Compass North

1200 S. Pokegama Ave. Ste. 160 Grand Rapids, MN 55744
(P) (218)999-0051 (F) (218)999-7020 admin@compassnorthmn.com

Minor Client Intake Information

Date: ____________________

Client Information

Name: ____________________ Date of Birth: ____________________
Age: __________ Gender: ☐ Male ☐ Female ☐ Other: ____________________

Preferred Language: ____________________

Ethnic Background: (Check all that Apply)
☐ Hispanic or Latinx ☐ Not Hispanic or Latinx ☐ Both Hispanic and Non-Hispanic
☐ Other: __________

Race: (Check all that Apply)
☐ Asian ☐ Black/African ☐ Caucasian ☐ Hispanic/Latinx
☐ Native American ☐ Alaska Native ☐ Hawaiian Native
☐ Pacific Islander ☐ Prefer not to Answer ☐ Other: __________

Marital Status: ☐ Married ☐ Never Married ☐ Separated ☐ Divorced
☐ Domestic Partnership/Civil Union ☐ Widowed

Physical Address: ____________________
City: __________ State: __________ Zip: __________
Home Phone: __________ Cell/Other Phone: __________

Parent / Guardian Information

Parent / Guardian Name: ____________________
Mailing Address: ____________________
City: __________ State: __________ Zip: __________
Home Phone: __________ Cell/Other Phone: __________

Parent / Guardian Name: ____________________
Mailing Address: ____________________
City: __________ State: __________ Zip: __________
Home Phone: __________ Cell/Other Phone: __________

Please Provide a Copy of Documentation to the Office for Records

Emergency Contact Information

Contact Name: ____________________ Relation to Client: __________
Contact Phone Number(s): ____________________

Insurance Information

Primary Insurance: ______________________________

Identification Number: ______________ Group Number: ______________

Policy Holder Name: ______________ Birth Date: ______________

Primary Insurance: ______________________________

Identification Number: ______________ Group Number: ______________

Policy Holder Name: ______________ Birth Date: ______________

Policy Holder Information

Mailing Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Home Phone: ______________ Cell/Other Phone: ______________

Appointment Reminder(s)

I opt to receive my appointment reminders via:

☐ Telephone

☐ Home ☐ Mobile at Phone Number: ______________

May we leave a message if you are not home or do not answer? ☐ Yes ☐ No

☐ Text to my Mobile phone Number: ______________

☐ Email reminder to my email address: ______________

Email reminders only available if you are not requesting text reminders

☐ I opt NOT to receive appointment reminders.

NOTE: Correspondence about late cancelations and no shows will be sent via the same option you choose for appointment reminders. If you opt NOT to receive reminders, you will receive your correspondence via letters.

ATTENTION:

This section must be completed if you are entering the Chemical Health Program

County of Residence: ______________________________

Workplace: ______________________________

Net Income: ______________________________

Gross Income: ______________________________

Client Signature: ______________________________ Date: ______________

Parent / Guardian Signature: ______________________________ Date: ______________

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BILLING AUTHORIZATION

I authorize the release of any medical, Rule 25 chemical dependency evaluations, or other information necessary to process this claim.

I also request payment of medical benefits from either a government or non-government source to Compass North.

I authorize Compass North to initiate a complaint to the insurance Commissioner on my behalf.

I further understand that I am responsible for all costs not covered by my insurance company. I will be legally responsible for all collection costs involved with the collection of this account if Compass North is unable to collect payment from me in a reasonable amount of time.

I affirm that the information on this form is accurate and true. I understand, acknowledge, and accept the billing authorization terms above. I consent to treatment at Compass North under those terms.

Client Signature: ________________________________ Date: ____________________

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT RECIPT

Client Name: ______________________________ Date of Birth: ______________

Compass North is required by law to maintain the privacy of and provide individuals with the attached Notice of our privacy practices with respect to protected health information.

I hereby acknowledge that I have been provided with a copy of the HIPAA Notice of Privacy Practice document.

Individual or legal representative signature

Signature: ______________________________ Date: ______________

Witness: ______________________________ Date: ______________

FOR OFFICE USE ONLY

We made the following efforts to obtain written acknowledgement of receipt of the Notice of Privacy Practices.

However, acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency prevented us from obtaining acknowledgement

☐ Other: ____

Staff Signature: ______________________________ Date: ______________

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Medical Information Form

Date: ____________________

Client Name: ______________________________ Date of Birth: ________________________

Have you had a Diagnostic Assessment or Psych Evaluation?
By Whom? ____________________________ Date of Evaluation: ______________________

Have you received therapy, or other mental health services?
By Whom? ______________________________________ Date(s): ______________________

Primary Care Physician: ____

Clinic / Hospital: ____

Additional Emergency Contact(s)
Name: ______________________________ Relationship: ________________________
Phone Number(s): ____

Name: ______________________________ Relationship: ________________________
Phone Number(s): ____

Current Medication(s):

____

____

Medical Condition(s):

____

____

Known Allergies:

____

____

Adverse Reactions:

____

____

Accommodations:

____

____

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Telemedicine Patient Consent/Refusal Form

______________________________ ______________________
Patient Name Date of Birth

Purpose: The purpose of this form is to obtain your consent to participate in telemedicine appointments in connection with the following mental health services that you are currently receiving:

____
____
____

Nature of Telemedicine Appointments: During the telemedicine appointment:

a. Details of your mental health status, history, and treatment will be discussed with other mental health professionals to promote effective treatment and services for your mental health.
b. Video, audio, and/or photo recordings may be taken during your mental health sessions to ensure continued effectiveness of your mental health services.

Medical Information and Recordings: All existing laws regarding your access to medical information and copies of your medical records apply to these telemedicine appointments. Please note not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for these telemedicine interactions will not be shared with outside entities without your prior approved consent.

Confidentiality: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine appointments and all existing confidentiality protections under federal and Minnesota state law apply to information disclosed during these telemedicine appointments. As a part of your agreement to participate in telemedicine appointments your accepting responsibility for securing confidentiality on your end of the telemedicine appointment. Any outside individual that you allow into your telemedicine session on your end is automatically assumed to have authorization from you to be in attendance for your telemedicine appointment. Compass North Psychological Services, Inc., and its employees, will not be held responsible for any information obtained by an outside individual that you allow access to during your telemedicine appointments. As a precautionary measure Compass North Psychological Services, Inc. employees will remind you about this policy if they become aware that you have allowed access to an outside individual during your telemedicine appointment.

Rights: You may withhold or withdraw consent to the telemedicine appointments at any time without affecting your right to future care or treatment from Compass North Psychological Services, Inc.

Disputes: You agree that any dispute arising from the telemedicine appointments will be resolved in Minnesota and that Minnesota state law will apply to all disputes.

Risks, Consequences, & Benefits: You have been advised of all the potential risks, consequences, and benefits of telemedicine appointments. Your health care practitioner has discussed with you the information above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine appointments. All your questions have been answered and you understand the written information provided above.

I agree to participate in telemedicine appointment for the mental health services described above.

Signature: ____

If this form is signed by someone other than the patient, indicate relationship:

____

I refuse to participate in telemedicine appointment for the mental health services described above.

Signature: ____

If this form is signed by someone other than the patient, indicate relationship:

____

Date: ______________________ Time: ______________________

Witness: ____

Date: ______________________ Time: ______________________

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Chemical Health– Intake Form

Client Information

Client Name:	SSN:	DOB:
Comprehensive Assessor *(If completed)*	Agency:	
Comprehensive Assessment Date *(If completed)*	Phone:	

Comprehensive Assessments that are 6+ months are expired. Chemical Health services cannot begin without a current Comprehensive Assessment.

Providers *(if applicable)*

Providers	Name	Agency
Psychologist/ Therapist		
Primary Care Physician		
Psychiatry/ Medication Manager		
Case Manager		
Probation Officer		
Social Worker		
Other		

Reasons Seeking services:

Services seeking and special accommodations:

Please send or deliver the completed entire intake form and a current release of information for Comprehensive Assessment Agency *(if applicable)* to Compass North. Information can be sent via fax at 218-999-7020 or email to admin@compassnorthmn.com

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AUTHORIZATION FOR THE EXCHANGE OF INFORMATION

Clients Name: ______________________________ Date of Birth: ______________

I give Compass North permission to: ☐ Give information to
☐ Receive information from

____
Outside Agency and/or Individual's Name

____
Address, City, State, Zip Code

______________________ ______________________
Phone Number Fax Number

Approximate Dates of Requested Information: ______________________
Information is being used for the purpose of: ______________________

Types of information to be disclosed by mail, telephone, email, or facsimile are as follows:

- ☐ Diagnostic Assessment
- ☐ Treatment Plan
- ☐ Discharge Summary
- ☐ Rule 25 CD Assessment
- ☐ Diagnosis
- ☐ Other (Specify): ______________________
- ☐ Billing & Financial information
- ☐ Psychological Testing
- ☐ Progress in Treatment
- ☐ Alcohol/Drug Abuse History/Treatment
- ☐ Verbal Consultation as Necessary

Records related to chemical dependency, mental health, or HIV/AIDS will be released, unless otherwise indicated by initialing here: _____

I understand that I have a right to revoke my authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Compass North. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by protected by federal laws and regulations.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure mental health treatment.

This authorization expires on ______________________
If I fail to specify an expiration date or event, this authorization expires one year from the date on which it was signed.

______________________ ______________________
Client Signature Compass North Staff

______________________ ______________________
Parent/Guardian Siganutre Date

Clear Form

DEPARTMENT OF HUMAN SERVICES

DHS-2780A-ENG 9-23

BEHAVIORAL HEALTH DIVISION

Behavioral Health Fund Request (BHF)

1. FINANCIAL ELIGIBILITY START DATE (DATE CLIENT REQUESTED BHF)
2. PMI NUMBER (RECIPIENT ID), IF ANY

3. CLIENT LAST NAME
3a. FIRST NAME
3b. MI

4. CLIENT ADDRESS
4a. CITY
4b. STATE
4c. ZIP CODE

5. RESIDENCE TYPE
◯ Private Residence ◯ Sober Home ◯ IRTS ◯ Nursing Home ◯ Group Home ◯ Treatment Program
◯ Hospital ◯ Other (please identify): ____________________

6. PREVIOUS RESIDENCE ADDRESS (if applicable)

7. RACE
◯ 1 = White ◯ 2 = Black ◯ 4 = American Indian ◯ 5 = Asian or Pacific Islander ◯ 8 = Other ◯ 9 = Unknown

8. CLIENT ALIAS, IF ANY
9. DATE OF BIRTH
10. COUNTY OF RESIDENCE
11. SOCIAL SECURITY NUMBER

12. LANGUAGE
13. HISPANIC ◯ Yes ◯ No
14. MARITAL STATUS
15. GENDER ◯ Male ◯ Female

16. IS CLIENT INCARCERATED? ◯ Yes ◯ No
16a. IF YES, CORRECTIONAL FACILITY
16b. DATE INCARCERATION BEGAN
16c. DATE INCARCERATION ENDS

Financial

17. FINANCIALLY RESPONSIBLE PERSON LAST NAME
17a. FIRST NAME
17b. MI

18. FINANCIALLY RESPONSIBLE PERSON'S ADDRESS (if different from client)
18a. CITY
18b. STATE
18c. ZIP CODE

19. LIMITED ELIGIBILITY
◯ M = Minor ◯ A = Adult with Minor ◯ P = Pregnant ◯ O = Other

20. ANNUAL INCOME (PER SFY ELIG GUIDELINES)
21. HOUSEHOLD SIZE (PER SFY ELIG GUIDELINES)

Private Insurance

22. EMPLOYER NAME			
22a. STREET ADDRESS	22b. CITY	22c. STATE	22d. ZIP CODE
23. MEDICARE CLAIM NUMBER			
24. HEALTH INSURANCE COMPANY NAME			
24a. STREET ADDRESS	24b. CITY	24c. STATE	24d. ZIP CODE

25. CERTIFICATE OR POLICY NUMBER	25a. GROUP NAME NUMBER	25b. PRE-CERTIFICATION NUMBER

26. POLICYHOLDER NAME			
26a. STREET ADDRESS	26b. CITY	26c. STATE	26d. ZIP CODE
27. RELATIONSHIP TO CLIENT			

I certify that to the best of my knowledge and belief, the information provided above is complete and correct. I understand that if the information provided is false or incomplete, I may be responsible for the total cost of treatment provided. I authorize access to medical information needed to determine health care and/or Medicare benefits payable for substance use services. I authorize payment of any third party benefits directly to the Department of Human Services. This authorization expires one year from the date services were rendered. I understand that I may revoke this authorization at any time except to the extent that actions have taken in advance of my revocation. If I revoke this authorization, I may be responsible for the total cost of treatment.

28. CLIENT SIGNATURE	28a. DATE
29. FINANCIALLY RESPONSIBLE PERSON SIGNATURE (AND/OR POLICYHOLDER IF NOT THE CLIENT)	29a. DATE

☐ I agree by typing my name in the signature field, I understand that I am electronically signing this form. I attest and certify that the information provided is true and accurate. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minn. Stat. Ch. 325L.07)

30. CONTACT NAME	30a. PHONE NUMBER	30b. FAX NUMBER	30c.EMAIL ADDRESS

Instructions for completing the BHF Request (DHS-2780A)

Box 1. Financial Eligibility Start Date – Enter the start date as the first billable date of service. This could be the date of the comprehensive assessment or the first date of treatment services provided. The date of the comprehensive assessment must be included in this span in order for the provider to be paid for it.

Box 2. PMI Number, If any – Recipient PMI can be found in MN–ITS Eligibility Search by doing a search of a combination of the recipient's name, date of birth, and social security number. If one is not found in MN–ITS eligibility search then leave this field blank and the County/Tribe will set the client up with one. Providers must search in MN–ITS eligibility search to find the new PMI number after the County/Tribe assigns one for the client.

Box 3. Client Name

Box 4. Client Address – Enter the client's address as reported by the client.

Box 4a. City

Box 4b. State

Box 4c. Zip Code

Box 5. Residence Type – Check the box type of residence client identifies they are residing in at time of application.

Box 6. Previous Residence Address (if applicable) – If client is residing in an excluded facility at time of application enter full address client identifies as residing at ***prior*** to residence in an excluded facility (MN 256G.02, Subd. 6).

Box 7. Race – Check the box representing the race of the client as reported by the client.

Box 8. Client Alias, if any – Enter any other name this client has been known as previously such as nicknames, maiden names, prior married names, etc.

Box 8. Date of Birth – Enter the client's date of birth as reported by the client.

Box 10. County of Residence – Enter the three digit county code from the drop down menu that represents the county in which the client currently resides.

Box 11. Social Security Number – Enter SSN as reported by client

Box 12. Language – Enter the language the client understands best as reported by the client

Box 13. Hispanic – Check whether the client is Hispanic or not.

Box 14. Marital Status – Enter a valid value from the drop down menu that best describes the client's marital status.

Box 15. Gender – Enter the gender in which the client associates with most. This field is in the process of being updated to be more inclusive and the form will be updated as appropriate.

Box 16. Is client incarcerated? – check yes or no

Box 16a. If yes, Correctional Facility – Enter name, and NPI if known, of Correctional Facility where client is residing at time of application.

Box 16b. Date Incarceration Began – If unknown, write in "unknown."

Box 16b. Date Incarceration Ends – Enter date client is anticipated to discharge from the correctional facility. If unknown, write in "unknown."

Box 17. Financially Responsible Person – Last Name

Box 17a. First Name

Box 17b. Middle initial

Box 18. Financially Responsible Person's Address, if different from client

Box 18a. City

Box 18b. State

Box 18c. Zip Code

Box 19. Limited Eligibility – choose one of the valid values to identify the eligibility of the client.

Box 20. Annual Income – (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6770-ENG) Enter the annual income calculated prospectively from the date of the first date of service forward one year. This is different from the MA determinations which calculate retrospectively, BHF calculates forward one year. This allows a recipient to gain immediate funding for their treatment needs under BHF and then pursue Medicaid enrollment while receiving treatment. Upon retro MA approval, previously paid claims will be reprocessed under MA so that no county share is applied.

Box 21. Household Size – (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6770-ENG) Enter the number of people in the household as defined as such on the Income Guidelines

Box 22. Employer Name – Enter the name

Box 22a. Street Address – Address of the employer where the insurance is issued

Box 22b. City

Box 22c. State

Box 22d. Zip Code

Box 23. Medicare Claim Number – Enter the Medicare claim number assigned for a Medicare enrolled recipient

Box 24. Health Insurance Company Name

Box 24a. Health Insurance Company Street Address

Box 24b. Health Insurance Company City

Box 24c. Health Insurance Company State

Box 24d. Health Insurance Company Zip Code

Box 25. Certificate or Policy Number – Enter the insurance certificate or policy number

Box 25a. Group Name Number – Enter the insurance group name or number

Box 25b. Pre-Certification Number

Box 26. Policyholder Name

Box 27. Relationship to client – Enter one of the following values:

1. Self
2. Spouse
3. Child

Box 28. Client signature – Client signs attesting the statement above is accurate and authorizing third party billing

Box 28a. Date of client signature

Box 29. Financially responsible person's signature – have the financially responsible person sign if not the client

Box 29a. Date of financially responsible person's signature

Box 30. Contact name – Enter name of the sender of this document in case you need to be reached.

Box 30a. Phone number – Enter phone number of the sender of this request.

Box 30b. Fax number – Enter fax number of the sender of this request.

Box 30c. Email address – Enter email address of the sender of this request.

Privacy of Alcohol and Drug Abuse Records

State laws and federal rules protect your placement and treatment records. The federal rule is Title 42, part 2 of the Code of Federal Regulations. The state laws are Minnesota Statutes, chapter 13 and Minnesota Statutes, section 254A.09. The agency must not identify you to others without your consent. Your consent must be in writing.

You do not have to answer the questions on this form. However, the state will not pay for your treatment unless you answer the questions.

Your records are private. Agency employees working on your placement in treatment can see the records. Workers in this agency who arrange for payment have access to your records. Workers from the Minnesota Department of Human Services who send out treatment payments or check county records also have access to your records.

Your records may be released outside the agency with your consent. Your records may also be released under the following conditions:

1. You are not identified as an alcohol or drug abuser in any way. This means a treatment center that treats other problems can release your name, but not say you are receiving alcohol or drug services.
2. A court orders the release of records after a hearing.
3. The disclosure is made during a medical emergency to medical treatment providers.
4. The disclosure is made to an agency which provides services such as bill collecting to the program.
5. A child abuse or neglect report is made. The report identifies the child, the child's caretaker and the alleged abuser. The amount and type of abuse and the identity of the reporter are also in the report. The abuse may be reported to local welfare or police agencies.
6. Staff in this agency and the Minnesota Department of Human services need the information to do their jobs.

Your alcohol and drug abuse record normally may not be used in criminal investigations. Crimes in programs or against program workers may be reported to police. A threat to commit a crime also may be reported to police. A court may order release of records if the crime is very serious.

You have the right to see your record. You have the right to obtain a copy of your record. The agency may charge you for the cost of finding the record and making copies. If you only want to see the record, the agency must provide it at no cost.

Breaking the federal privacy rule is a crime. The penalty is a fine of not more than $500 for the first offense and not more than $5,000 for repeat offenses.

Suspected violations may be reported to:

United States Attorney
District of Minnesota
300 South 4th Street, Room 600
Minneapolis, Minnesota 55401

You may complain if your record is wrong. You may also complain if your record is not complete. The agency must reply within 30 days. If you disagree with the agency's decision, you may appeal to the State Department of Administration. Your appeal should include:

1. Your name, address, and telephone number,
2. The name and address of the agency which has the records,
3. Description of the dispute and the date it happened, and
4. The relief you want.

If an agency breaks the state privacy law, you may also sue. Damages of not less than $100 or not more than $10,000 can be assessed by a court against the agency. Workers who break this law are guilty of a misdemeanor.

Discrimination Complaint Process

If you believe you have been discriminated against because of your race, color, creed, religion, national origin, disability, sex, sexual orientation, public assistance status, or age, while requesting or receiving alcohol or other drug abuse treatment services, you may file a discrimination complaint with one or more of the agencies listed below:

Minnesota Department of Human Services
Office for Equal Opportunity
PO Box 64997
St. Paul, MN 55164-0997
Minnesota Department of Human Rights

U.S. Department of Health and Human Services
Office for Civil Rights, Region V-Chicago
233 North Michigan Avenue, Suite 240
Chicago, IL 60601-5519

Your Civil Rights

Discrimination is against the law. The Minnesota Department of Human Services (DHS) does not discriminate on the basis of any of the following: race, color, national origin, creed, religion, public assistance status, marital status, age, disability, sex (including sexual orientation and gender identity) or political beliefs.

Free Services

Auxiliary aids

If you have a disability and need aids and services to have an equal opportunity to participate in our health care programs, DHS will provide them timely and free of charge. These aids and services include qualified interpreters and information in accessible formats.

Language assistance

If you have difficulty understanding English and need language help to access information and services, DHS will provide language assistance services timely and free of charge. These services include translated documents and interpreting spoken language.

To request these free services from DHS, call DHS Health Care Consumer Support at 651-297-3862 or 800-657-3672. Or use your preferred relay service.

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by a human services agency.

You may contact any of the following three agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services' Office for Civil Rights (OCR)

You have a right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following: race, color, national origin, age, disability, or sex (including sexual orientation and gender identity).

Contact the **OCR** directly to file a complaint:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
800-368-1019 (voice), 800-537-7697 (TDD)
202-619-3818 (fax)
OCRComplaint@hhs.gov (email)
https://ocrportal.hhs.gov/

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following: race, color, national origin, religion, creed, sex, sexual orientation, marital status, public assistance status, or disability.

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North, Suite 201
St. Paul, MN 55104
651-539-1100 (voice) or 800-657-3704 (toll free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)
https://mn.gov/mdhr/intake/consultationinquiryform/

DHS

You have a right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following: race, color, national origin, creed, religion, public assistance status, marital status, age, disability, sex (including sexual orientation and gender identity), or political beliefs.

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. After we get your complaint, we will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal the outcome if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
PO Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service.

Attention. If you need free help interpreting this document, call the above number.

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ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

ចំណាប់អារម្មណ៍ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တက့ၢ်. ဖဲနမ့ၢ်လိဉ်ဘဉ်တၢ်မၤစၢၤကလီလၢတၢ်ကကျိးထံဝဲၤလံာ်တီလံာ်မီတခါအံၤန့ၣ်, ကိးဘဉ်လီတဲစိနီၣ်ဂံၢ်လၢထးအံၤန့ၣ်တက့ၢ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

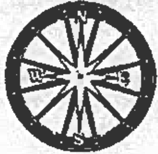
Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB2 (10-20)

For accessible formats of this information, ask your county worker. For assistance with additional equal access to human services, contact your county's ADA coordinator. ADA4 (2-18)



1200 S. Pokegama Ave. Ste. 160 Grand Rapids, MN 55744
(P) (218)999-0051 (F) (218)999-7020 admin@compassnorthmn.com

- Psychotherapy
- Targeted Case Management
- Adult Rehabilitative Mental Health Services
- ☒ Chemical Health

AUTHORIZATION FOR THE EXCHANGE OF INFORMATION

Clients Name: ______________________ Date of Birth: ______________

I give Compass North permission to: ☒ Give information to
☒ Receive information from

North Homes Inc: Ali Meyer
Outside Agency and/or Individual's Name

413 13th St. SE, Grand Rapids, MN 55744
Address, City, State, Zip Code

(218) 999-9908
Phone Number

(218) 999-9959
Fax Number

Approximate Dates of Requested Information: ______________________
Information is being used for the purpose of: Funding

Types of information to be disclosed by mail, telephone, email, or facsimile are as follows:

- ☐ Diagnostic Assessment
- ☐ Treatment Plan
- ☐ Discharge Summary
- ☐ Rule 25 CD Assessment
- ☐ Diagnosis
- ☐ Other (Specify): Behavioral Health Fund
- ☐ Billing & Financial information
- ☐ Psychological Testing
- ☐ Progress in Treatment
- ☐ Alcohol/Drug Abuse History/Treatment
- ☐ Verbal Consultation as Necessary

Records related to chemical dependency, mental health, or HIV/AIDS will be released, unless otherwise indicated by initialing here: _____

I understand that I have a right to revoke my authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Compass North. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal laws and regulations.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not to sign this form to ensure mental health treatment.

This authorization expires on ______________________
If I fail to specify an expiration date or event, this authorization expires one year from the date on which it was signed.

______________________ Client Signature

______________________ Compass North Staff

______________________ Parent/Guardian Signature

______________________ Date