Counseling Services of Southern Minnesota

CLIENT INFORMATION

NAME: ☐ MALE ☐ FEMALE

ADDRESS:

SOCIAL SECURITY #: BIRTH DATE:

HOME PHONE: CELL #:

RACE: ☐ Caucasian ☐ Hispanic ☐ Asian ☐ African American ☐ Native American

CLIENT EMPLOYER: WORK PHONE:

MINOR PARENT'S NAME(S): EMPLOYER:

SOCIAL SECURITY #: WORK PHONE:

BUSINESS ADDRESS: CITY: STATE: ZIP:

PERSON TO CONTACT IN CASE OF EMERGENCY:

FINANCIALLY RESPONSIBLE PARTY (If not listed above)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT: RELATIONSHIP TO CLIENT:

ADDRESS: HOME PHONE:

DATE OF BIRTH: SOCIAL SECURITY #: CELL PHONE:

EMPLOYER: WORK PHONE:

PRIMARY INSURANCE INFORMATION

NAME OF POLICY HOLDER: RELATIONSHIP TO PATIENT:

BIRTHDATE OF INSURED: SOCIAL SECURITY #:

INSURANCE CO.: PHONE:

POLICY/ID#: GRP#:

INS. CO. ADDRESS: CITY: STATE: ZIP:

SECONDARY INSURANCE ☐ YES ☐ NO

FOR DIVORCED PARENTS OF MINOR CLIENT CHILD ONLY:

What is the legal custody arrangement of minor client? ☐ Sole ☐ Joint

RELEASE OF INFORMATION/CONSENT FOR TREATMENT

PARENTS OR AUTHORIZED PERSON'S SIGNATURE: I consent to the release of any medical or other information necessary to process claims to my insurance carrier. I also authorize payment of medical benefits to Counseling Services of Southern Minnesota, Inc. for services rendered. I hereby certify I have received copies of the following Counseling Services of Southern Minnesota policies: Client's Rights and Responsibilities, and Data Privacy Notice to Client. By filling in the Emergency Contact Person, I am authorizing Counseling Services of Southern Minnesota to contact this person in the event of an emergency. I consent to medical treatment for myself or other identified client for whom I am a legally authorized representative.

This consent and authorization shall be valid until payment in full has been made for services rendered, unless canceled in writing.

Signature Date

I authorize demographic and outcome data to be shared with the Department of Human Services Mental Health Outcome Reporting System.

Counseling Services of Southern Minnesota

Signature _____ Date _____

TERMS

The below signature attests acceptance of financial responsibility, ability, and willingness to pay our statements in accordance with the following terms and conditions (fee policy will be provided upon request). In the event my insurance carrier sends payment to the policyholder, that payment will immediately be forwarded to Counseling Services of Southern Minnesota, Inc. I understand Medical Assistance and PMAP Payments will be considered payment in full, minus applicable co-pays. Counseling Services of Southern Minnesota, Inc. charges for copies of client records, except for the current treatment plan and/or assessment. Co-pays are due at the time of service. For deductible and co-insurance, payment is due upon receipt. In the event of default litigation, court costs will be assigned to the person signing the application. In the event of non-sufficient-funds check, a fee of $30 will be assessed. This agreement shall be enforced in accordance with the laws of the State of Minnesota.

Signature _____ Date _____

Appointment Reminder: (CHECK ONE).

☐ Email

☐ Text message*

☐ Phone call

*Text messaging rates may apply. Please contact your cell phone provider for more information

Signature _____ Date _____

Counseling Services of Southern Minnesota

Client Consent to the Use and Disclosure of Health Information

I, ,understand that as part of my health care for myself or as legal guardian for aforementioned client, Counseling Services of Southern Minnesota originates and maintains paper and/or electronic records describing health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. This information is called "Protected Health Information". Reasons for Protected Health Information include:

- A basis for planning care and treatment,
- A means of communication among the many health professionals who contribute to care,
- A source of information for applying diagnosis information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of health information for directory purposes (such as service areas/types of diagnoses treated) and
- The right to request restrictions as to how health information may be used or disclosed to carry out treatment, payment, or health care operations.

Restrictions requested:

I understand Counseling Services of Southern Minnesota is not required to agree to the restrictions requested. I understand I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to provide treatment as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand Counseling Services of Southern Minnesota reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Counseling Services of Southern Minnesota change their notice, they will send a copy of any revised notice to the address I have provided.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose protected health information to another entity (such as to an insurance company), and I consent to such disclosure for these permitted uses, including disclosures via fax.

I understand I have the right to revoke this CONSENT provided I do so in writing, except to the extent that Counseling Services of Southern Minnesota has already used or disclosed the information in reliance on this CONSENT.

☐ I fully understand and CONSENT to the terms of this consent:
☐ I fully understand and DECLINE CONSENT to the terms of this consent:

_____ _____

Signature of Client Date

_____ _____

Signature of Legal Guardian/Representative Date

Counseling Services of Southern Minnesota

Release of Information

Client Name: **DOB:** _____ **Date:** _____

I, _____ , authorize Counseling Services of Southern MN, Inc to:

Exchange Information With:	**Name:**	**Number:**
☐ County Case Manager		
☐ Psychologist		
☐ Psychiatrist		
☐ Physician/Clinic		
☐ Neuropsychologist		
☐ Day Program/School		
☐ Family		
☐ Guardian/Conservator		
☐ Other:		
☐ Other:		

The following information to be Exchange:

- ■ Discharge Summary
- ■ History and Physical
- ■ Consults
- ■ Neuropsychological/Psychological testing
- ■ Diagnosis
- ■ Chemical Health Information
- ■ Case Plan/Notes
- ■ Medications/Dosage
- ■ Education Records

Purpose for disclosure: Coordination of Care, Assessment

ROI Valid Dates: -

Records Request Dates: -

Patient Restrictions on Methods for Disclosure:

I understand that communication of the items to Exchange can occur:

▣ Verbally ▣ In person conference ▣ Written questionnaire ▣ Mailed or faxed medical record / correspondence

I understand that:

* My health information is protected by federal regulation (Alcohol and Drug Abuse Patient Records, 42 CFR Part 2: and/or HIPAA 45 CFR) and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances described in Counseling Services of Southern MN, Inc's Privacy Notice. I understand that I have a right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws.
* I can revoke this authorization at any time except to the extent that action has been taken in reliance on it. Counseling Services of Southern MN, Inc's Privacy Notice outlines the procedure for revocation. This authorization will expire in one year from the date I sign or unless I request an earlier expiration in writing.
* For disclosures other than for treatment, payment and healthcare operations purposes, treatment may not be conditioned on my agreement to sign and authorization (unless I am receiving care solely to create protected health information for disclosure to a third party) (45 CFR & 164.508 (b)(4)(III)
* Communications resulting from this authorization will reveal that I receive services at Counseling Services of Southern MN, Inc.
* Federal confidentiality regulations (at 42 CFR Part 2) prohibit re-disclosure of information from alcohol and drug abuse patient records. However, HIPAA requires Counseling Services of Southern MN, Inc to notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA rules.
* This authorization may be used by Counseling Services of Southern MN, Inc owned or managed programs upon transfer of my

care to them.

Patient Signature _____ **Date:** _____

Parent/Guardian Signature _____ **Date:** _____

Witness Signature _____ **Date:** _____

Staff Signature _____ **Date:** _____

**** Information to be disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR 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 or prosecute any alcohol or drug abuse patient.**

Agreement Form for Email, Cell Phone or Text Communications

The use of electronic communication including email, text and cell phone use may be used if both parties agree on this communication method and this form is completed and signed by both the provider and the Client or the Client's personal representative (if appropriate).

A copy of this form and all email communication will be filed in the Client's Medical Record and a hard copy of this form will be provided to the Client if requested. This agreement is limited to communications using the email addresses and cell phone numbers listed below. Copies of texts WILL NOT be filed in the client's medical record but may be summarized by the clinician in a separate case note to be included in the medical chart.

* *Text messaging should be administrative in content and should not contain client PHI.*

Sending Protected Health Information (PHI) by email/text exposes the PHI to two risks:

- The email/text could be sent to the wrong person, usually because of a typing mistake or selecting the wrong name in an auto-fill list.
- The email/text could be captured electronically en route or not properly deleted.

HIPAA requires that we take reasonable steps to protect against these risks but acknowledges that a balance must be struck between the need to secure PHI and the need to ensure that clinicians can efficiently exchange important client care information.

Provider Awareness:

Standard email and texting is not a secure means of communication, so as the provider I will use the minimum necessary amount of PHI when responding to your questions or communicating information to you. Counseling Services of Southern Minnesota communications with you via email will be administrative in nature; or if it is to contain sensitive PHI regarding treatment, it will be solely in response to any client-initiated contact or question. However, Clients are encouraged to contact their clinician via phone regarding any sensitive PHI or clinical information.

Client Awareness:

Please note that most standard email does not provide a secure means of communication. There is some risk that any PHI contained in email or text messaging may be disclosed to, or intercepted by, unauthorized third parties. Use of more secure communications, such as phone is always an alternative that is available to you.

- In regards to phone calls, conversations are only confidential if we are both on a landline.
- I understand that email is considered an unsecured means of communication.

By completing this form, the provider and I understand and are willing to accept the risks involved with insecure email, cell phone and text communication of my protected health information. I have also been given my primary provider's contact information.

Counseling Services of Southern MN, Inc

Email/Text Consent

#: Date of Birth:

Date: _____

Client's Name (print name): _____

Email Address (print): _____

Cell Phone: _____

☐ **By checking this box, I give Counseling Services of Southern Minnesota permission to send me appointment reminders via email to the address listed above, or text.**

Client's or Representative's Signature: _____

Withdrawal of Agreement for Email Communication

Should either party no longer wish to communicate via email please complete the form below and deliver in person or send by U.S. mail to the other party. A copy of the form will be filed in the Medical Record.

☐ I no longer wish to communicate via email.

Date: _____

Client's Name (print name): _____

Email Address (print): _____

Signature: _____

Counseling Services of Southern MN, Inc

Telehealth Consent

#: Date of Birth:

Telehealth allows my therapist to diagnose, consult, treat and educate using interactive audio, video and/or data communication regarding my treatment. I hereby consent to participating in psychotherapy via the internet (hereinafter referred to as Telehealth) with the clinician listed below:

Client Name: _____

Clinician/Therapist: All CSSM Staff

Agency Address: 1306 Marshall Street | Saint Peter, MN 56082

I understand I have the following rights under this agreement:

- I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential. There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person.
- I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger.
- Further, I understand that the dissemination of any personally identifiable images, or information from the Telehealth interaction, to any other entities shall not occur without my written consent.
- I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective.
- Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured. I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons.
- In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction. I understand that I can withdraw my consent to Telehealth communications by providing written notification to Counseling Services of Southern MN, Inc at the address above. My signature below indicates that I have read this Agreement and agree to its terms.

_____

Signature of Client

_____

Parent/Legal Guardian Signature

_____

Staff Signature

Counseling Services of Southern Minnesota

Client Name: Client Number:

Treatment Plan Disclosure Statement - Minor Child

This disclosure statement is to inform you about the policies and practices in the development and release of individual treatment plans (ITP) at Counseling Services of Southern Minnesota (CSSM). An ITP is a document completed at intake, and reviewed every 180 days to ensure provision of treatment services. The ITP outlines the plan of care, which requires consent of the client or client's legal representative. In cases of clients who are minors, under the age of 18 years old, it is necessary that the legal guardian (caregiver, parent, representative) give consent to the prescribed treatment through a signature on the ITP. This transaction is not always convenient for guardians, as there are instances where meeting face-to-face or transmitting via fax is not feasible, and mailing the document is more efficient. This means that CSSM is asking for your approval to mail the ITP to you, the legal guardian, for your consent, approximately every 180 days unless something else is discussed with your provider. Further, a copy of the ITP will be provided, in session, to the minor client, for their records.

We are committed to maintaining the privacy of your personal health information, but need you to be aware that as soon as the ITP leaves our facility, we are unable to guarantee confidentiality for that document. The risk of breaches to confidentiality are limited but we ask that you keep CSSM updated on any changes in address and/or change of names to minimize any further risks. You are allowed to make copied of the ITP at your own discretion, but you will be asked to return the original ITP with a signature in its entirety to demonstrate your consent with the plan for treatment. We will include a stamped return-envelope for your convenience.

This disclosure statement covers only the transmission of ITPs. Requests for other clinical documentation will need to be accessed through a separate formal request for medical records with your CSSM provider.

By consenting to this practice, you are allowing CSSM to more efficiently provide services without disruption of client care. Please have a discussion with your child's provider concerning this TREATMENT PLAN DISCLOSURE STATEMENT so that you are comfortable with this process and of all of your rights and responsibilities regarding the treatment of the minor client.

My signature below signifies that I have read the policies and procedures regarding the TREATMENT PLAN DISCLOSURE STATEMENT, and that I give my consent to have individual treatment plans (ITPs) mailed to me for my review and consent approximately every one hundred and eighty (180) days. I understand that once I have received the ITP, I share in the responsibility to keep this private health information confidential.

Consenting Legal Guardian Signature Date

CSSM Provider Signature Date

Counseling Services of Southern Minnesota

Safe Harbor Agreement for

1. Goal. The therapeutic goal of a Safe Harbor Agreement is to permit the children to have a place they deem safe to be able to speak to a mental health provider about any apprehension, concerns, or issues without fear that what they say will be used to interfere with or create problems in their relationship with either legal guardian.

2. Safe Harbor. It is helpful that legal guardian acknowledge the importance of the therapist's office being a safe harbor - a place where the children can be truthfully assured that what they say will not be disclosed to third parties without their consent.

3. **AGREEMENT:** Therefore, to create the safe harbor for the children, the parties agree as follows:

   a. No Court/No Dispositions. Neither legal guardian shall, nor will either legal guardian permit his or her attorney to, subpoena the therapist or his/her notes to a trial, hearing, deposition, or arbitration.

   b. No Interrogations. Neither legal guardian shall, nor will either legal guardian permit his or her attorney to, demand answers from either the therapist or the children to questions about the content of therapy.

   c. Limited Disclosure. When providing mental health treatment to adolescents, the therapist agrees she/he will divulge only clinically relevant information to either legal guardian, either attorney, the Judge, or any other third party, relating to the content of the therapy with the children (except required disclosures under the Child Abuse Reporting Act or other safety concerns) with the child's explicit consent.

   d. Enforcement. Any party, or his or her attorney, who seeks to interrogate or subpoena the therapist shall be liable for all fees and costs, including preparation time, travel time, and testimony time. An engagement letter will be used to clarify the person responsible for costs.

_____ _____

Parent Signature Date

_____ _____

Parent Signature Date

_____ _____

Therapist Signature Date

Counseling Services of Southern Minnesota

Financial Assistance Application for School Linked Mental Health Services

Counseling Services of Southern Minnesota provides an array of mental health service that are co-located in area schools with the support of a grant sponsored by The Minnesota Department of Human Services. The services costs are covered by Medical Assistance and most health insurance plans. However, for some families the cost of insurance deductibles or insurance co-pays can be a barrier. For these families the grant has set aside monies that we can use to assist with these costs. We are asked to demonstrate the need for this financial assistance.

Student/Client Name: Phone Number(s):

Address:

County of Residence: Case Manager? ☐ Yes ☐ No

Number of persons living in your household (include yourself): ☐

☐ Per Month ☐ Year

Income Source	Self	Spouse/Partner	Other	Total
Gross wages, salaries, tips, etc.				
Social Security, Pension				
Interest, dividends				
Rental income				
Self-Employment income				
Veterans Benefits				
Unemployment, Workers' Comp				
Disability Income				
Child Support, alimony, military family				
Public assistance				
Other				
Total	0	0	0	0

Request for Grant Supported Financial Assistance

Name	Date of Birth
Address	Phone
County of Residence	Case Manager

Reason for Request (please check all that apply)

☐ I do not have health insurance.
☐ I have health insurance but have a deductible, coinsurance or copay that is too high.
☐ I have health insurance but does not cover ancillary services or if my Medical Assistance (MA) coverage lapses.

By signing below I attest that:

- I am the legal guardian of the child for which services are being sought
- The information provided is accurate to the best of my knowledge
- I am requesting financial assistance for my child's School Linked Mental Health Services

_____ _____

Signature Date

****Please enclose a copy of your last year W-2 or last 2 paystubs for everyone in household to verify income****

Counseling Services of Southern Minnesota

COUNSELING SERVICES OF SOUTHERN MINNESOTA
CHILD SOCIAL HISTORY
(TO BE COMPLETED BY PARENT/CAREGIVER)

PART 1 -Please provide the following information in preparation for your interview with your mental health clinician.

Name of Individual Completing Form		
Relationship to Child		
Child's Name	Client Number	Referral Source
Reason for Referral		

Current Service Providers
- Medical:
- Psychiatry/Psychology:
- Case Manager:
- Other:

Parents	
PARENT 1:	
Occupation:	Employer:
Age:	Age at time of pregnancy with child:
School: Highest grade completed:	
☐ Learning problems ☐ Attention problems ☐ Behavior problems	
Medical Problems:	
Current Marital Status:	
If currently married or in a relationship, please describe length & living arrangements:	
Please list previous marriages and significant relationships:	

PARENT 2:	
Occupation:	Employer:
Age:	Age at time of pregnancy with child:
School: Highest grade completed:	
☐ Learning problems ☐ Attention problems ☐ Behavior problems	
Medical Problems:	
Current Marital Status:	
If currently married or in a relationship, please describe length & living arrangements:	
Please list previous marriages and significant relationships:	

Siblings		
Name	*Age*	*Living at Home?*
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Counseling Services of Southern Minnesota

Living Situation

☐ Parent's Home	☐ Residential Care/Treatment Facility**	☐ Other**
☐ Rent ☐ Own	☐ Hospital ☐ Temporary Housing ☐ Residential Care ☐ Nursing Home	☐ Friend's Home ☐ Relative/Guardian's Home ☐ Homeless ☐ Foster Home
**Identify Person's Name or Facility		

Primary Household

Household Member Name	Relationship to Child	Age	Occupation/School	Highest Level of Education	Quality of Relationship

Street Address (If different from child's address listed on Demographic Information form.)

Does the client live in more than one household? ☐No ☐Yes

If no, skip to "Additional Family Members" If yes, complete the secondary household information below

Secondary Household

Household Member Name	Relationship to Child	Age	Occupation/School	Highest Level of Education	Quality of Relationship

Street Address (If different from child's address listed on Demographic Information form.)

Family members who live in both households

☐ Only Child ☐ Child and (list):

Additional Family Members

☐ No, parents or sibling other than those listed in primary or secondary households
☐ Yes, list family members:

Custody and Parenting Plan

☐ Lives with both parents (biological or adoptive) in same household
☐ Single parent
☐ Shared Physical Custody - parents in different households
☐ Shared Legal Custody
☐ Other (describe):

Family Environment/Relationships

Please indicate below the best descriptions of parent-child relationships.

Parent-Child (Client) Relationship(s) P=Primary household S=Secondary household B=Both										
Parent-child conflict		None-Mild		Moderate		Severe				
Issues with supervision and monitoring of child		Always		Usually		Inconsistently		Rarely		
Cooperation between parents regarding child-rearing		Always		Usually		Inconsistently		Rarely		Not Pertinent
Parent positive activities with child		Frequent		Occasionally		Infrequent				
Parent satisfaction with relationship		Satisfied		Neutral		Dissatisfied				
Child satisfaction with		Satisfied		Neutral		Dissatisfied				

relationship											
Comment on Parent-Child Relationships (describe further if needed)											

Please indicate below the best descriptions of sibling-child relationships.

Sibling-Child (Client) Relationship(s) ☐**No Siblings**	**P=Primary household**		**S=Secondary household**		**B=Both**	
Child-Sibling conflict		None-Mild		Moderate		Severe
Sibling(s) positive activities with child		Frequent		Occasional		Infrequent
Sibling(s) satisfaction with relationship		Satisfied		Neutral		Dissatisfied
Child satisfaction with relationship		Satisfied		Neutral		Dissatisfied
Comment on Sibling-Child Relationships (describe further if needed)						

Please indicate below the best descriptions of parent marital or couple relationships.

Parent Marital or Couple Relationship(s) ☐**Not Applicable**	**P=Primary household**		**S=Secondary household**		**B=Both**	
Marital or couples conflict		None-Mild		Moderate		Severe
Marital or couples satisfaction		Satisfied		Neutral		Dissatisfied
Comment on Parent Marital or Couples Relationships (describe further if needed)						

Other Family Concerns		**If yes, indicate:**		
		Parent	**Sibling**	**Other**
Family member health problems	☐ No ☐ Yes	☐	☐	☐
Family member disability	☐ No ☐ Yes	☐	☐	☐
Family member legal issues	☐ No ☐ Yes	☐	☐	☐
Family financial concerns	☐ No ☐ Yes	☐	☐	☐
Family member alcohol abuse	☐ No ☐ Yes	☐	☐	☐
Family member substance abuse	☐ No ☐ Yes	☐	☐	☐
Family member anxiety	☐ No ☐ Yes	☐	☐	☐
Family member depression	☐ No ☐ Yes	☐	☐	☐
Family member ADHD	☐ No ☐ Yes	☐	☐	☐
Family member mania	☐ No ☐ Yes	☐	☐	☐
Family member schizophrenia/other psychosis	☐ No ☐ Yes	☐	☐	☐
Significant family stressors (moves, deaths, divorce, loss of employment)	☐ No ☐ Yes	☐	☐	☐
Comment on Other Family Concerns and information Relating to Financial Status (Specify problems that impact child's needs)				

☐ Learning problems ☐ Attention problems ☐ Behavior problems

Developmental Issues

Have you ever had concerns about the following issues with this child?

Pregnancy	
Had bleeding during first three (3) months	☐ Yes ☐ No ☐ Unknown
Had bleeding during second three (3) months	☐ Yes ☐ No ☐ Unknown
Had bleeding during last three (3) months	☐ Yes ☐ No ☐ Unknown

Had Toxemia	☐ Yes ☐ No ☐ Unknown
Had to take medications Specify any medication:	☐ Yes ☐ No ☐ Unknown
Got injured or hurt	☐ Yes ☐ No ☐ Unknown
Gained less than 15 lbs. (7 kgs.) Specify:	☐ Yes ☐ No ☐ Unknown
Took narcotic drugs	☐ Yes ☐ No ☐ Unknown
Drank alcohol	☐ Yes ☐ No ☐ Unknown
Had an infection	☐ Yes ☐ No ☐ Unknown
Smoked during pregnancy	☐ Yes ☐ No ☐ Unknown
Length of pregnancy: months	☐ Yes ☐ No ☐ Unknown
Other pregnancy problems/illnesses Specify:	☐ Yes ☐ No ☐ Unknown
Birth/Early Infancy	
Birth Weight: lbs oz. Length: in.	
Born prematurely	☐ Yes ☐ No ☐ Unknown
Born with cord around neck	☐ Yes ☐ No ☐ Unknown
Injured during birth	☐ Yes ☐ No ☐ Unknown
Had trouble breathing	☐ Yes ☐ No ☐ Unknown
Turned blue (cyanosis)	☐ Yes ☐ No ☐ Unknown
Was a twin or triplet	☐ Yes ☐ No ☐ Unknown
Had an infection	☐ Yes ☐ No ☐ Unknown
Had seizures (fits, convulsions)	☐ Yes ☐ No ☐ Unknown
Needed oxygen	☐ Yes ☐ No ☐ Unknown
Was very jittery	☐ Yes ☐ No ☐ Unknown

Childhood Health Issues		**If yes, age first noted**	**If yes, still occurring?**
Seizures (convulsions) or spells	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
High fevers (over 103 degrees F. or 39 degrees C.)	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Head injury	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Asthma	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Trouble with hearing	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Trouble with vision	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Lead poisoning	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Other poisoning or overdose	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Other serious illness	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Other hospitalizations	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No

Functioning		**If yes, age first noted**	**If yes, still occurring?**
Poor appetite	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Constipation	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Stomach aches	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Trouble falling asleep	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Trouble staying asleep	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Over-activity	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Head banging	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Rocking in bed	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Temper tantrums	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Self-destructive behavior	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Difficulty in being comforted or consoled	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Stiffness or rigidity	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Looseness or floppiness	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Crying often and easily	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Shyness with strangers	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Irritability	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Extreme reaction to noise or sudden movement	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Chews on nails and/or lips	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Picks nose	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Attention problems		**If yes, age first noted**	**If yes, still occurring?**
Can concentrate for only a short time unless things are very interesting	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Understand the main ideas of things but misses important details	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Does work or performs many tasks carelessly without thinking	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Learns a new skill well one day and then can't seem to do it a few days later	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Receives very unpredictable (inconsistent) grades or test scores in school	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Can work well only on things he/she really enjoys doing or thinking about	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Often doesn't notice when he/she makes mistakes	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Seems not to realize when he/she is disturbing someone	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Doesn't do much better after punishment or correction	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Makes comments about or is distracted by background noises or unimportant things	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Seems to want things right away and/or is hard to satisfy	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Annoys or bothers other children	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No

Behavior is variable and hard to predict	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Is a troublemaker; bullies others	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Behaviors		**If yes, age first noted**	**If yes, still occurring?**
Has bad dreams	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Is often very quiet or withdrawn	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Is often "down" on himself/herself	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Is often tired	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Speaks unclearly, stutters, or stammers	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Wets bed or pants often	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Soils underwear or has accidents with bowel movements	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Is often too neat or orderly	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Is often too concerned about cleanliness	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Often plays with matches	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Destroys objects at home	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Destroys objects away from home	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Is fearless	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Is cruel to animals	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Is not liked by other children	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Feels ill on school mornings	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Has eating problems (either overeats or undereats)	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Is preoccupied with food or diet	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Is part of a clique or gang that causes trouble	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Other behaviors not noted above	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Have you ever had concerns about your child's early development (i.e. walking, talking, learning)?	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Have you ever had concerns about your child's sexual development or behaviors?	☐ Yes ☐ No ☐ Unknown		☐ Yes ☐ No
Other issues or Comments			

Developmental Milestones

Please record the age at which your child reached the following developmental milestones.

Sat without support	Bowell and Bladder trained day and night
Walked without assistance	Tied Shoelaces
Spoke two words together	Rode bicycle (without training wheels)
Began to read	

Child's School Functioning

Education Classification

Does your child receive special education services? ☐ Yes ☐ No

Counseling Services of Southern Minnesota

If no, has your child ever been tested and determined not to need services?	☐ Yes ☐ No
Regular education classroom, no special services	☐ Yes ☐ No

If no, check all that apply below.

☐ Early Childhood Spec. Ed./Developmental Delay	☐ Special Learning Disability
☐ Hearing Impaired	☐ Visually Impaired
☐ Speech or Language Impaired	☐ Physically Impaired
☐ Emotional/Behavioral Disorder	☐ Developmental/Cognitive Disability
☐ Special Learming Disability	☐ Autism Spectrum Disorder
☐ Traumatic Brain Injury	☐ Other Health Impaired
☐ Unsure	☐ Current 504 Plan
☐ Other:	

Comments on Education Classification

Child's Legal History

Does your child have a history of legal charges?	☐ Yes ☐ No
If yes, describe charges	
Is the child currently on probation?	☐ Yes ☐ No
Has the child ever been on probation?	☐ Yes ☐ No
Has the child ever been court-ordered into chemical health or mental health treatment?	☐ Yes ☐ No
Has the child ever had involvement with Children's Protective Services (CPS)?	☐ Yes ☐ No
If yes, describe	
Name of CPS caseworker(s) assigned to family (If applicable)	☐ None Reported
Name of Guardian Ad Litem (GAL) or Court Appointed Special Advocate (CASA) assigned to family	☐ None Reported

Child's Trauma History

Has your child ever experienced or witnessed any of the following? (check all that apply)

☐ Car accident	☐ Other accident	☐ Physical illness	☐ Physical abuse
☐ Domestic violence/abuse	☐ Emotional abuse	☐ Physical neglect	☐ Sexual assault/molestation
☐ Community violence	☐ Fire	☐ Natural Disasters	☐ None of the above

Child's Mental Health Treatment History

Previous Mental Health Treatment ☐ No ☐ Yes If yes, please list reason for treatment, and dates:

Reason	Date

Currently on any medication(s)? ☐ No ☐ Yes

If yes, please list and bring medications to next appointment

Primary Care Physician			Phone Number
Address	City	State	Zip Code
Other Prescribing Physician(s)			Phone Number

Address	City	State	Zip Code

Child's Alcohol and Drug History

Do you have any concerns about your child's use of alcohol or drugs? ☐ No ☐ Yes
Do you have any other issues or concerns about your child you would like to have addressed? ☐ No ☐ Yes
Comments

Completed by: _____ Date: _____

Counseling Services of Southern Minnesota

Notice of Client Rights, Data Privacy & Grievance Appeal Procedure

This notice describes how information about you may be used and disclosed, and how you can get access to this information. Please review carefully.

Introduction

At Counseling Services of Southern Minnesota (CSSM), we are required by federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations. Anyone who illegally shares information about you is subject to fines, dismissal, or other legal action.

Understanding Your Health Record/Information

Each time you visit CSSM, a record of your visit is made. Typically this record contains your symptoms, any psychological assessment, diagnoses, treatment, and a plan for future care or treatment. This information, referred to as your medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third party payer can verify that services billed were actually provided
- Tool to educate health professionals
- Source of data for medical research
- Source of information for public health officials charged with improving the health of this state and the nation
- Source of data for planning and to improve care outcomes
- To aid CSSM in maintaining its current licensures

Your Health Information Rights

Although your health record is the physical property of Counseling Services of Southern Minnesota, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information upon request
- Inspect and copy your health record as provided in 45 CFR 164.524. Your file will be available for your access within 10 working days after making a request to see the file.
- Amend your health record as provided in 45 CFR 164.528

- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Revoke your authorization to use or disclose health information

Our Responsibilities
Counseling Services of Southern Minnesota is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- There are certain situations in which this corporation may be unable to protect your privacy. CSSM is required by law to report suspected child or vulnerable adult abuse and neglect. Law also requires that staff have a sworn duty to warn of or take reasonable precautions to provide protection from violent behavior threatened by a client. The duty exists when either the client or other person (defined as an immediate family member or someone who personally knows the client and has reason to believe the client is capable of and will carry out the threat) informs a staff person of the threat.

Data Privacy for Minors
Minors may request Counseling Services of Southern Minnesota, Inc.'s data about them not be open to their parents. All such requests shall be in writing and submitted to their therapist or In-home counselor. A decision about whether to honor the request will take into account the following factors:

- Whether the minor is of sufficient age and maturity to explain the reasons for, and to understand the consequences of, giving or not giving access.
- Whether the minor's situation is such that denying access will protect the minor from physical or emotional harm.
- Whether there are grounds for believing the minor's reasons for the request are reasonably accurate.

Parental access may be denied without request whenever required or permitted by Minnesota Statute 144.335, or any other statute or federal law, if the statute or law provides standards that limit the discretion of the responsible authority to withhold access.

We reserve the right to change our practices and make the new provision effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or, if you agree, we will email the reviewed notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem:

If you have any questions and/or would like additional information, you may contact Counseling Services of Southern Minnesota's Privacy Officer, Monique Sebring, at 507-931-8040.

If you believe your privacy rights have been violated, you can file a complaint with Counseling Services of Southern Minnesota's Privacy Officer, Monique Sebring, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the Office of Civil Rights is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509 F, HHH Building
Washington, D.C. 20201

Client's Rights and Responsibilities

I. PURPOSE The purpose of this policy is as follows:

1. To provide written policies and procedures designed to enhance the dignity of all consumers and to protect their rights as human beings.
2. To ensure the human rights and civil liberties of all consumers are safeguarded.
3. To comply fully with Minnesota Statues pertaining to clients' rights.
4. To define clients' rights while with Counseling Services of Southern Minnesota, Inc. staff.
5. To define CSSM's expectations of each individual client in order to ensure the rights of all clients are safeguarded.
6. To develop a mechanism to resolve any conflicts between procedures for a sound, therapeutic program and clients' civil liberties.

II. POLICY

1. It is CSSM's policy that however meritorious a certain therapeutic procedure may appear to be, it fails and is in conflict with official agency policy if it violates the human rights and civil liberties of the client being treated.

2. Clients' rights shall include, but not necessarily be limited to, the following:

   a. Each client will be informed of his or her rights, including but not limited to considerate and respectful care.
   b. Each client can reasonably expect to obtain from the appropriate agency staff complete and current information concerning his or her diagnosis, treatment, and prognosis in language the client can reasonably be expected to understand. In instances where it is not medically advisable to give such information to the client, the information may be made available to an appropriate person on the client's behalf.
   c. Each client shall have the right to know by name and specialty, if any, the staff persons involved with the client's case.
   d. Each client can reasonably expect to be informed, prior to or at the time of admission, of the services provided by CSSM, and the costs involved.
   e. Each client will be informed of CSSM's rights and responsibilities, and Counseling Services of Southern Minnesota, Inc.'s expectations for him or her as a client.
   f. Each client shall have the right to be free from discrimination based on age, race color, creed, religion, national origin, gender, marital status disability, sexual orientation, and status with regard to public assistance. CSSM will follow federal law and Minnesota Human Rights Act, chapter 363A.
   g. Each client has the right to be informed prior to a photograph or audio or video recording being made of the client. The client has the right to refuse to allow any recording or photograph of the client that is not for the purposes of identification or supervision by the license holder.
   h. If CSSM restricts a client's right, then CSSM will document in the client file the mental health professional's approval and reasons for the restriction.
   i. Each client has the right to respectfulness.
   j. Each client has the right to expect agency staff to make a reasonable response to the client's request consistent to with the program's legal and corporate obligations and policies.
   k. Each client shall have the right to give input to the corporation's Executive Director.

l. Each client has the right to obtain information about any relationship of the corporation to other health care and related institutions insofar as the treatment program is concerned.
m. Clients shall have the right to expect reasonable continuity of care which shall include, but not necessarily be limited to, the appointment times staff that are available.
n. Every client can reasonably expect to have explanations given in a language he or she can understand.
o. Each client will be invited to participate in the planning of his or her treatment based on his or her diagnostic assessment.
p. The client has the right to terminate services with CSSM. Each client has the right to expect that if a scheduled appointment cannot be kept, this agency will make all possible efforts to advise the client in a reasonable time period.
q. CSSM must give a copy of the client's rights according to each client on the day of the client's admission and document that a copy of the client's rights was given to each client. CSSM will post a copy of the client rights in an area visible or accessible to all clients. The license holder must include the client rights in Minnesota Rules, chapter 9544.

3. In order for Counseling Services of Southern Minnesota, Inc. to safeguard the rights of all clients, each individual client has certain responsibilities as follows:

a. The client has the responsibility to be direct and honest.
b. Each client is responsible for clearly understanding his or her health problem to his or her satisfaction and to actively participate in the designated treatment plan. In cases where the client feels he or she cannot follow a certain plan, it is the client's responsibility to advise those caring for him or her of this.
c. Every client has the responsibility to know the staff that is treating him or her. It is also the client's responsibility to advise the staff of other care and medication being received.
d. The client has the responsibility to respect the rights of other clients and staff using the facility. This includes an honest attempt by the client to avoid getting distracted or distracting others from the therapeutic process and objectives of the program.
e. The client has the responsibility to tell those caring for him or her about any changes in his or her health.
f. The client has the responsibility to honor and preserve the confidentiality of the other clients.
g. If a client feels his or her rights are being violated, it is the client's responsibility to inform the staff. It is CSSM's hope the client would first express his or her concerns to the person directly responsible for the client's treatment. If the matter is not then satisfactorily resolved, the client is encouraged to direct his or her complaint in writing to the Executive Director, who shall respond within 15 days. The Executive Director would welcome client complaints that are not resolved through the above process. Clients who still feel their complaints have not been satisfied, may contact the Licensing Division of the Minnesota Department of Human Services, P.O. Box 64242; St. Paul, MN 55164.
h. The client is responsible for keeping all scheduled appointments and cooperating with the staff to assure continuity of care. Cancellation of an existing appointment should be made at least 24 hours in advance. CSSM retains the right to discontinue services due to failure to give a 24 hour notice or failure to attend scheduled appointments.
i. The client has the responsibility to advise those concerned if he or she feels that being referred to another health care facility is not in his or her best interest.

Staff Rights in Serving Clients

1. Staff have the right to be treated with courtesy and respect. Failure to notify in a timely manner may result in a charge.
2. Staff have the right to timely notification when appointments will not or cannot be kept.
3. Staff have a right to privacy during non-work hours, except as otherwise agreed upon by both the staff member and client, and as necessary for providing emergency services needed to ensure the safety of the client or the community.
4. Staff have the right to terminate treatment if there is not sufficient client agreement and cooperation with the treatment plan to allow for a reasonable expectation of positive outcomes.

Reporting Procedures

Counseling Services of Southern Minnesota follows Minnesota Statute 626.55 in regard to reporting maltreatment of minors and Minnesota Statute 626.557 in regard to reporting maltreatment of vulnerable adults.

Grievance and Appeal Procedure

In an effort to give evidence of our respect for the clients to whom we provide services, and our concern for their rights, the following grievance procedure may be used by clients of CSSM who experience problems with the services they are receiving:

1. If a family member of client has a concern about the services they are receiving, the need to discuss their concerns with their provider. It is hoped this discussion could occur as soon as possible, but no longer than 15 days after the incident or concern occurs. If the concern is of a delicate nature and the family or client feels uncomfortable sharing it with either the provider, it is within the rights of the family to go to the Clinical Director and discuss this issue. The provider will take appropriate action within 2 working days of hearing the grievance. This action will be discussed with the Clinical Director and documented in the client's file.
2. If, in going to the provider, the client or family cannot find resolution to the satisfaction of both parties, the matter should be brought to the attention of the Clinical Director. This step should be taken within 15 calendar days following the discussion with the provider. The Clinical Director will take appropriate action within two working days of hearing the grievance. This action will be documented in the client's file.
3. If the family and/or client and the Clinical Director cannot resolve the matter to the satisfaction of both parties, the matter may be brought to the attention of the Executive Director. This step should take place within 15 days following the meeting with the Clinical Director. The Executive Director will take appropriate action within 2 working days of hearing the grievance. This action will be documented in the client's file.
4. Family and/or clients who still feel their complaints have not been satisfied, may contact the Licensing Division of the Minnesota Department of Human Services, 444 Lafayette Road, St. Paul, Minnesota 55101, (612) 296-3971.

Counseling Services of Southern Minnesota

CSSM On-Call Service

CSSM offers on-call support to our clients who are experiencing distress outside of appointments. If you need to speak with a mental health provider, please call us at 507-931-8040. During business hours (8AM-5PM), we will attempt to connect you with your provider or a supervisor for assistance. Outside of business hours, please call us and press option #7 to reach our answering service. Please leave them your name and phone number and allow 30 minutes for a CSSM mental health provider to contact you.

If you are having a mental health emergency, please call 911.