CABOT psychological services

7301 Ohms Lane, Suite 450
Edina, Minnesota 55439

Phone: 952.831.2000
Fax: 952.835.6134
www.cabotpsychologicalservices.com

Client Information

This is a strictly confidential client medical document. Redisclosure or transfer is expressly prohibited by law unless specified otherwise.

Today's date: _____

Note: If you have been a client here before, please fill in only the information that has changed.

A. Identification

Your name: _____ Date of birth: _____ Age: ____

Gender:_____ Preferred Pronouns:_____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ e-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions: _____

Insurance company: _____ ID #: _____ Group #: _____ Copay: _____

B. Referral: Who gave you my name to call?

Name: _____ Phone: _____

Address: _____

May I have your permission to thank this person for the referral? ❑ Yes ❑ No
How did this person explain how I might be of help to you? _____

_____

C. Religious and racial/ethnic identification

Current religious denomination/affiliation: _____

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? _____

Which (if any) church, synagogue, temple, or meeting are you involved with? _____

Ethnicity/national origin: _____ Race: _____ or any other way you identify yourself and consider important: _____

D. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

E. Your current employer

Employer: _____ Address: _____

Work phone: _____ or other means of communication _____

Calls will be discreet, but please indicate any restrictions: _____

F. Emergency information

If some kind of emergency arises and I cannot reach you directly, or I need to reach someone close to you, whom should I call?
Name: _____ Phone: _____ Relationship: _____

Address: _____

Significant other/nearest friend or relative not residing with you: _____

G. Your education and training

Dates From	Dates To	Schools	Special classes? Adjustment to school? Did you graduate?

H. Employment and military experiences

Dates From	Dates To	Name of employers	Job title or duties	Reason for leaving

I. Family-of-origin history

Relative	Name	Current age (or age at death)	Illnesses (or cause of death, if deceased)	Education	Occupation
Father					
Mother					
Brothers					
Sisters					
Stepparents					
Grandparents					
Uncles/aunts					
Others					

J. Marital/relationship history

	Spouse's name at marriage	Date of marriage at marriage	Has spouse remarried? divorced/widowed
First			
Second			
Third			

K. Significant nonmarital relationships

	Name of other person	Date of relationship when started	when started	Reasons for ending relationship when ended
First				
Second				
Third				
Current				

L. Children

Indicate those from a previous marriage or relationship with "P" in the last column.

Name	Current Age	Sex	School	Grade	Adjustment problems?	P?

M. Is there any other information you think I should know?

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the "Information for Clients" brochure and/or other information about the therapy I am considering. I have had all my questions answered fully. I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing for which I will still be responsible is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, **I will be charged a fee of $100 for that missed appointment.** This fee is not covered by insurance. I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

_____ I understand and agree with all of these statements.

Agreement to Pay for Professional Services

I request that the therapist named in these documents provide professional services to me, and I agree to pay this therapist's fee of $175 per session ($250 for intake interview) for these services, or ensure that my insurance company is providing appropriate reimbursement for services rendered.

I agree that my financial relationship with this therapist will continue as long as the therapist provides services or until I inform them that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me up until the time I end the relationship.

I agree that I am responsible for the charges for services provided by this therapist to me, although other persons or insurance companies may make payments on my account.

I have also read this therapist's "Information for Clients" brochure and agree to act according to everything stated there, as shown by my signature below and on the brochure.

_____ I understand and agree with all of these statements.

Consent to Use and Disclose Your Health Information

This form is an agreement between you and your therapist. When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others if necessary. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to us. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

_____ I understand and agree with all of these statements. **If you do not initial this form, we cannot treat you.** In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, we will contact you.

Electronic Records Disclosure

In keeping with Minn. Stat. §62J.495, CPS keeps and stores records for each client in a record-keeping system produced and maintained by BreezyNotes. This system is "cloud-based," meaning the records are stored on servers which are connected to the Internet. Here are the ways in which the security of these records is maintained:

- CPS has entered into a HIPAA Business Associate Agreement with BreezyNotes. Because of this agreement, BreezyNotes is obligated by federal law to protect these records from unauthorized use or disclosure.
- The computers on which these records are stored are kept in secure data centers, where various physical security measures are used to maintain the protection of the computers from physical access by unauthorized persons.
- BreezyNotes employs various technical security measures to maintain the protection of these records from unauthorized use or disclosure.
    - With data security and full HIPAA compliance as top priorities, the team at BreezyNotes partnered with cloud services provider, 7 Medical Systems, to host BreezyNotes on HIPAA-compliant, SSAE16 audited servers.
- CPS has its own security measures for protecting the devices that we use to access these records:
    - On computers, we employ firewalls, antivirus software, passwords, and disk encryption to protect the computer from unauthorized access and thus to protect the records from unauthorized access.

Here are things to keep in mind about CPS's record-keeping system:

- While CPS's record-keeping company and CPS both use security measures to protect these records, their security cannot be guaranteed.
- Some workforce members at BreezyNotes, such as engineers or administrators, may have the ability to access these records for the purpose of maintaining the system itself. As a HIPAA Business Associate, BreezyNotes is obligated by law to train their staff on the proper maintenance of confidential records and to prevent misuse or unauthorized disclosure of these records. This protection cannot be guaranteed, however.
- CPS's record-keeping company keeps a log of our transactions with the system for various purposes, including maintaining the integrity of the records and allowing for security audits. These transactions are kept for six years.

I understand that CPS will be storing some of my personal health information (PHI) on a cloud-based system, maintained by BreezyNotes EHR. I understand the advantages and potential risks associated with this system, and I have been given an opportunity to ask any questions about the process and system. I authorize CPS to use this system to keep and store my health record.

_____ I understand and agree with all of these statements.

Authorization to Electronically Communicate Protected Health Information

By filling out the following information, you are authorizing CPS to send you future correspondence regarding your treatment via email or text. Your authorization does not obligate CPS to communicate by email/text or cease non-electronic communication.

Authorize email/text communication

☐ I authorize the CPS staff to email/text me regarding the course of my treatment, billing, scheduling and any other related issues. **I would also like to receive appointment reminders via the method listed below.**

Client's email address (please print): _____

Client's text number (please print): _____

_____ I understand and agree with all of these statements.

- I understand that any email/text transmission between my provider and me/the client will become part of my medical record. These email/text transmissions may be disclosed in accordance with future authorizations.
- I understand that I have the right to revoke this authorization at any time by indicating so above. If I want to revoke this authorization, I must do so in writing and address it to the entity that I had previously authorized to disclose my information. I understand that if I revoke this authorization, it will not apply to any information already released as a result of this authorization.
- I understand that this authorization is voluntary and that I may refuse to sign it. I also understand that the institutions or individuals named above cannot deny or refuse to provide treatment if I refuse to sign this authorization.
- I understand that, once information is disclosed pursuant to this authorization, it is possible that it could be disclosed by the entity that receives it for authorized purposes under the HIPAA privacy rule.

Alert for Electronic Communication

Clients and/or personal representatives who want to communicate with their health care providers by email/text should consider all of the following issues before signing an authorization to Electronically Communicate Protected Health Information:

1. Email/text at CPS can be forwarded, intercepted, printed and stored by others.
2. Email/text communication is a convenience and is not appropriate for emergencies or time-sensitive issues**.**
3. Highly sensitive or personal information should only be communicated by email/text at the client's discretion (i.e., HIV status, mental illness, chemical dependency, and workers compensation claims).
4. Employers generally have the right to access any email received or sent by a person at work.
5. Staff other than the health care provider may read and process email/text.
6. Clinically relevant messages and responses will be documented in the medical record at the provider's discretion.
7. Communication guidelines must be defined between the clinician and the client, including (1) how often email/text will be checked, (2) instructions for when and how to escalate to phone calls and office visits, and (3) types of transactions that are appropriate for email/text.
8. Email message content must include (1) the subject of the message in the subject line (i.e., schedule change, appointment request, etc.) and (2) clear client identification such as client name in the body of the message.
9. CPS will not be liable for information lost or misdirected due to technical errors or failures.

Credit Card Payment Consent Form

CPS asks all clients to have a valid credit card on file prior to any sessions being held as well as require any copays or deductibles owed to be paid at the time of service.

We ask for your credit card information for several reasons:

1. If you miss more than one appointment without calling 24 hours in advance, we charge your card the missed appointment fee of $100.00 (plus fees). This charge cannot be submitted to insurance.
2. In the event that you have an outstanding balance past 90 days, we will notify you that your card will be charged for the outstanding balance within 15 days if you do not call to make partial or full arrangements for payment.

As part of this service, our credit card providers charge CPS a service fee of **2.95% + $0.30** on each transaction. This additional fee is passed on to you as part of the payment and is covered by this signed consent form. The Minn. Stat. 16A.626 related to credit card fees is available at https://www.revisor.mn.gov/statutes/?id=16A.626 or we can provide a copy upon request. CPS does not generate any profit from the charging of this fee.

No fee is charged for clients who wish to pay off their balance in cash or via standard check.

_____ I authorize CPS to keep my credit card and signature on file to charge the card for late cancellation fees or outstanding balances past 90 days as detailed above.

_____ I understand this form is valid until the credit card expires or I cancel the authorization in writing. I promise not to dispute charges ("charge back") for sessions I have received or that I have not cancelled 24 hours prior to a scheduled session. I further authorize CPS to disclose information about my attendance/cancellation to my credit card issuer if I dispute the charge.

_____
Client Name

_____ _____
Cardholder Name Card Type (MC, Visa, Discover, AMEX)

_____
Cardholder Billing Address City State Zip

_____ _____ _____
Account Number Expiration Date CVV (3 or 4 digits)

_____ _____
Cardholder Signature Date

Autopay

Have your card charged for your outstanding balance, avoiding the need to worry about copays or paying your bill on time. Note: You will be charged a **2.95% + $0.30** fee for all charges made on your card. This fee will be charged separately after the end of the month.

☐ Yes, sign me up to have my credit card charged automatically for my outstanding balance

☐ No, I prefer to pay my copay/deductible at the time of service.

The following signatures are intended as confirmation that you have read and understand all information that you have completed and/or initialed in the preceding pages.

Client Signature
My signature below shows that I understand and agree with all of the statements in this document.

_____ _____
Signature of client (or person acting for client) Date

_____ _____
Printed name Relationship to client (if necessary)

Therapist Signature
I have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of therapist Date

_____
Printed name

❑ Copy accepted by client

CABOT psychological services

7301 Ohms Lane, Suite 450
Edina, Minnesota 55439

Phone: 952.831.2000
Fax: 952.835.6134
www.cabotpsychologicalservices.com

CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

When thinking of drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions	Yes	No
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

Permission for use granted by Richard Brown, MD.

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 figety 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	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 _____

A2663B 10-04-2005