

**Initial Client Information**

Date 05/26/2020

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN# \_\_\_\_\_ Marital Status \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ best way to contact you? \_\_\_\_\_

E-MAIL \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_

Medical Clinic \_\_\_\_\_ City \_\_\_\_\_ Physician \_\_\_\_\_

Person/organization who referred you to this appointment \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

*Communication between health care providers can be beneficial to your receiving services and establishing continuity of care. Your permission is required for this communication. Please check one of the following:*

\_\_\_\_\_ No. I do not want communication with my primary health care provider.

\_\_\_\_\_ I do not have a primary health care provider.

\_\_\_\_\_ Yes, I want communication with my health care provider, (Letter or phone call indicating you have been seen at this location)

Your Signature: \_\_\_\_\_ Date \_\_\_\_\_

***For parents/guardians of minors: I attest that I have the legal authority to request and permit the above named minor to be seen and treated.***

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Primary Insurance Company \_\_\_\_\_

Policy Holder \_\_\_\_\_ Policy Number \_\_\_\_\_

Employer/Group \_\_\_\_\_ SS Number \_\_\_\_\_

Mailing Address \_\_\_\_\_

Other 3rd Party Coverage \_\_\_\_\_

Policy Holder \_\_\_\_\_ Policy Number \_\_\_\_\_

Employer/Group \_\_\_\_\_ SS Number \_\_\_\_\_

Mailing Address \_\_\_\_\_

***Failure to provide timely information about your health insurance can result in your being totally responsible for the cost of services provided. Many insurances require billing to be done in a "timely manner" and will not pay claims submitted after the allotted time.***

PLEASE CHECK PLACES WHERE MESSAGES AND REMINDERS CALLS CAN BE LEFT.

___ HOME	_____	___ Yes	___ No	_____
	How should we identify ourselves ?	May we say the clinic name?		Phone number if different
___ WORK	_____	___ Yes	___ No	_____
	How should we identify ourselves ?	May we say the clinic name?		Phone number if different
___ CELL	_____	___ Yes	___ No	_____
	How should we identify ourselves ?	May we say the clinic name?		Phone number if different

Please click on initials area and add another signature (initials) and proceed

### PERMISSION STATUS



**My Initials (all 6 on left) and Signature below indicates the following:**

- I have received a copy of Limits of Confidentiality.  
--I agree to the above limits of confidentiality and understand their meanings and ramifications.
- I am authorizing permission to receive treatment by the mental health professional.
- I have indicated my preference on electronic communication between APPS/staff and myself (email, text, cell phone, internet) and have received a copy of the electronic communication information sheet.
- I agree to meet my responsibility towards payment for services rendered.  
I hereby authorize the release of any medical information necessary to process my claims to the insurance company. I hereby authorize payment of medical benefits for services rendered to me and/or my dependents by Mary M. Andersen, APRN, CNS, MSN to be paid to Mary M. Andersen, APRN, CNS, MSN  
I understand that I am financially responsible to Mary M. Andersen, APRN, CNS, MSN for the charges not covered by the assignments of the benefits above.  
I (we) have read, understand, and agree with the provisions of the Financial Policy and "missed appointment or late cancellation fees."
- I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to this clinic.
- I understand that APPS will not condition treatment or eligibility for care on my providing this authorization.

Patient Signature/Date Signed: \_\_\_\_\_ Date \_\_\_\_\_

Responsible Party Signature/Date Signed \_\_\_\_\_ Date \_\_\_\_\_

#### Release Required on all Behavioral Healthcare Providers (BHP) Managed Patients

I understand the confidentiality of my records as protected by law. Information about me cannot be released without my consent. I understand I may revoke this consent at any time, and it will automatically expire without my revocation after one (1) year from the date of signature. I do not authorize release of this information by the recipient unless further release is specifically authorized.

I hereby give authorization for **Mary M. Andersen, APRN, CNS, MSN** to contact and inform BHP Intake of all medical information included in this treatment plan, and

I hereby give authorization for **Mary M. Andersen, APRN, CNS, MSN** to contact and inform my Primary Care Physician of all medical information included in this treatment plan; and I hereby give authorization for BHP Intake to contact and inform my Primary Care Physician of all medical information included in this treatment plan.

Patient Signature/Date Signed: \_\_\_\_\_ Date \_\_\_\_\_

Responsible Party Signature/Date Signed \_\_\_\_\_ Date \_\_\_\_\_

**Consent for Electronic Communication**

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

This form, when completed and signed by you, authorizes your therapist/APPS staff to release and/or exchange protected information from your clinical record using electronic mail (e-mail) or other forms of electronic communication.

**ASSUMPTIONS**

- E-mail/text messages can be immediately broadcast worldwide and be received by many intended and unintended recipients. E-mail and other forms of electronic communication are not "secure" means of communication.
- Recipients can forward e-mail or text messages to other recipients without the original sender's permission or knowledge.
- Users can easily misaddress an e-mail message or text message.
- E-mail or text messages may be altered and is easier to falsify than handwritten or signed documents.
- Backup copies of e-mail or text messages may exist even after the sender or the recipient has deleted his/her copy.
- E-mail or text messages containing information pertaining to a patient's diagnosis and/or treatment constitutes a part of the patient's medical record. All e-mail and text messages may be discoverable in litigation regardless of whether it is in a patient's medical record.
- Messages transmitted via e-mail or text messages may not be picked up in a timely fashion. To avoid unnecessary delays in the transmission of important information, do not use e-mail or text messages to send urgent messages.

**\*\*Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and may no longer be protected by the HIPAA privacy rule. You have the right to revoke this authorization, in writing, at any time by sending such written notification to the APPS business address. Your revocation will not be effective to the extent that APPS staff have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. If the authorization is signed by a personal representative of the client, a description of such representative's authority to act for the client must be provided.\*\***

\_\_\_\_\_ I(we) understand the assumptions stated above and understand that electronic communication (text, email, cell phone) is not a secure means of communication. I am aware that the provider may decline to communicate via electronic communication based upon the nature of the medical information. I give permission for APPS to use electronic communication as a means of communication regarding my care. I understand that I may withdraw this authorization at any time by notifying APPS administrative staff or my therapist in writing.

**Please initial on line and** click on appropriate box

\_\_\_\_\_ Email communication is:    **Permitted**            **Not Permitted**

\_\_\_\_\_ Text communication is:    **Permitted**            **Not Permitted**

**This provider does not use any communication made through social media sites, such as Facebook, MySpace, Instant Messaging, LinkedIn, etc.**

**By signing below I understand and agree to the above stated policy regarding electronic communication.**

Signature: \_\_\_\_\_ Date \_\_\_\_\_

**CHILD'S NAME:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **BIRTHDAY:** \_\_\_\_\_

**CURRENT CONCERNS:**

**1. Does your child have any of the following problems, more than other children of the same age?**

- make careless mistakes, and show poor attention to detail?
- have a poor attention span?
- have problems with being spacey and not listening when being spoken to?
- not complete assigned tasks and does not follow through on instructions even if capable and motivated?
- have problems organizing his/her work or activities?
- show dislike, avoid, or refuse tasks that require concentration?
- lose things that he/she needs?
- have problems being easily distracted?
- have problems being forgetful?
- fidget or squirm while seated?
- leaves seat when remaining seated is expected?
- runs or climbs inappropriately or, if he/she is a teenager, feels restless?
- have problems doing things quietly or doing quiet things?
- seems to be always on the go, or like he/she is driven by a motor?
- talk all the time?
- calls out answers before the question is finished?
- have problems taking turns or waiting in line?
- interrupt or intrude on others?

When did these symptoms first appear? \_\_\_\_\_

Do these problems come and go, or are they mostly the same from one day to the next? \_\_\_\_\_

Are these problems getting better or worse? \_\_\_\_\_

Occurs only at home  only at school  or everywhere ?

**2. Does your child regularly behave in the following ways?**

- annoyed easily by others, touchy?
- argues?
- defiance?
- angry, resentful?
- loses temper, tantrums?
- deliberately bothers others?
- spiteful, mean?
- blames others for own mistakes?

On the average, how often does your child follow directions or requests the first time asked?

most of the time    often    sometimes    rarely    never

On the average, does your child eventually follow directions or requests? (circle)

most of the time    often    sometimes    rarely    never

**3. Does your child regularly behave in the following ways?**

- bullies, threatens, intimidates?
- starts fights?
- has used a weapon?
- has been physically cruel to people?
- has been physically cruel to animals?
- has forcibly stolen from a victim?
- has forced someone into sexual activity?
- has deliberately set fires, wanting to cause serious damage?
- has deliberately destroyed someone else's property?
- has broken into someone else's property?
- often lies or cons?
- has stolen without confronting a victim?
- often stays out at night -- beginning before age 13?
- run away from home overnight at least twice or once for a lengthy period?
- often truant from school beginning before age 13.

When did these symptoms first appear? \_\_\_\_\_

Are these problems getting better or worse? \_\_\_\_\_

Occurs only at home  only at school  or everywhere ?

What have you tried to do to correct these problems?

talking to your child      time out      removal of privileges      rewards      physical punishment  
giving in

Which of these has worked for you? \_\_\_\_\_

**4. Does your child show any of the following symptoms or behaviors:**

- change of appetite and/or weight \_\_\_\_ increased \_ decreased
- change in energy \_\_\_\_\_ increased \_ decreased
- sleep disturbance (describe) \_\_\_\_\_
- worse concentration than usual
- drop in school grades or performance
- crying spells
- unable to enjoy his or herself and/or loss of interest in usual activities
- hopeless feelings
- guilty feelings
- stays by himself or herself, loner, isolative
- low self-esteem, "I hate myself," "I'm stupid"
- giving away his/her things
- wishes to be dead, suicidal thoughts or behavior, self injurious behavior
- thinks about death and violence a lot
- rage outbursts
- bizarre behavior, hallucinations, paranoia
- rapid, hard to follow, strange speech or thoughts
- thinks he or she is the smartest, most powerful, most beautiful, cleverest person in the world

Have these problems been getting worse  better ?

**5. In general, does your child:**

- worry that something terrible is going to happen to him/her?
- worry that something terrible is going to happen to important adults in his or her life?
- frequently refuses or is reluctant to go to school or other places because of fear of separation?
- frequently refuses or is reluctant to go to sleep without someone close by or to sleep away from home?
- make efforts to avoid being alone, clingy?
- have nightmares about separation?
- have lots of physical complaints - headaches, stomachaches when separations occur or are anticipated?
- worry about leaving home or parents leaving?
- have panic episodes?
- have intense fears or phobias?
- have an extreme fear of meeting new or unfamiliar children his/her age?
- have obsessions, compulsions, rituals, or habits?
- worry too much? If so, are the worries
  - A.  hard to control for him/her
  - B. When worrying, he/she
    - is keyed up, restless, on edge?
    - is easily tired?
    - has trouble concentrating?
    - is irritable?
    - is tense?
    - has trouble sleeping?

**6. In the past few weeks to months, has your child exhibited any of the following?**

- Tourette's symptoms motor tics, vocal tics
- feels he/she is too fat when the opposite is true
- induces vomiting, takes diet pills or laxatives to control weight, binge eats
- sexually inappropriate behavior
- bedwetting
- soiling

**7. Describe your child's mood during the past several weeks? (For example, depressed, angry, anxious, suicidal, too high, happy or other)** \_\_\_\_\_

\_\_\_\_\_

Do moods change quickly? Yes  No  If yes, explain: \_\_\_\_\_

\_\_\_\_\_

Is your child's mood of the past several weeks different from their usual mood? Yes  No

Explain: \_\_\_\_\_

## Strengths and Difficulties Questionnaire

P 4-10

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behavior over the last six months.

Your child's name .....

Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children, for example toys, treats, pencils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often loses temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, prefers to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally well behaved, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries or often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, depressed or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often offers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets along better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good attention span, sees chores or homework through to the end	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behavior or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes", please answer the following questions about these difficulties:

• How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties upset or distress your child?

Not at all	Only a little	A medium amount	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	A medium amount	A great deal
HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLASSROOM LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	A medium amount	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature .....

Date .....

Mother/Father/Other (please specify:)

**Thank you very much for your help**

## Current and Past Medication

MaryAPRN.com | from the desk of Mary Andersen APRN, CNS, MSN

- CELEXA -- citalopram
- CYMBALTA -- duloxetine
- EFFEXOR-- venlafaxine
- FETZIMA -- levomilnacipran
- LEXAPRO -- escitalopram
- LUVOX -- fluvoxamine
- PAXIL -- paroxetine
- PRISTIQ -- desvenlafaxine
- PROZAC -- fluoxetine
- TRINTELLIX-- vortioxetine
- VIIBRYD -- vilazodone
- WELLBUTRIN-- Budeprion--Bupropion
- ZOLOFT -- sertraline
  
- ANAFRANIL -- clomipramine
- ELAVIL, ENDEP -- amitriptyline
- NORPRAMINE -- desimpramine
- PAMELOR, AVENTYL -- nortriptyline
- REMERON -- mirtazapine
- SINEQUAN, ADAPIN -- doxepin
- TOFRANIL -- imipramine
  
- ATIVAN -- lorazepam
- KLONOPIN -- clonazepam
- TRANXENE -- chlorazepate
- VALIUM -- diazepam
- XANAX -- alprazolam
  
- AMBIEN -- zolpidem or INTERMEZZO
- BELSOMRA -- suvorexant
- LUNESTA -- eszopiclone
- RESTORIL -- temazepam
- ROZEREM -- ramelton
- SONATA -- zaleplon
- Trazodone -- DESYREL, OLEPTRO
  
- AUSTEDO -- deutetrabenazine
- INGREZZA -- valbenazine
- ARICEPT -- donepezil
- SYMMETREL --amantadine
  
- BUSPAR -- buspirone
- COGENTIN -- benztropine
- VISTARIL, ATARAX -- hydroxyzine
- INDERAL -- propranolol
- MINIPRESS -- prazosin
  
- EMSAM -- selegiline
- MARPLAN -- isocarboxazid
- NARDIL -- phenelzine
- PARNATE -- tranylcypromine
  
- ADDERALL --Amphetamine/dexamphetamine
- CATAPRESS -- clonidine
- CONCERTA, RITALIN, METHYLIN, METADATE-- methylphenidate
- DAYTRANA -- methylphenidate transdermal
- DEXEDRINE -- dextroamphetamine
- FOCALIN -- dexmethylphenidate
- TENEX OR INTUNIV -- guanfacine
- JORNAY -- Methylphenidate
- KAPYVAY -- clonidine hydrochloride
- STRATTERA -- atomoxetine
- VYVANSE -- lisdexamfetamine
  
- DEPAKOTE -- divalproex/valproic acid
- KEPPRA -- levetiracetam
- LAMICTAL -- lamotrigine
- LITHIUM -- lithobid -- eskalith
- NEURONTIN -- gabapentin
- TEGRETOL -- carbamazepine
- TOPAMAX -- topiramate
- TRILEPTAL -- oxcarbazepine
  
- ABILIFY -- aripiprazole     Abilify Maintena
- ARISTADA --aripiprazole injection
- CLOZARIL, FAZACLO -- clozapine
- FANAPT -- lloperidone
- GEODON -- ziprasidone
- INVEGA -- paliperidone         Invega Sustenna
- LATUDA -- lurasidone
- REXULTI -- brexpiprazole
- RISPERDAL -- risperidone     Risperda-Consta
- SAPHRIS -- asenapine
- SEROQUEL -- quetiapine
- VRAYLAR--cariprazine
- ZYPREXA -- olanzapine
  
- HALDOL -- haloperidol
- LOXITANE -- loxapine
- NAVANE -- thiothixene
- PROLIXIN -- fluphenazine
- STELAZINE -- trifluoperazine
- THORAZINE -- chlorpromazine
- TRILAFON -- perphenazine
  
- ANTABUSE--disulfiram
- CAMPRAL -- acamprostate
- CHANTIX -- varenicline
- METHADONE --methadone
- REVIA -- naltrexone
- SUBOXONE, SUBUTEX -- buprenorphine
- VIVITROL -- naltrexone IM

## FINANCIAL POLICY

- As a service to you, the facility will bill insurance companies and other third-party payers, but cannot guarantee such benefits or the amounts covered
- In some cases insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services.
- We charge our clients the usual and customary rates for the area. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.
- **The client is responsible for providing the insurance information to the clinic at the time of service and updating this information with any changes in insurance coverage.**
- **Failure to provide this information may affect the claim being filed in a timely manner, and the insurance company will then refuse to cover the services provided. The client will then be responsible for those charges.**
- The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers.
- Payments not received after 120 days are subject to collections. A 3% per month interest rate is charged for accounts over 60 days.
- Insurance deductibles and co-payments are due at the time of service..
- The client has the option of paying out of pocket and not utilizing their insurance coverage, otherwise, all insurance benefits will be assigned to this clinic (by insurance company or third party provider).
- Clients are responsible for payments at the, time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied non-emergency service unless charges have been preauthorized to an approved credit plan, charge card, or payment at the time of service.
- Fees can be adjusted on a case by case basis after review if there are significant financial constraints for the client. The client is responsible for identifying this situation as needed.

**Missed appointments or cancellations less than 24 hours prior to the appointment may be charged a rate to not exceed \$50.00.** This fee can be waived after review by the facility for specific situations that affect the person's ability to attend the appointment or cancel in a timely manner.

#### **IV. YOUR ACCESS TO YOUR INFORMATION**

- Requests must be in writing. You will receive a response from APPS within 30 days. If the request is denied, the reason will be communicated to you.
- You may request limits on uses and disclosures of your PHI. While your request will be considered, APPS is not legally bound to agree. You do not have the right to limit the uses and disclosures that APPS is legally required or permitted to make.
- You may choose how your PHI is sent to you. (i.e., sent to your work address instead of home address, cell phone vs. home phone, etc.) We are obliged to agree to your request provided that we can do so without undue inconvenience.
- If you believe that there is some error in your PHI or that Important information has been omitted, it is your right to request (in writing) that the existing information is corrected or the missing information is added.
- To receive a paper or email copy of this notice.

#### **V. ELECTRONIC COMMUNICATION**

APPS staff are trained to limit electronic communication of client information whenever possible. If you choose to communicate with your service provider electronically (i.e.; email, text messages, cellular phones, etc.) you will be asked for written permission to do so. Please also be aware of the security risks involved in this type of communication.

#### **VI. HOW TO COMPLAIN ABOUT APPS PRIVACY PRACTICES**

If you believe your privacy rights have been violated or if you object to a decision made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about APPS privacy practices, no retaliatory action will be taken against you.

#### **VII. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES**

If you have any questions about this notice or any complaints about APPS privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact: Mary Andersen at [MMAcns@MaryAPRN.com](mailto:MMAcns@MaryAPRN.com)

HIPAA Notice of Privacy Practices  
Rev: 10-2019

Please sign:

## HIPAA Notice of Privacy Practices

I. It is Advanced Practice Psych Services known here as 'APPS' legal duty to safeguard your protected health information (PHI) and inform you of our Privacy Practices. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

### II. DEFINITION

By law APPS is required to insure that your PHI is kept private. The PHI constitutes information created or noted by APPS that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care.

### III. HOW APPS WILL USE AND DISCLOSE YOUR PHI

APPS may use and disclose your PHI for the following reasons on a "need to know" basis:

- A. To provide treatment or services;
- B. For health care operations (i.e., case consultation, quality control, accreditation processes, etc.);
- C. To obtain payment for treatment or services.
- D. In cases where a client is served in more than one APPS program;
- III. When required by federal, state, or local law:
  - A. If we become aware that you may be a danger to yourself or a reasonably identifiable other;
  - ii. If we become aware of/suspect child abuse or neglect (MN Stat 626.645, Subdivision 3);
  - iii. If we become aware of/suspect abuse or neglect of a vulnerable adult (MN Stat 626.557, NDCC Ch, 50-25-2);
  - iv. If we are court ordered to testify or to submit our records to the court;
- IV. For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, we may need to give the county coroner information about you
- V. For specific government functions. APPS may disclose PHI of military personnel and veterans under certain circumstances. We may disclose PHI in the interests of national security or assisting with intelligence operations;
- VI. For research or educational purposes;
- VII. For Workers' Compensation purposes;
- J. Appointment reminders and health related benefits or services;
- K. Disclosures to family, friends, or others. APPS may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.
- L. If disclosure is otherwise specifically required by law;

### IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the right:

- A. To see and get copies of your PHI at the cost of no more than \$ .15 per page. Requests must be made in writing. You will receive a response within 30 days of APPS receiving your written request. If denied, reasons for the denial will be provided to you.
- B. To request limits on uses and disclosures of your PHI. While your request will be considered, APPS is not legally bound to agree. You do not have the right to limit the uses and disclosures that APPS is legally required or permitted to make.
- C. To choose. how your PHI is sent to you. (i.e., sent to your work address instead of home address, cell phone vs. home phone, etc.) We are obliged to agree to your request provided that we can do so without undue inconvenience.
- D. To amend your PHI. If you believe that there is some error in your PHI or that Important information has been omitted, it is your right to request (in writing) that the existing information is corrected or the missing information is added.
- E. To receive a paper or email copy of this notice.

V. ELECTRONIC COMMUNICATION

APPS staff are trained to limit electronic communication of client Information whenever possible. If you choose to communicate with your service provider electronically (i.e.; email, text messages, cellular phones, etc.) you will be asked for written permission to do so. Please also be aware of the security risks involved in this type of communication.

VI. HOW TO COMPLAIN ABOUT APPS PRIVACY PRACTICES

If you believe your privacy rights have been violated or if you object to a decision made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about APPS privacy practices, no retaliatory action will be taken against you.

VII. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about APPS privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact: Mary Andersen at mmacns@hotmail.com

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Authorization for Telehealth Medicine

First name	Last name		
Street address	City	State	ZIP
Date of birth	Email		

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

**Patient medical records.** Live two-way audio and video. Output data from medical devices and sound and video files.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

**Benefits:** Improved access to medical care by enabling a patient to remain in his/her ophthalmologist's office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.

- More efficient medical evaluation and management.

Obtaining expertise of a distant specialist. **Possible Risks:**

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to: In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);

Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment; In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information; In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

**I hereby authorize Mary M. Andersen APRN, CNS, MSN to use telemedicine in the course of my diagnosis and treatment.**

Signature of Patient (or person authorized to sign for patient): \_\_\_\_\_

Date: \_\_\_\_\_ If authorized signer, relationship to patient: \_\_\_\_\_

Witness Date: \_\_\_\_\_ I have been offered a copy of this consent form (patient's initials) \_\_\_\_\_

I have been offered a copy of this consent form. A copy will be sent to your email address after you fill out all fields of this form.

### **By signing this form, I understand the following:**

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.

I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My ophthalmologist has explained the alternatives to my satisfaction.

I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

I understand that it is my duty to inform my prescriber of electronic interactions regarding my care that I may have with other healthcare providers.

I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.