

northwinds

counseling services, p.a.



21395 John Milless Drive | Suite 400 | Rogers, MN 55374

Phone: 763.424.1888 | 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 Disclosures 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 PHI to prevent or lessen 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 your 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 issue 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 for Service of Minor Child

By law, on-going counseling services may not be provided to minors without the informed consent of a parent or legal guardian. Parents and legal guardians have the right to be kept informed as to what takes place in therapy. ☐

I/We _____ D.O.B. _____
_____ D.O.B. _____

The parent/guardian(s) of _____ D.O.B. _____

Authorize Northwinds Counseling Services to provide counseling services to minor child
(named above) beginning on the _____ day of _____, ear _____

For the purpose of _____ . By _____

signing below I attest that I am the legal guardian of the above said minor.

Signature of parent/legal guardian Date

Signature of parent/legal guardian Date

Signature of client Signature of Counselor

- ☐ These rights may be waived when a minor's life or health is believed to be at risk; the minor is emancipated, married or has an unborn child; or when in need of services relating to pregnancy, VD or substance abuse.
- ☐ A child is considered a minor in the state of Minnesota until they have both reached the age of 18 and graduated high school, but no later than the age of 20.
- ☐ If parents are legally married, then only one parent needs to sign for consent.



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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 – Minor

Client 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:

- | | | | |
|-------------------|--------------------|---------------------|-----------------------|
| Aggression | Worrying | Hallucinations | Attention Deficit |
| 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 |

Does the minor report feel suicidal at this time? Yes or No

Does the minor report have a plan for suicidal? Yes or No

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

Has the minor 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 (years) _____

Special circumstances (e.g., raised by person other than parents, information about spouse/kids not living with you etc.): _____

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 the minor generally gets along with other people:

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

What is the minor's sexual orientation? _____

Have you experienced any Sexual dysfunctions? Yes or No

Spiritual/Religious

Is the minor 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 |
|--------------------------|-----------------------------|---------------------|---------------------|--------------------|-------------------------|-------------------------|
| 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.

Thank you for your time completing the questionnaire.

ADOLESCENT BEHAVIOR CHECKLIST

Name: _____ DOB: _____ Date: _____

| ATTENTION | CONDUCT |
|---|---|
| Makes careless mistakes | Stolen items |
| Attention Span is Poor or limited | Forces sexual activity |
| Doesn't listen to simple instruction | Deliberately sets fires |
| Avoids tasks requiring concentration | Lies or cons |
| Doesn't finish tasks to complete | Broken into property |
| Problems organizing self | Bullies, threatens others |
| Loses needed items often | Starts fights |
| Easily distracted | Used a weapon |
| Forgetful | Physically cruel to people/animals |
| Fidgets, squirms | Forcibly stolen from victim |
| Leaves seat when required to sit | ANXIETY/WORRY |
| On the go seems driven | Intense fears or phobias |
| Runs, climbs or excessively restless | Worries something terrible will happen to self/adults |
| Talks excessively | Refuses/reluctant to go somewhere because of fear |
| Interrupts others conversations or activity | Frequent fear to go to sleep without someone |
| Problems waiting for a turn | Avoids being alone, clingy |
| Bizarre behaviors | Nightmares about separation |
| MOOD | Physical complaints about the time of separation |
| No symptoms for more than two months during past year | Worries about parent(s) leaving |
| Weight changes, appetite changes | Obsessive or compulsive behavior or rigid rituals |
| Energy level changes | Extreme fear of new places or situations |
| Sleep disturbances | OPPOSITIONAL BEHAVIORS |
| Concentration problems | Touchy easily annoyed |

| | | | |
|--|---|--|--------------------------------|
| | Crying spells | | Argues |
| | Loss of interest, pleasure in once enjoyable activities | | Defiant |
| | Hopeless feelings | | Tantrums |
| | Guilty feelings | | Bothers others deliberately |
| | Isolates self | | Spiteful/mean |
| | Low self esteem | | Blames others for own mistakes |
| | Gives things away | | OTHERS: |
| | Wishes to be dead/talks of death | | |
| | Injures self | | |
| | Thinks about death/violence often | | |
| | Rage outburst | | |
| | Thinks she/he is smartest/best person in the world | | |

MY STRENGTHS:

In school settings:

In social settings:

Special Interests/Hobbies:

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behavior over the last six months.

Your child's name

Male/Female

Date of birth.....

| | Not True | Somewhat True | Certainly True |
|--|--------------------------|--------------------------|--------------------------|
| Considerate of other people's feelings | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Restless, overactive, cannot stay still for long | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Often complains of headaches, stomach-aches or sickness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Shares readily with other children, for example toys, treats, pencils | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Often loses temper | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rather solitary, prefers to play alone | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Generally well behaved, usually does what adults request | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Manages worries or often seems worried | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Helpful if someone is hurt, upset or feeling ill | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Constantly fidgeting or squirming | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Has at least one good friend | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Often fights with other children or bullies them | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Often unhappy, depressed or tearful | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Generally liked by other children | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Easily distracted, concentration wanders | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Nervous or clingy in new situations, easily loses confidence | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Kind to younger children | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Often lies or cheats | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Picked on or bullied by other children | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Often offers to help others (parents, teachers, other children) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thinks things out before acting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Steals from home, school or elsewhere | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Gets along better with adults than with other children | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Many fears, easily scared | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Good attention span, sees chores or homework through to the end | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Do you have any other **comments or concerns**?

Please turn over - there are a few more questions on the other side



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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:

- | | |
|---|--|
| <input type="checkbox"/> Initial Assessment | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> Case Notes | <input type="checkbox"/> Psychological Testing and Evaluations |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Educational Assessments |
| <input type="checkbox"/> Chemical dependency Evaluation | <input type="checkbox"/> 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 _____ | Northwinds Counseling Provider _____ |
| Address _____ | 21395 John Milless Drive #400 |
| Phone _____ | Rogers, MN 55374 |
| Fax: _____ | 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.

AUTHORIZATION 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 PART 2

| | |
|-------------------------|------------|
| Patient Signature _____ | Date _____ |
| Parent /Guardian _____ | Date _____ |
| Witness Signature _____ | Date _____ |