Lakeville Behavioral Health Client Privacy Statement

There are laws that protect your rights as a client of this clinic. This statement of rights applies to your current contact with this clinic and all future contacts whether the contact is in person, by telephone, or by mail. If you have any questions about this statement or any of your rights as described, you may discuss them with your counselor or any other staff person. Specific information about how you can get copies of data, appeal accuracy and completeness of data, request summary data, and other procedures are available upon request.

DATA PRIVACY - The Minnesota Government Data Practices Act requires us to tell you:

- Why we ask for information;
- Whether you must give it or can refuse to give it;
- What will happen if you give or don't give the information; and
- Who else may see the information.

PURPOSES - The information we ask from you will be used for determining what help you need, developing a treatment plan, and giving you the services you want. The information will also be used for determining if you can pay for the services or if you can collect payment from other persons such as insurance companies or social service agencies.

LEGAL REQUIREMENTS AND CONSEQUENCES - There is no law that says you have to give us any information. But if you do not give us some information we will be unable to help you or our help will be delayed. If you are here because of a court order and you refuse to provide information, that refusal may be communicated to the court. Without certain information, we may not be able to tell who should pay for your care.

SHARING - Information we have about you may be shared with other agencies or individuals under the following circumstances:

- If you consent to the sharing or if we get a court order;
- If a law says we have to give information, including laws that require reporting child abuse or vulnerable adult abuse, or if a client is a danger to himself or another person.
- If there is a contract granting access, including the release of information to auditors and accrediting agencies;
- To staff in this clinic who need the data to do their jobs;
- To tell family members or other persons about your condition in accordance with acceptable medical practice, including the release of information in emergencies;
- To get the service fees due us through the courts or collection agencies;
- Workers Compensation, if you see us for a work related emotional problem;
- To the Secret Service to report security threats; and
- To a coroner / medical examiner if you die and your death is investigated.

MINORS - If you are under 18, you may request that data about you be kept from your parents. You must give us your request in writing, describe the data and tell us why you don't want your parents to see it. If, after receiving your request, this center believes that giving the data to your parents is not in your best interests, we will withhold the data from them. If you are 16, you may ask for mental health services without the consent of your parents but you might have to pay for the services if you don't want your parents to know. Ask your therapist about this.

ACCESS - You may see and have copies of most of the information about you. You may not see data that is confidential or data about another person without that person's consent.

PLANNING YOUR TREATMENT - You have the right to help develop your treatment plan. You have the right to help determine the best treatment options.

PATIENT RIGHTS:

- In your interaction with Lakeville Behavioral Health staff, you have the right to be treated with respect, dignity and privacy.
- You have the right to make complaints about Lakeville Behavioral Health staff, services or other care given by providers.
- You have the right to know about covered services and benefits offered under your plan, and how to seek care services.
- You have the right to receive timely care consistent with your need for care.
- You have the right to know all the facts about any charge or bill you receive, no matter who is making payment.

PATIENT RESPONSIBILITIES:

- You have the responsibility to provide information (including past treatment records) that Lakeville Behavioral Health may need to plan your treatment.
- You have the responsibility to learn about your condition and work with your provider to develop a plan for your care.
- You have the responsibility to follow the plans and instructions for care you have agreed to with your provider.
- You have the responsibility to notify Lakeville Behavioral Health and your provider of changes to medical or mental health and/or phone number changes.

Please sign this form. Your signature shows that you understand it.

_____ _____

Signature Date

Lakeville Behavioral Health, LLC

10535 165th Street West
Lakeville, MN 55044
Phone (952) 435-0022 Fax (952) 435-0095

Authorization to Release Information for Benefits

I authorize Lakeville Behavioral Health 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 and to process health care claims for my health care visit(s) at Lakeville Behavioral Health, LLC.

Professional Services and Fees

I, the undersigned, understand that I am responsible for payment in full for services incurred at Lakeville Behavioral Health. I also understand that, I am responsible for any deductible or percentage not paid for by my insurance. I understand that, as a courtesy, Lakeville Behavioral Health will attempt to bill my insurance company with the information I provide.
If for any reason, the insurance company fails to pay the amount estimated, I am responsible for the balance

I agree to a charge of $250.00 for the initial appointment at Lakeville Behavioral Health. This includes fifty minute appointment, set up costs, initial paperwork and charting.

I agree to a charge of $190.00 per hour for each additional sixty minute appointment at Lakeville Behavioral Health.

NOTE:
*I understand I will be charged a late/cancellation fee of **$100.00** for any scheduled appointments that I fail to attend or that I do not cancel within 24 hours prior to the scheduled appointment time. I also understand that cancellations for Monday appointments must be made before noon on Friday to avoid the late cancellation fee.*

Insurance Provider:_____

Estimated Insurance Benefits Provided by Your Insurance Company to Lakeville Behavioral Health, LLC

Deductible: $_____ Insurance Covers: _____% Personal: _____% Co-Pay per visit: $_____

Maximum insurance benefits paid by the Insurance Company: $_____

I understand that the estimated insurance benefits that were given to Lakeville Behavioral Health by my insurance company may not be the same as the actual payments made by my insurance company, and that I am responsible for any portion not covered by my health insurance plan.

_____ _____ _____
Patient Signature (or Responsible Party) Print Patient's Name Date

_____
Relationship to Patient

Copy to Client_____

Medical Contact Form
Lakeville Behavioral Health, LLC
10535 165th Street West - Lakeville, MN 55044
Phone (952) 435-0022 Fax (952) 435-0095
info@lbhealth.net

Patient Name:_____ Date of Birth_____

Client Signature:_____ Date: _____

Signature of Parent/Guardian:_____ Date:_____

Relationship to Patient:_____

YES. □ **I WOULD** like my primary care physician notified that I have been seen at LBH.
NO. □ **I WOULD NOT** like my primary care physician notified that I have been seen at LBH.

IF YES, complete below. IF NO, do not finish form.

Primary Care Physician: _____

Clinic Name: _____

City: _____

Phone: _____ Fax: _____

Authorization for Release of Confidential Information:

By signing above, and checking YES, I authorize to Receive from or Release to physician named above and LBH, any or all records.
I also authorize written and verbal communication between the physician and LBH.

These records are for the purpose of treatment coordination.

This authorization will remain in effect for one year from the date of signature and may be cancelled by me in writing at any time.

***For the physician**:* this form indicates that the above patient has been seen at LBH.
DO NOT FORWARD TO ANOTHER PERSON OR AGENCY. Minnesota Govt. Practices Act (Chapter 328: H.F.738.S.F. 1213, 7/1/91, FEDERAL LAW VOLUME #40, PART IV, 71/1/75 LBH 1-2017

Lakeville Behavioral Health, LLC
Intake Form - Child

Please complete the following information about your child. Today's Date:_____

Form completed by: _____ Relationship: _____

Name: _____D.O.B. _____ Age: _____ Gender: _____

How did you hear about our clinic? Friend ☐ Physician ☐ Insurance ☐ Internet ☐ Ad ☐

What school does your child currently attend? _____
What grade level is your child currently in? _____
What kind of grades does your child typically get? _____
Does your child work? Yes ☐ No ☐ Employer: _____

Briefly describe your/your child's concern(s): _____
_____
_____

Briefly describe your/your child's goal(s) for therapy: _____
_____
_____

Family and Psychological History:
Please list all of the child's immediate family members. If there is more than one household, check the box on the right to indicate who is residing in the house with the child.

Name: _____ Age: _____ Relationship:_____ ☐
Name: _____ Age: _____ Relationship:_____ ☐
Name: _____ Age: _____ Relationship:_____ ☐
Name: _____ Age: _____ Relationship:_____ ☐
Name: _____ Age: _____ Relationship:_____ ☐
Name: _____ Age: _____ Relationship:_____ ☐
Name: _____ Age: _____ Relationship:_____ ☐
Name: _____ Age: _____ Relationship:_____ ☐

Please indicate the child's parent's marital status: Single ☐ Engaged ☐ Living w/partner ☐
Married ☐ (Date: _____) Divorced ☐ (Date:_____) Separated☐ (Date:_____)
Widowed ☐ (Date:_____) Remarried ☐ (Date: _____)

Are any of the child's parents deceased? Yes ☐ No ☐ If yes, who?
☐bio mother ☐bio father ☐stepmother ☐stepfather ☐adoptive parent(s) ☐foster family ☐ Other
How old was the child at the time of death(s): _____

Is there any history of alcoholism or drug abuse in the child's family of origin? Yes ☐ No ☐ If yes, who?
☐bio mother ☐bio father ☐stepmother ☐stepfather ☐Sibling ☐Other relative_____

Is there any history of mental health issues in the child's family of origin? Yes ☐ No ☐ If yes, who?
☐bio mother ☐bio father ☐stepmother ☐stepfather ☐Sibling ☐Other relative_____

Has your child ever attempted suicide? Yes ☐ No ☐ If yes, when?_____
Please explain: _____
Has your child ever engaged in any self-injurious behavior? Yes, currently ☐ Yes, in the past ☐ No ☐
Please explain: _____

Is your child a survivor of childhood sexual abuse? Yes ☐ No ☐
Is your child a survivor of childhood physical abuse? Yes ☐ No ☐
Is your child a survivor of childhood emotional abuse? Yes ☐ No ☐
Has your child ever been sexually assaulted? Yes ☐ No ☐
Has your child ever had any other traumatic experiences? Yes ☐ No ☐ If yes, please explain: _____
_____

Does your child use alcohol and/or drugs? Yes ☐ No ☐ If yes, please describe your child's use: _____
_____

Medical and Medication History:
Does your child have any significant health concerns and/or impairments or disabilities? Yes ☐ No ☐
If yes, please identify: _____
_____

Is your child <u>currently</u> taking any prescription medication(s) for mental health reasons? Yes ☐ No ☐
If yes, please identify: _____

Has your child ever taken any prescription medication(s) for mental health reasons <u>in the past?</u> Yes ☐ No ☐
If yes, when?: _____Medication: _____

Past Counseling and/or Treatment History:
Has your child ever been in counseling or psychotherapy before? <u>Or</u> have you received outpatient mental health and/or chemical dependency treatment in the past? Yes ☐ No ☐
If yes, please provide the date(s) of counseling/treatment and briefly explain the nature of that treatment:
From _____ to _____ Reason: _____ Where:_____
From _____ to _____ Reason: _____ Where:_____
From _____ to _____ Reason: _____ Where:_____
From _____ to _____ Reason: _____ Where:_____

Has your child ever been hospitalized for mental health reasons, including chemical dependency?
Yes ☐ No ☐ If yes, please provide the dates, reasons, and what hospital:
From _____ to _____ Reason: _____ Where:_____
From _____ to _____ Reason: _____ Where:_____
From _____ to _____ Reason: _____ Where:_____

Is your family currently seeing any counselors, social workers, psychologists, psychiatrists, alcohol or drug counselors or other therapists, and/or are you currently receiving social services of any kind? Yes ☐ No ☐
If yes, whom are you seeing and what clinic or agency do you go to?
Name: _____ Agency:_____
Name: _____ Agency:_____
Name: _____ Agency:_____

Is your child currently involved in any legal issues? Yes, parents divorcing ☐ Yes, custody issue ☐
Yes, other ☐ No ☐ If yes, please explain:

_____

_____

Developmental History:
Were there any difficulties in the child's pregnancy, labor, or infancy? Yes ☐ No ☐ If yes, what?_____

_____

Any developmental problems with your child? Yes ☐ No ☐ If yes, what?_____

_____

Social and Other History:
What activities does your child participate in for physical exercise?_____

_____

What activities does your child participate in for leisure (hobbies, recreation, relaxation, etc.): _____

_____

_____

Do you practice any religious or spiritual beliefs? Yes ☐ No ☐ If yes, what? _____

Check the following places your child finds social connection and/or support: ☐ Parents ☐ Siblings
☐ Significant other ☐ Friends ☐ Other relatives ☐ Faith community ☐ Work ☐ School
☐ Other: _____ ☐ Other: _____ ☐ Other: _____

Child Problem Checklist:

The following is a list of problems and symptoms that children experience. Please check those that your child has experienced over the past month.

- ☐ Crying more than usual
- ☐ Loss of interest or pleasure in activities
- ☐ Decrease or increase in appetite (circle)
- ☐ Fatigue or low energy level
- ☐ Concerns about eating
- ☐ Feelings of hopelessness
- ☐ Feelings of worthlessness
- ☐ Difficulty concentrating
- ☐ Suicidal thoughts
- ☐ Thoughts of harming others
- ☐ Anxiousness
- ☐ Worried about health
- ☐ Fears
- ☐ Trouble falling or staying asleep
- ☐ Depressed mood
- ☐ Compulsion to do things
- ☐ Socially withdrawn
- ☐ Trouble with memory
- ☐ Outburst of anger
- ☐ Legal difficulties or problems with the law
- ☐ Disturbing thoughts
- ☐ Fear of losing control
- ☐ Trouble making decisions
- ☐ Dizzy or unsteady feelings
- ☐ Irritable
- ☐ Getting along with others
- ☐ Difficulty following directions
- ☐ Difficulty going to school
- ☐ Other: _____

Strengths:

Please check which of the following items describe your child's strengths:

- ☐ Hard worker
- ☐ Patient
- ☐ Learns from experience
- ☐ Athletic
- ☐ Healthy
- ☐ Physically strong
- ☐ Courageous
- ☐ Responsible
- ☐ Honest
- ☐ Creative
- ☐ Enthusiastic
- ☐ Adaptable
- ☐ Flexible
- ☐ Not easily upset
- ☐ Cheerful/Optimistic
- ☐ Follows directions
- ☐ Persistent/Determined
- ☐ Assertive
- ☐ Average or (+) Intelligence
- ☐ Good memory
- ☐ Liked by others
- ☐ Outgoing
- ☐ Caring
- ☐ Thoughtful
- ☐ Seeks support from others
- ☐ Can compromise and share
- ☐ Helpful, supportive
- ☐ Accepts comfort and guidance
- ☐ Feels capable
- ☐ Other: _____