

Date _____/_____/_____

**PATIENT INFORMATION SHEET
(CHILDREN AND ADOLESCENTS)**

PATIENT'S NAME _____
(Last) (First) (MI)

ADDRESS _____
(# and Street) (City) (Zip)

Patient's

Home #(_____) _____

Work #(_____) _____

Cell # (_____) _____

Please check boxes next to the phone number(s), if any, where Jeff Shively has your permission to leave a message identifying information, if necessary, such as his name, phone number, and appointment time if needed.

REFERRED BY:

Self Family Member Friend School Church Professional (Doctor/Clinic)

Insurance Co Website (which one?) _____

Other _____

BIRTHDATE _____/_____/_____ **AGE** _____ **SEX** _____

CURRENT GRADE AND NAME OF SCHOOL _____

NAME OF EMPLOYER, IF ANY _____

NUMBER IN PRIMARY HOUSEHOLD _____ **AGES** _____

PERSON TO NOTIFY IN AN EMERGENCY:

NAME _____

RELATIONSHIP TO PATIENT _____

PHONE _____

The information given on this form is true, complete, and correct to the best of my knowledge.

Parent/Guardian Signature

Date

Date _____/_____/_____

PARENT/GUARDIAN INFORMATION SHEET

(To be completed by parent/guardian attending first meeting with minor patients)

MOTHER'S NAME _____
(Last) (First) (MI)

ADDRESS _____
(# and Street) (City) (Zip)

FATHER'S NAME _____
(Last) (First) (MI)

ADDRESS _____
(# and Street) (City) (Zip)

Please check boxes next to the phone number(s) below, if any, where Jeff Shively has your permission to leave a message identifying information, if necessary, such as his name, phone number, and appointment time.

Mother's:

Home#(_____) _____

Work#(_____) _____

Cell # (_____) _____

Father's:

Home #(_____) _____

Work #(_____) _____

Cell # (_____) _____

OK to text or email appointment reminders if necessary? Yes No

MARITAL STATUS OF PATIENT'S MOTHER:

Single Married Separated Divorced Widowed

MARITAL STATUS OF PATIENT'S FATHER:

Single Married Separated Divorced Widowed

DO BOTH PARENTS, IF LIVING, KNOW AND APPROVE OF PATIENT BEING IN THERAPY?

YES NO ONE OR BOTH PARENTS ARE DECEASED

MOTHER'S EMPLOYER _____

FATHER'S EMPLOYER _____

PERSON TO NOTIFY IN AN EMERGENCY, IF OTHER THAN MOTHER OR FATHER:

NAME _____

RELATIONSHIP TO PATIENT _____

PHONE _____

The information given on this form is true, complete, and correct to the best of my knowledge.

Parent/Guardian Signature

Date

Name _____ Date _____

Check here if the patient does not have insurance or Medical Assistance

Insurance or Medical Assistance Patients

Name of ins. company _____ Phone _____

Policy holder _____ Employer _____

Date of birth of **policy holder** _____

Subscriber ID # _____ Group # _____

I hereby authorize payment directly to Jeff Shively, MSW, LICSW for outpatient mental health benefits for services received by me or my dependents.

Patient signature

Date

Release of Medical Information

I authorize Jeff Shively, MSW, LICSW to disclose to my insurance company (if Medicaid, to the MN Medical Assistance Program), information concerning the nature and diagnoses, extent, dates, cost, and outcome of the services provided to me, for the purpose of payment of services, billing verification, and evaluation. I understand that my records are protected under state and federal confidentiality regulations, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I understand that I may revoke this consent at any time except to the extent that information has been released in good faith or release of information is a condition of parole, probation, or court confinement. In any event, this consent expires automatically when my period of treatment ends and the financial liability for it has been satisfied, or within one year, whichever is earlier. I also understand that if I revoke this consent before any third-party payer or funding source has received data required for billing verification, I will assume full responsibility for the cost of the services provided to me. I understand that failure to pay my bill may result in my name being referred to a collection agency or a conciliation court.

Signature

Date

Relationship if other than patient

Date: _____

Name: _____

ADOLESCENT SELF-REPORT FORM

(ages 13-17)

(to be filled out by the adolescent)

In the last 4 weeks, please indicate how much you were distressed by:

	0 = Not at all		4 = Extremely		
	0	1	2	3	4
Feeling depressed/sad	0	1	2	3	4
Feeling anxious/tense/panic	0	1	2	3	4
Relationships with:					
My parents	0	1	2	3	4
My friends	0	1	2	3	4
My girlfriend/boyfriend	0	1	2	3	4
Others _____	0	1	2	3	4
Grief/loss issues	0	1	2	3	4
Physical/sexual abuse issues	0	1	2	3	4
Lack of assertiveness	0	1	2	3	4
Memories of childhood experiences affecting my current life	0	1	2	3	4
Thoughts of hurting myself	0	1	2	3	4
Thoughts of hurting others	0	1	2	3	4
School	0	1	2	3	4
Work	0	1	2	3	4
My physical health	0	1	2	3	4
Feeling lonely	0	1	2	3	4
Chemical abuse issues	0	1	2	3	4
Eating disorder issues	0	1	2	3	4
Addictive or compulsive behavior	0	1	2	3	4
Other _____	0	1	2	3	4

PATIENT AGREEMENT

TREATMENT PHILOSOPHY

As your therapist, I believe in providing goal-directed treatment. This means that a treatment goal or several goals are established after a thorough assessment. All treatment is then planned with the goal in mind and progress is made toward accomplishment of that goal in a time-efficient manner. If you ever have any questions about the nature of the treatment or anything else about your care, please don't hesitate to ask.

CONFIDENTIALITY

All information between Jeff Shively, MSW, LICSW and the patient is held strictly confidential unless:

1. The patient authorizes release of information with his/her signature.
2. The patient presents a physical danger to self.
3. The patient presents a danger to others.
4. Child/elder abuse/neglect is suspected.

In the latter two cases, Jeff Shively is required by law to inform potential victims and legal authorities so that protective measures can be taken.

FINANCIAL TERMS

Fees are \$160.00 per session for intake session(s) and \$130.00 per session for subsequent sessions.

Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed for you, and Jeff Shively, MSW, LICSW will be paid directly by the carrier. You will be responsible for any applicable deductibles and co-payments. Co-payments must be paid at the time services are rendered. If you are not eligible for insurance reimbursement at the time services are rendered, you are responsible for full payment. If your account becomes delinquent and Jeff Shively forwards your account to a collection agency and/or attorney, you agree to pay collection costs, attorney fees, interest, and court costs. **The balance of fees not paid by the insurance company within 90 days of claim submission will be billed to the patient (parent/guardian if the patient is a minor).**

Additionally, a \$25.00 fee will be charged for checks returned for non-sufficient funds.

CANCELLED/MISSED APPOINTMENTS

A scheduled appointment means the time is reserved only for you. If an appointment is missed, or cancelled with less than 48 hours notice, you will be billed \$75.00 for the missed session. Your health plan does not cover payment for missed appointments; therefore, you will be responsible for the \$75.00 no-show/late cancellation fee.

EMERGENCY PROCEDURES

If you need to contact me, leave a message on my phone, and your call will be returned. If an emergency situation arises, state that your call is an emergency. If you deem your situation to be a life or death situation, immediately call 911 or go to the nearest emergency room.

RELEASE OF INFORMATION

I authorize the release of information regarding my care to my health plan for the payment of claims, certifications/case management decisions, and other purposes related to the administration of benefits for my health plan.

CONSENT FOR TREATMENT

I further authorize and request that Jeff Shively, MSW, LICSW carry out mental health examinations, treatments, and/or diagnostic procedures, which now or during the course of my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

I understand and agree to all of the above information.

Printed Name of Parent/Guardian

Parent/Guardian Signature

Date

Coordination of Care with your child's Primary Care Physician (PCP)

To ensure more informed, effective, and coordinated treatment of your child's mental health or chemical health needs, it is often helpful (and sometimes critical) for your child's Mental Health Provider (MHP), Jeff Shively, MSW, LICSW, to have direct contact with your child's medical doctor (PCP). This is especially true if/when your child has a medical condition which affects his/her mental/chemical health or vice versa, or when your child's PCP is responsible for prescribing psychiatric medications.

If you choose to have Jeff Shively contact your child's PCP, please understand that the initial information released will include diagnosis and general treatment plan. After the initial information is sent, there may be additional contact by telephone between providers for the purpose of continued coordination of care, and other pertinent reports (for example psychological testing reports or chemical health assessment) may be exchanged as deemed necessary. If you choose to authorize such contact between your child's health providers, you will be asked to sign the attached Release of Information Form, and to provide contact information for your child's PCP. Please speak with Jeff Shively if you have any concerns or questions regarding your choices.

Please select the option below that applies to you.

YES, I want you to notify my child's medical doctor that I am receiving care from Jeff Shively. (You will need to sign the Release of Information Form and provide contact information for your PCP.)

NO, I do not want any communication with my child's medical doctor.

Your signature below confirms that you have been informed of your choices regarding contact with your child's PCP.

Parent's signature (or legal guardian)

Date

HIPAA Notice of Privacy Practices

Effective Date: 3/1/2013

JEFF SHIVELY, MSW, LICSW, Inc.
License #18053 (MN)

12805 Highway 55, Ste. 200, Plymouth, MN 55441
612-723-0408

Available on my website at www.therapymn.com, in the Forms section

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

If you have any questions about this notice, please contact Jeff Shively, LICSW at 612-723-0408. **Please note that this notice is required by Federal law, and the information it contains is mandated by that law.** If you have any questions about how your Protected Health Information (PHI) is used, please contact me.

I. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI) I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice. However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it on my website as noted at the beginning of this document. You can also request a copy of this Notice from me, or you can view a copy of it on my website as noted at the beginning of this document.

II. HOW I MAY USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written

Consent. I can use and disclose your PHI without your consent for the following reasons:

- 1. For treatment.** I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if you're being treated by a psychiatrist, I can disclose your PHI to your psychiatrist in order to coordinate your care. However, it is my practice to only do so if you have directly authorized me in writing, unless a threat to your safety is involved.
- 2. To obtain payment for treatment.** I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.
- 3. For health care operations.** I can disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to our accountants, attorneys, consultants, and others to make sure I'm complying with applicable laws.
- 4. Other disclosures.** I may also disclose your PHI to others without your consent in certain situations. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Uses and Disclosures Do Not Require Your Consent . I can use and disclose your PHI without your consent or authorization for the following reasons:

- 1. When disclosure is required by federal, state or local law; judicial or administrative proceedings; or, law enforcement** . For example, I may make a disclosure to applicable officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.
- 2. For public health activities**. For example, I may have to report information about you to the county coroner.
- 3. For health oversight activities**. For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
- 4. For research purposes**. In certain circumstances, I may provide PHI in order to conduct medical research.
- 5. To avoid harm**. In order to avoid a serious threat to you or another person, I may disclose PHI to law enforcement personnel or persons able to prevent or lessen such harm.
- 6. For specific government functions** . I may disclose PHI of military personnel and veterans in certain situations. And I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
- 7. For workers' compensation purposes**. I may provide PHI in order to comply with workers' compensation laws.
- 8. Appointment reminders and health related benefits or services** . I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

- 1. Disclosures to family, friends, or others** . I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization . There are specific disclosures that would require your authorization, but that this practice does not do. These include disclosing your PHI for marketing purposes (marketing of services other than those of Families Counseling), sale of PHI to third parties, and fundraising purposes.

In these, or any other situation not described in sections III A, B, and C above, I will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

III. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI You have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI . You have the right to ask that I limit how I use and disclose your PHI. I am not required to agree to your request unless you are asking me to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid me "out-of-pocket" in full. If I agree, I will comply with your request unless the information is needed to provide you with emergency treatment. You may not limit the uses and disclosures that I am legally required or allowed to make.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that I not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and I will honor that request.

B. The Right to Choose How I Send PHI to You . You have the right to ask that I send information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail) I must agree to your request so long as I can easily provide the PHI to you in the format you requested.

C. The Right to See and Get Copies of Your PHI . In most cases, you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to you within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance. If you request copies of your PHI, I will charge you not more than \$.25 for each page.

In my practice, I keep "treatment notes" which are a regular part of your PHI. I do not keep what are called "psychotherapy notes", which are a separate sort of record and are generally not accessible to clients.

D. The Right to Get a List of the Disclosures I Have Made .

You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

E. The Right to Correct or Update Your PHI . If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. The Right to Get This Notice by E-Mail . You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

G. Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me via the address and/or phone number at the beginning of this document.

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003. The latest version was effective on the date noted at the beginning of this document.

Parent/Guardian Signature