Healthwise
behavioral health & wellness

PHONE: 763.400.7828
FAX: 763.400.7444
WWW.BEHAVIORALHEALTHMN.COM

REGISTRATION INFORMATION

How did you hear about us?

CLIENT INFORMATION

Patient Name	Date of Birth	Gender ❑ Male ❑ Female ❑ Other
Street Address	City/State/Zip	
Home Phone / Cell Phone	Email Address	May we contact you by ❑ Phone ❑ Email ❑ Both
Marital Status ❑ Single ❑ Married ❑ Partnered ❑ Separated ❑ Divorced ❑ Widowed ❑ Other	Employer / Occupation	

EMERGENCY CONTACT

Emergency Contact Name	Phone	Relationship to Patient

RESPONSIBLE PARTY (IF DIFFERENT THAN CLIENT)

Billing Full Name	Relationship to Client ❑ Legal Guardian ❑ Spouse ❑ Parent of 18+ Dependent ❑ Other
Billing Address City/State/Zip	
Billing Phone Leave Message? ❑ Yes ❑ No	E-mail Address OK to send receipts or statements via email? ❑ Yes ❑ No

INSURANCE INFORMATION Copy of both sides of the insurance card(s) needed at intake

Primary Insurance Company	Secondary Insurance Company
Policy ID# Group#	Policy ID# Group#
Claims Address City/State/Zip	Claims Address City/State/Zip

ALL COPAYS AND BALANCES ARE DUE IN FULL AT THE TIME OF YOUR APPOINTMENT

Policies with a Deductible or Out of Network Insurance Coverage REQUIRE a Credit Card on File			Do you have a HSA Credit Card? Note: A deductible REQUIRES a non-HAS credit card on file as a back-up to any HAS card.		
❑ Visa ❑ Mastercard ❑ Discover ❑ American Express	Exp Date	CVV Code	❑ Visa ❑ Mastercard ❑ Discover ❑ American Express	Exp Date	CVV Code
Card Number			Card Number		
Card Holder Name			Card Holder Name		
I hereby give consent to charge my credit card above for any outstanding balance such as deductibles, co-payments, fees or other amounts my carrier determines as payable by me.			I hereby give consent to charge my credit card above for any outstanding balance such as deductibles, co-payments, fees or other amounts my carrier determines as payable by me.		
Card Holder Signature Date			Card Holder Signature Date		

PRIVATE PAY: Payment due in FULL at the time of service

Service Description	Rate/Unit $_____/ _____

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your health record contains personal information about you and your health. This information, which may identify you and relates your past, present, or future physical or mental health or condition and related health care services, is referred to as Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy our on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to quality assessment activities, employee review activities, remind you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Abuse and Neglect	Judicial & Administrative Proceedings
Emergencies	Law Enforcement
National Security	Public Safety (Duty to Warn)

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)
- Required by Court Order
- Necessary to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures are not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to Healthwise Behavioral Health & Wellness:

Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.

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Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

Breach Notification. If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

Right to a Copy of this Notice. You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy officer, at Healthwise Behavioral Health & Wellness, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619.0257. **We will not retaliate against you for filing a complaint**.

Notice of Privacy Practices Receipt and Acknowledgment of Notice

Patient/Client Name: DOB:

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Healthwise Behavioral Health & Wellness Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer at 11280 86th Ave, Maple Grove, MN 55369.

Signature of Client: Date:

Signature of Parent, Guardian or Personal Representative: Date:

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, parent, etc.) Please print name and authority.

❑ **Patient/ Client Refuses to Acknowledge Receipt:**

Signature of Staff Member: Date:

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COUNSELING POLICIES

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating you have fully read and understand the information below.

CONSENT TO TREATMENT

- Psychological services include consultation services regarding behavioral, developmental, or emotional concerns; which provides diagnostic clarification and treatment recommendations, and psychotherapy; which has been shown to have benefits in the reduction of feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. There are no guarantees or assurances of what you will experience.
- Providers are often not immediately available by telephone. A message may be left with the front desk or on the provider's confidential voicemail. Every effort to return your call within a reasonable time is made during business hours. In the event of an emergency, contact your family physician, call 9-1-1, or proceed to the nearest emergency room.

ASSIGNMENT OF BENEFITS / PAYMENT FOR SERVICES

- There is a standard fee for professional services. Please ask for a fee schedule for details.
- Insurance will be billed for services. Insurance may or may not cover the services provided at Healthwise. You are responsible for the amount due for any services not covered by your insurance plan. I understand that I am financially responsible for all charges.
- Insurance companies require a formal diagnosis with their claims. Diagnoses are technical terms that describe presenting concerns.
- Any checks returned to the office are subject to an additional fee of $25.00.
- Past due accounts more than 60 days will be turned over to a collection service or small-claims court.
- Healthwise will bill your insurance company for your appointments. If you do not pay your deductible, co-pay, or co-insurance at the time of your appointment, we will send you a billing statement. Any statement amount that you do not pay in full via the due date of that statement will be charged to the credit card on file. **It is our office policy to have a credit card number on file.**
- If your account is sent to collections for non-payment, there will be a 33.33% fee added to the outstanding balance to cover incident collection costs.

CONFIDENTIALITY

- Healthwise Behavioral Health & Wellness follows all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.
- Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all person mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentially that may result.
- Healthwise Behavioral Health & Wellness is a group practice and may share responsibility for and information about clients only within the practice. However, we do not share any personal or clinical information with outside parties without proper consent of the client. Confidentiality is taken very seriously and strictly adhered to at Healthwise Behavioral Health & Wellness. We ask that you also protect the privacy of other clients you may encounter in the waiting room or in a group therapy setting.

FINANCIAL POLICY

- Services provided by Healthwise are billed on an hourly basis. Charges are submitted under the client's name. If a child is the client, billing is submitted under the child's name.
- Services provided at Healthwise may be covered under the mental health benefits of your health insurance contract. Educational services are not covered. We do not submit claims for these visits.
- If we are billing your primary health insurance company, we will attempt to gather information about your mental health benefits. However, this information does not guarantee payment. If your insurance plan does not cover a service, a procedure, or a diagnosis, you are responsible for these charges.

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- We collect payment to meet your deductible, if applicable, and copayments/coinsurance amounts on the day of your appointment. The agreement with your insurance carrier is a contract between you, your insurance company and, in some cases, your employer. Please remember, billing insurance is not a guarantee of payment. **A current credit card number on file is required.**
- Financial arrangements between divorced parents must be handled independently of Healthwise. Although court orders may assign responsibility for a child's healthcare expenses to one parent or another, we, as mental health providers, are not bound by the terms of such court orders. In cases of divorce, the parent seeking service is responsible for the account. If the other parent holds the insurance, they must complete the appropriate consent and acknowledgement forms to give us permission to bill the health insurance. Fees due on the day of an appointment must be collected at every visit regardless of who brings a child to the appointment.
- We will bill a patient's primary insurance carrier if we are provided current and correct information. Accounts unpaid after 30 days will be assessed a re-billing charge. Please notify us prior to your next appointment if you have a change in insurance.
- Accounts with balances owing after 60 days will be referred for collection action. To avoid collection action and re-billing charges you will be asked to provide a credit card number. This will be kept on file and can be used to settle the balance. We make every attempt to contact you prior to charging an unpaid balance.
- Payment can be made with a check, cash, Mastercard, Visa or Discover. Please make checks payable to Healthwise. We cannot guarantee that your HSA, HRA or Benefits credit card will work in our office. Please call ahead to make a payment arrangement for teenagers coming on their own. Please call our Billing Office at (763) 400.7828 if you need a printout of your account or to answer any questions.
- In the event of non-payment of charges, Healthwise shall be entitled to recover all costs and expenses incurred in seeking collection of such charges, including, without limitation, court costs and reasonable attorney's fees, whether such claims are pursued through court proceedings, appellate or bankruptcy proceedings, arbitration, and/or mediation.
- We are not obligated to provide continuing services in the event that Healthwise Behavioral Health & Wellness is named as a creditor in any bankruptcy filing.

MISSED APPOINTMENTS & CANCELLATION POLICY

- If you cancel an appointment and do not provide at least 24 hour notice, you will be charged a late cancellation fee of $50 for your appointment. Please note insurance does not cover missed appointments.
- If you do not show for your scheduled appointment, you will be charged a no-show fee of $85 for your appointment. Please note insurance does not cover missed appointments.

This policy is designed to protect our providers' time, not to penalize our clients financially. When an appointment is made with one of our providers, that time is booked and is no longer available for scheduling. Late cancellation and no show appointments are rarely filled due to lack of advance notice and result in a loss of our providers' time. Payment for late cancel or no show appointments is to be made before the next appointment.

UNATTENDED CHILDREN: We are unable to provide supervision for children in the waiting room and cannot accept responsibility for their safety if left unattended. For the safety and welfare of the children and out of consideration for others, please make arrangements for childcare during therapy sessions, or provide adult supervision for children while waiting in the waiting room. Parents will be held responsible for any property damage caused by their child.

COURT & LEGAL PROCEEDINGS

- Should we be called to court by a judge court order, or our records court ordered or subpoenaed, we will charge the full amount applicable under law for our services. Copies of records are available for a $20.00 processing fee.
- In the event that it is necessary, by court order or by subpoena, for the therapist to testify before any court, arbitrator, or other hearing officer to testify at a deposition, whether the testimony is factual or expert, or to present any or all records pertaining to the counseling relationship to a court official, the client agrees to pay the therapist for his or her services, (including but not limited to: travel, necessary expenditures (copies, parking, meals, and the like), time spent speaking with attorneys, reviewing records and preparation of reports) @ the rate of $250.00 per hour, rounded to the nearest half hour.
- The client further agrees to pay a retainer fee of $2,000.00 two weeks prior to the appearance, presentation of records, or testimony requested. Checks will not be considered an acceptable form of payment for these services.
- Court ordered psychological and neuropsychological evaluations are an out-of-pocket cost of $1500. The amount is due in full at the time of service. Checks will not be considered an acceptable form of payment for these services.

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IMPORTANT SIGNATURES

By signing this Counseling Policy form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, Healthwise Behavioral Health & Wellness will not render services to your child until the Therapist has received and reviewed a copy of the most recent applicable court order.

Client/Parent Signature: Date:

Therapist Signature: Date:

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

Client/Parent Signature: Date:

I authorize the payment of medical benefits to the provider of services.

Client/Parent Signature: Date:

I authorize the use of my email/phone number for contact related to appointment reminders.

Client/Parent Signature: Date:

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CONSENT FOR TREATMENT OF A MINOR

- We/I, the undersigned _____ parent(s) and/or guardian(s) of a minor child _____DOB:_____, give you full and unconditional authority to proceed with a clinical evaluation and treatment as your judgment indicates. This consent is given by me/us as parent(s) and/or guardian(s) of said child. We/I have legal power to consent to medical, psychological, and mental health assessment and treatment of said minor child. It is clearly understood that you are hereby fully released from any claims and demands that might arise, or be incident to the evaluation and/or treatment, provided that your duties are performed with standard care and responsibility to the best of your professional ability.
- Financial arrangements between divorced parents must be handled independently of Healthwise Behavioral Health & Wellness. Although court orders may assign responsibility for a child's healthcare expenses to one parent or another, we, as mental health providers, are not bound by the terms of such court orders. In cases of divorce, the parent seeking service is responsible for the account. If the other parent holds the insurance, they must complete the appropriate consent and acknowledgement forms to give us permission to bill the health insurance. Fees due on the day of an appointment must be collected at every visit regardless of who brings a child to the appointment.

Signature of Parent/Guardian: Date:

Mother or Guardian's Name (Please Print):

Father or Guardian's Name (Please Print):

Step Mother/Significant Other/Guardian (Please Print):

Step Father/Significant Other/Guardian (Please Print):

If parents are divorced, please provide a copy of legal documentation for child custody and proof of legal guardianship. Who is the legal guardian of the child?

_____

If parents are divorced, who has physical custody of the child?

_____

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YOUTH INFORMATION FORM

Child's Name: Date

Reason for referral: what are your primary concerns?_____

_____

_____

_____

MEDICAL HISTORY

Name of Primary Care Physician: _____ Physician's Phone:_____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? ❑ Yes ❑ No Please sign here for either answer:_____

Date of Last medical evaluation: _____ Date of next appointment:_____

Current Medications being taken: Prescribed by: _____

Medication	Dosage/Freq	Start Date	Purpose
1.)			
2.)			
3.)			
4.)			

Has your child ever been hospitalized for medical or psychiatric reasons? ❑ Yes ❑ No

Hospital	Mo/Yr	Reason
1.)		
2.)		
3.)		

Describe all important medical history, chronic ailments, or other health problems your child has experienced: _____

_____

_____

Describe all health problems or important medical history about your child's immediate family members and close relatives, including chronic ailments: _____

_____

_____

_____

Does your child have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: _____

_____

_____

_____

Does your child frequently complain of or have problems with (check all that apply):

❑ Headache ❑ Dizziness ❑ Stomach Aches ❑ Weakness ❑ Nausea ❑ Diarrhea ❑ Fatigue ❑ Wetting/soiling Accidents ❑ Muscle Tension

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Family Medical History: Has anyone in your child's immediate family had any of the following?

	Yes	Who	Explain
Neurological Disease			
Seizures			
Psychiatric Problems			
Alcoholism Problems			
Substance Abuse Problems			
Hyperactivity			
Learning Problems			
Autism Spectrum Disorders			

SCHOOL AND FAMILY HISTORY

Does your child experience any developmental, academic, or behavior problems as a child or while in school, with peers or teachers?

❑ Yes ❑ No If yes please explain: _____

_____

Grade in school (or last grade completed if not currently in school):_ _____

What school does your child attend? _____ For how many years? _____

Is your child home-schooled? ❑ Yes ❑ No

Please describe your child's current support network? (include friends, relatives, etc.): _____

_____

Please check all information which applies to your child's biological parents:

Mother	Father
❑ Living ❑ Deceased ❑ Married ❑ Divorced ❑ Remarried	❑ Living ❑ Deceased ❑ Married ❑ Divorced ❑ Remarried

With whom does your child live: _____

What custody and/or visitation orders are in place? _____

Who has legal custody? _____

Does your child consider anyone else to be a "parent" in his/her life? ❑ Yes ❑ No If so, whom? _____

Describe your relationship with your child in the past: _____

_____

Currently: _____

Describe your child's relationship with his/her other parent in the past: _____

_____

Currently: _____

List first names and ages of your child's brothers and sisters:

Name	Age	Relationship (biological/step)	Lives with

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Describe your child's family relating to past or present:

Alcohol/ drug abuse: _____

_____

_____

Sexual/physical/emotional abuse: _____

_____

_____

MENTAL STATUS

Please check any of the following that describe how you believe your child has been feeling lately:

❑ Sad ❑ Anxious ❑ Depressed ❑ Frightened ❑ Guilty ❑ Angry ❑ Ashamed ❑ Aggressive ❑ Resentful ❑ Worthless ❑ Tearful

❑ Irritable ❑ Confused ❑ Extreme Ups/Downs ❑ Jealous ❑ Hopeless ❑ Helpless

Describe any behaviors your child has demonstrated that cause concern: _____

_____

Has your child had any change in sleeping habits? ❑ Yes ❑ No Describe: _____

_____

Has your child had any change in eating habits? ❑ Yes ❑ No Describe: _____

_____

Has your child ever considered suicide in connection with his/her **current** problem? ❑ Yes ❑ No

If so, please give a brief description with dates: _____

Has your child ever **considered suicide** in the **past**? ❑ Yes ❑ No

Has your child **attempted suicide recently** or in the **past**? ❑ Yes ❑ No

If so, please give a brief description with dates: _____

Has your child tried to hurt others or animals recently or in the past? ❑ Yes ❑ No

If yes, please explain: _____

_____

LEVEL OF FUNCTIONING

Please describe what activities your child participates in: _____

_____

Please describe your child's level of physical activity: _____

_____

How much time does your child play on the computer, watch TV, or play video games: _____

_____

Is there any other information regarding your child that you would like to share with your child's Therapist that is not covered on this form? You may also use this space to complete earlier responses.

_____

_____

_____

_____

Please list your therapy goals for your child:

_____

_____

_____

_____