Compass North

502 10th Street SE Grand Rapids, MN 55744
(P) (218)999-0051 (F) (218)999-7020 admin@compassnorthmn.com

Adult Client Intake Information

Date: _____

Client Information

Name: _____ Date of Birth: _____
Age: _____ Gender: ☐ Male ☐ Female ☐ Other: _____
SSN: _____

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: _____

Mailing Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell/Other Phone: _____

Power of Attorney / Guardianship Information

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

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: _____

POA/Guardian Signature: _____ Date: _____

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BILLING AUTHORIZATION

I authorize the release of any medical, substance use disorder comprehensive assessments, 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

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.

Notice of Receipt for other family members under the age of 18. (Please list name(s) of all children) _____

_____

_____

_____

_____

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 situation 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 appointments for the mental health and/or chemical health services described above.

Signature: _____

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

_____

I refuse to participate in telemedicine appointments for the mental health and/or chemical 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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Psychotherapy Information Disclosure Statement

Therapy is a relationship that works best with having clearly defined roles and responsibilities held by each person. As a client in psychotherapy, certain rights are important to know before beginning the therapeutic relationship. It is your responsibility to be aware of your personalized goals to achieve your optimal health.

Responsibilities of the Therapist

Service providers are required to follow The Code of Ethics which includes; helping clients with their needs and connecting them to the appropriate services, advocating for social justice, valuing everyone with dignity and worth, enhancing human relationships, maintaining professionalism with integrity and truthfulness staying within professional training competence and maintaining licensing standards.

I. Confidentiality

You have the right to the confidentiality of your therapy, with the exception of certain specific situations described below. A therapist cannot and will not tell anyone else what you have told them, or even that you are in therapy without your prior verbal or written permission. Under the provisions of the Health Care Information Act of 1992, a therapist may legally speak to another health care provider or a member of your family about you without your prior consent, but they will not do so unless the situation is an emergency. As a client you may direct the therapist to share information with whomever you choose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you.

You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. Whenever a therapist transmits information about you electronically (e.g. sending bills for faxing information), it will be done with special safeguards to insure confidentiality.

If you elect to communicate with a therapist by email at some point in your work together, please be aware that email is not completely confidential. All emails are retained in the logs of your or the therapist's internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to read by the system administrator(s) of the

internet service provider. Any email received from you by a therapist, and any responses that the therapist sends to you, will be kept in your treatment file.

The following are legal exceptions to your right to confidentiality. The therapist would inform you of any time when they think they will have to put these into effect.

1. If a therapist has good reason to believe that you will harm another person. The therapist must attempt to inform that person and warn them of your intentions. They must also contact the police and ask them to protect your intended victim.

2. If a therapist has good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give the therapist information about someone else who is doing this, they must inform Child Protective Services within 24 hours and Adult Protective Services immediately. If you are between the ages of 16 and 18 and you tell the therapist that you are having sex with someone more than four years older than you, or sex with a teacher or a coach, they must also report this to CPS.

3. A therapist will explore your symptoms with you in session and assess your safety if deemed necessary. If you are unwilling to take steps to guarantee your safety and the therapist believes that you are in imminent danger of harming yourself, they may legally break confidentiality and call the police or the local crisis response team (2-1-1).

4. If you tell a therapist of the behavior of another named health or mental health care provider that this person has either A) engaged in sexual contact with a client, including yourself or B) is impaired from practice in some manner by cognitive, emotional, behavioral, or health problems, then the law requires them to report this to their licensing board at the MN Department of Health. The therapist would inform you before taking this step.

The next is not a legal exception to your confidentiality. However, it is policy you should be aware of if you are in couples therapy.

If you and your partner decide to have some individual sessions as part of the couples therapy, what you say in those individual sessions will be considered to be a part of the couples therapy, and can and probably will be discussed in the joint sessions unless you tell the therapist otherwise. The therapist will remind you of this policy before beginning such individual sessions.

II. Record-Keeping

The Diagnostic Assessment (using the Diagnostic and Statistical Manual of Mental Disorders, fifth edition) will be reviewed with you, and the treatment plan will be approved with your authorized signature. Under the provisions of the Health Care Information Act of 1992, you have the right to a copy of the Diagnostic Assessment and Treatment Plan at any time. Copies

of the Diagnostic Assessment and Treatment Plan may be requested with the understanding that Compass North will no longer be able to guarantee privacy once the documents leave the facility. Progress notes are kept confidential for each therapy session which include your presentation status, therapeutic modalities used during the session, goals and objectives as well as session responses to your individualized treatment plan. You have the right to request a review of your progress notes at any time. You have the right to request that any errors be corrected in your file.
You have the right to request that a copy of your Diagnostic Assessment and/or Treatment Plan be given to any other health care provider at your written request. Your records are maintained in a secure location that cannot be accessed by anyone else.

III: Managed Mental Health Care

If your therapy is being paid for in full or in part by a managed care firm, there are usually further limitations to your rights as a client imposed by the contract of the managed care firm. These may include their decision to limit the number of sessions available to you, or to decide the time period within which you must complete your therapy. They may also determine if a provider is not within their network. Managed care firms usually require verification of treatment necessary for authorization to access benefits. Your therapist will do all they can to maximize the benefits you receive by filing necessary forms and gaining required authorizations for treatment and assist you in advocating with the managed care firm as needed.

Therapy Basics

Therapy has potential emotional risks. Approaching feelings or thoughts that you have tried not to think about for a long time may be painful. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to the relationships you already have. You may find the therapeutic relationship to be a source of strong feelings, some painful at times. It is important that you consider carefully whether these risks are worth the benefits that therapy can provide. Most people who take these risks find therapy is helpful.

You will normally be the one who decides therapy will end with a few exceptions. If the presenting issues you disclose are outside the scope of practice for the therapist, the therapist will inform you of this fact and refer you to another therapist who may better meet your needs. If you do violence to, threaten, verbally or physically, or harass the therapist, the office, any office staff or family members of the therapist or office staff, the therapist reserves the right to terminate you unilaterally and immediately from treatment. If they terminate you from therapy, they will offer you referrals to other sources of care.

A therapist may be away from their office several times in the year for vacation or to attend professional meetings. A therapist will tell you well in advance of any anticipated lengthy absences. If you are experiencing an emergency when your therapist is away, you can call the office to see if another therapist is available to see you. If you are experiencing an emergency outside of regular office hours, please call the local Crisis Response Team at 2-1-1. If you believe

that you cannot keep yourself safe, please call 9-1-1, or go to the nearest hospital emergency room for assistance.

Your Responsibilities as a Therapy Client

Clients are expected to be on time for scheduled sessions. If you are late, the session will end on time and not run over into the next person's session. If you miss a session without canceling, or cancel with less than 24 hours notice, this will count as a no call no show. The answering machine has a time and date stamp which will keep track of the time you called to cancel. The only exception to this rule about cancellations is if you would endanger yourself by attempting to come (for instance, driving on icy roads without proper tires), or if you or someone whose caregiver you are has fallen ill suddenly. If you no call no show for three sessions and do not attempt to reschedule, you will be notified that all future scheduled appointments are canceled. If this occurs, you have the right to call your individual therapist to discuss the option of you returning to therapy.

If you are self-pay you are responsible for paying for your session prior to that session. The fee for the session is based on the services provided during that session. If you have insurance, you are responsible for providing complete insurance identification information, and a copy of your card. You must pay your co-payment, or any amount deemed your responsibility by your insurance company, at each session. You must arrange for any pre-authorizations necessary. If a check is mailed to you to cover your balance due, you are responsible for paying that amount at the time of your next appointment. If the insurance overpays your account will be credited or you will be refunded if you would prefer that.

Credit cards, check, money order, or cash are accepted forms of payment. Payment plans are available for any overdue bills that cannot be paid in full. If your bill is overdue a payment plan needs to be set up before services can continue. If you eventually refuse to pay your debt, or default on your payment plan, Compass North reserves the right to give your name and amount due to a collection agency.

Complaints

Clients unsatisfied with services or treatment modalities are encouraged to notify their therapist. Therapists have the responsibility to address client concerns with care and respect. If issues are not addressed appropriately, Alexander Meyer, CEO of Compass North or the therapist's Licensing Board may be contacted.

Client Consent to Psychotherapy

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I consent to the use of a diagnosis in billing, and to the release of that information and other information necessary to complete the billing process. I understand my rights and responsibilities in the therapeutic relationship and agree to participate in therapy with Compass North. I know I can end therapy at any time and may refuse recommendations or suggestions within therapy.

Client Name (Printed) _____

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(If a minor)

Therapist's Signature: _____ Date: _____

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Advanced Psychiatric Health Care Directive Notice

Please select one:

____ I have a advanced psychiatric health care directive.

____ I do NOT have an advanced psychiatric health care directive.

If you have an advanced healthcare directive, please select one:

__ I am giving Compass North a copy of my advanced psychiatric health care directive to keep in my file. (Please include copy, or bring directive to our office to have a copy made)

___ I am NOT giving Compass North a copy of my advanced psychiatric health care directive to keep in my file.

_____ _____

Client Signature Date

***Agency Use Only**: Copy of directive received_____ Staff initials:_____*

CAGE-AID Questionnaire

Patient Name: _____ **Date of Visit:** _____

When thinking about drug use, include illegal drug use and the use of prescription drug other than prescribed.

Questions:	**YES**	**NO**
1. Have you ever felt that you ought to cut down on your drinking or drug use?		
Drinking	☐	☐
Drug use	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?		
Drinking	☐	☐
Drug use	☐	☐
3. Have you ever felt bad or guilt about your drinking or drug use?		
Drinking	☐	☐
Drug use	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning **to steady your nerves or to get rid of a hangover?**		
Drinking	☐	☐
Drug use	☐	☐

Scoring

Regarding one or more positive responses to the CAGE-AID as a positive screen.

Psychometric Properties

The CAGE-AID exhibited:	**Sensitivity**	**Specificity**
One or more **YES** responses	0.79	0.77
Two or more **YES** responses	0.70	0.85

(Brown 1995)