Fax: 218-237-2520

LAKE COUNTRY ASSOCIATES, INC.

515 Bridge Street East, Park Rapids, MN 56470 ph: 218-366-9229
1426 Bemidji Ave NW, Ste 1 Bemidji, MN 56601 ph: 218-444-2233
11 Main Street East Menahga, MN 56164 ph: 218-564-9229

Date: _____

Name of Client: _____ Former or Maiden name: _____

Date of Birth: _____ Age: _____ SSN# _____ Gender: ☐ Male ☐ Female

Mail Address: _____ Physical Address: _____

City: _____ State: _____ Zip: _____ County: _____ Referral Source: _____

Indicate the best way to reach you: ☐Home #_____ ☐Cell #_____ Text OK? ☐Yes ☐ No

Do you have difficulty with reading or writing? ☐ Yes ☐ No Name of person completing form: _____

Employment: ☐ Full-time ☐ Part-time ☐ Student ☐ Retired ☐ Unemployed ☐ Disabled

Employer: _____ Occupation: _____

Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Never Married

Education: 1 2 3 4 5 6 7 8 9 10 11 12 ☐ Diploma ☐ GED ☐ College/Vocational 1 2 3 4 5 6 Degree:_____

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ Alaskan/Native American Tribe: _____

Client Lives: ☐ Alone ☐ With immediate family ☐ With extended family ☐ With non-related

Client Lives in: ☐ Private Residence (home/apartment) ☐ Shelter/Homeless ☐ Other Residential Setting
☐ Correctional Facility ☐ Other institution setting ☐ Other: _____

Are you a Veteran? ☐ Yes ☐ No If yes, date of discharge: _____

Is the reason you are wishing to be seen at LCA military related? ☐ Yes ☐ No

Have you had a diagnostic assessment completed within the past year at another mental health agency? ☐ Yes ☐ No

If yes, please tell us the agency: _____

Does a copy of your assessment need to be forwarded to someone outside of this office? ☐ Yes ☐ No If yes, please tell us:

Who: _____ Office: _____

People Living in the same household:

Name	Age	Relationship	M/F	Employer	Phone

In case of emergency, who may we contact?

Name	Relationship to You	Phone Number

Initial: _____* *I authorize Lake Country Associates, Inc. to release necessary information to my emergency contact in the event of emergency.*

PHQ – 9 Depression Assessment

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Circle the number under the correct answer heading for each question.

	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 over eating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching TV	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 that you have been moving around a lot more than usual	0	1	2	3
9. Thought that you would be better off dead or hurting yourself in someway	0	1	2	3
Total Score of each column	_____	_____	_____	_____

If you checked 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

PHQ-9 Score	Depression Severity
1 to 4	None
5 to 9	Mild
10 to 14	Moderate
15 to 19	Moderately Severe
20 to 27	Severe

Total of all Columns: _____

Client Initial: _____ DOB: _____ Today's Date: _____ Chart # _____

The Generalized Anxiety Disorder 7-Item Scale

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

Total Score ☐ = Add Columns _____ + _____ + _____ + _____

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

☐ Not Difficult at all ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult

Interpreting the Score:

Total Score	**Interpretation**
≥ 10	Possible diagnosis of GAD; confirm by further evaluation
5	Mild Anxiety
10	Moderate Anxiety
15	Severe Anxiety

Substance Use History

Alcohol: Age at first time used: _____ Age at first used to intoxication: _____

Last Used: _____ Last used to intoxication: _____

What? How often? How much? _____

_____

Marijuana: Age at first time used: _____ Age at first used to intoxication: _____

Last Used: _____ Last used to intoxication: _____

What? How often? How much? _____

_____

Other drugs Age at first time used: _____ Age at first used to intoxication: _____

Or abuse of Last Used: _____ Last used to intoxication: _____

Prescriptions: What? How often? How much? _____

_____

CAGEAID

1. Have you ever felt you ought to cut down on your drinking or drug use? ☐ Yes ☐ No
2. Have you ever had people annoy 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 as an eye-opener first thing in the morning to steady your nerves or get rid of a hangover or to get the day started? ☐ Yes ☐ No

Do you use tobacco products? ☐ Yes ☐ No

What? How often? How much? _____

Do you drink caffeinated beverages? ☐ Yes ☐ No

What? How often? How much? _____

Order for protection and restraining order policy (Please read and sign):

In order to ensure the safety of our clients and clinicians, it is mandatory that we be informed and provided copies of any current or future Orders for Protection and/or Restraining Orders concerning our clients. We are further bound to comply with existing OFP's and Restraining Orders. I understand and will comply with the LCA policy concerning disclosure of restraining orders.

_____ _____

Signature of Client (or client's guardian) **Date**

Is there currently an Order of Protection (OFP) or Harassment Order in place from any state regarding a member of your household?

☐ Yes ☐ No If yes, name of family member: _____

Name of other party involved: _____

Expiration Date of Order: _____

Checklist of Concerns

Describe what changes in your life you are seeking by coming to LCA:

_____

Please mark all of the items below that apply to you. Circle the one that is the most important.

☐ Marital/family Problems
☐ Social/interpersonal (not family) problems
☐ Coping with daily roles
☐ Medical Physical symptoms
☐ Depression
☐ Attempt, threat, danger of suicide
☐ Alcohol/drugs
☐ Court Evaluation Referral
☐ Program entrance Evaluation
☐ Eating disorder
☐ Anxiety
☐ Abuse/assault victim
☐ Sexual abuse/rape victim
☐ Child behavior problems
☐ Major mental illness
☐ Psychiatric medication
☐ Other: _____
☐ Perpetrator of sexual abuse
☐ Anger Management
☐ Gambling
☐ Stress
☐ ADD/ADHD

Please continue checking all items that apply to you:

☐ Aggression, violence
☐ Career concerns, goals and choices
☐ Childhood issues (your own childhood)
☐ Children, child management, child care, parenting
☐ Concentration
☐ Compulsions (actions that are repeated)
☐ Custody of children
☐ Decision making, indecision, putting off decisions
☐ Delusions (false ideas)
☐ Dependence
☐ Emptiness
☐ Failure
☐ Fatigue, tiredness, low energy
☐ Fears, phobias
☐ Financial or money worries
☐ Work problems, workaholic, can't keep a job
☐ Grieving, mourning, deaths, losses, divorce
☐ Guilt
☐ Relationship problems
☐ Self-centeredness
☐ Self-neglect, poor self-care
☐ Shyness, over sensitivity to criticism
☐ Smoking and tobacco use
☐ Thought disorganization and/or confusion
☐ Weight and diet issues
☐ Recreation/hobbies
☐ Headaches, other kinds of pain
☐ Inferior feelings
☐ Impulsiveness, loss of control, outbursts
☐ Irresponsibility
☐ Judgement problems, risk taking
☐ Legal matters, charges, suits
☐ Loneliness
☐ Memory problems
☐ Menstrual problems, PMS, menopause
☐ Mood swings
☐ Motivation, laziness
☐ Nervousness, tension
☐ Obsessions (thoughts that are repeated)
☐ Overly sensitive to rejection
☐ Panic or anxiety attacks
☐ Perfectionism
☐ Pessimism
☐ Procrastination, work inhibitions
☐ School problems
☐ Self-esteem
☐ Sexual issues (dysfunction, conflicts, desire differences)
☐ Sleep problem (too much, too little insomnia, nightmares)
☐ Suspiciousness
☐ Threats, violence
☐ Withdrawal, isolating
☐ Other concerns or issues: _____

Medical Information Supplement – page 1

In order to provide high quality care, please complete the following. This information will become part of the Diagnostic Assessment.

Are you allergic to any drugs? ☐ Yes ☐ No

If yes, please list: _____

Do you have any other allergies? ☐ Yes ☐ No

For example: foods, air borne, etc. If yes, please list: _____

Are you pregnant? ☐ Yes ☐ No

Who is your medical Doctor? _____

Name of Clinic and location: _____

When was your last physical examination? _____ Results: _____

Have you experienced a recent weight loss or weight gain? ☐ Yes ☐ No

Do you have any problems that might interfere with your receiving services at Lake Country Associates? ☐ Yes ☐ No

If yes, please list: _____

Have you received services for alcohol and/or drug problems in the past? ☐ Yes ☐ No

If yes, where? _____

Have you ever been treated for any of the following?

☐ Birth or developmental problems in childhood
☐ ADHD
☐ Alcohol issue
☐ Anemia
☐ Anxiety
☐ Cancer
☐ Chronic pain
☐ Diabetes ☐ Type I ☐ Type II
☐ Depression
☐ Head injury (epilepsy, seizures, convulsions, confusion)
☐ Headaches, migraines
☐ Constipation
☐ Urinary incontinence
☐ Vision problems
☐ Hearing problems
☐ Low energy
☐ Skin problems
☐ Past surgeries
☐ Gastric bypass
☐ Chronic illness
☐ Hepatitis
☐ Heart disease
☐ High blood pressure (hypertension)
☐ Chest pain, palpitations
☐ Kidney disease
☐ Lung disease, pneumonia
☐ PTSD
☐ Serious injury or accident
☐ Sexual performance problems
☐ Stroke
☐ Thyroid problems
☐ Tuberculosis
☐ Ulcer
☐ Sexually transmitted disease
☐ Problems with appetite
☐ Gastrointestinal problems
☐ Ongoing pain or discomfort
☐ Other: _____

If any of the boxes are checks, please comment on length and duration of problem: _____
_____
_____
_____

Medical Information Supplement – page 2

Have you had any past suicide thoughts or attempts? ☐ Yes ☐ No

If so, please list: _____

When: _____

Have you had any visits to the Emergency Room in the last year? ☐ Yes ☐ No

If yes, what symptoms were you were experiencing when you went to the ER? _____

_____

Have you had any hospitalizations related to mental health? ☐ Yes ☐ No

If yes, when: _____

Where: _____

What symptoms were you experiencing when you were hospitalized? _____

_____

Are you currently or have you been treated for any mental health conditions? ☐ Yes ☐ No

If yes, when: _____

Where: _____

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please list below:

Medication Name	Dosage	How often	Prescribed by

Past medications: _____

_____

Do you take vitamins, herbal medications, diet supplements or over the counter medications? ☐ Yes ☐ No

If yes, what type, how much, and for how long? _____

Have you taken more of a prescription medication that recommended by your doctor? ☐ Yes ☐ No

If yes, for how long? _____

Do you have a Health Care Directive? ☐ Yes ☐ No

*If yes, where do you keep it? _____

*If no, would you like information on one? ☐ Yes ☐ No If yes, was the information given to the client? ☐ Yes ☐ No

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Client Name:_____ DOB:_____

By signing below as a client of Lake Country Associates, I agree to the following statements with regard to payment for services:

1. Clients are required to pay for services received. A client may choose to bill a third party insurance including Medical Assistance and Medicare. In the event that the third party insurance is billed, clients will be required to pay for all services which are not covered by insurance. Exceptions will include those items which are not appropriate to bill the client under the terms of the provider contract.
2. If clients choose to use insurance, they agree to provide insurance information to Lake Country Associates and agree to assist in billing for insurance reimbursement.
3. Self-pay clients are expected to pay for services at the time they are received. A 10% discount is offered for full cash payment at the time of service. Billing arrangements accepted by LCA other than full payment at the time of service are listed below under SPECIAL CONDITIONS.
4. If a billing arrangement is made, a minimum payment of $75 per month or 10% of the total bill, whichever is higher, will be expected.
5. Any services provided by LCA not covered by client's insurance which are 60 days in arrears will be charged monthly interest at a rate of 1.5% of the balance.
6. In the event of non-payment, the bill will be sent to collections.
7. LCA reserves the right to decline service or to require cash payment if a previous billing arrangement has not been honored.
8. The client agrees that if circumstances such as income, number of dependents, insurance or eligibility for various programs change, the client will notify LCA.

SPECIAL CONDITIONS:_____

Charges for services are to be billed to the following sources:

☐ Insurance (primary)
Company_____ Subscriber Name_____
Group #_____ Subscriber _____
Policy # _____ Subscriber Relationship_____
Co-Pay Amount _____ Subscriber Address _____

☐ Insurance (secondary)
Company_____ Subscriber Name_____
Group #_____ Subscriber dob _____
Policy # _____ Subscriber Relationship_____
Co-Pay Amount _____ Subscriber Address _____

☐ Medical Assistance
Carrier_____ MA#_____

☐ EAP Provider
Name_____ Number of sessions_____

By signing below I understand if coverage has lapsed, if services requested are not covered by the plan, if plan caps have been exceeded, or if the services are denied by the carrier but I wish to have them anyway, **that I will be responsible for the payment.** I also agree to any self-pay amounts indicated by the carrier contract. I authorize LCA to furnish information to the payment sources concerning my illness and treatments and hereby assign to Lake Country Associates all payments for services rendered to my dependents or myself. This authorization shall remain in effect until otherwise cancelled by Policy Holder or Representative. I understand my insurance carrier or other third party payer may inform the "subscriber" of any services billed to the payer.

****

☐ **Private Pay Clients:**

Name_____ Relationship_____
Address _____ Phone # _____

By signing below I agree that payment for services requested is the responsibility of the patient or guardian. I agree to accept the terms and conditions as indicated on the FEE SCHEDULE and PAYMENT CONTRACT. Any financial assistance that applies to these services is listed in the payment contract.

****

_____ _____ _____
Client or Guardian Signature **Date** **LCA representative**

Lake Country Associates, Inc.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors, clinical business associates, or other treatment team members. We may disclose PHI to any other consultant only with your authorization. We may also contact you to remind you of your appointments or to provide information to you about treatment alternatives or other health-related benefits and services that may be of interest to you.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations. As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

- **Child Abuse or Neglect.** We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

- **Judicial and Administrative Proceedings.** We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

- **Deceased Patients.** We may disclose PHI regarding deceased patients as mandated by state law. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate.
- **Medical Emergencies.** We may use or disclose your protected health information in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.
- **Family Involvement in Care.** We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.
- **Health Oversight.** If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.
- **Law Enforcement.** We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.
- **Specialized Government Functions.** We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.
- **Public Health.** If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.
- **Public Safety.** We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- **Research.** PHI may only be disclosed after a special approval process.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at Lake Country Associates, Inc., P.O. Box 806, 515 Bridge Street East, Park Rapids, MN 56470 Telephone: 218-366-9229.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Breach Notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at 218-366-9229, or with the MN Department of Human Services, Attn: Privacy Official, PO Box 64998, St. Paul, MN 55164-0998, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

Additional Client Rights

Quality treatment:
You have the right to be treated in a professional, respectful manner. You have the right to expect quality and effective treatment.

Equal Access:
Lake Country Associates, Inc, provides equal access to employment, programs, and services without regard to race, color, creed, religion, age, gender, disability, marital status, sexual orientation, HIV status, public assistance, criminal record or national origin.

Minor Rights:
If you are a minor, you have a legal right to request that information about you not be shared with your parents. You will need to make this request in writing, state your reasons for withholding this information, and show that you understand the consequences of doing so. In a few cases we can withhold this information without your formal request. Feel free to discuss this with your therapist.

Treatment Planning and Goals:
You have the right and responsibility to participate in helping determine your treatment plan and reaching your goals. If you feel you have not been allowed to help in this process, or that a change in counselors might be helpful to you, please advise your counselor or contact the Clinic Director.

Supplying Information:
You have the right to refuse to supply the information we request. However, without certain information, we may not be able to provide you the services you request. If you feel certain information that we request is an unwarranted invasion of privacy, please ask us for clarification.

Staff Rights*:*
Staff have the right:
- *To preserve their personal life and to receive respect for their personal privacy;*
- *To courtesy and freedom from verbal abuse, harassment and threats;*
- *To your full cooperation and participation in the therapy process;*
- *To your reliability and promptness in keeping appointments;*
- *To 24 hour notice when you must cancel an appointment;*
- *To terminate treatment or recommend a transfer if reasonable progress is not being made.*

The effective date of this Notice is April 1, 2010.
Revised August 16, 2012.

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Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Client Name: _____

Date of birth: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Lake Country Associates' Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Jean Greseth, MSW, LICSW at 218-366-9229.

_____ _____

Client Signature **Date**

_____ _____

Parent, Guardian or Personal Representative Signature* **Date**

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

☐ Patient/Client Refuses to Acknowledge Receipt:

_____ _____

Signature of LCA staff Date

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Informed Consent for Assessment and Treatment

NAME: _____ Date of Birth: _____

1. I understand that as a participant in mental health services at Lake Country Associates (LCA) I am eligible to receive a range of mental health services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks.

2. I understand that all information shared with the clinicians at LCA is confidential and no information will be released without my consent. During the course of treatment at LCA, it may be necessary for my clinician, ARMHS Mental Health Practitioner or mental health provider to communicate with other LCA staff and clinical business associates of LCA. My authorization for the release of information within LCA acknowledges my awareness of this communication. The purpose of this communication is to provide for continuity of care, consult on diagnosis, treatment planning or recommendations and is always done with the goal of providing the best and most appropriate services for my needs. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:
    a. When there is risk of imminent danger to me or to another person; the clinician is ethically bound to take necessary steps to prevent such danger.
    b. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child or elder and to inform the proper authorities.
    c. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

3. I understand that a range of mental health professionals and practitioners, some of whom may be in training, provide LCA services. All professionals-in -training are supervised by licensed staff. I will be informed if the professional I am seeing is receiving supervision and is in training.

4. I understand that while psychotherapy may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories.

5. The Counselor-Client relationship is unique in that it is exclusively therapeutic. In other words, it is almost always inappropriate for a client and a counselor to spend time together socially, to give each other gifts, or to attend functions together. The purpose of these boundaries is to ensure that you and your counselor are clear in understanding your roles for treatment and that your confidentiality is maintained.

6. If there is ever a time when I believe that I have been treated unfairly or disrespectfully, I can discuss the situation with my mental health provider. Any issues that might interfere with the counseling process should be identified and discussed as quickly as possible. This includes personal, family, administrative, financial and other issues.

7. Office Policies: Most counseling sessions last 45 - 50 minutes, but occasionally 20 - 30-minute sessions may be scheduled. We attempt to end each session promptly. Payment of co-pays or uncovered services is requested at the time of your appointment. We can accept cash or checks for your payment. If you must cancel an appointment, we ask that you call our office at least 24 hours in advance. A late cancel or no showed appointment may result in a no-show fee. Repeated No Shows or Late Cancels may also result in limited availability for you to reschedule future appointments.

8. Our telephone is answered 24 hours a day by a digital answering system. Throughout the day we check messages and whenever possible we try to return phone calls the same day. If we have not returned your call within 24 hours, please try again. If you leave a message after office hours the message will be checked the following morning. On Fridays after closing at 1:00pm, calls go to the answering machine and will be checked on Monday mornings. If you have an emergency after hours or on the weekend, please call 911 or go to your closest emergency room.

9. LCA has my permission to contact me using:

Text YES _____ (initial) _____ (cell phone number) NO _____ (initial)

Email YES _____ (initial) _____ (email address) NO _____ (initial)

If I have any questions regarding this consent form or about the services offered at Lake Country Associates, I may discuss them with my mental health provider. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by Lake Country Associates. It is understood that either of us may discontinue the evaluation and treatment at any time and that I am free to accept or reject the treatment provided.

_____ _____

Client or Legal Guardian Signature **Date**

IF CLIENT IS A MINOR

In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.

_____ _____

Signature of client's guardian **Date**

Name of minor child: _____

Minor child's date of birth: _____

Relationship to minor child: _____

Chart # _____

LAKE COUNTRY ASSOCIATES, INC.
515 Bridge Street East, Park Rapids, MN 56470 ph: 218-366-9229
1426 Bemidji Ave NW, Ste 1 Bemidji, MN 56601 ph: 218-444-2233
11 Main Street East Menahga, MN 56164 ph: 218-564-9229
Fax: 218-237-2520

Telehealth Informed Consent

I _____, consent to engaging in telehealth with Lake Country Associates, Inc. as a part of the therapy process. Telehealth involves the patient being at one site and the licensed provider being at another site providing services in the same manner as if the service was delivered in person. Telehealth sessions are not recorded, rather are in real time between the clinician and the patient. Network and software security protocols are in place to protect patient information and safeguard data that is exchanged. Telehealth services will comply with all applicable federal and state regulations, including, but not limited to confidentiality and privacy requirements. All policies and practices of Lake Country Associates, Inc. will apply to telehealth visits as they would face-to-face visits.

I understand I have the following with respect to telehealth:

1) I have the right to withhold or remove consent at any time without affecting my right to future care or treatment.

2) The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentially including, but not limited to, reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law.

3) I understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

4) I understand that there are risks and consequences from telehealth including but not limited to, the possibility, despite reasonable efforts on the part of Lake Country Associates, Inc. that the transmission of information could be delayed, disrupted and/or distorted by technical failures and/or the possibility of confidentiality breaches. The use of telehealth is still relatively new, so there may be risks not yet known to clinicians.

5) I understand that I am responsible for providing a safe and secure site, with electronic devices that can use the videoconferencing application. This must include audio and a camera.

5) I understand that telehealth services and care may not be as complete as in-person services. I understand that if my therapist believes I would be better served by other interventions, I will be referred to a mental health professional that can provide those services in my area. I also understand that there are potential risks and benefits associated with any form of mental health treatment, and that despite my efforts and efforts of my therapist, my condition may not improve, or may have the potential to get worse.

6) I agree that certain situations including emergencies and crises are inappropriate for telehealth or outpatient mental health services. If I am in crisis or in an emergency, I should immediately call 911 or go to the nearest hospital or crisis facility. I understand that emergency situations include but are not limited to thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if I am in a life threatening or situation, and/or if I am abusing drugs or alcohol and are not safe.

By signing below, I am indicating that I have read and understand the information provided to me on the use of telehealth services at Lake Country Associates, Inc. I have had the opportunity to discuss my concerns and my questions have been answered to my satisfaction. I understand that this is not a legal contract, but rather a treatment agreement. I give my consent for the use of telehealth in the course of my diagnosis and treatment.

_____ _____
Client Printed Name Client or Legal Guardian Signature

_____ _____
Email Address Date

Initial: _____ During this crisis situation, I consent to receiving services via telephone