**Assessment and Therapy Associates of Grand Forks, PLLC**
**3535 South 31st St., Suite 201**
**Grand Forks, North Dakota 58201 (701)**
**780-6821 (phone) (701) 780-1973 (fax)**
**info@grandforkstherapy.com**

# PEDIATRIC BACKGROUND INFORMATION FORM

## GENERAL INFORMATION

| Child's First Name: | Last Name: | Date of Birth: | Age: |
|---|---|---|---|
| Name of Parent(s)/Guardian: (mother): | | (father): | |
| Name of Person Completing This Form: | | Relationship to Child: | |
| Do you have legal custody of this child? ☐ Yes ☐ No | | | |
| Address: Street: | City: | State: | Zip: |
| Phone: Home: ( ) - | Work: ( ) - | Cell/Other: ( ) - | |
| May we leave messages at: Home? ☐ Yes ☐ No Work? ☐ Yes ☐ No Cell? ☐ Yes ☐ No | | | |
| E-mail Address (if you would like to use this for communication): | | | |
| How were you referred to this clinic? | | | |
| Who is your child's primary care physician/provider? | | | |
| Would you like a copy of this evaluation sent to your child's physician/provider? ☐ Yes ☐ No | | | |
| If yes, where does this provider practice (i.e., name/address of clinic): | | | |

## INSURANCE INFORMATION

**(Please give your insurance card to the office manager)**

| Person responsible for bill: | Date of Birth: | Relationship to patient: |
|---|---|---|
| Address of responsible party (if different): | Home phone no.: ( ) - | |
| Is this patient covered by insurance? ☐ Yes ☐ No | Name of Insurance Company/Plan: | |
| Subscriber's name: | Plan Number/ID: | Group Number: |
| Patient's relationship to subscriber: ☐ Self ☐ Child ☐ Other | Subscriber's Date of Birth: | |

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the clinician. I understand that I am financially responsible for any balance. I also authorize Assessment and Therapy Associates of Grand Forks, PLLC or insurance company to release any information required to process my claims (please initial):

## CURRENT PROBLEMS

Please describe the problems that your child is demonstrating:

How long have these problems been present?

Are these problems related to any specific event or situation? ☐ Yes ☐ No

If yes, describe the event/situation:

Is your child currently in therapy for these problems? ☐ Yes ☐ No If yes, who is the therapist?

Does your child currently take medication(s) for this or any other emotional or behavioral problem? ☐ Yes ☐ No

| If yes, what medication(s) does he/she take? | Who manages this medication? |
|---|---|

If your child is being seen for an assessment, what questions would you like to have answered?

## PREVIOUS TREATMENTS AND EVALUATIONS

| Has your child had therapy previously? ☐ Yes ☐ No | If yes, who was therapist? |
|---|---|

What problems did previous therapy address?

Has your child previously taken any medication(s) for this or any other emotional or behavioral problem? ☐ Yes ☐ No

| If yes, what medication(s) did he/she take? | Who managed this medication? |
|---|---|

Has your child ever been evaluated for learning, developmental, emotional, or behavioral issues? ☐ Yes ☐ No

**If yes, what types of evaluation(s) has your child had (CHECK AND DESCRIBE ALL THAT APPLY):**

| | |
|---|---|
| ☐ Emotional/Behavioral Problems | Who conducted evaluation? |
| ☐ Cognitive/Learning Evaluation | Who conducted evaluation? |
| ☐ Developmental Delays | Who conducted evaluation? |
| ☐ Speech/Language Problems | Who conducted evaluation? |
| ☐ Fine or Gross Motor | Who conducted evaluation? |
| ☐ Sensory Integration | Who conducted evaluation? |
| ☐ Visual Processing Evaluation | Who conducted evaluation? |
| ☐ Central Auditory Processing | Who conducted evaluation? |
| ☐ Other (Describe): | Who conducted evaluation? |

## PRENATAL HISTORY

| ***Did your child have any of the following problems? PLEASE CHECK AND DESCRIBE ALL THAT APPLY*** | |
|---|---|
| ☐ Prenatal problems | If yes, describe: |
| ☐ Alcohol or drug exposure in utero | If yes, describe: |
| ☐ Delivery problems | If yes, describe: |
| ☐ Caesarian Section Delivery | Reason for C-Section: |
| ☐ Prematurity | If yes. how early was child delivered? |
| ☐ Health problems at birth | If yes, describe: |
| What was your child's birth weight? pounds ounces | |

## MEDICAL HISTORY

| ***Has your child had any of the following medical problems? PLEASE CHECK AND DESCRIBE ALL THAT APPLY*** | |
|---|---|
| ☐ Chronic Ear Infections Age infections began: | ☐ Ear Tubes Age ear tubes were placed: |
| ☐ Chronic medical issues | If yes, describe: |
| ☐ Seizures | If yes, describe: |
| ☐ Prolonged high fevers | If yes, describe: |
| ☐ Head injury | If yes, describe: |
| ☐ Surgeries | If yes, describe: |
| ☐ Serious Medical Illnesses | If yes, describe: |

## MEDICAL HISTORY (CONTINUED)

**Does your child currently take any medications for health problems?** ☐ **Yes** ☐ **No**

If yes, what medications?

What are medications for?

**Does your child have any of the following problems with sleep (CHECK ALL THAT APPLY):**

☐ severe resistance to going to bed
☐ problems falling asleep once in bed
☐ sleeping less than usual (WITH daytime fatigue)
☐ sleeping less than usual (WITHOUT daytime fatigue)
☐ sleeping too much
☐ waking in the night
☐ waking too early in the morning
☐ nightmares

**Does your child have any of the following appetite or eating problems (CHECK ALL THAT APPLY):**

☐ excessively picky eating
☐ eating too little
☐ eating too much
☐ trying to lose weight when weight is normal

| | |
|---|---|
| Has you child recently ***gained*** a significant amount of weight? ☐ Yes ☐ No | ***If yes, how much?*** |
| Has you child recently ***lost*** a significant amount of weight? ☐ Yes ☐ No | ***If yes, how much?*** |

## DEVELOPMENTAL HISTORY

***Has your child had developmental delays in any of these areas? PLEASE CHECK AND DESCRIBE ALL THAT APPLY***

| | |
|---|---|
| ☐ Gross (large) motor skills | If yes, describe: |
| ☐ Fine (small) motor skills | If yes, describe: |
| ☐ Language skills | If yes, describe: |
| ☐ Self-help skills | If yes, describe: |
| ☐ Social skills | If yes, describe: |
| ☐ Other delays | If yes, describe: |

**What hand does your child use?** ☐ Right hand ☐ Left hand ☐ Both ☐ Has not chosen dominant hand

## DEVELOPMENTAL HISTORY (CONTINUED)

**Does your child demonstrate any of the following behaviors or problems (CHECK ALL THAT APPLY):**

- ☐ tics
- ☐ unusual movements
- ☐ speaking "her own language"
- ☐ poor eye contact
- ☐ "echoing" or repeating what he/she hears
- ☐ repeating movies/conversations
- ☐ not responding to his/her name when called
- ☐ difficulty imitating others
- ☐ hand flapping or other unusual behavior when excited
- ☐ walking on his/her toes
- ☐ waving fingers or other objects in front of his/her face
- ☐ lining up toys in play
- ☐ lack of imaginative play
- ☐ poor response to changes or transitions
- ☐ disinterest in people/peers
- ☐ unusual interests or attachment objects
- ☐ problems talking about things other than his/her interests
- ☐ oversensitivity to sounds
- ☐ seeking out loud sounds or noises
- ☐ oversensitivity to visual stimuli
- ☐ oversensitivity to touch
- ☐ high pain tolerance
- ☐ oversensitivity to smells
- ☐ oversensitivity to food textures

Describe your child's friendships and peer relationships:

Describe your child's strengths:

## FAMILY AND SOCIAL HISTORY

| | | |
|---|---|---|
| Where does your child live (city, state)? | | Who does child live with? |
| Mother's name: | Mother's occupation: | Child's relationship with mother: |
| Father's name: | Father's occupation: | Child's relationship with father: |
| Other Caregivers (e.g., step-parents): | | Child's relationship with caregivers: |

***List child's siblings below:***

| | | |
|---|---|---|
| Name: | Age: | Child's relationship with this sibling: |
| Name: | Age: | Child's relationship with this sibling: |
| Name: | Age: | Child's relationship with this sibling: |
| Name: | Age: | Child's relationship with this sibling: |

***Have any of the following stressors impacted your child in the last year?***

- ☐ Divorce
- ☐ Death of friend
- ☐ Victim of accident
- ☐ Conflict in family
- ☐ Conflict with friends
- ☐ Expelled from school
- ☐ Break-up of relationship
- ☐ Natural disaster
- ☐ Death of parent
- ☐ Starting new job
- ☐ Serious illness
- ☐ Financial problems
- ☐ Death of a pet
- ☐ Birth of a child
- ☐ Conflict at work
- ☐ Surgeries
- ☐ Death of family member
- ☐ Abuse/victim of crime
- ☐ Illness of family member
- ☐ Illness in close friend
- ☐ Foster home placement
- ☐ Separation from family
- ☐ Moving to a new area
- ☐ Separation

**Provide further description of family stressors (if needed):**

# FAMILY MEDICAL AND PSYCHIATRIC HISTORY

***List any family medical problems that your child is at risk for:***

***Family Psychiatric History (CHECK ALL THAT APPLY):***

| | | |
|---|---|---|
| ☐ Depression | ☐ Bipolar Disorder (Manic-Depression) | ☐ Anxiety/nervousness |
| ☐ Panic Attacks | ☐ Schizophrenia | ☐ Suicide Attempts |
| ☐ Alcohol problems | ☐ Drug problems | ☐ Suicide Completion |
| ☐ Learning Problems | ☐ Attention Problems | ☐ Legal Problems |
| ☐ Autism | ☐ Hyperactivity | ☐ Delayed Development |
| ☐ Eating Disorders | ☐ Hospitalization for mental problems | ☐ Tics/Tourette's Syndrome |

# ACADEMIC HISTORY

| What grade is your child in currently? | What school does your child attend? |
|---|---|

Who is your child's teacher (if child is in middle or high school and has multiple teachers, enter "team"):

***Does child currently have problems in any of the following academic areas? CHECK AND DESCRIBE ALL THAT APPLY***

| | |
|---|---|
| ☐ Reading problems | If yes, describe: |
| ☐ Writing problems | If yes, describe: |
| ☐ Math problems | If yes, describe: |
| ☐ Behavior problems (at school) | If yes, describe: |
| ☐ Homework problems | If yes, describe: |

Does your child have an Individualized Education program (IEP)? ☐ Yes ☐ No If yes, what does programming address?

| | | |
|---|---|---|
| ☐ Speech/language problems | ☐ Specific Learning Disability | ☐ Autism |
| ☐ Noncategorical Delay | ☐ Mentally Handicapped | ☐ Emotional/Behavioral Problems |
| ☐ Other Health Impaired | ☐ Traumatic Brain Injury | ☐ Other (describe) |

Does your child have a 504 Accommodation Plan? ☐ Yes ☐ No If yes, what do accommodations address?

| | | |
|---|---|---|
| ☐ attention/organizational problems | ☐ fine motor problems | ☐ emotional problems |
| ☐ behavioral problems | ☐ sensory problems | ☐ other (describe): |

Has your child ever been retained (held back) in a grade? ☐ Yes ☐ No If yes, why?

## BEHAVIOR

***Check the symptoms your child demonstrates regularly and/or symptoms severe enough to cause impairment:***

***Attention Problems (CHECK ALL THAT APPLY):***

- ☐ fails to give close attention to details
- ☐ makes careless mistakes in schoolwork
- ☐ has difficulty sustaining attention in tasks or play
- ☐ demonstrates poor listening when spoken to directly
- ☐ avoids tasks that require sustained mental effort
- ☐ becomes easily distracted by extraneous stimuli
- ☐ has difficulty refocusing after distraction
- ☐ has difficulty following through on instructions
- ☐ fails to finish work
- ☐ has difficulty with multitasking

***Organization Problems (CHECK ALL THAT APPLY):***

- ☐ generally messy
- ☐ loses things necessary for tasks
- ☐ forgets to turn work in
- ☐ has many missing assignments
- ☐ forgetful in daily activities
- ☐ forgets to bring home homework

***Activity Level Problems (CHECK ALL THAT APPLY):***

- ☐ fidgets or squirms in his/her seat
- ☐ leaves his/her seat in the classroom or in other situations
- ☐ runs about or climbs excessively
- ☐ reports feeling restless
- ☐ often has difficulty playing quietly
- ☐ is 'on the go' or often acts as if 'driven by a motor'
- ☐ talks excessively

***Impulse Control Problems (CHECK ALL THAT APPLY):***

- ☐ blurts out answers to questions
- ☐ has difficulty awaiting his/her turn
- ☐ interrupts or intrudes on others
- ☐ behaves in a way that could be dangerous because he/she does not think through their actions

***Other Behavioral Problems (CHECK ALL THAT APPLY):***

- ☐ is often angry or resentful
- ☐ misbehavior has anger management problems
- ☐ often loses his/her temper
- ☐ has temper tantrums
- ☐ argues with adults
- ☐ defies and refuses to comply with adults' requests or rules
- ☐ often blames others for his/her own mistakes
- ☐ steals at home
- ☐ steals outside of home
- ☐ uses alcohol/drugs
- ☐ has trouble with the law

How long have the behavioral problems you checked above existed?

## EMOTIONS

***Check the symptoms your child demonstrates regularly and/or symptoms severe enough to cause impairment:***

***DEPRESSIVE SYMPTOMS (CHECK ALL THAT APPLY)***

- ☐ excessive, frequent sadness and/or crying
- ☐ poor self esteem
- ☐ excessive or frequent irritability
- ☐ overreactions to events
- ☐ extreme mood swings
- ☐ difficulty making decisions
- ☐ excessive physical
- ☐ energy loss/excessive fatigue
- ☐ loss of interest in activities
- ☐ social withdrawal
- ☐ self-harm (e.g., cutting)
- ☐ suicidal thoughts/behavior

***ANXIETY SYMPTOMS (CHECK ALL THAT APPLY)***

- ☐ specific fears
- ☐ general worry about what is going to happen
- ☐ worry about family members
- ☐ worry about school
- ☐ panic attacks (i.e., racing heart, extreme fear)
- ☐ frequent physical complaints
- ☐ exaggerated startle response
- ☐ frequent physical complaints
- ☐ obsessive thoughts
- ☐ repetitive acts
- ☐ fear of public places
- ☐ fear of social interactions
- ☐ avoids people/places/things/topics
- ☐ trauma/triggers
- ☐ increased negative/decreased positive emotion

How long have the emotional problems you checked above existed?

Are the above describe emotional and/or behavioral problems related to a specific situation/event? ☐Yes ☐No
If yes, describe:

What questions would you like to have answered as a result of this evaluation?

Is there anything else you feel we should know about your child?

# ASSESSMENT AND THERAPY ASSOCIATES OF GRAND FORKS (ATAGF), PLLC
# PATIENT SERVICES AGREEMENT

**Please note that your signature is needed on pages 6 and 7 of this Agreement.**

Welcome to our practice. This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations.

The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging we provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before your session. You and your provider can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between you, ATAGF, and your provider.

## YOUR PROVIDER

Your provider is a Licensed Psychologist, Psychology Resident, a Licensed Professional Clinical Counselor (LPCC), or a Licensed Independent Clinical Social Worker (LICSW). Individuals who are Licensed Psychologists have a Ph.D. in Clinical or Counseling Psychology and have completed the requirements for licensure as a psychologist in the state of North Dakota. Individuals who are Psychology Residents have a Ph.D. in Clinical or Counseling Psychology and are working toward completing the requirements for licensure as a psychologist in the State of North Dakota. Psychology Residents are supervised by a Licensed Psychologist in our practice and will provide you with the name of his or her supervisor during the initial session. Individuals who are LPCCs have a Master's degree in Counseling Psychology and have completed the requirements for licensure as a counselor in the state of North Dakota. Individuals who are LICSWs have a Master's degree in Social Work and have completed the requirements for licensure as social workers in the state of North Dakota.

## PSYCHOLOGICAL SERVICES

You are likely coming to ATAGF for psychotherapy, psychological testing, or both. Psychotherapy is not easily described in general statements. It varies depending on the personalities of the provider and patient and the particular problems you are experiencing. There are many different methods we may use to deal with the problems you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things you and your provider talk about both during your sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Yet, there are no guarantees of what you will experience.

The first few sessions with your provider will involve an evaluation of your needs. Part of this evaluation may involve completing psychological testing with your psychologist/psychology resident or with a psychology technician (who is supervised by a licensed psychologist). By the end of the evaluation, your provider will be able to offer you some first impressions of what your work together will include. There may also be a treatment plan to follow which may include referrals to other providers for services (such as psychotherapy and/or other treatment recommendations). You should evaluate this information along with your own opinions of whether you feel comfortable working with these providers. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the provider you select. If you have questions about our procedures at ATAGF, you should discuss them with your provider whenever they arise. If your doubts persist, your provider will be happy to help you set up a meeting with another mental health professional for a second opinion.

## MEETINGS

Our providers normally conduct an evaluation during the first session that typically consists of answering questions. During this time, you and the provider can both decide if he/she is the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, your provider will usually schedule one 45-minute session (one appointment hour of 45 minutes duration) per week at a time you agree on, although some sessions may be shorter / longer or more / less frequent. If you are coming for psychological testing, this testing is likely to be conducted in several different sessions. Your provider will be able to discuss his/her plan for testing with you after the initial session.

**Once an appointment hour is scheduled, you are asked to provide 24 hours [1 day] advance notice of cancellation if you are unable to make it to your appointment.** Although ATAGF provides reminder calls or SMS (text) messages for appointment times as a courtesy, it is your responsibility to know when you are scheduled to meet with your provider. Given reminder calls or SMS (text) messages can be made less than 24 hours in advance, if you cancel when you get your reminder, it is likely that your cancellation will be considered a late cancellation/no-show. After two late cancellations and/or no-shows, ATAGF providers reserve the right to remove you from a regular spot in their schedules and speak with you prior to scheduling additional appointments to determine your commitment to therapy and/or the psychological evaluation.

## PROFESSIONAL FEES

The fees involved for services at ATAGF depend upon the particular service and type of provider involved. Please contact ATAGF administrative staff or speak with your provider for more information about fees for the services provided to you. In addition to weekly appointments, ATAGF providers may charge for other professional services you may need, although the provider will break down the hourly cost if he/she works for periods of less than one hour. Other services may include but are not limited to telephone conversations lasting longer than 5 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of your provider. If you become involved in legal proceedings that require your provider's participation, you will be expected to pay for all of your provider's professional time, including preparation and transportation costs, even if your provider is called to testify by another party. Because of the difficulty of legal involvement, ATAGF providers charge more than the hourly rate for preparation and attendance at any legal proceeding. You are encouraged to discuss this fee with your providers prior to any legal involvement.

## CONTACTING YOUR PROVIDER

Due to the work schedules of our providers, they are often not immediately available by telephone. Although ATAGF providers are usually in the office between 8 AM and 5 PM these hours vary based upon the individual provider with whom you are working. Please discuss office hours of your provider with him/her. Your provider probably will not be available when he/she is with a patient. The telephone is answered by an administrative assistant 8am to 8pm Monday through Thursday and from 8am to 5pm on Friday. These administrative assistants know where to reach your provider and may inform you when he or she is available to speak with you.

Your provider will make every effort to return your call on the same day you make it, with the exception of evenings, weekends, and holidays. If you are difficult to reach, please inform ATAGF administrative assistants of times when you will be available. If you are unable to reach your provider and feel that you cannot wait for him/her to return your call, it is advised you call 911, go to your local Emergency Room, or call the 24-hour crisis line at Northeast Human Service Center at (701) 775-0525. If your provider will be unavailable for an extended time, he/she will provide you with the name of a colleague to contact, if necessary. PLEASE NOTE: **ATAGF providers do not carry a pager and are not available 24 hours a day. If you believe you may need such crisis services, ATAGF may not be the best practice for you.**

## LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a provider. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- Your provider may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, he/she makes every effort to avoid revealing the identity of the patient. The other professionals are also legally bound to keep the information confidential. If you don't object, your provider will not tell you about these consultations unless he/she feels it is important to your work together. Your provider will note consultations in your Clinical Record (which is called "PHI" in our Notice of Privacy Practices attached to this Agreement).

- You should be aware ATAGF providers practice with other mental health professionals and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

- We also have contracts with various entities that enable us to perform treatment, billing, and practice management operations. As required by HIPAA, we have formal business associate contracts with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, we can provide you with the names of these organizations and/or a blank copy of this contract.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

- If a patient threatens to seriously harm himself/herself or someone else, your provider or ATAGF staff may take actions to prevent this, including seeking hospitalization for him/her, notifying law enforcement, or contacting family members or others who can help provide protection.

There are some situations where ATAGF is permitted or required to disclose information without either your consent or authorization:

- If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis and treatment, such information is protected by the provider-patient privilege law. ATAGF providers cannot provide any information without your written authorization or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your provider to disclose information.

- If a government agency is requesting the information for health oversight activities, your provider may be required to provide it for them.

- If a patient files a complaint or lawsuit against an employee of ATAGF, the ATAGF employee may disclose relevant information regarding that patient in order to defend him or herself.

- If a patient files a worker's compensation claim, ATAGF must, upon appropriate request, provide appropriate information including a copy of the patient's record or other information concerning mental health care services, to the North Dakota Worker's Compensation Bureau.

- There are some situations in which an ATAGF provider is legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a patient's treatment.

- If we have reason to suspect that a child is abused or neglected, the law requires that we file a report with the Department of Human Services. Once such a report is filed, we may be required to provide additional information.

- If we have knowledge of or reasonable cause to suspect that an adult with developmental disabilities or mental illness is abused, neglected, or exploited, the law requires that we report such information to the Protection and Advocacy Project. Once such a report is filed, we may be required to provide additional information.

- If a patient threatens serious physical harm to an identifiable victim, we may take actions to protect the victim. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

If such a situation arises, your provider will make every effort to fully discuss it with you before taking any action and will limit my disclosure to what is necessary.

Although this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important you and your provider discuss any questions or concerns you may have now or in the future. The laws governing confidentiality can be complex, and your provider is not an attorney. In situations where specific advice is required, formal legal advice may be needed.

**PROFESSIONAL RECORDS**

The laws and standards of your provider's profession require that he/she keep Protected Health Information about you in your Clinical Record. You may examine and/or receive a copy of your Clinical Record (or a summary or explanation of the information contained in your Clinical Record if agreed by you in advance), if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, ATAGF recommends that you initially review them in your provider's presence or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, ATAGF can charge a copying fee of $20 per page for the first 25 pages, 75 cents per page for any pages beyond twenty-five and includes administrative, document retrieval, and postage charges. There may be instances in which your provider does not believe reviewing your record is in your best interest, and this will be discussed with you should this occur.

**RECORDING**

Your sessions with any ATAGF provider may not be recorded in any way by any party unless agreed to in writing by mutual consent (between you/your guardian and your ATAGF provider). The end date of this mutual consent will be included in the written agreement. A copy of this written agreement will be maintained in your medical record.

**APPOINTMENT REMINDERS**

ATAGF utilizes electronic SMS messaging (texting) for appointment reminders which may include phone calls with voicemail. It is your responsibility to ensure that contact information is updated with ATAGF staff and that failure to do so may result in someone other than yourself receiving the appointment reminder. You may also choose to opt out of text messaging reminders. In order to do so, please submit the request to ATAGF staff in writing and appointment reminders will be handled accordingly.

**PATIENT RIGHTS**

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that ATAGF amends your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about ATAGF policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and ATAGF privacy policies and procedures. Your provider or an ATAGF administrative assistant is happy to discuss any rights with you.

**MINORS & PARENTS**

Patients under 18 years of age who are not emancipated and their guardians should be aware the law may allow guardians to examine their child's treatment records unless your provider decides that such access is likely to injure the child or the legal guardian and the child's provider agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes ATAGF's policy to request an agreement from guardians that they consent to give up their access to the child's records. If they agree, during treatment, the provider will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. The

provider may also provide guardians with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless the provider feels the child is in danger or is a danger to someone else, in which case, the provider will notify the guardians of his/her concern. Before giving guardians any information, the provider will discuss the matter with the child, if possible, and do his/her best to handle any objections the child may have.

**BILLING AND PAYMENTS**

You will be expected to pay for each session at the time it is held, unless you and your provider agree otherwise or unless you have insurance coverage that requires another arrangement. Credit card payments and similar arrangements are more confidential than checks (with names on them), as we deposit these checks into our banking account. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, your provider may be willing to negotiate a fee adjustment (if allowed by managed care contracts) or payment plan.

If you would like someone other than yourself to pay your bill at ATAGF (such as parent of someone over the age of 18), we need additional information from you. We ask you provide contact information for the individual responsible for the account and provide your written authorization for us to speak with this individual about matters pertaining to your bill. Additional information is included in the form Payment of Outstanding Balances attached to this Agreement (page 8).

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, ATAGF has the option of using legal means to secure the payment. This may involve hiring a collection agency (i.e., United Accounts) or going through small claims court which will require your provider to disclose otherwise confidential information. In most collection situations, the only information ATAGF releases regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon or if the arrangements have not been followed, your individual provider may speak with you about a referral to another agency or individual provider who is able to provide more cost-effective services to you.

**INSURANCE REIMBURSEMENT**

In order for you and your provider to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. ATAGF administrative assistants and your provider will fill out forms and provide you with whatever assistance he/she can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of your provider's fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, ATAGF administrative staff will provide you with whatever information they can based on their experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, ATAGF administrative staff will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. Although much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed care plans will not allow providers to provide services to you once your benefits end. If this is the case, your provider will do his/her best to find another provider who will help you continue your psychotherapy.

You should also be aware that your contract with your health insurance company requires that ATAGF provides it with information relevant to the services that your provider provides to you. Your provider is required to provide a clinical diagnosis. Sometimes your provider is required to provide additional clinical information such as treatment plans or

summaries, or copies of your entire clinical record. In such situations, your provider will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Although all insurance companies claim to keep such information confidential, ATAGF has no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. Your provider will provide you with a copy of any report he/she submits, if you request it in writing. By signing this Agreement, you agree that ATAGF can provide requested information to your carrier.

Once we have all information about your insurance coverage, you and your provider will discuss what you can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above unless prohibited by contract.

**CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION TO INSURANCE COMPANY**

You authorize Assessment and Therapy Associates of Grand Forks, PLLC to disclose to your current insurance carrier past and present information that is necessary to prepare an insurance claim. The insurance company will use this information to process claims for benefits. You authorize all insurance payable on claims originating from Assessment and Therapy Associates of Grand Forks, PLLC to be paid directly to Assessment and Therapy Associates of Grand Forks, PLLC. You understand that no other use will be made of this information except for that otherwise authorized by law.

YOUR SIGNATURE BELOW INDICATES YOU HAVE READ THE INFORMATION IN THE *PATIENT SERVICES AGREEMENT* (Revised April 2019), *CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION TO INSURANCE COMPANY,* AND AGREE TO ABIDE BY ITS TERMS DURING THE PROFESSIONAL RELATIONSHIP YOU HAVE WITH ATAGF, ITS STAFF, AND ITS PROVIDERS. YOUR SIGNATURE ALSO INDICATES YOU WERE OFFERED A COPY OF THIS AGREEMENT FOR YOUR OWN RECORDS.

Patient Name (printed): ________________________________________

Patient or Legal Guardian Signature: ________________________________ Date: _____________

*If person signing this acknowledgement is not the patient, please print your name and relationship to the patient below:

Name: ____________________________________________

Relationship to the Patient: _____________________________

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NPP)**

I acknowledge I was provided a copy of the Notice of Privacy Practices (NPP) for Assessment and Therapy Associates of Grand Forks, PLLC (effective date September 23, 2013; updated April 9,2019).

Patient Name (printed): ________________________________________

Patient or Legal Guardian Signature: ________________________________ Date: _____________

*If person signing this acknowledgement is not the patient, please print your name and relationship to the patient below:

Name: ____________________________________________

Relationship to the Patient: _____________________________

<u>For Office Use Only</u>:

If no acknowledgement could be obtained, please document the reason(s) why below and efforts taken to obtain the acknowledgement:

______________________________________________________________________________

## PAYMENT OF OUTSTANDING BALANCES

Please provide information regarding where you would like your bill sent:

**Name of individual**:

**Address of individual**:

**Telephone number of individual**:

If the individual responsible for paying the bill is someone other than you please complete the section below. This allows ATAGF staff to communicate with the individual paying the bill regarding matters that pertain only to bill payment. We will not communicate with this individual about other matters regarding your care unless you authorize us to do so.

I authorize Assessment and Therapy Associates of Grand Forks, PLLC (ATAGF) to communicate with ___________________________________ (print name of individual) regarding matters related to payment of my bill. I understand this may involve providing this individual with an invoice that includes dates services were provided.

_________________________________________ ____________________

Patient signature Date

_________________________________________

Patient name (printed)

It is your responsibility to update this information if it changes, and you are welcome to change this information yourself at any time. If you have any questions, please contact our billing manager.

Assessment and Therapy Associates of Grand Forks, PLLC (ATAGF)
3535 S. 31st St., Suite 201, Grand Forks, ND 58201
Phone: 701-780-6821; Fax: 701-780-1973
www.grandforkstherapy.com

# EMAIL INFORMED CONSENT

Email can be a useful method of correspondence for clients. Transmitting confidential information by email can create a number of risks, both general and specific that clients need to be aware of if they choose this method of correspondence.

**A. General email risks include but are not limited to the following:**

- Email can be immediately broadcasted worldwide and received by many intended and unintended recipients;
- Recipients can forward email messages to other recipients without the original sender's permission or knowledge;
- Users can easily send an email to the incorrect address;
- Email is easier to falsify than handwritten or signed documents;
- Backup copies of email may exist even after the sender or recipient has deleted his or her copy;
- Without the benefit of face-to-face interaction, emails can be misinterpreted in tone and meaning.

**B. Specific email risks include but are not limited to the following:**

- Email containing information pertaining to a client's diagnosis and/or treatment must be included in the client's medical record. Thus, all individuals who have access to the medical record will have access to the email messages;
- If you are sending your emails from your employer's computer, your employer does have access to your emails;
- While it is against the law to discriminate, an employer who has access to your email could use the information to discriminate against the employee. Additionally, the employee could suffer social stigma from a workplace disclosure;
- Insurance companies who learn of your PHI information could deny you coverage;
- Although therapists and ATAGF staff will endeavor to read and respond to email correspondence promptly, they cannot guarantee that any particular email message will be read and responded to within any particular time frame.

**C. Conditions for use of email**

All email messages sent or received that concern your diagnosis or treatment or that are a part of your medical record will be treated as part of your PHI. Reasonable means will be used to protect the security and confidentiality of the email. Because of the risk outlined above, the security and confidentiality of email cannot be guaranteed.

**Your consent to email correspondence includes your understanding of the following conditions:**

- All emails to and from you concerning your protected health information (PHI) will be a part of your file and can be viewed by health care, insurance providers, and ATAGF office support staff.
- Your email messages may be forwarded within ATAGF as necessary for diagnosis, treatment, and reimbursement. However, they will not be forwarded outside the office without your consent or as required by law.
- Though all efforts will be made to respond promptly, this may not be the case. Because the response cannot be guaranteed *please do not use email in a medical emergency.*
- You are responsible for following up with the therapist or support staff if you have not received a response.
- Medical information is sensitive and unauthorized disclosure can be damaging. You should not use email for communications concerning diagnosis or treatment of AIDS/HIV infection, other sexually transmittable diseases, mental health, developmental disability, or substance abuse issues. It is your right, however, to choose to communicate about this information if you desire.
- Since employers do not observe an employees right to privacy in their email system, you should not use their employer's email system to transmit or receive confidential emails.

*Client information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320 et seq. 45 C.F.R. Parts 160 & 164 and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2. Federal rules prohibit you from making any disclosure of this information further unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate any Alcohol or Drug abuse patient (42 C.F.R. 2.32).*

Assessment and Therapy Associates of Grand Forks, PLLC (ATAGF)
3535 S. 31st St., Suite 201, Grand Forks, ND 58201
Phone: 701-780-6821; Fax: 701-780-1973
www.grandforkstherapy.com

# EMAIL INFORMED CONSENT

- ATAGF will take reasonable steps to ensure that all information shared through emails is kept private and confidential. However, ATAGF is not liable for improper disclosure of confidential information that is not a result of our negligence or misconduct.
- If you consent to the use of email, you are responsible for informing your therapist of any type of information that you do not want sent to you by email.
- You are responsible for protecting your password and access to your email account and any email you send or receive from ATAGF to ensure your confidentiality. Your therapist cannot be held liable if there is a breach of confidentiality caused by a breach in your account security.
- Any email that you send that discusses your diagnosis or treatment constitutes informed consent to the information being transmitted. If you wish to discontinue emailing information, you must submit a written notification that you wish to discontinue or an email informing your therapist that you are withdrawing consent to email information.

☐ **Yes, I have read the above and consent to email correspondence between ATAGF/my provider and me.**

☐ **Yes, I have read the above and consent to email correspondence between ATAGF/my provider and other individuals for whom I have signed a release of information form.**

**Email address to use for correspondence:** ________________________________________________________

_________________________________________________
Printed client name

_________________________________________________ ____________________
Client signature Date

**If parent is signing on behalf of a client under 18, please complete the information:**

_________________________________________________ ____________________
Print name of parent (custodial and non-custodial) or guardian (circle relationship) Date

_________________________________________________ ____________________
Signature of parent (custodial and non-custodial) or guardian Date

*Client information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320 et seq. 45 C.F.R. Parts 160 & 164 and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2. Federal rules prohibit you from making any disclosure of this information further unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate any Alcohol or Drug abuse patient (42 C.F.R. 2.32).*

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## Assessment and Therapy Associates of Grand Forks, PLLC
## Notice of Privacy Practices (Brief Version)

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.

**Our commitment to your privacy**

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the attached, full, legally required notice of privacy practices. Please talk to our privacy officer (see the end of this form) about any questions or problems.

**How we use and disclose your protected health information with your consent**

We will use the information we collect about you mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities that are called, in the law, **health care operations** (e.g., billing for services). After you have read this notice we will ask you to sign a **consent form** to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this. We send appointment reminders that include phone calls (with voicemails) or SMS messaging (texting). If this is a problem for you, please notify us, and you can no longer receive these reminders.

**Disclosing your health information without your consent:** There are times when the laws require us to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For workers' compensation and similar benefit programs.

There are some other rare situations. They are described in the longer version of our notice of privacy practices (please ask for a copy).

**Your rights regarding your health information**

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
2. You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact our privacy officer to arrange how to see your records. See below.
4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this notice, we will post the new version in our waiting area, and you can always get a copy of it from the Privacy Officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our privacy officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.
7. You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for our services.
8. You have a right to be notified if there is a breach involving your PHI, if your PHI has not been encrypted to government standards; and our risk assessment fails to determine there is a low probability your PHI has been compromised.
9. You have the right to decide you would not like to be included in fundraising communications that we may send out.

**Your choices regarding your health information:** You also have some choices regarding whether or not we share your information. For example, whether or not we tell family or friends about your health care, releasing Psychotherapy Notes, or whether or not you are contacted for fundraising efforts. Please see the long version of our Notice of Privacy Practice for additional information.

Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or our health information privacy policies, please contact our privacy officer, who is Tiram Gamliel, LPCC and can be reached by phone at (701) 780-6821. The effective date of this notice is September 23, 2013. It was updated on April 25,2019.

**Assessment and Therapy Associates of Grand Forks, PLLC**
**3535 S. 31st St., Suite 201, Grand Forks, ND 58201 701-780-6821 (phone) 701-780-1973 (fax)**

# AUTHORIZATION FOR RELEASE AND EXCHANGE OF CONFIDENTIAL PROTECTED HEALTH INFORMATION, PSYCHOLOGICAL INFORMATION, EDUCATIONAL RECORDS AND/OR ALCOHOL AND DRUG TREATMENT RECORDS

Patient Name:________________________________________DOB:____________________

This form, when completed and signed by you, authorizes outside agencies or individuals to release Protected Health Information including mental health, educational, or substance abuse treatment records, from the above named patient's medical, educational, and/or clinical records to Assessment and Therapy Associates of Grand Forks, PLLC by mail, facsimile, or personal communication. Your signature indicates that you understand that these records may contain information regarding drug, alcohol, psychological or psychiatric conditions and communicable diseases and that they are protected by Federal Law (42CFR Part 2) and cannot be disclosed without this written consent unless otherwise provided in the federal regulations. Your signature also authorizes any receiving individual or entity to honor copies of this signed form as having the same legal authority and force as the original.

**I authorize the following individuals, agencies or their representative to release and exchange information with Assessment and Therapy Associates of Grand Forks, PLLC and/or its administrative and clinical staff:**

____________________________________________________________
Name/Agency Address/City/State

____________________________________________________________
Name/Agency Address/City/State

____________________________________________________________
Name/Agency Address/City/State

____________________________________________________________
Name/Agency Address/City/State

**The specific information to be released and exchanged with Assessment and Therapy Associates of Grand Forks, PLLC includes the following individually checked items in their entirety:**

- ☐ Educational Records
- ☐ Verbal Release
- ☐ Mental Health Records
- ☐ Progress Notes
- ☐ Testing Records
- ☐ Special Education records (IEP, 504 Accommodation Plan, testing reports)
- ☐ Alcohol/Drug Treatment Records
- ☐ Entire mental health record for all dates
- ☐ Other____________________________
- ☐ Other____________________________

**This information is to be used for the following purposes:**
☐ Continuing Care ☐ Educational Planning ☐ Insurance Claim ☐ Litigation ☐ At My Request ☐ Other____________________

List any restrictions on information to be released:________________________________________

I understand that this authorization will remain in effect upon fulfillment of the above stated purpose or twelve (12) months from the date of my signature (whichever occurs first). This consent will automatically expire without my express revocation. I understand that I may revoke this consent at any time, except to the extent action has already been taken in reliance on it, by notifying the provider of the information in writing and that my cancellation will take effect when the provider receives my written notice.

I understand that treatment, payment, enrollment, or eligibility of benefits may not be conditioned on obtaining this authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of this information, and no longer protected by the HIPAA Privacy Rule or by Federal or State law or rules. Assessment and Therapy Associates of Grand Forks, PLLC, its staff, interns, and students are hereby released from any legal responsibility or liability for disclosure of the above information covered under this Authorization.

________________________________________ ____________________
Signature of Patient/Legal Guardian/Representative Relationship to Patient

____________________ ________________________________________
Date Signed Witness