Zung Self-rating Anxiety Scale

Provider: _____ PCN: _____

Name: _____ Date: _____

Listed below are 20 statements. Please read each one carefully and decide how much the statement describes how you have been feeling **during the past week**. Circle the appropriate number for each statement.

	None or a little of the time	Some of the time	Good part of the time	Most or all of the time
1. I feel more nervous and anxious than usual.	1	2	3	4
2. I feel afraid for no reason at all.	1	2	3	4
3. I get upset easily or feel panicky.	1	2	3	4
4. I feel like I'm falling apart and going to pieces.	1	2	3	4
5. I feel that everything is all right and nothing bad will happen.	4	3	2	1
6. My arms and legs shake and tremble.	1	2	3	4
7. I am bothered by headaches, neck and back pains.	1	2	3	4
8. I feel weak and get tired easily.	1	2	3	4
9. I feel calm and can sit still easily.	4	3	2	1
10. I can feel my heart beating fast.	1	2	3	4
11. I am bothered by dizzy spells.	1	2	3	4
12. I have fainting spells or feel faint.	1	2	3	4
13. I can breathe in and out easily.	4	3	2	1
14. I get feelings of numbness and tingling in my fingers and toes.	1	2	3	4
15. I am bothered by stomachaches or indigestion.	1	2	3	4
16. I have to empty my bladder often.	1	2	3	4
17. My hands are usually dry and warm.	4	3	2	1
18. My face gets hot and blushes.	1	2	3	4
19. I fall asleep easily and get a good night's rest.	4	3	2	1
20. I have nightmares.	1	2	3	4

Score Total*: [ ]

*Score is for healthcare provider interpretation.

Adapted from Zung WWK. A rating instrument for anxiety. *Psychosomatics*. 1971;XII:371-379.
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Scored By: Date Scored:

PHQ-9

Provider: _____ PCN: _____

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle the number corresponding to 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 asleep, 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

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

FOR HEALTH CARE PROFESSIONAL Add columns:				
TOTAL:				

Scored By: _____ Date: _____

Name_____ PCN#_____ Date_____

CAGE-AID QUESTIONNAIRE

1. Have you ever felt you ought to cut down on your drinking or drug use?

   _____Yes _____No

2. Have people annoyed you by criticizing your drinking or drug use?

   _____Yes _____No

3. Have you ever felt bad or guilty about your drinking or drug use?

   _____Yes _____No

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 (eye-opener)?

   _____Yes _____No

Score ____/4 Scorer's Initials_____

WHODAS 2.0

Name _____
PCN _____
Date _____

This questionanaire askes about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question circle only one response.

		(1)	(2)	(3)	(4)	(5)
S1	Standing for long period such as 30 minutes?	NONE	MILD	MODERATE	SEVERE	EXTREME OR CANNOT DO
S2	Taking care of your household responsibilities?	NONE	MILD	MODERATE	SEVERE	EXTREME OR CANNOT DO
S3	Learning a new task, for example, learning how to get to a new place?	NONE	MILD	MODERATE	SEVERE	EXTREME OR CANNOT DO
S4	How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	NONE	MILD	MODERATE	SEVERE	EXTREME OR CANNOT DO
S5	How much have you been emotionally affected by your health problems?	NONE	MILD	MODERATE	SEVERE	EXTREME OR CANNOT DO
S6	Concentrating on doing something for ten minutes?	NONE	MILD	MODERATE	SEVERE	EXTREME OR CANNOT DO
S7	Walking a long distance such as a kilometer (or equivalent)?	NONE	MILD	MODERATE	SEVERE	EXTREME OR CANNOT DO
S8	Washing your whole body?	NONE	MILD	MODERATE	SEVERE	EXTREME OR CANNOT DO
S9	Getting dressed?	NONE	MILD	MODERATE	SEVERE	EXTREME OR CANNOT DO
S10	Dealing with people you do not know?	NONE	MILD	MODERATE	SEVERE	EXTREME OR CANNOT DO
S11	Maintaining a friendship?	NONE	MILD	MODERATE	SEVERE	EXTREME OR CANNOT DO
S12	Your day-to-day work?	NONE	MILD	MODERATE	SEVERE	EXTREME OR CANNOT DO

H1	Overall, in the past 30 days, how many days were these difficulties present?	Record number of days _____
H2	In the past 30 days, for how many days were you totally unable to carry our your usual activities or work because of any health condition?	Record number of days _____
H3	In the past 30 days, not counting the days that you wre totally unable, how many days did you cut back or reduce your usual activities or work because of any health condition?	Record number of days _____

This completes the questionnaire. Thank you.

Please print clearly and complete fully.
Patients 16 & older MUST sign all forms
****Use Blue or Black ink ONLY****

Date: _____
Provider: _____
Revised 8/31/17

Intake Information

PCN#_____

Client's Name _____

Parent / Guardian / Legal Representative_____
**If patient is under 18-Do you have full custody of child? (*circle one*) Yes or No
If No-please list legal guardian/parent _____
(Legal guardianship paperwork must be provided to the clinic if different from parents)

Client Information

Address_____

Apt. _____ City _____ State _____ Zip Code_____

Primary Phone #1 _____ Phone #2 _____ Phone #3_____

DOB _____ Social Sec. #_____Occupation _____ Employer _____

Client's Identified Gender and Preferred Pronouns_____

Your Spouse (or if child, Parent or Guardian Information)

Name _____ DOB_____ Address _____

City _____ State _____ Zip Code _____ County _____

Primary Phone #1 _____ Phone #2 _____ Phone #3_____

Relationship to Client _____ Employer _____

Reason for seeking counseling at this time: _____

Do you have any serious medical problems or infectious diseases?_____

Marital Status: Single Engaged Married Separated Divorced Widowed Cohabitating For how long? _____

Who Referred You? _____ Religious Affiliation (optional) _____

Race/Ethnicity/Tribe _____ Nation of Origin _____ Length of Time in US _____

Preferred Language _____ Is an interpreter needed for services? _____

Current Medication _____

Names and Dates You Saw In the Past: Psychiatrist, Psychologist, Counselor, and/or Therapist:

_____

Insurance Company _____ Policy ID _____ Group # _____

Policy Holder _____ DOB _____ Social Sec _____

Address _____ City _____ State _____ Zip Code _____

Contact Phone # _____ Employer _____ Relationship to Client _____

Emergency Contact: Name and Phone number: _____
(If unable to contact you, who can we call?

Minnesota
Mental Health Clinics

Consent for Services

Guarantee of Account: I agree to pay Minnesota Mental Health Clinics for all charges for services not covered by any third party payer. I understand that I am responsible to comply with the rules and regulations of my insurance company regarding pre-certification and prior-authorization requirements. I agree if a pre-authorization of service is required, unauthorized visits are my responsibility for payment. We will assist you in keeping a count of your number of sessions used.

Insurance Consent: I request that payment of authorized benefits be made directly to Minnesota Mental Health Clinics, and the facility's participating physicians and therapists, for any services furnished to me. I authorize this facility to release to Medicare, and other accident or health insurer, medical or financial information as needed for claims processing, fraud investigation, or quality of care review and studies.

Transportation: I authorize Minnesota Mental Health Clinics to release to my transportation company information regarding my appointment attendance.

Consent for Release of Information: I consent to the release of information about my medical condition to any health care provider working for this facility involved with my current treatment. I understand that other agency personal involved in billing, medical records and other necessary duties may see my medical records. I understand that a facility representative who is conducting a Rule 29 case consultation or a quality of care review may access my record. I further understand that a representative may contact me after discharge, and that information from my medical record has been made available to that representative. The representative will seek your opinion about the helpfulness of services and about any problems you may have had. We will follow any direction you may have had for us to contact you on the "Treatment Agreement" form.

Consent for Personnel in Training: I am aware that clients at this facility may be attended by medical, nursing, and/or other mental health care personnel in training, who may be present during client care as part of their education.

I hereby agree to the above and that a photographic copy of this authorization is as valid as the original. This authorization expires after one year but may be revoked or limited in writing by me at anytime, but such revocation will not apply to information already released. I may disagree with the use of my medical record for any purpose listed above by crossing through the paragraph and initialing in the left margin. I understand that if I refuse or revoke consent to release information, this may change my providers' ability to continue providing services.

Client Name (please print) _____

Signature _____ Date: _____

Parent or Guardian Signature _____ Date: _____

Minnesota
Mental Health Clinics

Treatment Agreement

Privacy Policy and Client Rights and Responsibilities: The privacy of your medical information is important to us and we are committed to protecting it. A record of your care will be created for the services received while a patient at our office. This record is necessary to provide you with quality care and to comply with certain legal requirements. Your medical information may be disclosed to other treating providers at your request, your insurance company to assist in payment of your claim and to pharmacies to assist in obtaining your medications. Full notice of our privacy policy is posted on our waiting room wall. You are being given a copy of your rights and responsibilities. **My signature on this form acknowledges I have read this policy and have been informed of the privacy policy of this office.**

Complaints, Grievances, or alleged violations of rights: I have received a copy of the procedure to report a complaint, grievance or rights violation and understand its contents. You have the right to file a complaint with us about our privacy practices or our compliances with our Notice of Privacy Practices, our Privacy Policies and Procedures, or federal or state privacy rules or law. The contact information to do so is: Minnesota Department of Health and Human Service, 540 Cedar St, St Paul, MN 55101, (651) 431-2000

Mental Health Services: I give permission to Minnesota Mental Health Clinics to evaluate, administer diagnostic testing, prescribe medication, develop a treatment plan and provide treatment with my participation. I understand that the practice of medicine and psychotherapy is not an exact science and I acknowledge that no guarantees have been made to me as the result of assessment or treatment in this facility.

After Hours Emergency: If there is an after hour emergency, I can call the agency and follow the directions given on the recording or refer to the list I've been given for crisis assistance.

Telephone Confidentiality: In the event the Minnesota Mental Health Clinics staff must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Unless you give us other instructions below, we will call your home and/or office, first we will ask to speak to the client or guardian without identifying the name of the agency (to protect confidentiality). If necessary we will identify ourselves as your therapist's/provider's office, we do not say the name of the agency or nature of the call, but rather the mental health professional's name only. If we reach an answering machine or voice mail we will follow the same guidelines. If you'd like us to contact you by another procedure, please list where we may reach you by phone and how you would like us to identify ourselves. Include phone numbers and how you would like us to identify ourselves when phoning you.

I wish to be contacted in the following manner (check all that applies):

Home Telephone: _____
___ OK to leave message with detailed information
___ Leave message with callback number only

For Email or Texting:
Email address: _____

Cell Phone: _____

___ OK to leave message with detailed information
___ OK to send appointment information
___ Ok to send customer surveys
___ Ok to send communications on services or offerings

For Written Communication:
___ OK to mail to my home address
___ OK to mail to my work/office
___ OK to fax to this number: _____

Work Phone: _____

___ OK to leave message with detailed information
___ Leave message with callback number only

Client Name (please print) _____

Signature_____ Date: _____

Parent or Guardian Signature _____ Date: _____

Parent or Guardian (please print) _____

Minnesota
Mental Health Clinics

Fee Policies and Authorization of Benefits Agreement

Fees/Insurance
If you plan to submit your own claims to your insurance company, it is our policy that payment of the entire fee is due at the time of service.

As a service to our clients, Minnesota Mental Health Clinics staff will submit your insurance claims. Please provide us with the necessary information. **CO-PAYMENTS, OUTSTANDING BALANCES, AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.**

Minnesota Mental Health Clinics can make no guarantee that your insurance company will provide payment for services rendered. **IT IS YOUR RESPONSIBILITY TO KNOW WHAT IS AND IS NOT COVERED UNDER YOUR POLICY. YOU ARE RESPONSIBLE FOR THE FULL AMOUNT OF THE CHARGE, WHETHER OR NOT YOUR INSURANCE WILL COVER ANY PORTION.** If your insurance company requires preauthorization of services you are responsible to inform us. Be aware that most insurance companies have an annual maximum benefit for outpatient mental health coverage. Time billed for court appearances, court case review, report writing, telephone consultation and other charges excluded by insurance coverage are client responsibility.

A service charge of 1.5% (18% annual rate) or the highest statutory amount allowed, whichever is higher, will be charged on accounts past due 60 days. If payment from insurance is not received within 90 days the account is due and payable in full. Accounts 90 days past due will be subject to collection procedures and/or small claims court, the client agrees to be held responsible for the cost disbursement including reasonable attorneys, collection and court fees. There is a fee of $20 for checks returned for insufficient funds.

Medical Records
There is a fee for the copies as defined is Minnesota State Statute 144.292

Cancellations
We ask that you give us 24-hour notice during regular business hours when canceling an appointment. This will allow us to schedule the time for someone else. To cancel an appointment, please call 651-454-0114 during regular office hours. Please **NOTE: IF YOU FAIL A SCHEDULED APPOINTMENT OR CANCEL WITH LESS THAN A 24 HOURS NOTICE OR CALL OUTSIDE OF REGULAR BUSINESS HOURS, YOU MAY BE CHARGED FOR THE SESSION.** Your insurance cannot be billed for missed appointments. If you fail or cancel an appointment with less than 24 hours notice of the scheduled appointment two times in a row or three times in a six-month period, it is possible that you will be referred to another clinic for future service. Final decisions are made by the provider.

I HAVE READ AND AGREE TO THE ABOVE AND HEREBY GUARANTEE PAYMENT OF ALL CHARGES FOR PSYCHOLOGICAL SERVICES WITH THE FINANCIAL ARRANGEMENTS OF MINNESOTA MENTAL HEALTH CLINICS. ANY SPECIAL ARRANGEMENTS CONTRARY OR IN ADDITION TO THE ABOVE ARE WRITTEN BELOW.

I hereby authorize the release of any medical information necessary to process this claim to the insurance company and/or the responsible party for this account. I authorize payment of medical benefits for services rendered to me and/or my dependents to Minnesota Mental Health Clinics.

Client Name (please print): _____

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Insurance Company: _____

Group & Policy Numbers: _____

Mailing Address: _____

_____

A copy of this authorization shall be as valid as the original

Minnesota
Mental Health Clinics

Consent for Telehealth Services

Mental health care services are available by two-way interactive video communications and/or by the electronic transmission of information. Referred to as "telemedicine" or "telehealth," this means that I will be evaluated and treated by a mental health care provider or specialist from a different location. Since this is different than the type of service from which I am familiar, **I understand and agree to the following:**

1. The mental health care provider will be at a different location from me. I will be connecting to remote services from a location in the state of Minnesota that is private and comfortable to me.
2. I will identify and sign a release of information form for an Emergency Contact (EC) who will be available to me in relative close physical proximity during all telehealth sessions in case of an emergency. I will provide the contact information for this person to my mental health provider, as well as the information for local emergency services.
3. I will be informed if any additional personnel are to be present other than myself, individuals accompanying me, the consultant and presenting practitioner. I will give my verbal permission prior to additional personnel being present. I will inform my mental health care provider if someone is attending the session with me or if there are other people in the room where I am receiving telehealth services.
4. Video recordings may be taken of the telehealth session, after I have given my written permission prior to recording. Video recordings may be kept, viewed, and used for purposes including teaching, training, technical, scientific, research, or administrative purposes.
5. If I am having technological issues connecting to my telehealth session, I can call my provider directly. They will be able to assist me in connecting to services or transfer me to someone who can help.
6. I have the option to test out the telehealth technology prior to my first telehealth session with my provider. I will be provided with the appropriate connection instructions. My provider will be able to assist me with setting up a separate appointment to learn how to use the technology.

Noting all the above, I understand that my participation in the process described (called "telemedicine" or "telehealth") is voluntary and constitutes a waiver of the usual right to provider-client privacy and may possibly increase the risk of disclosure of my personal data.

I further understand that I have the right to:

1. Refuse the telehealth session or stop participation in the telehealth session at any time.
2. Request that the presenting practitioner refrain from transmitting my information if I make the request before the information is transmitted.

I acknowledge that the mental health care providers involved have explained the sessions in a satisfactory manner and that all questions that I have asked about the sessions have been answered in a manner satisfactory to me or to my representative. Understanding the above, I consent to the telehealth process described above.

I hereby agree to the above and that a photographic copy of this authorization is as valid as the original. This authorization expires after one year but may be revoked or limited in writing by me at anytime, but such revocation will not apply to information already released.

Client Name (please print) _____

Signature_____ Date: _____

Parent or Guardian Signature_____ Date: _____

Minnesota Mental Health Clinics Eagan Clinic-3450 O'Leary Lane, Eagan MN 55123 Phone: 651-454-0114 Fax: 651-454-3492
Edina Clinic- 6525 Drew Ave. So. Edina, MN 55435 Appointments call 651-365-8222 Fax: 651-454-3492
Lakeville Clinic-18586 Joplin Ave., Lakeville, MN 55044 Phone: 952-435-8700 Fax: 952-435-0559
Maplewood Clinic-2785 White Bear Ave #403, Maplewood MN 55109 Phone: 651-365-8289 Fax: 651-365-8283
Southwest Minneapolis Clinic-5346 Lyndale Ave. So., Minneapolis, MN 55419 Phone: 612-746-5888 Fax: 612-746-5518
Woodbury Clinic-1000 Radio Dr. Suite 210, Woodbury, MN 55125 Phone: 651-365-8209 Fax: 651-739-0272

Minnesota
Mental Health Clinics

CLIENTS' RIGHTS AND RESPONSIBILITIES

Welcome to the Minnesota Mental Health Clinics. Our staff will be continually working to provide you with appropriate, high quality services. We believe that a client who understands and participates in his/her case may achieve better results. We have the responsibility to give you the best care possible, to respect your rights and recognize your responsibilities as a client. We have prepared this information to help you identify these rights and responsibilities.

YOUR PRIVACY RIGHTS

As a client of this clinic you have a right to privacy and to review information we keep in your file. Under of the Minnesota Data Privacy Practices Act and the Health Insurance Portability and Accountability Act you have the right to:

1. Be told why the information we request is needed.
2. Be told how the information will be used.
3. Be shown all information about yourself.
4. Be told of the consequences of refusing to supply the requested information.
5. Contest the accuracy of information in your file.
6. All information about you will be kept private.

You will also receive a brochure titled, "Your Privacy" which details the use and handling of your protected health information. Please read this brochure carefully to understand how medical information about you may be disclosed and how you can get access to it.

If you have any questions about your Privacy Rights, please contact your therapist or the Clinic Director.

RIGHT TO DIGNITY You have a right to be treated with dignity and respect and to receive the same consideration and treatment as anyone regardless of your race, creed, religion, disability or sexual or affectional preference.

RIGHT TO UNDERSTAND You have a right to be informed of the staff's assessment of your problem in language you understand; treatment alternatives; possible outcomes and side effects of treatment, expected length; cost and hoped for outcome of treatment. In addition, you have the right to and responsibility to help develop your own treatment plan.

You also have a right to understand why information requested about you is needed. In general, such information is used to determine whether you are eligible for services, to help us evaluate your needs for services and develop a plan to meet those needs, and to collect information from others, which will be helpful in developing an effective treatment plan.

You have the right to understand how the information requested of you will be used. The information we collect will be used by staff members of the Minnesota Mental Health Clinics for clinical management, planning and evaluation purposes. No information will be released to any other agency or individual without your written consent within the exceptions outlined above.

Clinical information relating to your social history and present concerns is necessary in order for our staff to correctly and completely assess your needs and develop a plan for meeting them. If you do not supply such information, it cannot be determined which services are most appropriate for you and will make it difficult for us to carry out an effective treatment plan for you and/or your family member and you may be refused services.

RIGHT TO CONSENT OR REFUSE You can be treated without consent only if there is an emergency and in the opinion of your therapist failure to act immediately would jeopardize your health. Otherwise, you may refuse treatment and change your mind at any time. Discuss your objections with your therapist. Try to be sure of what you do or do not want.

RIGHT TO ACCESS YOUR RECORDS You have a right to request in writing access to and may obtain a copy of the medical and billing records that MMHC clinical staff maintain. Your clinician can deny your request only if he/she has a substantial belief the information would be harmful to you. You are entitled to see such information about yourself. This includes the therapist's treatment plan and notes. Your therapist or the Clinic Director or his designee are the only persons allowed to review your treatment related records with you. Do not expect the office staff to review your file or photo copy information for you. A charge does apply for a copy of your records per Minnesota State Statute

RIGHT TO REQUEST TO CHANGE INACCURATE INFORMATION You have the right to request a MMHC Staff to amend your health information. MMHC requires clients to make requests for amendments in writing and to provide a reason to support a requested amendment, provided that he/she informs clients in advance of such requirements. MMHC makes the final determination with those requests.

RIGHT TO REQUEST RESTRICTIONS ON DISCLOSURE The Privacy Rule permits clients *to request* restrictions on the use and disclosure of parts of the client's PHI or the entirety for treatment, payment, and health care operations, or to family members. While MMHC clinical staff is not required to agree to such restrictions, MMHC clinical staff will attempt to accommodate a reasonable request. Once MMHC clinical staff have agreed to a restriction, MMHC clinical staff may not violate the restriction; however, restricted PHI may be provided to another health care provider in an emergency treatment situation.

The Privacy Rule also permits clients to request receiving communications from MMHC through alternative means or at alternative locations. As required by the Privacy Rule, MMHC clinical staff will accommodate all reasonable requests.

MINORS' RIGHT TO INFORMATION All minor clients under the age of 18 years old must have the consent of their parents following an initial intake session to receive further treatment services.

RIGHT TO A SAFE ENVIRONMENT No weapons are allowed on the premises. For safety purposes no child should be left unattended on the premises.

REQUIRED OR PERMITTED BY LAW We may use or disclose your medical information when we are required or permitted to do so by law. For example, we must disclose your medical information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your medical information when authorized by worker's

compensation or similar laws. We may disclose your medical information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

LAW ENFORCEMENT We may disclose your medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process. Under limited circumstances, such a court order, warrant, or grand jury subpoena, we may disclose your medical information to the law enforcement officials. We may disclose limited information to a law enforcement official concerning medical information if a suspect, fugitive , material witness, crime victim, or missing person. We may disclose the medical information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances.

ABUSE OR NEGLECT We may disclose your medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your medical information to the extent necessary to avert a serious threat to your health or safety or the health or the safety of others. We may disclose medical information when necessary to assist law enforcement officials to capture an individual who has admitted to participate in a crime or has escaped from lawful custody.

NATIONAL SECURITY We may disclosed to military authorities the medical information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official, medical information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or individual under certain circumstances.

YOUR RESPONSIBILITIES

TO BE HONEST You are responsible for being honest and direct about everything that relates to you as a client. Tell the staff exactly how you feel about the things that are happening to you.

TO UNDERSTAND AND FOLLOW THE TREATMENT PLAN You are responsible to actively participate in the development of your treatment plan. Your ideas on what you need to do are as important as the therapist's. You are also responsible for understanding the treatment plan. If you do not understand, ask your therapist. Be sure you do understand and make efforts to follow your treatment plan since this is important to the success of your treatment plan. If you don't want to or think you can accomplish your goals, let your therapist know.

TO KEEP APPOINTMENTS... You are responsible for keeping your scheduled appointments; refer too: Fee Policies & Authorization of Benefits Agreement.

TO KNOW YOUR THERAPIST Therapists must have special formal training in order to be licensed or certified in their specific fields. You are entitled to ask your therapist what his/her training is, where it was received and if he/she is licensed/certified.

TO BE RESPONSIBLE FOR YOUR VALUABLES You are responsible for your valuables both on your person as well as in your car and your car itself. Minnesota Mental Health Clinics cannot be held responsible for loss or damage to your property on the premises.

CRISIS INFORMATION Should you have an emergency, go to your hospital emergency room or call 911. Should you need to talk to someone right away, the following crisis lines are available 24 hours, seven days a week.

Crisis Connection	612-379-6363
Dakota Co. Crisis Response Unit	952-891-7171
Washington Co. Crisis Line	651-777-5222
Ramsey Co. Crisis Service	651-266-7900
Hennepin Co. Suicide Prevention	612-873-2222
Hennepin Co. Crisis Intervention Center	612-873-3161
Anoka Co. Crisis Intervention	763-755-3801
Carver/Scott Co. Crisis Service	952-442-7601
First Call for Help (Not an emergency service but information and referral.)	211

Should you ever be in a crisis situation, you can ask your therapist to help you develop a crisis plan to prepare you to deal with an emergency that might arise. This plan lists things you can do to seek help during a crisis. Should you have an urgent need, you can call and leave a message for your therapist during clinic hours. If your matter cannot wait, you may communicate your urgent need to our office staff and they will contact your therapist immediately. If you should call after clinic hours, our after hours answering service will assist you as necessary and contact the on-call after hours therapist.

ADDRESS CHANGE
So that we may contact you whenever necessary, we will rely upon you to notify us of any changes in your address, home telephone number or work telephone number.

Print Client Name _____ Client Signature _____ Date _____

Print Parent/Guardian Name _____ Parent/Guardian Signature _____ Date _____

Minnesota
Mental Health Clinics

RELEASE OF INFORMATION FORM

Client:	Name:	Previous Last Name (if any)	
	Address	Phone number	
	City	State	Zip
	Date of Birth		
Who has the information you would like released?	Name Minnesota Mental Health Clinics	Phone Number 651-454-0114	Fax Number 651-454-3492
	Address 3450 O'Leary Lane		
	City Eagan	State Minnesota	Zip 55123
Whom should we contact if we are unable to contact you OR an emergency should come up?	Name	Phone Number	Fax Number
	Address		
	City	State	Zip

Information to be Disclosed:

Mental Health
- ☐ [redacted] Assessment
- ☐ [redacted] Notes/ Progress Notes
- ☐ [redacted]
- ☐ [redacted]
- ☐ [redacted]
- ☐ [redacted]
- ☐ [redacted]
- ☐ Psychological Reports/Testing Sc[redacted]

Legal
- ☐ Court Documents/ Letters/Reports/Affidavits
- ☐ Information Investigations
- ☐ Child Abuse Investigations

School
- ☐ Academic Testing
- ☐ Other Academic Records

Chemical Dependency
- ☐ Chemical Depend[redacted] Treatment Records
- ☐ Evaluation Repo[redacted]

[redacted]
- [redacted] Histo[redacted] Physic[redacted]
- [redacted] Histo[redacted]

Other
- ☐ On going consultation and exchange of information
- ☐ Telephone Contact
- ☐ Letter/Affidavit
- ☒ Other (Specify) Clinic Business
- ☐ Make, break or change appointments

Emergency Contact

Reason for Release:
- ☐ Continuation of Care
- ☐ Personal
- ☐ Disability/SSI Appeal
- ☐ Legal/Court
- ☐ Out of town move
- ☐ Other (Specify)
- ☐ On going consultation and exchange of information
- ☐ Telephone Contact
- ☐ At the request of the individual

Revocation:
I understand that I may revoke this consent at any time by providing written notice, and after 24 months this consent automatically expires. I understand that once the information is released by this authorization, we cannot prevent the re-disclosure by the above named party to a third party. I also understand this information will be shared with the treatment team and that refusal to sign this release will not condition treatment being provided. I have been informed of what information will be given, its purpose, and who will receive the information.

Authorization:
I authorize MMHC to release the information marked above. I understand there may be a charge for my records per Minnesota Statute 144.335.

Signature of Client _____ Date _____ Signature of Parent/Guardian _____ Date _____

Personal Representative _____ Date _____ A Personal Representative is a person legally acting on behalf of an individual

Revised 3/25/2016

Minnesota
Mental Health Clinics

Release for Coordination of Care

Client:	Name:	Previous Last Name (if any)	
	Address	Phone number	
	City	State	Zip
	Date of Birth	Work/Cell number	
Who has the information you would like released?	Name **Minnesota Mental Health Clinics (MMHC)**	Phone Number **651-454-0114**	Fax Number **651-454-3492**
	Address **3450 O'Leary Lane**		
	City **Eagan**	State **Minnesota**	Zip **55123**
Coordination of Care	☐ I **AGREE** to allow MMHC to Release my treatment data to my Primary Care Physician. (continue filling out form) ☐ I **AGREE** to allow my Primary Care Physician to release my treatment data to MMHC. (continue filling out form) ☐ I **AGREE** to allow MMHC to release my treatment to Dakota County for services. (continue filling out form) ☐ I **DO NOT AGREE** to allow MMHC to Release information to my Primary Care Physician. (sign & date form) ☐ I **DO NOT** have a Primary Care Physician that I am currently seeing. (sign & date form) ☐ I **DO NOT AGREE** to allow MMHC to release my treatment to Dakota County. (sign & date form)		
Primary Care Physician/ Information	Clinic Name		
	Physician Name	Phone Number	Fax Number
	Address		
	City	State	Zip
Information to be Disclosed:	(x) Any Information relating to Mental Health Status or Medication		
Reason for Release:	(x) Continuation of Care (x) On going consultation and exchange of information (x) Telephone Contact		
Revocation:	**I understand that I may revoke this consent at any time by providing written notice, and after 24 months this consent automatically expires.** I understand that once the information is released by this authorization, we cannot prevent the re-disclosure by the above named party to a third party. I also understand this information will be shared with the treatment team and that refusal to sign this release will not condition treatment being provided. I have been informed of what information will be given, its purpose, and who will receive the information.		
Authorization:	I authorize Minnesota Mental Health Clinics to release the information marked above. Signature of Client Date Signature of Parent/Guardian Date Personal Representative Date A Personal Representative is a person legally acting on behalf of an individual		

Please return all information to:

Release for Coordination of Care for Behavioral Providers

Client:	Name:	Previous Last Name (if any)	
	Address	Phone number	
	City	State	Zip
	Date of Birth	Work/Cell number	
Who has the information you would like released?	Name **Minnesota Mental Health Clinics (MMHC)**	Phone Number **651-454-0114**	Fax Number **651-454-3492**
	Address **3450 O'Leary Lane**		
	City **Eagan**	State **Minnesota**	Zip **55123**
Coordination of Care	☐ I **AGREE** to allow MMHC to Release my treatment data to my Behavioral Care Provider. (continue filling out form) ☐ I **AGREE** to allow my Behavioral Care Provider to release my treatment data to MMHC. (continue filling out form) ☐ I **DO NOT AGREE** to allow MMHC to Release information to my Behavioral Care Provider. (sign & date form) ☐ I **DO NOT** have a Behavioral Care Provider outside of MMHC that I am currently seeing. (sign & date form)		
Behavioral Care Provider Information	Clinic Name		
	Physician Name	Phone Number	Fax Number
	Address		
	City	State	Zip
Information to be Disclosed:	**(x)** Any information relating to Mental Health Status or Medication		
Reason for Release:	**(x)** Continuation of Care **(x)** On going consultation and exchange of information **(x)** Telephone Contact		
Revocation:	**I understand that I may revoke this consent at any time by providing written notice, and after 24 months this consent automatically expires.** I understand that once the information is released by this authorization, we cannot prevent the re-disclosure by the above named party to a third party. I also understand this information will be shared with the treatment team and that refusal to sign this release will not condition treatment being provided. I have been informed of what information will be given, its purpose, and who will receive the information.		
Authorization:	I authorize Minnesota Mental Health Clinics to release the information marked above. Signature of Client Date Signature of Parent/Guardian Date Personal Representative Date A Personal Representative is a person legally acting on behalf of an individual		

Please return all information to:

Minnesota
Mental Health Clinics

PNC#_____

Referral for Psychiatry Services

In the course of your therapy treatment at any of the Minnesota Mental Health Clinics, you may be referred by your therapist for a psychiatry evaluation and medication management. During your therapy treatment you may continue to see a staff psychiatrist. Once your therapy treatment is completed, our staff will assist you in transferring your medication needs to your family doctor or other community resources. Limited psychiatry resources are available to meet the needs of our clients. Psychiatry services are reserved for clients actively involved in therapy treatment.

You will need to make your own arrangements for a transfer of care; including contacting and scheduling appointments. Many providers are scheduled far in advance and it may take some time to arrange an appointment. The clinic will transfer your records with the proper releases. Please check with your insurance provider to assure your fees will be covered.

** If you fail or late cancel with less than 48 hours your initial psychiatry appointment for any reason, we will not reschedule any further psychiatry services**

_____
Client Name (please print)

_____ _____
Signature Date

_____ _____
Parent or Guardian Signature Date

Minnesota
Mental Health Clinics

PCN: _____

Name:_____ Date: _____

REVIEW OF SYSTEMS: Please check problems you have currently in each body system.

Constitutional: ☐none ☐ fever ☐weight gain ☐weight loss ☐appetite change ☐night sweats ☐fatigue ☐chills

Eyes: ☐none ☐blurry vision ☐double vision ☐vision loss ☐ tearing ☐ redness ☐ pain ☐sensitivity to light ☐glaucoma

Ears, Nose, Mouth, Throat: ☐none ☐hearing loss ☐ringing in ears ☐ear pain ☐nasal congestion ☐nasal drainage ☐nosebleeds ☐mouth/throat irritation ☐tooth problem

Cardiovascular: ☐none ☐chest pain/pressure ☐heart racing palpitations ☐sweating leg ☐Swelling ☐high/low blood pressure

Respiratory/Pulmonary: ☐none ☐cough ☐yellow/green sputum ☐ shortness of breath ☐wheezing

Gastrointestinal: ☐none ☐nausea ☐vomiting ☐diarrhea ☐constipation ☐ abdominal pain ☐blood in stool ☐heartburn ☐difficulty swallowing

Genitourinary: ☐none ☐ incontinence ☐ abnormal bleeding ☐abnormal discharge ☐urinary frequency ☐ urinary hesitancy ☐ pain ☐ impotence sexual problem ☐ infection ☐urinary retention

Integumentary (skin): ☐none ☐rashes ☐lesions ☐wounds ☐tumors ☐eczema ☐excessive dryness

Musculoskeletal: ☐none ☐pain ☐stiffness ☐joint redness/warmth ☐arthritis ☐back pain ☐weakness ☐ sprain/fracture

Neuro: ☐none ☐headache ☐ weakness ☐ dizziness ☐ change in voice ☐ change in taste ☐change in vision ☐change in hearing ☐loss/change sensation ☐trouble walking ☐ balance problem ☐ coordination problem ☐shaking ☐speech problem

Endocrine: ☐none ☐ cold or heat intolerance ☐ blood sugar problem ☐ weight gain/loss ☐Missed periods ☐ hot flashes/sweats ☐ change in body hair ☐ change in libido ☐ Increased thirst ☐ increased urination

Heme/Lymph: ☐ none ☐ swelling ☐ bleeding problem ☐ anemia ☐ bruising ☐ enlarged lymph node

Allergic/Immunologic: ☐ none ☐itch ☐post-nasal drip ☐watery/itchy eyes ☐nasal drainage

Revised January 16, 2012

PCN#_____

Psychiatry Safety Plan for After Hours Care

Clinic hours are 8:30 am to 9:00 PM Monday through Thursday and 8:30 am to 5:00 PM Friday and Saturday. To reach your psychiatrist during clinic hours please call our psychiatry services coordinator at 651-365-8260 or our main number at 651-454-0114. Minnesota Mental Health Clinics does not provide 24-hour emergency psychiatry call coverage. Therefore, in order to safely receive services here, it is important that you have a safety plan in place should you experience any potential emergency conditions, such as: suicidal or homicidal ideation; or serious medication side effects; or an unexpected loss of residence.

Please briefly describe a safety plan that you would use.

_____

_____

_____

Who are two individuals or agencies that you would contact if an emergency situation arose?

1 Name _____
Relationship to you _____
Contact Numbers _____

2. Name _____
Relationship to you _____
Contact Numbers _____

After hours agencies you may contact are: Crisis Connection at 612-379-6363 or Dakota County residents call 952-891-7171, Hennepin County residents call 612-347-3161, Ramsey County residents call 651-266-7900, or Washington County Residents call 651-777-5222.

Client Printed Name _____

Client Signature_____ Date _____
Provider Signature_____ Date_____

Revised: March 30/2012

PCN#_____

Pharmacy Release of Information

In the course of your treatment at this office, you may be prescribed medication. If this occurs it may be necessary to share health information with your pharmacy by fax, mail or phone to facilitate your medication or refills. If prior authorization is needed by your insurance company to cover your medication, it may also be necessary to share information with your insurance company.

Your signature below acts as a release and authorization to share this information.

Client Name (please print): _____

Signature_____ Date_____

Parent or Guardian Signature (if needed)_____

Date_____

Minnesota Mental Health Clinics Eagan Clinic-3450 O'Leary Lane, Eagan MN 55123 Phone: 651-454-0114 Fax: 651-454-3492
Edina Clinic- 6525 Drew Ave. So. Edina, MN 55435 Appointments call 651-365-8222 Fax: 651-454-3492
Lakeville Clinic-18586 Joplin Ave., Lakeville, MN 55044 Phone: 952-435-8700 Fax: 952-435-0599
Maplewood Clinic – 2785 White Bear Ave. Suite 403, Maplewood, MN 55109 Phone:651-454-0114 Fax:651-454-3492
Southwest Minneapolis Clinic-5346 Lyndale Ave. So., Minneapolis, MN 55419 Phone: 612-746-5888 Fax: 612-746-5518
Woodbury Clinic-1000 Radio Dr. Suite 210, Woodbury, MN 55125 Phone: 651-365-8209 Fax: 651-739-0272

MINNESOTA MENTAL HEALTH CLINICS

IMPORTANT MEDICATION REFILL INFORMATION

Turn in your written prescription to your pharmacy if your prescription is not sent to your pharmacy electronically. We will not process a refill request if you have already been issued a written prescription.

Please contact your pharmacy for medication refills. Calling in to your prescribing physician's office for refills only delays your request. We **MUST** receive information from your pharmacy before your refill can accurately be processed. Prescriptions can take up to 72 hours before refills can be authorized, therefore, it is important to remember to call your pharmacy at least 5 days before your medication is to run out.

If you run out of medication before your next appointment **CALL YOUR PHARMACY.** Your pharmacy will contact us with your request. Your provider may be able to authorize refills **as long as you have a future appointment scheduled.**

Lost or stolen prescriptions for controlled substances such as Adderall, Ritalin, Concerta, Dexadrine, Focalin, or Metadate **may not** be re-issued.

Week-end or Holiday refills are not considered emergencies, and therefore, will not be available.

If you have any complications with your pharmacy, feel free to contact our psychiatry department and we will assist you.

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Southwest Minneapolis Clinic-5346 Lyndale Ave. So., Minneapolis, MN 55419 Phone: 612-746-5888 Fax: 612-746-5518
Woodbury Clinic-1000 Radio Dr. Suite 210, Woodbury, MN 55125 Phone: 651-365-8209 Fax: 651-739-0272