSN card) and valuables that you need secured until they can be returned home or held until discharge. PORT is not responsible for locating money or valuables that are not specified on this form. Complete the following inventory.

Item	Description (include condition)	Quantity

Where were the items secured? _____

Resident Signature_____ **Date**_____

_____ **Date**_____

Signature of staff Completing This Form

*File a copy with Resident Intake Inventory

OUT-OF-HOME CARE - AUTHORIZATION FOR PLACEMENT

I. POLICY

It is the policy of PORT Group Homes pre-authorize all new placements in Residential Group Homes, as well as review requests for placement extensions to ensure adherence to providing quality care to youth in the safest, least restrictive setting. The purpose of the Out-of-Home Care Authorization/Agreement is to document the legal authority for out of home placement prior to the placement of the resident in residential services.

ALL YOUTH PLACED IN RESIDENTIAL OR GROUP HOME CARE MUST HAVE AN APPROVED OUT-OF-HOME CARE AUTHORIZATION/AGREEMENT UPON ADMISSION.

Name:_____is being or will admitted to

PORT Group Homes, Brainerd MN

by order of or under the authority of: _____
(Law Enforcement, Social Worker, Probation Officer, Judge)

of _____ _____ _____ ON _____
(County) (Date)

_____
Signature of placing authority or placing authority representative

Placement Status**:**(Check one)

_____Short Term Services (72 Hrs or less)

_____Short Term Services (72 Hrs or more)

_____30-Day Evaluation

_____Program

_____Other

Have the parents been notified? Yes - No

By Whom _____ _____ Time: _____

Officer/s Involved: _____ Agency: _____

Reason(s) for placement/offense:_____

Consent for Release of Confidential Information

I, _____, parent/guardian of, _____,

_____, _____,
D.O.B. Address

hereby authorize PORT Group Homes to obtain and exchange confidential information regarding the above named client. The purpose for which this information will be used is to coordinate comprehensive treatment and treatment planning. The agencies with which information may be exchanged are listed below. **(Please, initial the white boxes. The initialed boxes authorize exchange of information.)**

Agencies	All Information	Medical / Diagnostic	Authorized to Transport Child
_____County Court Services			
_____County Social Services			
ADAPT outpatient chemical dependency treatment			
Brainerd Medical Center			
Brainerd School District #181			
CARE outpatient chemical dependency treatment			
The Counseling Center			
Core Professional Services			
Crow Wing County Family Services Collaborative			
Dr Richard Carlson, Dental			
Good Neighbors Home Health Care			
Holistic Psychological Services			
Lake Country Dental			
Lakes Area Counseling			
Lutheran Social Services			
Medicine Shoppe			
Northern Pines Mental Health Center			
Nystrom's and Associates			
School District #_____ (home school)			
St. Joseph's Medical Center			
Other:			
Other:			

I understand that I have a right to refuse to release this information, and I understand my consent is voluntary. This consent may be revoked upon written notice, unless the information has already been released. This release automatically expires after one year. I further understand that a photocopy of this authorization will be accepted with the same authority as the original.

Signed: _____ Date: _____
Parent/Guardian

Signed: _____ Date: _____
Resident

Approved Visitor/Communication List

Resident: _____ Primary Counselor: _____

PO: _____ Phone #: _____

SW: _____ Phone #: _____

List information on Parents, Extended Family Members, Adult Siblings for phone contact.

List **others** whom may have phone contact or visitation and indicate if the individual is approved to visit (V), or have telephone contact (P) by placing a check mark in the spaces provided.

APPROVED

V	P	Name	Relationship	Phone Number	Address

List any Court ordered restrictions on communication / visitation with Parents, Adult Siblings or Adult Extended Family Members? (Attach copy of court order)

List **others** whom may not have phone contact or visitation and indicate the individual is not approved to visit (V), or have telephone contact (P) by placing a check mark in the spaces provided.

RESTRICTED

V	P	Name	Relationship	Phone Number	Address

The following persons may transport my child:

_____ _____

_____ _____

_____ _____

_____ _____

Parent Date

_____ _____

Probation Officer/Social Worker Date

Created on 10/19/05 10:09 AM

Authorization for Medical Services

In case of an emergency, illness, accident or injury, I hereby authorize PORT Group Homes to take, at its discretion, any action necessary for the health and welfare of my child, _____ while in residence at PORT.

Medical Insurance Company is:_____

Subscriber: _____

I also authorize any and all medical bills, including prescriptions, to be billed to me the undersigned**.**

My insurance company is:_____

My insurance group # is: _____

My Medical ID # or SSN # is: _____

My child's SSN # is: _____

My child's Medical Assistance # is:_____

Dental insurance company is: _____

Subscriber: _____

My dental insurance company's address is: _____

My Dental ID # or SSN # is: _____

Current medications my child is taking: _____

Is child allergic to any medications? [ ] Yes [ ] No

If yes, explain: _____

Family or child's physician: _____

Address and phone number: _____

Last time child was seen by a physician:_____

My child is now being treated for: _____

My child has a medical history of the following: _____

_____

My place of employment is: _____

Signed: _____ Relationship: _____ Date: _____

**Please include a copy of your child's social security card and each insurance card. If you do not have the card, please contact your client's Primary Counselor or the local Social Security office for assistance in receiving a duplicate.

Created on 10/18/05 4:18 PM

Patient Name:_____

Date:_____

File In Chart #_____

Brainerd Medical Center, P.A.

2024 South Sixth Street
Brainerd, MN 56401-5504

AUTHORIZATION FOR RELEASE OF INFORMATION AND FINANCIAL RESPONSIBILITY

RECORD RELEASE: I authorize Brainerd Medical Center, P.A., to release medical information about me to my insurance carriers, the Social Security Administration or its intermediaries/carriers, Centers for Medicare & Medicaid Services (CMS) and its agents for purposes of payment, and to referring physicians and other providers involved in my care.

ASSIGNMENTS OF BENEFITS: I authorize payment of Medical/Medicare benefits to Brainerd Medical Center, P.A., for any services furnished by this clinic to me. I understand I am financially responsible for charges not covered by Medicare and/or my insurance carriers.

This authorization also covers charges generated by Brainerd Medical Center physicians for services received at St. Joseph's Medical Center or other medical facilities.

I permit a copy of this authorization to be used in place of the original.

DATE_____

SIGNATURE_____

(Relationship if patient is a minor:_____)

AREA EDUCATION CENTER
INDEPENDENT SCHOOL DISTRICT 181
311 10th AVE NE
BRAINERD, MINNESOTA 56401
TELEPHONE (218) 454-4500
FAX (218) 454-4501

AUTHORIZATION TO RELEASE PUPIL INFORMATION

The following student is enrolling in the Area Education Center

Date: ----------

Last Name First Middle

Grade Year of Graduation

Date of Birth_____

Date of Last Attendance:_____

Telephone:_____

Name of Former School:
_____

Address:_____

_____
State **Zip Code**

Please forward the following information as soon as possible:

1. State Reporting Number ----------
2. BST Scores Reading_____ Math_____ Writing_____
3. Graduation Standards
4. Explanation of grading system
5. Date of Last Attendance
6. Immunization and health records
7. Courses currently being taken with marks to date
8. IEP & Evaluation Report

_____ _____
Student Signature Parent/Guardian Signature

Revised 3/22/05

Activity Authorization Form

I grant permission for _____, to participate in extra-curricular activities such as field trips, sports, employment, Kinship, culturally diverse activities and outdoor work responsibilities such as yard work and gardening while in residence at PORT Group Homes.

I further state that my son/daughter may attend any or all of the following: (please specify by a check mark)

_____ To attend local church services (functions) of his/ her choice

_____ To attend only services (functions) of the _____ denomination.

_____ Bible study (Weekly at PORT)

Signed: _____ Date: _____

Relationship: _____

Need to Know

Maximum Clothing List

Listed below is the recommended clothing/accessory list for PORT residents. Please take weather conditions into account when sending clothes. PORT residents are not allowed to have more than the maximum number of any item listed. If the maximum is exceeded, residents will make arrangements to have the extra belongings picked-up. Inappropriate clothing or clothing with holes will be sent home. PORT will store luggage but not extra belongings.

NECESSARY ITEMS:	Min.	Max.
Assorted Shirts	5	8
Underwear	7	10
Sweatshirts		2
Bras	2	4
Assorted Pants	4	8
Socks	7	10
Sweaters (seasonal)		4
Shorts (seasonal)	1	5
Sleepwear	1	2
Bathrobe		1
Slippers		1 pr
Dress Shoes		1 pr
Athletic Shoes		1 pr
Casual Shoes		1 pr
Winter Boots (mandatory in winter)	1 pr	1 pr
Winter Jacket (mandatory in winter)	1	2
Snow Pants (encouraged in winter)		1
Mittens/Gloves (mandatory in winter)	1	2
Stocking cap (mandatory in winter)	1	2
Scarf		1
Wind Breaker - Light Jacket		1
Swimsuit	1	1
Dress Outfit (skirt, dress pants)		1

OPTIONAL ITEMS:	Allowed
Hair Dryer	1
Curling Iron	1
Electric Razor	1
Belt	1
Base Ball Cap	2
Watch	1
Necklace	3
Earrings	4 pr
Rings per hand	1
Stuffed Animals	2
Clock	1
Make-up (Only bring minimal amount. No glass bottles, products with mirrors, liquid or alcohol-based products.)	

ITEMS NOT ALLOWED:

Clock Radio
Personal Towels
Keys
Razor (electric allowed)
Musical Tapes/CDS or Tape/CD Player
Personal Bedding
Tobacco, Alcohol or Concert paraphernalia or clothing of any kind (including lighters)
Aerosol products of any kind (i.e. hair spray, perfume, mousse)
Finger nail polish and/or remover

PORT encourages residents to leave valuables home.

Social Security Card

There are programs at PORT that require a copy of a resident's social security card. Please mail a copy of your child's or client's social security card, or the card itself, to PORT. If you do not have the card, please contact your child's Primary Counselor or your local Social Security office for assistance in receiving a duplicate.

Medical Insurance

Shortly after coming to PORT, your child is required to have a physical examination. There may be other medical needs, such as prescriptions, dental or vision services. With your child's placement coming soon, now is the time to arrange for medical insurance. If private insurance is not an option, you may apply for Minnesota Health Care Programs (MA, GAMC, MN Care) at your local county social services office. If your child is currently receiving Managed Care Medical Assistance, ask your financial worker to change it to regular Medical Assistance, so that providers out of your area can provide services.

PORT will not be responsible for the loss of personal items

Created on 10/18/05 4:24 PM

PORT Group Homes Behavioral Assessment

Client Name:_____

Please complete the following behavioral assessment on the client being placed at PORT Group Homes. This is to be completed by the referral agent, and one or two parent/guardians.
Place (P) in the box if you believe this is a problem or risk area.
Place (S) in the box if you believe this is a strength or asset.
Leave the box blank if it is neither a problem nor a strength.

Referring Agent	Parent or Guardian	Parent or Guardian	Behavior Definitions
			Compliance with rules or expectations at home.
			School attendance.
			School participation.
			Compliance with rules or expectations at school
			Compliance with rules or expectations in the community.
			Disrespectfulness, verbal aggressiveness, hostility or defiance toward most adults/authority figures.
			Physical aggressiveness toward adults/authority figures.
			Respectfulness (verbally) toward siblings/peers
			Physical aggressiveness toward siblings/peers.
			Accepting responsibility for misbehavior. Not a pattern of blaming others.
			Attempts to deceive through lying, conning, or manipulating.
			Personal hygiene and cleanliness.
			Considers the consequences of actions, takes appropriate risks, and engages in thrill-seeking behaviors.
			History of breaking and entering, stealing, and other illegal activity.
			Deliberately annoys people and is easily annoyed by others.
			Demonstrates impulsive behavior.
			Other strengths or problems

Medical Referral Form

Due to Medical Assistance and Minnesota Care and other insurance company's policies, a referral is needed from a primary care physician in order for a child to be seen by another provider. This form gives PORT Group Homes permission to have the child named below receive services at the local facilities available to PORT for any medical needs that may occur. This referral will remain in effect only while the child is residing at PORT Group Homes.

I authorize/refuse/deny referral of _____ (DOB: _____),
(Circle One) (Resident)
to facilities listed below for any medical or therapeutic services that may be necessary during placement at PORT Group Homes.

_____ _____
Doctor's Signature Date

_____ _____
Medical Facility Phone Number

Below is a list of facilities that residents may receive services from during their stay at PORT.

_____ Brainerd Medical Center (clinic)

_____ St. Joseph's Medical Center

_____ Brainerd Eye Care

_____ Dr. Moen/Dr. Mattson/Dr. Carlson, DDS

_____ Northern Orthopedics

_____ Adapt of Minnesota - outpatient chemical dependency treatment services

_____ Other _____
(List facility)

Please check one of the following:

☐ Reason for refusal:

☐ Reason for denial:

Face Sheet

Full Name: _____ DOB: _____ Age: _____
First Middle Last

Intake Date: _____ Gender: ☐ Male ☐ Female Race: _____

SS#: _____ Primary Counselor: _____

Placement County: _____

Social Worker: _____ Phone: _____

Agency: _____ Fax: _____

Address: _____ Email: _____

Probation Officer: _____ Phone: _____

Agency: _____ Fax: _____

Address: _____ Email: _____

Other Contact: _____ Phone: _____

Agency: _____ Fax: _____

Address: _____ Email: _____

Family Information

Mother: _____ Phone: _____

Address: _____ Work: _____

_____ Cell: _____

Father: _____ Phone: _____

Address: _____ Work: _____

_____ Cell: _____

Medical Information

Allergies:_____ Insurance Co: _____

ID#: _____ Grp#: _____ BIN#: _____

Cardholder Name: _____ Relationship: _____

DOB: _____ SS#: _____ Employer: _____

Any tattoos or other identifying body marks? _____

School Information

IEP: ☐ Yes ☐ No Grade: _____ Last School Attended:_____

Last Date Attended: _____ Graduation Year: _____

Special Education: ☐ Yes ☐ No If yes, what classes: _____

FORM 23005

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

NAME OF INDIVIDUAL: _____

This is to acknowledge receipt of a copy of **PORT of Crow Wing County**'s Notice of Privacy Practice with an effective date of April 14, 2003.

Individual's (or Legal Representative's) Name: _____

Individual's (or Legal Representative's) Signature: _____

Date: _____

Capacity or Authority of Legal Representative (if applicable)*:_____

*May be requested to provide verification of representative status.

For Office Use Only

We made the following efforts to obtain written acknowledgement of receipt of the Notice of Privacy Practices:

_____

_____

_____

However, acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify): _____

_____

_____

FORM 23000

NOTICE OF PRIVACY PRACTICES

PORT OF CROW WING COUNTY, INC

EFFECTIVE DATE OF THIS NOTICE: APRIL 14, 2003

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

Our Pledge And Legal Duty To Protect Health Information About You.

The privacy of your health information is important to us. We are required by federal and state laws to protect the privacy of your health information. We refer to this information as "protected health information," or "PHI". We must give you notice of our legal duties and privacy practices concerning PHI, including:

- We must protect PHI that we have created or received about your past, present, or future health condition, health care we provide to you, or payment for your health care.
- We must notify you about how we protect PHI about you.
- We must explain how, when and why we use and/or disclose PHI about you.
- We may only use and/or disclose PHI as we have described in this Notice.
- We must abide by the terms of this Notice.

We are required to abide by the terms of this Notice. We reserve the right to change the terms of this Notice and to make new notice provisions effective for all PHI that we maintain. We will post a revised notice in our offices, make copies available to you upon request and post the revised notice on our website ***www.portgrouphomes.org***.

Minnesota Patient Consent for Disclosures
For most disclosures of your health information we are required by State of Minnesota Laws to obtain a written consent from you, unless the disclosure is authorized by Law. This consent may be obtained at the beginning of your treatment, during the first delivery of health care service, or at a later point in your care, when the need arises to disclose your health information to others outside of our organization.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

A. Uses and Disclosures of Your Protected Health Information for Purposes of Treatment, Payment and Health Care Operations.

Health Care Treatment. We may use and disclose PHI about you to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing the delivery of health services with others. For example, we may use and disclose PHI about you when you need a prescription, lab work, an x-ray, or other health care services. In addition, we may use and disclose PHI about you when referring you to another health care provider.

Payment. We may use and disclose your medical information to others to bill and collect payment for the treatment and services provided to you. For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used. Before you receive scheduled services, we may share information about these services with your health plan(s). Sharing information allows us to ask for coverage under your plan or policy and for approval of payment before we provide the services. We may also share portions of your medical information with the following: 1) Billing departments; 2) Collection departments or agencies; 3) Insurance companies, health plans and their agents which provide you coverage; 4) Utilization review personnel that review the care you received to check that it and the costs associated with it were appropriate for your illness or injury; and 5) Consumer reporting agencies (e.g., credit bureaus).

Health Care Operations. We may use and disclose PHI in performing business activities, which we call "health care operations". For example: Members of our staff such as the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Our Business Associates. There are some services provided in our organization through contacts with business associates. Examples include physician services in the Emergency Department and Radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third party payer for services rendered. So that your health information is protected, however, we require the business associate to sign a contract ensuring their commitment to protect your PHI consistent with this Notice and to appropriately safeguard your information.

C. Uses and Disclosures of Your Protected Health Information that Require Your Authorization.

In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization, different from the Minnesota Patient Consent, to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

- *Research*: We may disclose information to external researchers with your authorization, which we will attempt to collect in a manner consistent with applicable state laws.
- *Marketing*: We will not be able to use or disclose your name, contact information or other PHI for purposes of marketing without your written authorization. This does not include informing you about treatment alternatives or other health related products or services that may be of interest to you.
- *Fundraising:* We may use and/or disclose PHI about you, including disclosure to a foundation, to contact you to raise money for our organization. We would only release contact information and the dates you received treatment or services at our facility. If you do not want to be contacted in this way, you must notify in writing our contact person listed in this Notice.

D. Uses and Disclosures of Your Protected Health Information that Require Your Opportunity to Agree or Object.

In the following instances we will provide you the opportunity to agree or object to a use or disclosure of your PHI:

- *Facility Directory*: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation to other people who ask for you by name.

- *Notification*: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.
- *Communication with Family*: Health professionals, using their best judgement, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

If you would like to object to our use or disclosure of PHI about you in the above circumstances, please call our contact person listed on the cover page of this Notice.

E. Use And Disclosure Authorized by Law that Do Not Require Your Consent, Authorization or Opportunity to Agree or Object.

Under certain circumstances we are authorized to use and disclose your health information without obtaining a consent or authorization from you or giving you the opportunity to agree or object. These include:

- When the use and/or disclosure is authorized or required by law. For example, when a disclosure is required by federal, state or local law or other judicial or administrative proceeding.
- When the use and/or disclosure is necessary for public health activities. For example, we may disclose PHI about you if you have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.
- When the disclosure relates to victims of abuse, neglect or domestic violence.

- When the use and/or disclosure is for health oversight activities. For example, we may disclose PHI about you to a state or federal health oversight agency which is authorized by law to oversee our operations.
- When the disclosure is for judicial and administrative proceedings. For example, we may disclose PHI about you in response to an order of a court or administrative tribunal.
- When the disclosure is for law enforcement purposes. For example, we may disclose PHI about you in order to comply with laws that require the reporting of certain types of wounds or other physical injuries.
- When the use and/or disclosure relates to decedents. For example, we may disclose PHI about you to a coroner or medical examiner, consistent with applicable laws, to carry out their duties.
- When the use and/or disclosure relates to products regulated by the Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.
- When the use and/or disclosure relates to cadaveric organ, eye or tissue donation purposes. Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.
- When the use and/or disclosure relates to Worker's Compensation information*:* We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
- When the use and/or disclosure is to avert a serious threat to health or safety. For example, we may disclose PHI about you to prevent or lessen a serious and eminent threat to the health or safety of a person or the public.
- When the use and/or disclosure relates to specialized government functions. For example, we may disclose PHI about you if it relates to military and veterans' activities, national security and intelligence activities, protective services for the President, and medical suitability or determinations of the Department of State.
- When the use and/or disclosure relates to correctional institutions and in other law enforcement custodial situations. For example, in certain circumstances, we may disclose PHI about you to a correctional institution having lawful custody of you.

YOUR INDIVIDUAL RIGHTS

A. Right to Request Restrictions on Uses and Disclosures of PHI.

You have the right to request that we restrict the use and disclosure of PHI about you. We are not required to agree to your requested restrictions. However, even if we agree to your request, in certain situations your restrictions may not be followed. These situations include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, and uses and disclosures described in subsection 4 of the previous section of this Notice. You may request a restriction by submitting your request in writing to us. We will notify you if we are unable to agree to your request.

B. Right to Request Communications via Alternative Means or to Alternative Locations.

Periodically, we will contact you by phone, email, postcard reminders, or other means to the location identified in our records with appointment reminders, results of tests or other health information about you. You have the right to request that we communicate with you through alternative means or to alternative locations. For example, you may request that we contact you at your work address or phone number or by email. While we are not required to agree with your request, we will make efforts to accommodate reasonable requests. You must submit your request in writing.

C. Right to See and Copy PHI.

You have the right to request to see and receive a copy of PHI contained in clinical, billing and other records used to make decisions about you. Your request must be in writing. We may charge you related fees. Instead of providing you with a full copy of the PHI, we may give you a summary or explanation of the PHI about you, if you agree in advance to the form and cost of the summary or explanation. There are certain situations in which we are not required to comply with your request. Under these circumstances, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of our denial.

D. Right to Request Amendment of PHI.

You have the right to request that we make amendments to clinical, financial and other health-related information that we maintain and use to make decisions about you. Your request must be in writing and must explain your reason(s) for the amendment and, when appropriate, provide supporting documentation. We may deny your request if: 1) the information was not created by us (unless you prove the creator of the information is no longer available to amend the record); 2) the information is not part of the records used to make decisions about you; 3) we believe the information is correct and

complete; or 4) you would not have the right to see and copy the record as described in paragraph 3 above. We will tell you in writing the reasons for the denial and describe your rights to give us a written statement disagreeing with the denial. If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, including persons you name who have received PHI about you and who need the amendment.

E. Right to Request and Accounting of Disclosures of PHI.

You have the right to a listing of certain disclosures we have made of your PHI. You must request this in writing. You may ask for disclosures made up to six (6) years before the date of your request (not including disclosures made prior to April 14, 2003). The list will include the date of the disclosure, the name (and address, if available) of the person or organization receiving the information, a brief description of the information disclosed, and the purpose of the disclosure. If, under permitted circumstances, PHI about you has been disclosed for certain types of research projects, the list may include different types of information. If you request a list of disclosures more than once in 12 months, we can charge you a reasonable fee.

F. Right to Receive a Copy of This Notice.

You have the right to request and receive a paper copy of this Notice at any time. We will provide a copy of this Notice no later than the date you first receive service from us (except for emergency services or when the first contact is not in person, and then we will provide the Notice to you as soon as possible). We will make this Notice available in electronic form and post it in our web site.

QUESTIONS OR COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact our Privacy Official. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may file a complain with our Privacy Official. You can also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Official Contact Information:

Privacy Officer
PORT of Crow Wing County
P.O. Box 488
Brainerd, MN 56401
Telephone: (218) 828-6274
Fax (218) 828-4209

Consent for Release of Information

I hereby authorize Lakes Area Counseling to obtain and exchange information regarding:

_____ _____
Client Name Date of birth

The agencies with whom the information will be obtained and/or exchanged include:

(Initial those that apply)

_____ Social Services _____ ___ _____
(County) (Other)

_____ Probation _____ ___ _____
(County) (Other)

_____ School _____ ___ _____
(Name of school) (Other)

The information to be exchanged/released is necessary for the purpose of coordinating comprehensive treatment planning. The required information is:

_____ Medical _____ Diagnostic Assessment _____ Treatment Plans

_____ Educational _____ Progress Notes _____ Discharge Summary

_____ _____
(Other)

I understand that I have a right to refuse to release this information and that my consent is voluntary. This consent may be revoked upon written notice unless the information has already been released. This release expires after one year. I further understand that a photocopy of this authorization will be accepted with the same authority as the original.

Signed: _____ Date: _____
(Parent/Guardian)

Signed: _____ Date: _____
(Client)

Signed: _____ Date: _____
(Staff)

F\Publishing\Referral packet\LAC Consent for rel
Revised 2/28/02

Lakes Area Counseling
New Patient Intake Form

Date: _____

Name:_____ Age:_____ Date of Birth:_____

Address:_____ Phone:_____

_____ Social Security #:_____

Parent/Guardian (if child):_____ Phone:_____

Address:_____

_____

Referral Source:_____ Phone:_____

Insurance Company:_____

Identification #:_____ Group #_____

Claims Address:_____

Insurance Phone Number: _____

Subscriber Name:_____ Social Security #:_____
(if available)

Subscriber Date of Birth: _____ (if on insurance card)

Subscriber's Employer:_____

Please attach copy of insurance card if available

Benefit Assignment and Consent for Treatment

I HEREBY AUTHORIZE Lakes Area Counseling to release any information necessary to process my insurance/medicaid claim, acquired in the course of my examination or treatment: to allow a photocopy of my signature to be used to process my insurance/Medicaid claim for the period of one year from signature date or until termination of services. I claim any insurance benefits due me for services rendered Lakes Area Counseling, and authorize and direct my carrier to issue payment check (s) directly to Lakes Area Counseling. Regardless of my insurance benefits, if any, I understand that I am fully financially responsible for any and all fees incurred, and I agree to pay such fees in full.

The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose precertification requirements for any and all plans to which I subscribe, may cause me to incur full liability for professional charges, as a result of non-payment by any carrier.

I hereby authorize the performance of psychological services including individual, group, or family therapy (as appropriate), assessment, and psychological testing.

I hereby release Lakes Area Counseling from any liability relating to, and agree to hold Lakes Area Counseling and its employees and independent contractors harmless from any effects caused directly or indirectly from psychological services including diagnostic testing, and evaluation.

_____ _____
Patient/Responsible Party Signature Date

LAKES AREA COUNSELING

Patient Concerns

Name:_____Date:_____

Please answer the following questions as completely as possible. You can discuss any areas of concern more fully with your therapist. It is your choice whether or not to answer any questions, but you are encouraged to respond to most of the items in order to provide your therapist with maximum information.

1. What problem brings you to Lakes Area Counseling? When did it begin? How long has it lasted?

2. What other concerns about yourself do you have?

3. What steps have you taken to try to solve these problems?

4. What do you hope to accomplish through your contact with Lakes Area Counseling?

5. Discuss any history of chemical dependency:

6. Discuss any history of treatment for a psychological disorder:

7. Are you taking any prescription drugs? (If, yes, which ones?)

8. Discuss any significant medical issues:

Lakes Area Counseling
Patient Rights, Risks and Tennesen Warning

Patient Rights

1. Every patient has the right to considerate and respectful treatment.

2. Every patient can expect to obtain from the appropriate staff, complete and current information concerning their diagnosis, treatment, and prognosis in language that the patient can understand.

3. Every patient has the right to consideration of his or her individuality as it relates to social, cultural, religious and psychological well being.

4. Every patient has the right to refuse treatment if, after thorough explanation, the patient (or those acting on their behalf) is of the opinion that the treatment is not in the best interest of the patient.

5. Every patient has the right to expect that if a scheduled appointment cannot be kept, the patient will be advised in a reasonable period of time.

6. A patient may use the following grievance procedure if they have a complaint regarding the service or treatment:

    a. The complaint or grievance must first be discussed with the staff involved.
    b. If that is not satisfactory, the complaint will be referred to the Program Director who will act on the complaint within 3 days.
    c. If the person making the complaint is not satisfied, a written complaint drafted by the patient will be referred to the Program's Governing Body. The Governing Body will render a recommendation within 10 days of receiving the complaint. The Program Director will deliver this recommendation to the persons involved within 3 working days. The written complaint drafted by the patient that is to be brought before the Governing Body must be placed on the meeting agenda at least 3 days prior to the meeting. Another person of the patient's choosing may assist the person(s) making the complaint in presenting the complaint.
    d. In cases where there has been alleged abuse or neglect, appropriate authorities will be notified as soon as allegations are made clear.

Risks

1. Lakes Area Counseling cannot guarantee your recovery from problems for which you are being treated. We can, however, teach you some of the tools and provide resources you will need in order to assume responsibility for your mental health. It is your responsibility to utilize these skills and resources while in treatment and after you leave treatment.

2. It is important for you to be aware that participation in treatment may impact your health insurance costs and coverage.

3. Minnesota State Law requires that we report any suspected child abuse or neglect to the proper authorities.

4. Your involvement in Lakes Area Counseling may be emotionally painful for you. Due to the nature of some mental health problems, the individual sometimes hides or covers up past painful behaviors and feelings. In order to help you, we need to take a realistic look at these issues.

Tennesen Warning

1. Information shared with Lakes Area Counseling will be held in confidence by staff. Only persons or parties that you or your parent or legal guardian (if under 18) have consented to have information released to will be kept informed as to your progress. There are 2 exceptions:

    a. As counselors we are bound by Minnesota State Law to report any suspected child abuse or neglect.
    b. We are also bound by the "Duty to Warn" rule which means that if you are threatening to harm another person or their property, it is our duty to make a reasonable effort to contact that person or law enforcement officials.

2. Minors have the right to request that data about him or her is withheld from the parents. This document constitutes notice of that right. Minors must notify Lakes Area Counseling staff in writing if they wish that data is withheld from parents. The request from the minor should include the reasons for denying parental access to data and should be signed by the minor. Lakes Area Counseling will withhold the information if it is in the best interests of the minor.

Lakes Area Counseling
Patient Rights, Risks and Tennesen Warning

My signature below indicates that I have received a copy of the handout titled *Patient Rights, Risks and Tennesen Warning.* I have read this document and have had an opportunity to discuss it with staff.

I agree to participate in therapy at Lakes Area Counseling.

_____ _____

Patient Signature Date

_____ _____

Staff Signature Date

- The patient takes home the attached: *Patient Rights, Risks and Tennesen Warning*
- This signature sheet is detached from the packet and placed in the patient's chart