

Lakeville Behavioral Health Client Privacy Statement

There are laws that protect your rights as a client of this clinic. This statement of rights applies to your current contact with this clinic and all future contacts whether the contact is in person, by telephone, or by mail. If you have any questions about this statement or any of your rights as described, you may discuss them with your counselor or any other staff person. Specific information about how you can get copies of data, appeal accuracy and completeness of data, request summary data, and other procedures are available upon request.

DATA PRIVACY - The Minnesota Government Data Practices Act requires us to tell you:

- Why we ask for information;
- Whether you must give it or can refuse to give it;
- What will happen if you give or don't give the information; and
- Who else may see the information.

PURPOSES - The information we ask from you will be used for determining what help you need, developing a treatment plan, and giving you the services you want. The information will also be used for determining if you can pay for the services or if you can collect payment from other persons such as insurance companies or social service agencies.

LEGAL REQUIREMENTS AND CONSEQUENCES - There is no law that says you have to give us any information. But if you do not give us some information we will be unable to help you or our help will be delayed. If you are here because of a court order and you refuse to provide information, that refusal may be communicated to the court. Without certain information, we may not be able to tell who should pay for your care.

SHARING - Information we have about you may be shared with other agencies or individuals under the following circumstances:

- If you consent to the sharing or if we get a court order;
- If a law says we have to give information, including laws that require reporting child abuse or vulnerable adult abuse, or if a client is a danger to himself or another person.
- If there is a contract granting access, including the release of information to auditors and accrediting agencies;
- To staff in this clinic who need the data to do their jobs;
- To tell family members or other persons about your condition in accordance with acceptable medical practice, including the release of information in emergencies;
- To get the service fees due us through the courts or collection agencies;
- Workers Compensation, if you see us for a work related emotional problem;
- To the Secret Service to report security threats; and
- To a coroner / medical examiner if you die and your death is investigated.

MINORS - If you are under 18, you may request that data about you be kept from your parents. You must give us your request in writing, describe the data and tell us why you don't want your parents to see it. If, after receiving your request, this center believes that giving the data to your parents is not in your best interests, we will withhold the data from them. If you are 16, you may ask for mental health services without the consent of your parents but you might have to pay for the services if you don't want your parents to know. Ask your therapist about this.

ACCESS - You may see and have copies of most of the information about you. You may not see data that is confidential or data about another person without that person's consent.

PLANNING YOUR TREATMENT - You have the right to help develop your treatment plan. You have the right to help determine the best treatment options.

PATIENT RIGHTS:

- In your interaction with Lakeville Behavioral Health staff, you have the right to be treated with respect, dignity and privacy.
- You have the right to make complaints about Lakeville Behavioral Health staff, services or other care given by providers.
- You have the right to know about covered services and benefits offered under your plan, and how to seek care services.
- You have the right to receive timely care consistent with your need for care.
- You have the right to know all the facts about any charge or bill you receive, no matter who is making payment.

PATIENT RESPONSIBILITIES:

- You have the responsibility to provide information (including past treatment records) that Lakeville Behavioral Health may need to plan your treatment.
- You have the responsibility to learn about your condition and work with your provider to develop a plan for your care.
- You have the responsibility to follow the plans and instructions for care you have agreed to with your provider.
- You have the responsibility to notify Lakeville Behavioral Health and your provider of changes to medical or mental health and/or phone number changes.

Please sign this form. Your signature shows that you understand it.

Signature

Date

Lakeville Behavioral Health, LLC

10535 165th Street West

Lakeville, MN 55044

Phone (952) 435-0022 Fax (952) 435-0095

Authorization to Release Information for Benefits

I authorize Lakeville Behavioral Health to release information, including medical records, to my insurance company or the designee of my third party payer (authorized agent) as may be necessary to determine benefits and to process health care claims for my health care visit(s) at Lakeville Behavioral Health, LLC.

Professional Services and Fees

I, the undersigned, understand that I am responsible for payment in full fees for services incurred at Lakeville Behavioral Health. I also understand that, I am responsible for any deductible or percentage not paid for by my insurance. If for any reason, the insurance company fails to pay the amount estimated, I am responsible for the balance.

I agree to a charge of \$210.00 for the initial appointment at Lakeville Behavioral Health. This includes fifty minute appointment, set up costs, initial paperwork and charting.

I agree to a charge of \$140.00 per hour for each additional fifty minute appointment at Lakeville Behavioral Health.

NOTE:

I understand I will be charged a late/cancellation fee of **\$20.00 (first time only)** and **\$50.00** for any subsequent scheduled appointments that I fail to attend or that I do not cancel within 24 hours prior to the scheduled appointment time. I also understand that cancellations for Monday appointments must be made before noon on Friday to avoid the late cancellation fee.

Insurance Provider: _____

Estimated Insurance Benefits Provided by Your Insurance Company to Lakeville Behavioral Health, LLC

Deductible: \$_____ Insurance Covers: _____% Personal: _____% Co-Pay per visit: \$_____

Maximum insurance benefits paid by the Insurance Company: \$_____

I understand that the estimated insurance benefits that were given to Lakeville Behavioral Health by my insurance company may not be the same as the actual payments made by my insurance company, and that I am responsible for any portion not covered by my health insurance plan.

Patient Signature (or Responsible Party)

Print Patient's Name

Date

Relationship to Patient

Copy to Client

ADULT PROBLEM CHECKLIST

The following is a list of problems and symptoms that people experience. Please check those that you have experienced over the past month.

- 1. Sadness
- 2. Crying more than usual
- 3. Loss of interest or pleasure in activities
- 4. Weight loss or gain (circle)
- 5. Decrease or increase in appetite (circle)
- 6. Fatigue or low energy level
- 7. Concerns about eating
- 8. Feelings of hopelessness
- 9. Feeling of worthlessness
- 10. Difficulty concentrating
- 11. Suicidal thoughts
- 12. Thoughts of harming others
- 13. Anxiousness
- 14. Panic attacks
- 15. Shortness of breath
- 16. Worried about health
- 17. Fears
- 18. Trouble falling or staying asleep
- 19. Depressed mood
- 20. Compulsion to do things
- 21. Socially withdrawn
- 22. Trouble with memory
- 23. Outburst of anger
- 24. Legal difficulties or problems with the law
- 25. Disturbing thoughts
- 26. Fear of losing control
- 27. Trouble making decisions
- 28. Dizzy or unsteady feelings
- 29. Irritable
- 30. Sexual concerns
- 31. Thoughts hard to ignore or suppress
- 32. Financial problems
- 33. Family problems
- 34. Marital problems
- 35. Problems in the workplace

THE BURNS ANXIETY INVENTORY

Place a check in the box to the right of each category to indicate how much this type of feeling has bothered you in the past several days.

Category I: Anxious Feelings	0 Not at All	1 Somewhat	2 Moderately	3 A Lot
1. Anxiety, nervousness, worry, or fear				
2. Feeling that things around you are strange or unreal				
3. Feeling detached from all or part of your body				
4. Sudden unexpected panic spells				
5. Apprehension or a sense of impending doom				
6. Feeling tense, stressed, "uptight," or on edge				
Category II: Anxious Thoughts	0 Not at All	1 Somewhat	2 Moderately	3 A lot
7. Difficulty concentrating				
8. Racing thoughts				
9. Frightening fantasies or daydreams				
10. Feeling that you're on the verge of losing control				
11. Fears of cracking up or going crazy				
12. Fears of fainting or passing out				
13. Fears of physical illnesses or heart attacks or dying				
14. Concerns about looking foolish or inadequate				
15. Fears of being alone, isolated, or abandoned				

16. Fears of criticism or disapproval				
17. Fears that something terrible is about to happen				

THE BURNS ANXIETY INVENTORY (Page 2)

Category III: Physical Symptoms	0	1	2	3
	Not at All	Somewhat	Moderately	A Lot
18. Skipping, racing, or pounding of the heart (palpitations)				
19. Pain, pressure, or tightness in the chest				
20. Tingling or numbness in the toes or fingers				
21. Butterflies or discomfort in the stomach				
22. Constipation or diarrhea				
23. Restlessness or jumpiness				
24. Tight, tense muscles				
25. Sweating not brought on by heat				
26. A lump in the throat				
27. Trembling or shaking				
28. Rubbery or jelly legs				
29. Feeling dizzy, light-headed, or off balance				
30. Choking or smothering sensations or difficulty breathing				
31. Headaches or pains in the neck or back				
32. Hot flashes or cold chills				

33. Feeling tired, weak, or easily exhausted				
Total Score on items 1-33				