Compass North

502 10th Street SE 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