northwinds
counseling services, p.a.

21395 John Milless Drive I Suite 400 I Rogers, MN 55374
Phone: 763.424.1888 I Fax: 763.424.7288
www.northwindscounseling.com

Welcome to
Northwinds Counseling Services P.A.

Our professional staff is highly skilled in caring for adults, adolescents and children, and is dedicated to serving your special needs and concerns. In a setting that is caring, supportive and ethical, we work to empower individuals, couples and families to manage their own well-being.

Patient Satisfaction
Thank you for trusting our ability to provide you with appropriate, high quality care. We make every effort to treat each client with respect and dignity regardless of race, beliefs, national origin, and source of payment, age, religion, disability, or sexual preference.

If you experience a problem with any service or staff person, please discuss this with your therapist. If the situation is not resolved, or if the nature of the concern prohibits such discussion, please contact Kevin Smith at: (763) 424-1888. The professional licensing board is also available to you.

Financial Responsibility
We request payment/co-payment at the time of service. We will submit insurance claims on your behalf. Some insurance plans limit the number of sessions covered so you will want to understand the benefits available to you. We are providers for most major insurance companies. However, if we are an out-of-network provider, you will want to check your out-of-network benefits with your insurance company.

Initial Appointment
Your first appointment will take approximately one hour. During this appointment, you can discuss your situation and concerns with a mental health professional. After this initial appointment, an assessment and recommendation for treatment will be made.

Confidential Information
Information you furnish to Northwinds Counseling Services is confidential according to the Minnesota Access to Health Records Statute. This means that only you and your assigned therapist have access to information in your medical chart. No treatment information will be released to persons, schools, or agencies without your consent, except by court order.

In some cases, it might be appropriate to coordinate your care with your primary care physician. If so, you will be asked to give your written permission. For those who are using insurance, your insurance company may require diagnostic information from Northwinds Counseling Services prior to providing payment for services.

By law, these are the exceptions to confidentiality:

- Health care providers are required by law to report cases of known or suspected abuse or neglect of children or vulnerable adults.
- In cases of threatened homicide or serious harm, the police and possible victim must be notified.
- In cases of threatened suicide, the police will be called.
- By law, information concerning dependent minors is accessible to the parents unless it is determined that such access would be harmful to the minor.

Clients under the age of 18:
All non-emancipated minor clients under the age of 18 years old must have the consent of their parents following an initial intake session to receive further services. These rights may be waived when a minor's life or health is believed to be at risk, the minor is emancipated, or when in need of services relating to pregnancy, VD, or substance abuse.

As a patient at Northwinds Counseling Services, you have the right to:

- Courteous and respectful treatment.
- A safe and comfortable environment.
- Appropriate behavioral health care.
- A clear explanation of your diagnosis and treatment plan.
- Privacy and confidentiality.
- Participate in planning your care.
- Refuse behavioral health treatment.
- Be free from discrimination based on your religion, race, gender or culture.
- Register complaints.
- Access to your records as provided by law.

You are asked to:

- Treat staff with respect.
- Ask questions about your care.
- Tell your therapist everything you can about your condition, including all symptoms, medications, and past medical history.
- Pay your bills on time.
- Keep appointments or give at least 24 hours' notice if you need to cancel your appointment.
- Let the therapist know about any changes in your symptoms, medications or general condition.
- Treat clinic property with care.

Emergency Procedures:
For emergency situations you can call 911, the Crisis Connection at (612)379-6363, or present at the local hospital emergency room.

Business Services:

- Most therapeutic sessions will be 50 minutes in length. Longer sessions may be advisable based on the need and the therapeutic methods being used.
- Therapists will return calls within 24 hours with the exception of weekends
- Phone consultations with the therapist that exceed 10 minutes in length will be billed as a session and charge based on the time spent.
- Your scheduled session is time dedicated for you. Thus, you are expected to be here for each session that you schedule. A $60 fee may be charged for sessions that are missed or cancelled without 24 hours' notice.

Notice of Information Practices

What is "Medical Information"?
The term "medical information" is synonymous with the terms "personal health information" and "protected health information" (PHI) for purposes of this Notice. It essentially means any individually identifiable health information (either directly or indirectly identifiable). Whether oral or recorded in any form or medium, that is created or received by a health care provider (Northwinds Counseling Services), health plan, or others and relates to the past, present, or future physical or mental health or condition of an individual (you): the provision of health care (e.g. mental health) to an individual (you); or the past, present, future payment for the provision of health care to an individual (you).

Northwinds Counseling has mental health providers from the fields of Psychology and Marriage and Family Therapy. Northwinds creates and maintains treatment records that contain individually identifiable health information about you. These records are generally referred to as "medical records" or "mental health records", and this notice, among other things, concerns the privacy and confidentiality of these records and the information contained therein.

Uses and Disclosures Without Your Authorization — For Treatment, Payment, or Health Care Operations
Federal privacy rules (regulations) allow health care providers (Northwinds Counseling) who have direct treatment relationship with the patient (you) to use or disclose the patient's personal health information, without the patient's written authorization, to carry out the health care provider's own treatment, payment, or health care operations. We may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization.

Uses and Disclosers of Your Protected Health Information That Require Your Authorization
In addition to our use of your health information for treatment, payment or healthcare operations, you may give Northwinds Counseling written authorization, to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Uses and Disclosures Authorized by Law that Do Not Require Your Consent, Authorization or Opportunity to Agree of Object
I may use or disclose PHI without your consent or authorization in the following circumstances:

1. When the use and/or disclosure is authorized or required by law.
2. When the use and/or disclosure is necessary for public health activities. For example, we may disclose PHI about you if you have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.
3. When the disclosure relates to victims of abuse& neglect or domestic violence.
4. When the use and/or disclosure is health oversight activities. For example, we may disclose PHI about you to a state or federal health oversight agency which is authorized to oversee our operations.
5. When the disclosure is for judicial and administrative proceedings. For example, we may disclose PHI in response to a court order or administrative tribunal.
6. When the disclosures are for law enforcement purposes. For example, we may disclose PHI to comply with laws that require the reporting of certain types of wounds or physical injuries.
7. When the use and/or disclosure relates to decedents. For example, we may disclose PHI to a coroner or medical examiner, consistent with applicable laws, to carry out their duties.
8. When the use and/or disclosure relates to cadaver, organ... eye, or tissue donation purposes. Consistent with applicable law, we may disclose health information to the organ procurement organizations or other entities engaged in the procurement, banking, or transplanting of organs for the purposes of tissue donation and transplant.
9. When the use and/or disclosure relates to Worker's Compensation. We may disclose relating to workers compensation or other similar programs established by law.
10. When the use and/or disclosure is to avert a serious threat to health or safety. For example, we may disclose P1-IT to prevent or lesson a serious and imminent threat to the health and safety of a person or the public.
11. When the use and/or disclosure relates to specialized government functions. For example, we may disclose PHI if it relates to military and veterans' activities, national security and intelligence activities, protective services for the President, & medical suitability or determinations of the Department of State.
12. When the use and/or disclosure relates to correctional institutions and in other law enforcement custodial situation. For example, in certain circumstances, we may disclose PHI about you to a correctional institution having lawful custody of you.

Client's Rights Regarding Protected Health Information

1. **Right to Request Restrictions** — You have the right to request restrictions on certain uses of disclosures of protected health information. However, I am not required to agree to a restriction you request.

2. **Right to Inspect and copy** — You have the right to inspect and obtain a copy of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Under certain circumstances, I may deny your access to PHI, but in some cases, you may have this decision reviewed.
3. **Right to Receive Confidential Communications by Alternative Means and Alternative Locations.** For example, you may not want a family member **to** know you are seeing me. On your request, I will send your bills to another address.
4. **Right to Request Amendment to PHI** — Your request must be in writing and must explain your reasons for the amendment and when appropriate to provide supporting documentation. I may deny your request under certain circumstances.
5. **Right to Request Accounting Disclosures of PHI** — You have the right to a listing of certain disclosures we have made of you PHI. You must request this in writing.
6. **Right to Receive a Copy of This Notice** — You have the right to request a paper copy of this Notice at any time. I will provide a copy of this Notice on the date you first receive service from me (except when the first contact is not in person, and then I will provide the Notice as soon as possible).

Questions or Complaints

If you have questions and would like additional information, you may contact Kevin Smith, Owner of Northwinds Counseling Services at (763)424-1888. There will be no retaliation for filing a complaint. You may also send a written complaint to the US Department of Health and Human Services: 200 Independence Avenue*SW Room 509F, HHH building* Washington D.C. 20201

If you are concerned that Northwinds Counseling has violated your privacy rights, or you disagree with a decision we made about access to your records, you may further discuss this with your therapist. If the issued is not resolved with your therapist, you may appeal directly to the clinic director for additional consideration, review and action in resolving the issue. Any client may also appeal to any of the following agencies if the matter is not satisfactorily resolved within the clinic setting.

Northwinds Counseling Services Client Registration

Date _____ Therapist _____ DX _____

Patient Information

Patient Name (Print)_____ **Date of Birth** _____
Last Name First Name Initial

Street Address_____Cell/Home Phone _____

City_____State_____ZIP_____Work Phone _____

Email:_____

Soc. Sec. #_____Emergency Contact_____Emergency Phone _____

Sex: G Female G Male Age_____ Marital Status: G Single G Married G Widowed G Divorced G Separated G Other

Employer _____Occupation_____

Referred by_____May we acknowledge this referral?_____

Primary Insurance

Primary Insurance Company_____ Phone _____

Ins Claims Address_____City_____State_____Zip_____

Policy / Member ID _____ Group/Account #_____

Policy Holder Information: (if the patient is not the employee/policy holder)

Name_____ **Date of Birth** _____
Last name First Name Initial

Address_____City_____State_____Zip_____Relationship_____

Soc. Sec#_____Employer_____

Secondary Insurance

Secondary Insurance Company_____ Phone_____

Ins Claims Address_____City_____State_____Zip_____

Policy / Member ID _____ Group/Account #_____

Policy Holder Information: (if the patient is not the employee/policy holder)

Name_____ **Date of Birth** _____
Last name First Name Initial

Address_____City_____State_____Zip_____Relationship_____

Soc. Sec#_____Employer_____

Responsible Party (Where should the patient's portion of the bill be sent, if not to the patient?)

Name _____Relationship _____

Address_____Phone _____

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

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Consent to Use Disclosure of Healthcare Information for Treatment, Payment or Healthcare Operations

This notice describes how Psychological and Medical information about you may be used and disclosed. Please review it carefully.

By signing this statement, I understand that as a part of my health care, Northwinds Counseling Services originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. This information could serve as:

- A basis for planning my care and treatment
- A means of communication among authorized health professionals who contribute to my care
- A source for applying my diagnosis information when filing a claim to my insurance
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

Informed Consent for Confidentiality

1. If anyone requests information about me, my therapist will not give it unless and until I have signed a separate written authorization for her/him to do so. My therapist will not discuss anything about me with anyone without my written permission, except as noted here:
    A. If I use insurance benefits, my therapist and Northwinds Counseling cannot guarantee confidentiality from the insurance company.
    B. If my therapist learns that I have abused a child, a spouse, or vulnerable adult (or if I am a child, spouse, or vulnerable adult and report having been recently abused), she/he must report it to the proper authority.
    C. If my therapist has good reason to believe that I intend to physically harm myself or someone else, she/he will discuss it with me and may be required to warn that person or persons (the Tarasoff duty), or to take steps to prevent such harm by notifying the authorities.
    D. If my therapist has good reason to believe that I may be a danger to myself, she/he will contact at least one concerned person and/or take steps to prevent such harm by notifying the authorities.
    E. If I give permission to release my records to a legal representative of my choice, these records could become discoverable by other legal representatives. If subpoenaed by the courts to release your records, we may have to do so.
    F. My therapist may discuss my case with Northwinds clinicians and/or other outside professional case consultation groups. Identifying information (such as full name) will not be shared without written permission.
    G. Northwinds Counseling is in compliance with the State Department of Human Services which has the right to review all cases. DHS must abide by all rules of confidentiality.
2. All non-emancipated minor clients under the age of 18 years old must have the consent of their parent(s)/guardian following an initial intake session to receive further treatment services. Exceptions to this rule are when a minor is seeking services related to pregnancy, venereal disease or substance abuse.

I understand that as part of Northwinds Counseling Services' treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of all information uses and disclosures. I fully understand and accept the terms listed in that document including my rights and privileges as a client of Northwinds Counseling Services.

_____ / _____Client's
Signature Legal Guardian /Relation to Client Date

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PAYMENT AGREEMENT

Payment Agreement – I understand that I am ultimately responsible for the payment of therapeutic services rendered. If you plan to use your private insurance, it is important to provide your therapists with the proper information required to submit insurance claims on your behalf. All out of network services, insurance deductibles and co-payments are the responsibility of the client.

Cancellation Policy – After an appointment is set, the appointment times is placed on hold and no longer open to other client's seeking appointments at the time. Therefore, Northinds requires at least a 24-hour notice of cancellation in order to best serve all clients. In the case of cancels or missed appointments, Northwinds reserves the right to charge the full amount but instead a **$100 fee will apply**. There is no charge in the case of emergencies. Please note-insurance companies will not pay for missed therapy appointments.

Past Due Accounts – An account is considered past due after the 60-day grace period. Accounts with a balance over $400 or 4 sessions that remain unpaid may be at risk of being placed on hold. If you are unable to pay the full amount, please discuss a payment plan with your therapist.

Rates – Please note these services charges might not accurately reflect negotiated insurance or in-network contracted rates.

- 90791- Diagnostic Session: $200.00
- 90832 - 30 Minute Individual/Couple Session: $90.00
- 90834 - 45 Minute Individual/Couples Session: $135.00
- 90837 - 60 Minute Individual/Couples Session: $180.00
- 90853 – Group Session: $65.00
- 90847/90846 – Family Sessions: $180.00
- Court Appearances and report preparations are charged at the hourly session rate of $180.00. Time will include drive time to and from court.

I understand and agree to the above conditions.

_____ /_____

Signature | Legal Guardian /Relation to Client | Date

Revised 2.5.2019

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CREDIT CARD AUTHORIZATION AGREEMENT

I authorize Northwinds Counseling Services, P.A to keep my signature and credit card information on file. I understand that this information will be stored in a secure file. My credit card listed below will be charged for any balance applied to the account that is:

___Session Fee

___Past due balance greater then 30 days from date of service

___Co-Pay in the amount of $_____

Client Account Name and Number _____

Credit Card Information:

( ) Visa ( ) Mastercard ( ) Discover ( ) American Express

Cardholder Name:_____

Billing Address:_____

City:_____State: _____Zip Code:_____

Credit Card #:_____

Expiration Date:_____/_____(mm/yy)

V-Code (the last 3 digits in the signature block on Visa & Mastercard):_____

I understand and agree to the above conditions.

_____	_____	
Cardholder Signature	Legal Guardian /Relation to Client	Date
_____	_____	
Therapist Name	Therapist Signature	Date

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Personal History Form - Adult

Name:_____Age:_____D.O.B._____Gender: M F

Primary reason(s) for seeking services:

____ Depression ____Anxiety ____Alcohol/drugs ____Anger management
____ Coping ____Fear/phobias ____Behavior Problems _____Martial issues/conflict
Other _____

Please circle behaviors and symptoms that are problematic: Hallucinations Attention Deficit
Aggression Worrying

Anxiety	Heart Palpitations	People avoidant	Trouble concentrating
Depression	Recurring Thoughts	Disorientation	Sexual problems
Alcohol problems	Irritability	Cyber addiction	Antisocial behavior
Fatigue/Tired	Impulsivity	Speech problems	Sleep problems
Panic attacks	Distractibility	Gambling problems	Fears/phobias
Anger	Chest pain	Sick often	Self-injury/behavior
Hopelessness	Loneliness	Alcohol/Drug issues	Memory problems
Suicidal thoughts	Mood Swings	Eating issues	Withdrawing/isolating

Do you feel suicidal at this time? Yes or No Do you have a plan if you are suicidal? Yes or No
Briefly describe how the symptoms impair your ability to function effectively. _____

_____
_____

Please include any additional information that would assist us in understanding your concerns and problems?

_____
_____
_____

Have you recently experienced any that follow?

Recent death or birth in the family	Accident, fire, disaster	Separation or divorce
Job loss or change	Arrest or DUI	Major Financial Problems
Change in living arrangements	Physical/emotional abuse	Sexual abuse or assault
Thoughts/acts of violence to others	Thoughts/acts of hurting self	Custody issues
Pregnancy, miscarriage, abortion	Diagnosis of major illness	Significant relationship discord

Parental Information (circle)

Parents legally married Parents never married Parents divorced at what age (yours) _____
Special circumstances (e.g., raised by person other than parents, information about spouse/kids not living with you etc.): _____

Marital status (circle):

Single Years living together ____ Years legally married ____ Years widowed _____
Divorcing Months separated _____ _____ Number of marriages _____
Years divorced _____

Assessment of current relationship: good fair poor abusive

Developmental history

Has there been a history of child abuse? Yes or No If yes, which type: ___Sexual ___Physical ___Verbal
Other childhood issues: ___Neglect _____Exposure to trauma _____Inadequate nutrition
Are there any special, unusual, or traumatic circumstances that affected your upbringing? Yes or No
Please explain _____

Social Relationships

Circle how you generally get along with other people:

Affectionate	Aggressive	Avoidant	fight/argue often	Follower
Friendly	Leader	Outgoing	Shy/withdrawn	Submissive

What is your sexual orientation? _____

Have you experienced any Sexual dysfunctions? Yes or No

Spiritual/Religious

Are you connected with a spiritual or religious group? Please explain_____
Were you raised within a spiritual or religious group? Yes or No
Would you like your spiritual beliefs incorporated into the counseling? Yes or No

Legal

Are you involved in any active legal cases (traffic, civil, criminal)? Yes or No
If yes, please describe charges _____
Are you currently on probation or parole? Yes or No
Have you been accusations of any sexual crimes? Yes or No

Education, Employment, Military (circle)

Education: Currently enrolled in school High school grad/GED Vocational School Some College College Graduate Masters or Doctorate
Any learning disabilities: Yes or No If yes, please explain _____

Employment: Current employer _____

Fulltime	Part time	Temp	Laid-off	Disabled	Retired	Social Security
Job satisfaction:		poor	good	fair	great	

Military experience? Yes or No Combat experience? Yes or No Service length _____
Where:_____Branch:_____Type of discharge _
_____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling sports, etc.)

_____

_____

Medical/Physical Health

phone _____

Primary care Doctor _

_____

List any current health conditions you have and any recent health changes: _____

Are you currently using any prescribed medications: _____

Please circle if there have been any changes in the following:

Sleep patterns Eating Patterns Behavior Energy Level Physical activity level

General Disposition Weight Nervousness/tension

Others: _____

Chemical use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Use in last 48 hours	Used in last 30 days
					yes	**yes**
Alcohol					**yes**	**yes**
Cocaine/Crack					**yes**	**yes**
Meth					**yes**	**yes**
Marijuana					**yes**	**yes**
Valium/Librium					**yes**	**yes**
Heroin/Opiates					**yes**	**yes**
PCP/LSD/Mescaline					**yes**	**yes**
Inhalants					**yes**	**yes**
Caffeine					**yes**	**yes**
Nicotine					**yes**	**yes**
Pain killers					**yes**	**yes**

Drug of choice

How does your use affect your life? _____

Has anyone expressed concern about your use? Yes or No

Are you concerned about your use? Yes or No

Are there presently or past history of a family member having problems with drugs or alcohol? Yes or No

Consequences experienced because of your use? Legal, relational, physical, mental, job, financial

Please explain: _____

Counseling Prior Treatment History

Information about client (past and present):

	Yes	No	When	Where
Counseling/Psychiatric Care	_____	_____	_____	_____
Suicidal thoughts/attempts	_____	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____	_____
Hospitalizations	_____	_____	_____	_____

Is there a family history of mental illness or substance abuse problems? _____

Please list treatment goals wished to accomplish.

_____

_____

GENOGRAM

	NAME	AGE	YEARS Deceased	Quality of relationships now	Living w/ you		
				Good/Fair/ Poor			
Father							
Mother							
Step-parent							
Step-parent							
Sibling							
Grandparent							
Other							

Thank you for your time completing the questionnaire.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

Over the *last 2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

add columns: _____ + _____ + _____

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL: _____

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- **Not difficult at all** _____
- **Somewhat difficult** _____
- **Very difficult** _____
- **Extremely difficult** _____

GAD-7 Screening Questions

	During the last 2 weeks, how often have you been bothered by the following problems?	not at all	several days	more than half the days	nearly every day
1	Feeling nervous, anxious, or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4.	Trouble relaxing	0	1	2	3
5.	Being so restless that it is hard to sit still	0	1	2	3
6.	Becoming easily annoyed or irritable	0	1	2	3
7.	Feeling afraid as if something awful might happen	0	1	2	3

Total Score: _____ = Add columns: _____ + _____ + _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

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Authorization for Release of Information

This form when completed and signed authorizes the release and/or exchange of protected information from your clinical record to the person(s) designated.

I_____authorize Northwinds Counseling Services to release and/or exchange the following types of information:

__ Initial Assessment
__ Case Notes
__ Consultation Reports
__ Chemical dependency Evaluation
_Treatment Plan
_Psychological Testing and Evaluations
_Educational Assessments
_Other (Specify)

I am authorizing the release of this information for the following reasons:

- Background information/Assessment
- Coordination of Care
- Other (specify)

This information will be released and/or exchanged with:
Individual and Clinic Name _____
Address:_____
Phone/Fax: _____

This authorization will expire:

- Immediately after requested information is received
- 30 days after termination of treatment

Other _____

You have the right to revoke this authorization, in writing to Northwinds Counseling, at any time. However, your revocations will not be effective on action already taken in reliance of this authorization or, if this authorization was obtained as a condition of obtaining insurance coverage, to which the insurer has a legal right to consent a claim.

Your therapist may not in general, condition the providing of psychological services upon your signing an authorization, unless the psychological services are being provided to you for the purpose of creating health information for a third party.

The information disclosed pursuant to this authorization may be subjected to redisclosure by the recipient of your information and no longer protected by the HIPPA privacy rule.

If this authorization is signed by a personal representative of the client, a description of such representative's authority to act on behalf of the client must be provided.

Signature of client and/or guardian for client_____Date _____

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Client Care Communication Form

Care Provider _____
Address _____

Phone_____
Fax: _____

Northwinds Counseling Provider _____
21395 John Milless Drive #400
Rogers, MN 55374
Tel: 763-424-1888
Fax: 763-424-7288

It is our desire to inform primary care providers when their patients are receiving services at Northwinds Counseling Services P.A. to facilitate the best possible coordination of care.

This is for your information. There is no need to reply unless you deem it helpful or appropriate.

Regarding: D.O.B. _____
Patient Name: _____

Patient/Legal Guardian: _____
Date of initial assessment:_____Follow-up appointment _____

Therapist notes regarding presenting problems, provisional diagnosis and treatment plan:

_____
_____
_____
_____
_____

Please call if we can be of further help and support.

AUTHORUIZATION TO DISCLOSE THE ABOVE INFORMATION

To the party receiving this information:

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations 42 CFR Part 2 prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART2

Patient Signature _____ Date_____

Parent /Guardian _____ Date_____

Witness Signature _____ Date _____