ACP ASSOCIATED CLINIC OF PSYCHOLOGY

Psychological Referral Form

Name of client: ________________________ **Date of physician's order for psych:** __________

Is the resident currently under Medicare A: Yes No Unknown

Client has a: Guardian Conservator POA None

Presenting problem/behavioral concerns: ______________________________

____

____

Desired Outcome: ______________________________

____

Anticipated discharge plan/date: unknown LTC short-term stay return home other: ________

Living situation prior to placement: independent living with family ALF LTC other: __________

Relevant medical diagnosis: ______________________________

____

Mental Status Scores *(score and date of SLUMS, BIMS, PHQ-9, ACLs, etc.):* ____________________

____

Current Psychotropic medications *(include dose and schedule):* ____________________

____

Current narcotic pain medication: Yes No **If yes list:** ____________________

Mental health history/diagnosis: Yes No **If yes list:** ____________________

Chemical health history: Yes No **If yes list:** ____________________

Known history of: mental health treatment self-harm abuse suicidal ideation physical aggression

Marital Status: single never married married widowed divorced long-term partner

Current Family/social support: none some good overly involved

Education: 8th grade or less some high school HS grad some college bachelors or more

Spiritual: Yes No **If yes list:** ____________________

Cultural considerations: ____________________

Additional relevant information: ____________________

- ☐ **Gave information packet**
- ☐ **Attached face sheet**
- ☐ **Attached signed release form**
- ☐ **Fax face sheet to 612-395-5371** ***or*** **email to nhinfo@acp-mn.com**

Authorization for Consent to Treatment and Acknowledgments

Client Name:______________________________ Date of Birth:________________

Facility:____

Authorizations

Informed Consent for Treatment

I consent to allow ACP to perform psychological and/or psychiatric services, including but not limited to diagnostic evaluations, counseling, psychotherapy, testing, consultation with other providers and other services.

Release of Private Health Information

I authorize ACP to use and disclose information from my mental health record including psychological, psychiatric and/or chemical dependence diagnostic evaluations, follow up notes and psychological testing reports, which may include information about diagnosis and treatment, to my residential facility, primary care providers, psychiatrist, other mental health providers, and other allied health care involved in my care. I authorize my residential facility, primary care providers, psychiatrist, other mental health providers and other allied health care professionals to provide medical and mental health records to ACP. The purpose of these disclosures is coordination of care between providers. This authorization will be in force throughout my treatment by an ACP provider at the facility stated above.

Assignment of Insurance Benefits and Financial Agreement

I authorize benefits of any type under my insurance plan or any party liable to me is hereby assigned to ACP. I authorize ACP to release health records to insurance carriers for purposes of processing claim for services rendered to me. I agree to pay all co-pays, deductibles, and charges not covered by my insurance plan.

Acknowledgements

Client Rights and Data Privacy

I have received a copy of the document "Client Rights and Data Privacy" and a copy of the "HIPAA Notice of Privacy Practices".

A photocopy of this form will be considered as valid as the original. This authorization may be revoked at any time by notifying ACP in writing at the address indicated above. This authorization will cease to be in effect *on the date that notification is received* and will not affect previously disclosed information.

By signing below, I consent to treatment and understand and agree to the terms outlined above.

Signature of Client/POA/Guardian: ____

Date: ____________________ Relationship to Client: ____________________________

If Client is unable to sign, reason: ____

ACP ASSOCIATED CLINIC OF PSYCHOLOGY

1. CLIENT RIGHTS AND DATA PRIVACY

1. You have the right to know what specific training I have as a clinician, what college or university I received my degree from, and if I am licensed or certified to practice in the State of Minnesota.

2. You have the right to decide not to receive services from me. If you wish, I shall provide you with the names of other qualified professionals.

3. You have the right to end services at any time without any moral or legal obligation. Your only obligation is to pay the balance of your account.

4. You have the right to ask any questions about the procedures used during treatment. If you wish, I shall explain my usual methods to you.

5. You have the right to prevent the use of certain treatment techniques. I shall inform you of my intention to use any unusual procedures and shall describe any risk involved.

6. You have the right to prevent electronic recording of any part of the sessions. Permission to record must be granted by you in writing on a form that explains exactly what is to be done and for what period of time. I shall explain my intended use of recordings and provide a written statement to the effect that they will not be used for any other purpose. You have the right to withdraw your permission to record at any time.

7. Information in this category deals with adoption, civil or criminal investigation, certain medical data, and the names of person(s) who reported child or vulnerable adult neglect or abuse. "Abuse" is defined as any act that violates the prostitution or criminal sexual conduct laws; or the intentional and non-therapeutic infliction of pain or injury; or a persistent course of conduct intended to produce mental or emotional distress. "Neglect" happens when someone supposed to take care of a minor or a vulnerable adult fails to supply or ensure that the person has necessary food, clothing, shelter, health care, or supervision.

8. If you request it, any part of your records in the files can be released to any person or agencies your designate. I shall tell you at the time whether or not I think making the record public will be harmful to you. If you live in a Residential Health Care environment, my assessment and recommendations will be revealed to relevant staff involved with your care including your physician.

2. STAFF EXPECTATIONS OF CLIENTS

As a client, you have responsibilities as well as rights. You can help yourself by being responsible in the following ways:

To be honest – You are responsible for being honest and direct about everything that relates to you as a client. Tell the staff about everything that relates to you as a client. Tell the staff exactly how you feel about the things that are happening to you. Do not wait. In order for us to help you, we need to know what you are feeling and thinking during your sessions.

To understand – You are responsible for understanding your treatment plan to your own satisfaction. If you do not understand, ask your clinician. Be sure you do understand since this is important to the success of treatment.

To follow the treatment plan – It is your responsibility to advise the people treating you whether or not you think you can and want to follow a certain treatment plan. Discuss this with your clinician.

3. INFORMED CONSENT

1. Psychotherapy may involve the risk of remembering unpleasant events and can arouse intense emotions of fear and anger. Intense feeling of anxiety, depression, frustration, loneliness, or helplessness may also be aroused. We will be asking questions about you, your family, vocational, social, and sex history. We realize these questions are personal, but the information enables us to gain a more complete and thorough understanding of your situation.
2. The benefits from psychotherapy may be that you will be better able to handle or cope with your family or other social relationships, thus experiencing more satisfaction from those relationships. Another possible benefit may be a better understanding of your personal goals and values; this may lead to greater maturity and growth as a person and assist in adjusting to residential living.
3. You should know that a psychologist is not a physician and cannot prescribe or provide you with any drugs or medication or perform any medical procedures. If pharmacological treatment is indicated, your therapist can recommend the staff physician for you or you may choose your own physician.
4. Physicians, Physician Assistants, Certified Nurse Specialists prescribe medications and can provide you with any drugs or medication. Even though they may be able to prescribe medication, they may not prescribe if it is not in your best interest.

4. BILL OF RIGHTS OF CLIENTS

Consumers of services offered by clinicians licensed by the State of Minnesota have the right:

1. To expect that a clinician has met the minimal qualification of training and experience required by the state law.
2. To examine public record maintained by the respective Board which contain the credentials of a clinician.
3. To obtain a copy of the rules of conduct from the State Register and Public Documents Division of Department of Administration, 117 University Avenue, St. Paul, MN 55155.
4. To report complaints to the:
   - MN Board of Psychology
   - MN Board of Medicinal Practice
   - MN Board of Social Work
   - MN Board of Nursing
5. To be informed of the cost of professional services before receiving the services.
6. To privacy as defined by state and federal rules and laws.
7. To be free from being the object of discrimination on the basis of race, religion, gender or other unlawful category while receiving treatment.
8. To be free from exploitation for the benefit or advantage of the clinician.
9. Access to records in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

5. COMPETENCIES OF YOUR CLINICAL STAFF:

1. Diagnosis
2. Assessment
3. Individual Treatment
4. Staff Training
5. Medication Management
6. Family Consultation
7. Testing
8. Working with Specialized Populations
9. Group Services

NOTICES OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL/PSYCHIATRIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. Uses and Disclosures for Treatment, Payment, and Health Care Operations

ACP may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions: • "PHI" refers to information in your health record that could identify you.

• *"Treatment, Payment, and Health Care Operations"*

– *Treatment* is when ACP provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when ACP consults with another health care provider, such as your family physician or another psychologist.

- *Payment* is when ACP obtains reimbursement for your healthcare. Examples of payment are when ACP discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

- *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.

• *"Use"* applies only to activities within our practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

• *"Disclosure"* applies to activities outside of our practice, such as releasing, transferring, or providing access to information about you to other parties.

2. Uses and Disclosures Requiring Authorization

ACP may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when ACP is asked for information for purposes outside of treatment, payment or health care operations, ACP will obtain an authorization from you before releasing this information. ACP will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes ACP have made about our conversation during a private, group, joint, or family counseling session, which ACP has kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) ACP have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

3. Uses and Disclosures with Neither Consent nor Authorization

ACP may use or disclose PHI without your consent or authorization in the following circumstances:

• **Child Abuse:** If ACP knows or has reason to believe a child is being neglected or physically or sexually abused, or has been neglected or physically or sexually abused within the preceding three years, ACP must immediately report the information to the local welfare agency, police or sheriff's department.

• **Adult and Domestic Abuse:** If ACP have reason to believe that a vulnerable adult is being or has been maltreated, or if ACP have knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, ACP must immediately report the information to the appropriate agency in this county. ACP may also report the information to a law enforcement agency.

"Vulnerable adult" means a person who, regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:

(i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and

(ii) because of the dysfunction or infirmity and the need for assistance, the individual has an impaired ability to protect the individual from maltreatment.

• **Health Oversight Activities:** The Minnesota Board of Psychology and the Minnesota Department of Psychiatry may subpoena records from me if they are relevant to an investigation it is conducting.

• **Judicial and Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that ACP has provided you and/or the records thereof, such information is privileged under state law and ACP must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. ACP will inform you in advance if this is the case.

• **Serious Threat to Health or Safety:** If you communicate a specific, serious threat of physical violence against a specific, clearly identified or identifiable potential victim, ACP must make reasonable efforts to communicate this threat to the potential victim or to a law enforcement agency. ACP must also do so if a member of your family or someone who knows you well has reason to believe you are capable of and will carry out the threat. ACP also may disclose information about you necessary to protect you from a threat to commit suicide.

• **Worker's Compensation:** If you file a worker's compensation claim, a release of information from me to your employer, insurer, the Department of Labor and Industry or you will not need your prior approval.

4. Patient's Rights and ACP's Duties

<u>Patient's Rights:</u>

• *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information. However, ACP is not required to agree to a restriction you request.

• *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen at ACP. On your written request, ACP will send your bills to another address.)

• *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI (and psychotherapy notes) in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. ACP may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, ACP will discuss with you the details of the request and denial process.

• *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. ACP may deny your request. On your request, ACP will discuss with you the details of the amendment process.

• *Right to an Accounting of Disclosures* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, ACP will discuss with you the details of the accounting process.

• *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

ACP Duties:

• ACP is required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

• ACP reserves the right to change the privacy policies and practices described in this notice. Unless ACP notifies you of such changes, however, ACP is required to abide by the terms currently in effect.

• If ACP revises the policies and procedures, ACP will provide you a copy of the revision at your first appointment after the revision date.

5. Complaints

If you are concerned that ACP has violated your privacy rights, or you disagree with a decision ACP made about access to your records, you may contact Mary Olsen, Practice Administrator, or John E. Brose, Clinic Director, at (612) 925-6033. You will not be penalized for filing a complaint.
You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. Either person listed above can provide you with the appropriate address upon request.

6. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14th, 2003 with updates made on October 7th, 2014.

ACP reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that ACP maintains. ACP will provide you with a revised notice at your first appointment after the update were made. ACP will also provide the revision on their website, www.acp-mn.com.