EUNOIA
FAMILY RESOURCE CENTER, PA

REGISTRATION INFORMATION

Account #
For Internal Use

DATE:

PATIENT INFORMATION

LAST NAME | FIRST NAME | MI | BIRTHDATE | SPOUSE'S NAME

HOME ADDRESS | CITY | STATE | ZIP | SEX: ☐ MALE ☐ FEMALE

MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED | HOME PHONE | OTHER PHONE

SOCIAL SECURITY NUMBER | **PLEASE STAR WHICH PHONE NUMBER YOU WOULD PREFER WE USE TO CONTACT YOU.

EMPLOYER OR SCHOOL NAME IF STUDENT: | HOW DID YOU FIND US?

EMERGENCY INFORMATION

NEXT-OF-KIN (For Emergency – Other than Spouse) | RELATIONSHIP

NEXT-OF-KIN ADDRESS | CITY | STATE | ZIP | NEXT-OF-KIN PHONE

RESPONSIBLE PARTY INFORMATION (If the same as patient, write "Same.")

RESPONSIBLE PARTY NAME | LAST | FIRST | MI | RESPONSIBLE PARTY HOME PHONE

RESPONSIBLE PARTY ADDRESS | CITY | STATE | ZIP | RESPONSIBLE PARTY SOCIAL SECURITY #

RESPONSIBLE PARTY DATE OF BIRTH | RELATIONSHIP TO RESPONSIBLE PARTY ☐ SELF ☐ SPOUSE ☐ SON ☐ DAUGHTER

INSURANCE INFORMATION

***Please note that we will need a copy of all of the patient's insurance cards.**

PRIMARY INSURANCE | CARDHOLDER | DATE OF BIRTH

GROUP NUMBER | IDENTIFICATION NUMBER

INSURANCE ADDRESS | CITY | STATE | ZIP | PHONE

SECONDARY INSURANCE | CARDHOLDER | DATE OF BIRTH

GROUP NUMBER | IDENTIFICATION NUMBER

INSURANCE ADDRESS | CITY | STATE | ZIP | PHONE

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment to Eunoia Family Resource Center, PA of any medical benefits otherwise payable to me for the services provided at Eunoia Family Resource Center, PA.

X

Patient Signature or Signature of Guardian or Parent | Date

RECORDS RELEASE

I hereby authorize Eunoia Family Resource Center, PA to release my records to my insurance company for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payor.

X

Patient Signature or Signature of Guardian or Parent | Date

EUNOIA
FAMILY RESOURCE CENTER, PA

1420 N. State Street
Fairmont, MN 56031
Phone: (507) 235-6070
Fax: (507) 235-6074

Authorization for Release of Information

I,_____ _____

Name of Client | Date of Birth

_____ _____

Address | Social Security Number - Optional

_____ _____

City, State, Zip | Phone Number

authorize Eunoia Family Resource Center, 1420 N. State Street, Fairmont, MN 56031 to disclose to and receive information from:

_____

Name of Individual and Organization Name, if Applicable

_____ _____

Address | Phone Number

_____

City, State, Zip

The following information relates to my treatment:

_____Treatment/Discharge Summary _____Progress Notes _____Assessment/Evaluation
_____Psychological Testing _____History and Physical Exam _____Lab Results
_____Family Questionnaire _____Treatment Plans _____Other (Specify)

_____

The information is needed for the following purpose(s):_____

_____

Date Needed By: _____

Client Restrictions on Methods for Disclosure:
I understand that communication of the items to be obtained or disclosed can occur:

_____Verbally _____In-person Conference _____Written Questionnaire
_____Pick Up _____Mailed Correspondence _____Faxed Correspondence

I understand that this authorization may be withdrawn by me at anytime. Revocation of this authorization will not affect any information already released. Unless this form is previously revoked in writing, this release of information will remain in force until one (1) year from date of signature.

_____ _____

Signature of Client or Parent/Guardian When Necessary | Date

_____ _____

Relationship to Client | Date

_____ _____

Witness | Date

EUNOIA
FAMILY RESOURCE CENTER, PA

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Phone: (507) 235-6070
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Consent for Treatment of a Vulnerable Adult

I,_____, the parent/legal guardian of the

vulnerable adult, _____, give my permission for this vulnerable adult to receive treatment, which may include individual therapy, family therapy and assessments/testing, from Eunoia Family Resource Center.

I am the legal custodian of this vulnerable adult, and there are no court orders in effect that would prohibit me from consenting to the treatment of this vulnerable adult. If at any point, my status as parent/legal guardian changes, I will provide Eunoia Family Resource Center with appropriate documentation.

If I wish to revoke this consent, I will provide appropriate notice to Eunoia Family Resource Center.

My signature below means that I understand and agree with all of the points above.

_____ _____

Signature of Parent/Guardian Date

Eumoia Family Resource Center, PA
Financial Policy

Thank you for choosing us as your health care provider. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

All clients must complete our Registration Form before seeing a psychotherapist.

ALL CO-PAYS ARE DUE AT THE TIME OF YOUR SESSION.

WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD/DISCOVER.

Regarding Insurance:
We may accept assignment of insurance benefits. The balance is your responsibility, whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a 3rd party to that contract. In the event that we do accept assignment of benefits and your insurance has not paid your account in full within 60 days, the balance will be automatically transferred to your responsibility. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance. You will be financially responsible for any services that are deemed not medically necessary, non-covered or investigational by your health insurance provider. Contact your employer or insurer if you have questions.

All co-pays are due at the time of your session when you use an insurance plan for which your therapist is a provider. In the event that your insurance coverage changes, it is your responsibility to notify us. If your new plan is one for which we are not participating providers, you are responsible for your account. Any follow-up or reporting to 3rd parties that become necessary due to unpaid balances on your account shall not be considered breach of confidentiality.

Adult Patients:
Adult patients are responsible for full payment of any co-pays at the time of service.

Minor Patients:
Parents or guardians accompanying minors are responsible for payment of co-pays at the time of service. If a minor is accompanied by an adult other than a parent or guardian, payment is still expected at the time of service. For unaccompanied minors, charges may be preauthorized to an approved credit plan, VISA/Mastercard/Discover, or paid by cash or check at the time of service.

Missed Appointments:
For ALL appointments, unless cancelled with at least 24 hours' notice, a charge equal to the full amount of the appointment will be applied to your account. This charge is normally not payable by your insurance, and will be billed as your responsibility. Please help us serve you better by keeping scheduled appointments. Exceptions: late cancellations due to illness or bad weather causing school closures will be honored.

Service/Finance Charges, Court Fees:
- A monthly finance charge of 1.5% is charged for balances exceeding 30 days.
- Accounts exceeding 90 days may be reported to a collection agency.
- There is a $25.00 service charge for returned checks.
- Fees for court are $500/hour for all time incurred on the case, including but not limited to prep time, office staff time, travel, and in-court time (regardless of whether on stand or not). These fees are not covered by insurance.

Nondiscrimination:
No person may be denied services because of the person's sex, race, religion, national origin, ancestry, creed, pregnancy, marital or parental status, sexual orientation or physical, mental, emotional or learning disability.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

Notice of Policies and Practices to Protect the Privacy of Your Health Information

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

We are required by law to maintain the privacy of your health information and provide you with a description of our privacy practices. This notice will also describe your rights and certain obligations we have regarding the use and disclosure of your health information.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health information is personal. We are committed to protecting your health information. We create a record of the care and services you receive at this office. We need this record to provide you with quality care and comply with certain legal requirements. This notice applies to all of the records of your care generated by this office, whether made by your therapist or one of the office's employees.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

The following describes the different ways that your protected health information (PHI) may be used or disclosed by this office. "PHI" refers to information in your health record that could identify you. For clarification, we have included some examples. Not every possible use of disclosure is specifically mentioned. However, all of the ways we are committed to use and disclose your PHI will fit within one of these general categories:

- For Treatment: "Treatment" is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
- For Payment: "Payment" is when we obtain reimbursement for your health care. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. We may also tell your health plan insurer about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover or continue to cover your treatment.
- For Healthcare Operations: "Healthcare Operations" are activities that relate to the performance and operation of our practice. Examples of healthcare operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination. We may use and disclose health information to provide you with appointment information. This may be done with voice mail, messages, postcards, or other mailings.
- Use: "Use" applies only to activities within our office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- Disclosure: "Disclosure" applies to activities outside of our office, such as releasing, transferring, or providing access to information about you to other parties.

II. Use and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or healthcare operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment, or healthcare operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, the law provides the insurer the right to contest the claim under the policy.

III. Use and Disclosures with Neither Consent Nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: If we have reasonable cause to suspect child abuse or neglect, we must report this suspicion to the appropriate authorities as required by law.
- Vulnerable Adult Abuse: If we have reasonable cause to suspect you have been criminally abused, we must report this suspicion to the appropriate authorities as required by law.
- Health Oversight Activities: If we receive a subpoena or other lawful request from the Department of Health or the Minnesota Board of Psychology, we must disclose the relevant PHI pursuant to that subpoena or lawful request.
- Judicial and Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and we will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated or a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may use your PHI to defend the office or to respond to a court order.
- Law Enforcement: We may release PHI about you if required by law when asked to do so by a law enforcement official.
- Serious Threat to Health or Safety: If you communicate to us a threat of physical violence against a reasonably identifiable third person and you have the apparent intent and ability to carry out that threat in the foreseeable future, we may disclose relevant PHI and take the reasonable steps permitted by law to prevent the threatened harm from occurring. If we believe that there is an imminent risk that you will inflict serious physical harm on yourself, we may disclose information in order to protect you.
- Worker's Compensation: We may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychologist's Duties

You have the following rights regarding the PHI that this office maintains about you:

- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen at our office. On your request, we will send your bills to another address.) To request confidential communications, you must complete our request form in writing and submit it to the Privacy Officer. We will accommodate all reasonable requests.
- Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. To inspect and/or obtain a copy of you PHI, you must complete our request form and submit it to the Privacy Officer. If you request copies, we will charge you $0.10 per page. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. To request an amendment, you must complete our request form and submit it in writing to the Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request. On your request, we will discuss with you the details of the amendment process.

- Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process. To request this accounting on disclosures, you must complete a request form and submit it in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six (6) years and may not included dates before April 14, 2003.
- Right to a Paper Copy: You have the right to obtain a paper copy of the Notice from us upon request.

Psychologist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact the Privacy Officer at Eunoia Family Resource Center listed below.

If you believe that your privacy rights have been violated and wish to file a complaint with us/our office, you may send your written complaint to the Privacy Officer at Eunoia Family Resource Center. All complaints must be submitted in writing to:

Privacy Officer:
Ramie M. Vetter, Psy.D., LP
Eunoia Family Resource Center, PA
1420 N. State Street, Fairmont, MN 56031
(507) 235-6070

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. We will not retaliate against you or penalize you in any way for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 14, 2003. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. If we revise our policies and procedures, we will post a copy of any revised Notice in this office.

Other uses and disclosures of your PHI not covered by this Notice of Privacy Practices will be made only with your written authorization. If you provide us such an authorization in writing to use or disclose PHI about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose PHI about you for the reasons covered by your written authorization. Be aware that we are unable to take back any disclosures we have already made with your permission, and we are required to retain our records of care that we provide to you.

In case of an emergency, please call 911. Outside of our normal business hours, you may leave a message on our voicemail or call 911.

ACKNOWLEDGMENT

By signing below, I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____ _____

Patient/Parent/Guardian Signature Date

ACKNOWLEDGMENT

By signing below, I acknowledge that I have received a copy of this office's Financial Policy.

_____ _____

Patient/Parent/Guardian Signature Date

ACKNOWLEDGMENT

By signing below, I acknowledge that I

☐ Do

☐ Do Not

intend to give permission for Eunoia Family Resource Center to contact my primary care physician. This will require a separate Release of Information.

_____ _____

Name of Primary Care Physician

_____

Address of Primary Care Physician

_____ _____

Patient/Parent/Guardian Signature Date