Parkdale Therapy Group, LLC
1000 Shelard Parkway, Suite 520
St. Louis Park, MN 555426-1053
1684 Selby Avenue (East)
St Paul, MN 55104-6149
952-224-0399 Fax 952-224-0396

CLIENT INFORMATION

The following information will help acquaint you with my office procedures, as well as provide information about your rights and responsibilities regarding consultation. You will also find updated information about your rights pursuant to the Health Insurance Portability and Accountability Act (HIPAA). If you have any questions about this information, please discuss them with me at any time. Some of the forms you are filling out ask for similar information. This is due to the forms being for different purposes (e.g. insurance). In any case, I apologize for the redundancy and thank you for taking the time to fill out the forms.

PROFESSIONAL RELATIONSHIP

Professional consultation is not easily described in general statements. It varies depending on the personalities of the consultant and client, and the particular concerns you are experiencing. There are many different methods we may employ to attend to the concerns that you hope to address. Consultation is not like a medical doctor and calls for a very active role on your part. It might even include other important people in your life. Consultation can have additional benefit as you work on your goals and strategies at home that we've talked about talk about during our meetings.

Consultation can have benefits and some risks. Since consultation may involve discussing challenging experiences of your life, you may experience sadness, guilt, anger, frustration, loneliness, etc. On the other hand, consultation may have many benefits. Successful consultation can lead to increased satisfaction in relationships, new possibilities for addressing specific concerns, and/or reductions in feelings of distress. But there are no guarantees of what you will experience.

MEETINGS & PROFESSIONAL FEES

I conduct an intake session that ranges from 60-75 minutes at a cost of $180. Following the intake session is an evaluation period that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your goals. We will work together to determine how often and for what length of time we meet. My fee per 45 minutes is $135, 55-60 minutes is $180. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation [unless you were unable to attend due to circumstances beyond your control, such as an unforeseen emergency, sudden illness, etc]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions

ADDITIONAL PROFESSIONAL FEES

In addition to weekly appointments, I charge $180 per 45 minutes for other professional services you may need, though I will break down the hourly cost if I work for periods of less than 45 minutes. Other services include report writing, telephone conversations lasting longer than 10-15 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 me. These services may not be covered by insurance. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs.

CONTACTING ME

When in the office, I am often not immediately available by phone, as I am likely with a client. If I am unavailable, my telephone will go to a voice mail that I monitor frequently. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. You may also contact me by email and text message.

EMERGENCIES

If you are experiencing and immediate crisis and are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call, or contact the Crisis Connection at (612) 379-6363, the St. Paul Ramsey Crisis Intervention Center at (651) 266-7900, or your local emergency services at 911. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary. Email is generally used to make or change appointments, or for general questions not requiring an immediate response. Please use our voicemail for messages of a critical nature.

BILLING AND PAYMENTS

You will be expected to make co-pays or deductibles for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. If your account has not been paid for more than 60 days an arrangement for payment must be agreed upon, to include a written plan of your intention for payment. If the agreement is not upheld, services may be suspended until payment is made.

INSURANCE REIMBURSEMENT

You should be aware that your contract with your health insurance company requires me to provide information relevant to therapeutic services, and this includes a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, and on rare occasion, copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information necessary for the purpose requested. This information will become part of the insurance company files, and while your insurance company may claim to keep this information confidential, we have no control over what happens to the information once it is submitted. Your private information might become part of a national medical information databank and could be used in determining future insurability. To avoid the problems described above [unless prohibited by contract] you may opt to pay for these services yourself. Upon request, you may have a copy of any report I submit.

Please do not submit your claims unless we instruct you to do so as this might reject our claim to your health care provider. We process all insurance claims on your behalf.

CONCERNS

I urge you to discuss with me any questions or concerns you may have with the consultation you receive. If you are not satisfied with the results of that discussion, and additional measures are necessary, a formal concern or complaint may be made with John L. Jankord, MA, LMFT, LADC, LPCC whose number is 952-224-0399 ext 101.

EMERGENCY CONTACTS

My first priority is maintaining the safety and privacy of those with whom I consult. If there comes a time when I am concerned with your safety or the safety of others in your life, I may need to contact them. I ask you to provide two names of people I could call if I am concerned about your safety. If you are the parent of a client I am seeing, there may be times when I am unable to contact you immediately and need someone else to verify your child's safety. Please list these individuals below.

Emergency Contact Name _____

Relation to You? _____

Work Phone _____ Cell/Other Phone _____

Email _____

Ok to Leave Message at Home? Yes ○ No? ○ **Ok** to Leave Message on Cell? Yes ○ No? ○

Emergency Contact Name _____

Relation to You? _____

Work Phone _____ Cell/Other Phone _____

Email _____

Ok to Leave Message at Home? Yes ○ No? ○ **Ok** to Leave Message on Cell? Yes ○ No? ○

*Client Name (and Parent's Name **if Client is a Minor**)*

_____

Work Phone _____ Cell/Other Phone _____

Email _____

Ok to Leave Message at Home? Yes ○ No? ○ **Ok** to Leave Message on Cell? Yes ○ No? ○

Insurance Registration Form

Today's Date_____

Client Name (Print)_____ **Date of Birth** _____
Last First Middle Initial

Street
Address_____City_____

State_____ Zip_____ Sex: F ○ M ○ O ○ Age ____ Partner Status: Sgl ○ Mar ○ Div ○ Sep ○ Other ○

Cell Phone
May I Leave A Message? **Yes** ○ **No** ○

Work Phone
May I Leave A Message? **Yes** ○ **No** ○

Other Phone
May I Leave A Message? **Yes** ○ **No** ○

Confidential Email Address: _____ May we send unencrypted confidential email? **Yes** ○ **No** ○

Employer _____Occupation _____

Primary Care Physician: _____ Phone: _____ May I contact: **Yes** ○ **No** ○

Insurance ***Please note: *I am not a Medicare provider****

Primary Insurance Company_____ Phone ( ) _____

Claims Address_____City_____State_____Zip_____

Policy/ID # Group/Plan # _____
(This can be the Policy Holder's social security number)

Policy Holder Information: (if the client is not the employee/policy holder)

Name_____ Relationship _____
Last First Middle Initial

Address_____City_____State____Zip_____

Employer_____ Date of Birth _____

Diagnosis _____ Therapist _____
(Required for Billing Insurance – Therapist will fill in)

Secondary Insurance Company_____ Phone ( ) _____

Policy/ID #_____Group/Plan # _____
(This can be the Policy Holder's social security number)

Policy Holder Information: (if the client is not the employee/policy holder)

Name Relationship _____
Last First Middle Initial

Address_____City_____State____Zip_____

Employer_____ Date of Birth _____

Diagnosis _____ Therapist _____
(Required for Billing Insurance – Therapist will fill in)

Responsible Party (Where should the personal portion of the bill be sent, if not to the person named at the top of the page?)

Name _____ Relationship _____

Address_____Phone _____

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider (therapist) listed on this form all insurance benefits, if any, otherwise payable for services rendered. I understand that I am financially responsible for all charges not covered by insurance. I hereby authorize the healthcare provider (therapist) to release all information necessary to secure the payment of benefits and to mail billing statements. I authorize the use of this signature on all insurance submissions. I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider (therapist) listed on this form all insurance benefits, if any, otherwise payable for services rendered. I understand that I am financially responsible for all charges not covered by insurance. I hereby authorize the healthcare provider (therapist) to release all information necessary to secure the payment of benefits and to mail billing statements. I authorize the use of this signature on all insurance submissions. *I understand John L Jankord is not a Medicare provider and cannot accept Medicare of any type for reimbursement of services.*

_____ _____ _____
Signature of Responsible Party Relationship (self, parent, etc) Date

CONFIDENTIALITY AGREEMENT

Information about clients and their families is confidential with exception to the following:

1) Written authorization by the client and/or family (valid authorization form).
2) Therapist's duty to warn another in the case of potential suicide, homicide or threat of imminent, serious harm to another individual.
3) Therapist's duty to report suspicion of abuse or neglect of children or vulnerable adults.
4) Therapist's duty to report prenatal exposure to cocaine, heroin, phencyclidine, methamphetamine, and amphetamine or their derivatives.
5) Therapist's duty to report the misconduct of mental health or health care professionals.
6) Therapist's duty to provide a spouse or parent of a deceased client access to their child or spouse's records.
7) Therapist's duty to provide parents of minor children access to their child's records. Minor clients can request, in writing, that particular information not be disclosed to parents. Such a request should be discussed with the therapist.
8) Therapist's duty to release records if subpoenaed by the courts.
9) Therapist's obligations to contracts (e.g. to employer of client, to an insurance carrier or health plan.

Consent for Sharing of Information within the Parkdale Therapy Group

The Parkdale Therapy Group, LLC consists of a clinical team including: John L Jankord, MA, LMFT, LADC, LPCC; Michelle Craviero, MA, LMFT; Jessie Brown, Psy D, LP; Heather Klein, Ph D, LP; Tyra Hughes, MA, LMFT; Randi Born, Psy D, LP, MA, LMFT; Annie Will, MA, LMFT; Jake Voelker MA, LMFT; Tiffany Leuthold, MS, LMFT; Michelle Hunt-Graham, MA, LMFT, CDWF; Aysem Senyurekli, PhD, LMFT; Libby Marx, MA, LMFT; Jessee Daley, MA, LPCC; Megan A. Jankord, MA; Kate Schmidt, MSW, LICSW.

During collegial consultation we will make every effort to provide only those details necessary to gain adequate feedback.

In Addition: Michelle A. Craveiro is an instructor and trains Graduate level students studying to become Marriage & Family Therapists at St. Mary's University. This is an opportunity for training future therapists in helpful and respectful ways of working that you have the opportunity to be a part of. You are entitled to know their names and are welcome to ask them questions during our meetings. The same Code of Ethics and confidentiality apply to students in training as to the Parkdale Therapy Group therapists.

Check this box if you would like to participate or would like to know more about this opportunity!

Check this box if you know that this is not for you at this time.

My signature indicates I understand the above confidentiality terms and of the training opportunity, and that I can inquire further at any time.

_____ _____

Client Signature Date

_____ _____

Client Signature or Parent/Guardian for minor Date

Client's Right To Know

As a client, you have the right to know and inquire about the following:

1) The cost of counseling, time frame for payment, access to billing statements, billing procedure for missed appointments, and any issues related to insurance coverage.

2) When the therapist is available and where to call during off hours in case of emergency.

3) The manner in which the therapist conducts sessions concerning intake, treatment, and termination. Clients may take an active role in the process by asking questions about relevant therapy issues, specifying therapeutic goals, and renegotiating goals when necessary.

4) The nature and perspective of the therapist's work, including techniques used, and alternative methods of treatment.

5) The purpose and potential negative outcomes of treatment. Clients may refuse any treatment intervention or strategy.

6) The anticipated length and frequency of treatment and limitations that may arise due to difficulties in financing.

7) The liberty of clients to discuss any aspect of their therapy with others outside the therapy situation, including consultation with another therapist.

8) The status of the therapist, including the therapist's training, credentials, and years of experience.

9) The maintenance of records, including security and length of time they are kept, client's rights to access personal records, and release policies.

10) The right to request a referral and the right to require the current therapist to send a written report regarding services to the qualified referred therapist or organization upon the client's written authorization.

11) The procedure followed in the event of the therapist's death/illness.

- I consent to treatment, have read and understand my rights listed above, and have reviewed the Client Bill of Rights posted in our waiting room.

_____ _____

Client Signature Date

_____ _____

Client Signature or Parent/Guardian for Minor Date

CONFIDENTIAL QUESTIONNAIRE

1. Who referred you to Michelle A. Craveiro, MA, LMFT? _____

2. May I acknowledge this referral? _____

3. What is the main concern or problem that brought you to consult with Michelle A. Craveiro, MA, LMFT at this time?

4. Who is the Person/Issue you are most concerned about and why?

Listed below are possible challenges for you or your relationships. Please rate each <u>according to your</u> experience of these concerns by circling the scale number and explain briefly, what makes them a concern at this time?

1. Depression? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

2. Suicidal Thoughts/Actions? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

3. Worry/Anxiety? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

4. Family/Relationship Conflict? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

5. Verbal Abuse/Behavior? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

6. Sexual Abuse/Behavior? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

7. Physical Abuse/Behavior? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

8. Legal Problems? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

9. Internet Usage Concerns? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

10. Alcohol/Chemical Health Concerns? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

11. Gambling Concerns? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

12. Spiritual/Faith Concerns? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

13. Other Problem/Behavior? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

ASSESSMENT

How/When did these problems first come into your life and/or the lives of your family?

PROBLEM SOLVING

What is the main goal or need you have for today's session?

With respect to the concerns that brought you in, what are your goals, desired outcomes, or hopes for the future?

What are your ideas on how these can be accomplished?

What attempts have you made in the past to deal with these concerns?

Your signature below indicates that you have read the entire 11 pages of this document and agree to abide by its terms during our professional relationship. Your signature also serves as an acknowledgement that you have received pages 1-3 of the AGREEMENT described above.

_____ _____

Client Signature Date

_____ _____

Client Signature or Parent/Guardian for minor Date

Thank you for taking the time to fill out these forms.

MINNESOTA NOTICE FORM
HIPPA

Notice of Parkdale Therapy Group, LLC
Policies and Practices to Protect the Privacy of Your Client's Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment, and Health Care Operations"
  – Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or a psychologist.
  - Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within my [office, clinic, practice group, etc.], such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI (may include "Psychotherapy notes") for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. Consultation notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: If I know or have reason to believe a child is being neglected or physically or sexually abused, or has been neglected or physically or sexually abused within the preceding three years, I must immediately report the information to the local welfare agency, police or sheriff's department.
- Adult and Domestic Abuse: If I have reason to believe that a vulnerable adult is being or has been maltreated, or if I have knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained.
- Immediately report the information to the appropriate agency in this county. I may also report the information to a law enforcement agency.

  "Vulnerable adult" means a person who, regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:
  (i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and
  (ii) because of the dysfunction or infirmity and the need for assistance, the individual has an impaired ability to protect the individual from maltreatment.
- Health Oversight Activities: The Minnesota Board of Marriage and Family Therapy or Board of Behavioral Health may subpoena records from me if they are relevant to an investigation it is conducting.
- Judicial and Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law and I must not release this information without written authorization from you or your legally appointed representative, or a court order.
- Serious Threat to Health or Safety: If you communicate a specific, serious threat of physical violence against a specific, clearly identified or identifiable potential victim, I must make reasonable efforts to communicate this threat to the potential victim or to a law

enforcement agency. I must also do so if a member of your family or someone who knows you well has reason to believe you are capable of and will carry out the threat. I also may disclose information about you necessary to protect you from a threat to commit suicide.

- Worker's Compensation: If you file a worker's compensation claim, a release of information from me to your employer, insurer, the Department of Labor and Industry or you will not need your prior approval.

IV. Client's Rights and Clinician's Duties

Client's Rights:

- Right to Request Restrictions –You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI (and psychotherapy notes) in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Clinician's Duties:

- I am required by law to maintain the privacy of PHI, to provide you with notice of my legal duties and privacy practices.
- Unless I notify you of any changes to this notice, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will send you a copy by mail or give you a copy in session.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Mr. John L. Jankord, MA @ 952-224-0399 ext 101.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person you are working with as well as any other colleagues may provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy; 4/14/2003

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE BEEN OFFERED A COPY OF THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____

Signature of Client Date

_____ _____

Signature of Client or Parent/Guardian for Minor Date