NYSTROM & ASSOCIATES, LTD.
www.nystromcounseling.com

Fee and Policies Agreement

Minnesota Clinics
Apple Valley | Bloomington | Brainerd/Baxter | Coon Rapids | Duluth | Eden Prairie | Elk River/Otsego
Maple Grove | Minneapolis/St. Paul | St. Cloud | Woodbury

Washington Clinics
Bellevue

Fees/Insurance

If you plan to submit your own claims to your insurance company, it is our policy that payment of the entire fee is due at the time of service.

As a service to our patients, Nystrom & Associates, Ltd. (NAL) staff will submit your insurance claims. Please provide us with the necessary information. If you fail to provide active insurance information in a timely manner you will be held liable for this negligence. CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. DEDUCTIBLES AND COINSURANCES ARE REQUESTED TO BE PAID AT THE TIME OF CHECK IN. In the event the undersigned is entitled to health insurance benefits of any type, insuring patient or any other party liable to the patient, their benefits are hereby assigned to this health care facility for application to the patient's account. I authorize this healthcare facility to release information, including medical records, to my insurance company or the designee of my third party payer (authorized agent) as may be necessary to determine benefits, process and pay health care claims, and perform quality of care reviews at NAL.

NAL can make no guarantee that your insurance company will provide payment for services rendered. IT IS YOUR RESPONSIBILTY TO KNOW WHAT IS AND IS NOT COVERED UNDER YOUR POLICY. YOU ARE RESPONSIBLE FOR THE FULL AMOUNT OF THE CHARGE, WHETHER OR NOT YOUR INSURANCE WILL COVER ANY PORTION. If your insurance company requires preauthorization of services you are responsible to inform us. Be aware that some insurance companies have an annual maximum benefit for outpatient mental health coverage.

Time billed for court appearances, court case review, report writing, letters, telephone consultation, and other charges excluded by insurance coverage are your responsibility. Charges vary based on time spent and type of service.

A service charge of 1.5% (18% annual rate), or the highest statutory amount allowed, whichever is higher, will be charged on accounts past due 28 days. If payment from insurance is not received within 90 days the account may be due and payable in full by the patient. An account 90 days past due will be subject to collection procedures and/or small claims court, and the patient agrees to be held responsible for the cost disbursement, including reasonable attorneys, collection, and court fees. There is a fee of $30 for checks returned for insufficient funds. Minnesota Care Tax will be added where applicable, and you agree to be held responsible for these fees.

_____ **Cancellations**
Initial Here

NAL requires a 24-business-hour notice (excluding weekends) when cancelling an appointment. This will allow us to schedule the time for someone else. Please note: **IF YOU FAIL A SCHEDULED APPOINTMENT OR CANCEL WITH LESS THAN 24 BUSINESS- HOURS NOTICE, YOU WILL BE CHARGED FOR THE SESSION**. Your insurance cannot be billed for missed appointments. At the discretion of NAL your services may be discontinued due to excessive failed appointments or late cancels.

_____ **Divorce / Custodial Situations**
Initial Here

The parent or guardian who brings the child in for care will be considered the responsible party and will receive all billing statements and letters. Any court-ordered financial arrangements must be worked out between the parents of the children.

Attestation for Consent

By signing this document you understand that the following forms will require your verbal consent be given to the provider. The provider will ask you for your verbal consent after reviewing the following forms: Initial Treatment Plan, Updated Treatment Plans, and the DBT Agreement Form.

I hereby acknowledge that NAL's HIPAA/Notice of Privacy Practices and Patient or Consumer Rights Handout, procedures for reporting alleged violations of patient's rights and grievance procedures have been made available to me.

I HAVE READ AND AGREE TO THE ABOVE AND HEREBY GUARANTEE PAYMENT OF ALL CHARGES FOR SERVICES WITH THE FINANCIAL ARRANGEMENTS OF NAL.

_____ _____
PRINTED NAME OF PATIENT PATIENT DATE OF BIRTH

_____ _____ _____
PRINTED NAME OF LEGAL GUARDIAN PHONE NUMBER OF LEGAL GUARDIAN ADDRESS OF LEGAL GUARDIAN

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

6/94 4/95 1/99 9/99 2/01 12/06 10/08, 6/12, 11/14, 7/15, 1/16

NYSTROM & ASSOCIATES, LTD.

13045 Falcon Drive, Suite 100
Baxter, MN 56425
www.nystromcounseling.com
218-829-9307 Fax 218-829-7649

Authorization for Release of Information to Primary Care Provider

- ☐ **I would like my Primary Care Provider (PCP) to receive information about my initial treatment plan from Nystrom & Associates, Ltd. (NAL) for the purposes of continuing care.**
- ☐ **I would like my NAL Provider to contact my Primary Care Provider as necessary to coordinate ongoing care.**
- ☐ **I do not want my Primary Care Provider to receive a copy of my information.**
- ☐ **I do not have a Primary Care Provider.**

I authorize NAL to RELEASE to:

Primary Care Provider/Clinic: _____

Address, City, State, Zip: _____

_____

Phone: _____ Fax: _____

I understand the following: See CFR §164.508(c)(2)(i-iii) a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. b. The information released in response to this authorization may be re-disclosed to other parties. c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. A photocopy of this authorization will be treated in the same manner as the original. This authorization shall be in force and effect until one year from date of execution at which time this authorization expires.

SIGNATURE of PATIENT _____ DATE _____
(See 45CFR § 164.508(c)(1)(vi))
PRINT NAME _____

SIGNATURE of PARENT/GUARDIAN_____ DATE _____
(See 45CFR § 164.508(c)(1)(vi))
RELATIONSHIP to PATIENT _____ WITNESSED BY_____ DATE _____
(See 45CFR §164.508(c)(1)(iv))

TREATMENT PLAN SUMMARY
(To be completed by Provider)

Your patient, _____D.O.B. _____was seen by _____.

Date of initial assessment _____ Next appointment _____

Diagnosis and / or presenting problem _____

_____

_____

Treatment recommendations _____

Medication (if applicable) _____

☐ Attached is a copy of the patient's initial evaluation, including their treatment plan.

This information was _____ faxed _____ mailed on _____ Staff Initials _____

NYSTROM & ASSOCIATES, LTD.
- Est 1991 -
www.nystromcounseling.com

FAMILY SUPPORT SERVICES, INC.
- Est. 1991 -
www.nystromcounseling.com

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

Patient Information

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

I Authorize

Nystrom & Associates, Ltd., and Family Support Services, Inc.

Address: 13045 Falcon Drive, Suite 100 Fax: 218-829-7649

City: Baxter State: MN Zip: 56425 Phone: 218-829-9307

To do the following:

- ☐ **Release to**
- ☐ **Receive from**
- ☐ **Both**

Agency/Name:_____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip: _____

Information to be Released

(**What** do you want sent or released?)

Check the appropriate box(s).

- ☐ **Any and all medical records**
- ☐ **All records** dated from _____ to _____
- ☐ **Verbal**

or

Only release the records checked below

- ☐ Most Recent Progress Note: _____
- ☐ Assessment Diagnostic Form, 3 most recent Progress Notes and Treatment Plan
- ☐ Psychological Testing Interpretive Report
- ☐ Itemized billing statement *
- ☐ Other: _____

Mental health information, alcohol/drug abuse information and AIDS related illness information appearing in any of the records/information selected above will be disclosed unless indicated otherwise below.

- ☐ Do not release records/information related to mental health, alcohol/drug abuse or AIDS related illness.

Purpose of Release

(Why is it needed?) Check the appropriate box(s).

- ☐ Coordination of care
- ☐ Social security appeal *
- ☐ Social security disability *
- ☐ Insurance payment/claim
- ☐ Litigation/legal *
- ☐ Personal use or review
- ☐ Other: _____

I understand the following: See CFR §164.508(c)(2)(i-iii) a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released according to this authorization. b. The information released in response to this authorization may be re-disclosed to other parties. c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. d. Communications resulting from this authorization will reveal I have received services from NAL/FSSI. e. My health information is protected by federal regulations and state laws. Disclosure is only allowed with my authorization, except in limited circumstance as described in NAL/FSSI Privacy Policy. f. I have the right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws. A photocopy of this authorization will be treated in the same manner as the original. This authorization shall be in force and effect until 1 year from date of execution at which time this authorization expires.*Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F. R. §164.524

SIGNATURE of PATIENT _____ DATE _____
(See 45CFR § 164.508(c)(1)(vi))
PRINT NAME _____

SIGNATURE of PARENT/GUARDIAN_____ DATE _____
(See 45CFR § 164.508(c)(1)(vi))
RELATIONSHIP to PATIENT _____ WITNESSED BY_____ DATE _____
(See 45CFR §164.508(c)(1)(iv)) NOTE: If signed by someone other than the patient, we need written proof of your authority.

DO NOT FORWARD TO ANOTHER PERSON OR AGENCY WITHOUT PATIENT CONSENT.

Guidelines for completing your Authorization for Releasing of Confidential Information

Nystrom & Associates, Ltd. (NAL), and Family Support Services, Inc. (FSSI), recognizes the importance of patient confidentiality as well as the importance of coordinating care and treatment with other professionals, family, friends, and others involved in your care. Please review all items on this form and contact NAL/FSSI with any questions concerning this form at the below listed offices or website.

Patient Information: Complete this entire section with clear and legible writing so the information easily identifies the patient whose information is being requested/released.

Agency/Name: Indicate clearly and legibly where or whom you wish to send/receive information from. **Be as Specific** as you can. **ALSO**, please check by either: (1) Release to, (2) Receive from, OR (3) Both Receive and Release. If you choose only to Receive information your NAL provider **CANNOT** share any information; if you choose Release only your NAL provider can only share information; if you choose both to Release **AND** Receive they may share and take in information from the agency/name listed on the form.

Information to be Received/Released: The purpose of this section is to have us share the information you want us to. "Any and all medical records" NAL/FSSI will release/receive ALL medical records across ALL programs/services at NAL/FSSI. All records dated from ___to___, NAL/FSSI will only send the records in the date range you indicate. Select Verbal if you only want to release or receive information verbally with the listed receiving/releasing party.

Purpose of Release: Identify the reason you need to release/request information. This helps NAL/FSSI appropriately provide care and track releasing confidential information. It informs us who may be responsible for the cost of medical records being released and is required on each release. * Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F. R. §164.524 (when applicable).

Authorization and Revocation: Signing this form (or having the legal guardian sign for a patient) will grant authorization to share/receive confidential information. Please sign and date this form to validate this authorization. If signed by someone other than the patient, you will be required to provide written proof of your authority. This consent will automatically expire in one year from the date signed. The authorization can be revoked or can be edited at any time at your written direction to our organization.

Helpful Tips:

- ✓ You may only enter one entity, clinic or individual per Release of Information.
- ✓ If requesting records, please allow 7-10 business days for processing of the Release of Information. In some cases it can take up to 30 days (45 CFR §164.524(b)(2)(i).

For questions or concerns regarding this form please contact your NAL facility listed below.

Minneapolis/St. Paul, MN
Brighton Professional Building
1900 Silver Lake Road, Suite 110
New Brighton, MN 55112
P (651) 628-9566
F (651) 628-0411

Apple Valley, MN
Merchants Bank Building
7300 West 147th Street, Suite 204
Apple Valley, MN 55124
P (952) 997-3020
F (952) 997-3026

Eden Prairie, MN
Prairie Lakes Corporate Center II
11010 Prairie Lakes Drive, Suite 350
Eden Prairie, MN 55344
P (952) 746-2522
F (952) 746-0887

Elk River/Otsego, MN
Waterfront Commons II Building
16201 90th Street NE, Suite 200
Otsego, MN 55330
P (763) 746-9492
F (763) 746-3685

Coon Rapids, MN
Coon Rapids Professional Building
3833 Coon Rapids Blvd, Suite 120
Coon Rapids, MN 55433
P (763) 767-3350
F (763) 767-0912

Brainerd/Baxter, MN
13045 Falcon Drive
Suite 100
Baxter, MN 56425
P (218) 829-9307
F (218) 829-7649

Duluth, MN
Providence Building
332 West Superior Street, Suite 300
Duluth, MN 55802
P (218) 722-4379
F (218) 722-4333

Woodbury, MN
Woodbury Plaza Office Building
1811 Weir Drive, Suite 270
Woodbury, MN 55125
P (651) 714-9646
F (651) 714-9647

Bellevue, WA
I-405 Corporate Center
301 116th Ave SE, Suite 105
Bellevue, WA 98004
P (425) 454-1919
F (425) 454-7018

Maple Grove, MN
13603 80th Circle North
Maple Grove, MN 55369
P (763) 274-3120
F (763) 274-3121

Bloomington, MN
1101 E 78th Street, Suite 100
Bloomington, MN 55420
P (952) 854-5034
F (952) 854-5363

St. Cloud, MN
Midsota Building
3701 12th Street, Suite 203
St. Cloud, MN 56303
P (320) 253-3512
F (320) 253-1037

NYSTROM & ASSOCIATES, LTD.
- Est 1991 -
www.nystromcounseling.com

FAMILY SUPPORT SERVICES, INC.
- Est. 1991 -
www.nystromcounseling.com

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

Patient Information

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

I Authorize

Nystrom & Associates, Ltd., and Family Support Services, Inc.

Address: 13045 Falcon Drive, Suite 100 Fax: 218-829-7649

City: Baxter State: MN Zip: 56425 Phone: 218-829-9307

To do the following:

- ☐ **Release to**
- ☐ **Receive from**
- ☐ **Both**

Agency/Name:_____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip: _____

Information to be Released

(**What** do you want sent or released?)

Check the appropriate box(s).

- ☐ **Any and all medical records**
- ☐ **All records** dated from _____ to _____
- ☐ **Verbal**

or

Only release the records checked below

- ☐ Most Recent Progress Note: _____
- ☐ Assessment Diagnostic Form, 3 most recent Progress Notes and Treatment Plan
- ☐ Psychological Testing Interpretive Report
- ☐ Itemized billing statement *
- ☐ Other: _____

Mental health information, alcohol/drug abuse information and AIDS related illness information appearing in any of the records/information selected above will be disclosed unless indicated otherwise below.

- ☐ Do not release records/information related to mental health, alcohol/drug abuse or AIDS related illness.

Purpose of Release

(Why is it needed?) Check the appropriate box(s).

- ☐ Coordination of care
- ☐ Social security appeal *
- ☐ Social security disability *
- ☐ Insurance payment/claim
- ☐ Litigation/legal *
- ☐ Personal use or review
- ☐ Other: _____

I understand the following: See CFR §164.508(c)(2)(i-iii) a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released according to this authorization. b. The information released in response to this authorization may be re-disclosed to other parties. c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. d. Communications resulting from this authorization will reveal I have received services from NAL/FSSI. e. My health information is protected by federal regulations and state laws. Disclosure is only allowed with my authorization, except in limited circumstance as described in NAL/FSSI Privacy Policy. f. I have the right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws. A photocopy of this authorization will be treated in the same manner as the original. This authorization shall be in force and effect until 1 year from date of execution at which time this authorization expires.*Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F. R. §164.524

SIGNATURE of PATIENT _____ DATE _____
(See 45CFR § 164.508(c)(1)(vi))
PRINT NAME _____

SIGNATURE of PARENT/GUARDIAN_____ DATE _____
(See 45CFR § 164.508(c)(1)(vi))
RELATIONSHIP to PATIENT _____ WITNESSED BY_____ DATE _____
(See 45CFR §164.508(c)(1)(iv)) NOTE: If signed by someone other than the patient, we need written proof of your authority.

DO NOT FORWARD TO ANOTHER PERSON OR AGENCY WITHOUT PATIENT CONSENT.

Guidelines for completing your Authorization for Releasing of Confidential Information

Nystrom & Associates, Ltd. (NAL), and Family Support Services, Inc. (FSSI), recognizes the importance of patient confidentiality as well as the importance of coordinating care and treatment with other professionals, family, friends, and others involved in your care. Please review all items on this form and contact NAL/FSSI with any questions concerning this form at the below listed offices or website.

Patient Information: Complete this entire section with clear and legible writing so the information easily identifies the patient whose information is being requested/released.

Agency/Name: Indicate clearly and legibly where or whom you wish to send/receive information from. **Be as Specific** as you can. **ALSO**, please check by either: (1) Release to, (2) Receive from, OR (3) Both Receive and Release. If you choose only to Receive information your NAL provider **CANNOT** share any information; if you choose Release only your NAL provider can only share information; if you choose both to Release **AND** Receive they may share and take in information from the agency/name listed on the form.

Information to be Received/Released: The purpose of this section is to have us share the information you want us to. "Any and all medical records" NAL/FSSI will release/receive ALL medical records across ALL programs/services at NAL/FSSI. All records dated from ___to___, NAL/FSSI will only send the records in the date range you indicate. Select Verbal if you only want to release or receive information verbally with the listed receiving/releasing party.

Purpose of Release: Identify the reason you need to release/request information. This helps NAL/FSSI appropriately provide care and track releasing confidential information. It informs us who may be responsible for the cost of medical records being released and is required on each release. * Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F. R. §164.524 (when applicable).

Authorization and Revocation: Signing this form (or having the legal guardian sign for a patient) will grant authorization to share/receive confidential information. Please sign and date this form to validate this authorization. If signed by someone other than the patient, you will be required to provide written proof of your authority. This consent will automatically expire in one year from the date signed. The authorization can be revoked or can be edited at any time at your written direction to our organization.

Helpful Tips:

- ✓ You may only enter one entity, clinic or individual per Release of Information.
- ✓ If requesting records, please allow 7-10 business days for processing of the Release of Information. In some cases it can take up to 30 days (45 CFR §164.524(b)(2)(i).

For questions or concerns regarding this form please contact your NAL facility listed below.

Minneapolis/St. Paul, MN
Brighton Professional Building
1900 Silver Lake Road, Suite 110
New Brighton, MN 55112
P (651) 628-9566
F (651) 628-0411

Apple Valley, MN
Merchants Bank Building
7300 West 147th Street, Suite 204
Apple Valley, MN 55124
P (952) 997-3020
F (952) 997-3026

Eden Prairie, MN
Prairie Lakes Corporate Center II
11010 Prairie Lakes Drive, Suite 350
Eden Prairie, MN 55344
P (952) 746-2522
F (952) 746-0887

Elk River/Otsego, MN
Waterfront Commons II Building
16201 90th Street NE, Suite 200
Otsego, MN 55330
P (763) 746-9492
F (763) 746-3685

Coon Rapids, MN
Coon Rapids Professional Building
3833 Coon Rapids Blvd, Suite 120
Coon Rapids, MN 55433
P (763) 767-3350
F (763) 767-0912

Brainerd/Baxter, MN
13045 Falcon Drive
Suite 100
Baxter, MN 56425
P (218) 829-9307
F (218) 829-7649

Duluth, MN
Providence Building
332 West Superior Street, Suite 300
Duluth, MN 55802
P (218) 722-4379
F (218) 722-4333

Woodbury, MN
Woodbury Plaza Office Building
1811 Weir Drive, Suite 270
Woodbury, MN 55125
P (651) 714-9646
F (651) 714-9647

Bellevue, WA
I-405 Corporate Center
301 116th Ave SE, Suite 105
Bellevue, WA 98004
P (425) 454-1919
F (425) 454-7018

Maple Grove, MN
13603 80th Circle North
Maple Grove, MN 55369
P (763) 274-3120
F (763) 274-3121

Bloomington, MN
1101 E 78th Street, Suite 100
Bloomington, MN 55420
P (952) 854-5034
F (952) 854-5363

St. Cloud, MN
Midsota Building
3701 12th Street, Suite 203
St. Cloud, MN 56303
P (320) 253-3512
F (320) 253-1037

NYSTROM & ASSOCIATES, LTD.
- Est 1991 -
www.nystromcounseling.com

FAMILY SUPPORT SERVICES, INC.
- Est. 1991 -
www.nystromcounseling.com

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

Patient Information

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

I Authorize

Nystrom & Associates, Ltd., and Family Support Services, Inc.

Address: 13045 Falcon Drive, Suite 100 Fax: 218-829-7649

City: Baxter State: MN Zip: 56425 Phone: 218-829-9307

To do the following:

- ☐ **Release to**
- ☐ **Receive from**
- ☐ **Both**

Agency/Name:_____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip: _____

Information to be Released

(**What** do you want sent or released?)

Check the appropriate box(s).

- ☐ **Any and all medical records**
- ☐ **All records** dated from _____ to _____
- ☐ **Verbal**

or

Only release the records checked below

- ☐ Most Recent Progress Note: _____
- ☐ Assessment Diagnostic Form, 3 most recent Progress Notes and Treatment Plan
- ☐ Psychological Testing Interpretive Report
- ☐ Itemized billing statement *
- ☐ Other: _____

Mental health information, alcohol/drug abuse information and AIDS related illness information appearing in any of the records/information selected above will be disclosed unless indicated otherwise below.

- ☐ Do not release records/information related to mental health, alcohol/drug abuse or AIDS related illness.

Purpose of Release

(Why is it needed?) Check the appropriate box(s).

- ☐ Coordination of care
- ☐ Social security appeal *
- ☐ Social security disability *
- ☐ Insurance payment/claim
- ☐ Litigation/legal *
- ☐ Personal use or review
- ☐ Other: _____

I understand the following: See CFR §164.508(c)(2)(i-iii) a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released according to this authorization. b. The information released in response to this authorization may be re-disclosed to other parties. c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. d. Communications resulting from this authorization will reveal I have received services from NAL/FSSI. e. My health information is protected by federal regulations and state laws. Disclosure is only allowed with my authorization, except in limited circumstance as described in NAL/FSSI Privacy Policy. f. I have the right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws. A photocopy of this authorization will be treated in the same manner as the original. This authorization shall be in force and effect until 1 year from date of execution at which time this authorization expires.*Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F. R. §164.524

SIGNATURE of PATIENT _____ DATE _____
(See 45CFR § 164.508(c)(1)(vi))
PRINT NAME _____

SIGNATURE of PARENT/GUARDIAN_____ DATE _____
(See 45CFR § 164.508(c)(1)(vi))
RELATIONSHIP to PATIENT _____ WITNESSED BY_____ DATE _____
(See 45CFR §164.508(c)(1)(iv)) NOTE: If signed by someone other than the patient, we need written proof of your authority.

DO NOT FORWARD TO ANOTHER PERSON OR AGENCY WITHOUT PATIENT CONSENT.

Guidelines for completing your Authorization for Releasing of Confidential Information

Nystrom & Associates, Ltd. (NAL), and Family Support Services, Inc. (FSSI), recognizes the importance of patient confidentiality as well as the importance of coordinating care and treatment with other professionals, family, friends, and others involved in your care. Please review all items on this form and contact NAL/FSSI with any questions concerning this form at the below listed offices or website.

Patient Information: Complete this entire section with clear and legible writing so the information easily identifies the patient whose information is being requested/released.

Agency/Name: Indicate clearly and legibly where or whom you wish to send/receive information from. **Be as Specific** as you can. **ALSO**, please check by either: (1) Release to, (2) Receive from, OR (3) Both Receive and Release. If you choose only to Receive information your NAL provider **CANNOT** share any information; if you choose Release only your NAL provider can only share information; if you choose both to Release **AND** Receive they may share and take in information from the agency/name listed on the form.

Information to be Received/Released: The purpose of this section is to have us share the information you want us to. "Any and all medical records" NAL/FSSI will release/receive ALL medical records across ALL programs/services at NAL/FSSI. All records dated from ___to___, NAL/FSSI will only send the records in the date range you indicate. Select Verbal if you only want to release or receive information verbally with the listed receiving/releasing party.

Purpose of Release: Identify the reason you need to release/request information. This helps NAL/FSSI appropriately provide care and track releasing confidential information. It informs us who may be responsible for the cost of medical records being released and is required on each release. * Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F. R. §164.524 (when applicable).

Authorization and Revocation: Signing this form (or having the legal guardian sign for a patient) will grant authorization to share/receive confidential information. Please sign and date this form to validate this authorization. If signed by someone other than the patient, you will be required to provide written proof of your authority. This consent will automatically expire in one year from the date signed. The authorization can be revoked or can be edited at any time at your written direction to our organization.

Helpful Tips:

- ✓ You may only enter one entity, clinic or individual per Release of Information.
- ✓ If requesting records, please allow 7-10 business days for processing of the Release of Information. In some cases it can take up to 30 days (45 CFR §164.524(b)(2)(i).

For questions or concerns regarding this form please contact your NAL facility listed below.

Minneapolis/St. Paul, MN
Brighton Professional Building
1900 Silver Lake Road, Suite 110
New Brighton, MN 55112
P (651) 628-9566
F (651) 628-0411

Apple Valley, MN
Merchants Bank Building
7300 West 147th Street, Suite 204
Apple Valley, MN 55124
P (952) 997-3020
F (952) 997-3026

Eden Prairie, MN
Prairie Lakes Corporate Center II
11010 Prairie Lakes Drive, Suite 350
Eden Prairie, MN 55344
P (952) 746-2522
F (952) 746-0887

Elk River/Otsego, MN
Waterfront Commons II Building
16201 90th Street NE, Suite 200
Otsego, MN 55330
P (763) 746-9492
F (763) 746-3685

Coon Rapids, MN
Coon Rapids Professional Building
3833 Coon Rapids Blvd, Suite 120
Coon Rapids, MN 55433
P (763) 767-3350
F (763) 767-0912

Brainerd/Baxter, MN
13045 Falcon Drive
Suite 100
Baxter, MN 56425
P (218) 829-9307
F (218) 829-7649

Duluth, MN
Providence Building
332 West Superior Street, Suite 300
Duluth, MN 55802
P (218) 722-4379
F (218) 722-4333

Woodbury, MN
Woodbury Plaza Office Building
1811 Weir Drive, Suite 270
Woodbury, MN 55125
P (651) 714-9646
F (651) 714-9647

Bellevue, WA
I-405 Corporate Center
301 116th Ave SE, Suite 105
Bellevue, WA 98004
P (425) 454-1919
F (425) 454-7018

Maple Grove, MN
13603 80th Circle North
Maple Grove, MN 55369
P (763) 274-3120
F (763) 274-3121

Bloomington, MN
1101 E 78th Street, Suite 100
Bloomington, MN 55420
P (952) 854-5034
F (952) 854-5363

St. Cloud, MN
Midsota Building
3701 12th Street, Suite 203
St. Cloud, MN 56303
P (320) 253-3512
F (320) 253-1037

PROFESSIONAL FAMILY BASED DIVISION

Nystrom & Associates, Ltd.
13045 Falcon Drive Suite 100
Baxter, MN 56425

RIGHTS AND RESPONSIBILITIES OF PROGRAM PARTICIPANTS

1. You have the **right** to considerate and respectful care. Our staff is responsible for considering your individuality as it relates to your ethnic, social, religious and psychological well-being and to provide you with those services which will best meet your individual needs in a professional and ethical manner. This includes appropriate behavior by staff and program participants. Any questions or concerns you have should be directed to your practitioner, their supervisor or the agency.

2. You have the **right** to privacy and confidentiality. No information concerning your involvement in the program shall be made available to any organization, agency or individual without your written consent, except as outlined in the *Notice of Privacy Practices*. In order to provide the best possible therapy, your case will be discussed with a supervising therapist during consultation and regular supervision.

3. You have the **right** to request and receive information about Professional Family Based Division and/or Family Support Services, Inc. and the rationale and goals of any services. You also have the right to request an explanation for any and all referral recommendations made in the program. You also have the right to seek a second opinion from another counseling service as well as refuse our services.

4. You have the **right** to contact your counselor during your involvement in our program. If problems do arise and you feel the need to talk, we encourage you to contact your practitioner. Calls will be returned during business hours of 8am-6pm. If a mental health crisis arises it is your **responsibility** to follow your crisis plan. Our business address is listed above.

5. Attendance **responsibility** of program participants : Home based services provide more intensive individual and family services, meeting several times a week for extended periods of time. We believe that the best therapy results from consistency of treatment. One way this is achieved is through maintaining scheduled appointments. Insurance companies also consider attendance a quality of care issue. However, we understand that conflicts do occasionally arise. Although we encourage you to maintain attendance as a priority, if you do need to reschedule we request at least 24 hour notice, and try to reschedule within the same week. These early notices will allow our staff to manage their caseload to meet the needs of other clients. If these policies are not adhered to, the missed appointment will be considered a no show. More than two no shows is considered an attendance problem and could result in an attendance agreement or termination of services.

6. **Responsibilities** of participating in home based services: Home based services are unique in that the service is provided in your home or community location. As a result there exists the natural distractions of daily life. It is your responsibility to limit these distractions in your environment as much as possible. This will create a more productive atmosphere for our work. In addition to the above responsibilities please consider the following: 1) Unless expecting an important call, please let your answering machine pick up your messages, 2) please limit the traffic in the home during our time with you, 3) please have the television turned off in the room where we are meeting and any radio turned low, 4) please have our time together be substance free (including cigarettes if possible). And please remember your children are your **responsibility**; we are not a childcare service.

I have read the above information on my rights and responsibilities as a program participant; I understand these rights and have received a copy of this statement.

Date:_____ Parent/Legal Guardian: _____

Client:_____

Agency Representative: _____

Mental Health services are governed by the State of Minnesota, by the following boards:
Board of Psychology (612) 617-2230, Board of Marriage & Family Therapy (612) 617-2220,
Board of Social Work (612) 617-2100, Board of Behavioral Health and Therapy (612)617-2178
And for everyone who does not fit in the above categories: Unlicensed Mental Health Practitioners 651-282-5621

PROFESSIONAL FAMILY BASED DIVISION
FAMILY SUPPORT SERVICES, INC
Nystrom & Associates, Ltd.

FINANCIAL RELEASE and PRIVACY RIGHTS NOTIFICATION

I, _____, hereby authorize the Professional Family Based Division and/or Family Support Services, Inc. of Nystrom & Associates, Ltd. to disclose to _____ the following information: diagnosis, procedure codes, service dates, family/social history, treatment planning and progress in treatment. The organization receiving this information will use it for the following purpose: processing of authorizations and insurance claims for: Client: _____ DOB: ___/____/____.

I have been given a copy of how my Protected Health Information (PHI) will be maintained under Federal Law, Health Insurance Portability and Accountability Act (HIPAA) and Minnesota Law (Data Privacy Act).

I understand no other uses will be made of this information, except for those previously communicated to me or as otherwise authorized by law, and that access to it will be limited to persons whose work assignment reasonably require access to accomplish the purpose stated above. I understand that I may revoke this data privacy consent at any time and that, in any event, the data privacy consent expires within *one year* of this date, _____, _____, or when the purposes for which it was granted have been accomplished, whichever occurs first.

_____ _____

Signature of client(s) or signature of parent or guardian if client is a minor

Signature of Person responsible for the Information within the agency

Professional Family Based Division of Nystrom & Associates, Ltd

Treatment Plan Signature Form

Due to the electronic nature of our Treatment Plans, this form is an addendum to the Treatment Plan to provide a signature portion at the time of completion.

Signatures for Treatment Plan Dated: _____

For the following Client: _____ DOB: _____

I _____have discussed the Treatment plan, as well as possible outcomes from treatment and other treatment alternatives, with the NAL Mental Health Professional/Practitioner. I concur with the report and desire to pursue the recommendations for treatment as stated in the Treatment Plan.

Date:	Mental Health Practitioner (Signature):	Client (Signature) if applicable:
Mental Health Professional:(if applicable)		Legal Guardian if Minor (Signature):
Next Treatment Plan Review will occur before ____/____/____		

PROFESSIONAL FAMILY BASED DIVISION
FAMILY SUPPORT SERVICES, INC.
Nystrom & Associates, Ltd.
13045 Falcon Drive, Suite 100
Baxter, MN 56425
TEL: 218-829-9307 FAX: 218-829-7649

CLIENT PHONE RECORD

CLIENT NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

NATURAL PARENT: _____ (H) _____ (W) _____

FOSTER PARENT: _____ (H) _____ (W) _____

GUARDIAN: _____ (H) _____ (W) _____

GRANDPARENTS: _____ (H) _____ (W) _____

CLERGY: _____ (H) _____ (W) _____

OTHER: _____ (H) _____ (W) _____

MEDICAL DOCTOR: _____

PSYCHOLOGIST/PSYCHIATRIST: _____

REFERRING WORKER: _____

PROBATION OFFICER: _____

SCHOOL SOCIAL WORKER: _____

OTHER: _____

_____

_____