CHILD BEHAVIOR CHECKLIST

Child's Name:_____Date:_____Completed By:_____

Please circle **Y** = yes for behaviors that are a concern for your child, **S** = sometimes for behaviors that are sometimes a concern for your child and **N** = no for behaviors that are not a concern for your child.

ATTENTION

When symptoms began (date)_____

Careless mistakes	Y	S	N
Poor attention span	Y	S	N
Doesn't listen	Y	S	N
Doesn't finish tasks	Y	S	N
Problems organizing	Y	S	N
Avoids tasks requiring concentration	Y	S	N
Loses needed items	Y	S	N
Easily distracted	Y	S	N
Trouble remembering/forgetful	Y	S	N
Fidgets, squirms	Y	S	N
Leaves seat when required to sit	Y	S	N
On the go, seems driven	Y	S	N
Runs, climbs excessively/restless	Y	S	N
Talks all the time	Y	S	N
Problems waiting turn	Y	S	N
Interrupts	Y	S	N

OPPOSITIONAL BEHAVIORS

When symptoms began (date)_____

Touchy, easily annoyed	Y	S	N
Argues	Y	S	N
Defiant	Y	S	N
Angry	Y	S	N
Tantrums	Y	S	N
Bothers others deliberately	Y	S	N
Spiteful/mean	Y	S	N
Blames others for own mistakes	Y	S	N

CONDUCT

When symptoms began (date)_____

Bullies/threatens others	Y	S	N
Starts fights	Y	S	N
Used a weapon	Y	S	N
Physically cruel to people/animals	Y	S	N
Forcibly stolen from victim	Y	S	N
Stolen without confronting victim	Y	S	N
Forces sexual activity	Y	S	N
Deliberately sets fires to cause damage	Y	S	N

MOOD

When symptoms began (date)_____

Weight changes/appetite changes	Y	S	N
Energy level changes	Y	S	N
Sleep disturbances	Y	S	N
Difficulty concentrating	Y	S	N
Crying spells	Y	S	N
Loss of interest/pleasure	Y	S	N
Hopeless feelings	Y	S	N
Guilty feelings	Y	S	N
Isolates self	Y	S	N
Low self-esteem/self-hate	Y	S	N
Gives things away	Y	S	N
Wishes to be dead	Y	S	N
Injures self	Y	S	N
Thinks about death/violence often	Y	S	N
Rage outbursts	Y	S	N
Bizarre behaviors, hallucinations	Y	S	N
Rapid, hard to follow speech/thoughts	Y	S	N
Thinks s/he is the smartest, best person in the world	Y	S	N

ANXIETY/WORRY

When symptoms began(date)_____

Worries something terrible will happen to self or important adults	Y	S	N
Frequently refuses or is reluctant to go somewhere fear of separation	Y	S	N
Avoids being alone	Y	S	N
Nightmares about separation	Y	S	N
Physical complaints about the time of separation transition	Y	S	N
Worries about parent(s) leaving	Y	S	N
Fearfulness of new situations, people or objects	Y	S	N
Engages in repeated behaviors (counting, cleaning organizing, hand washing, etc.)	Y	S	N
Excessive worry about everyday things	Y	S	N
Fear/excessive worry about social situations	Y	S	N

Further comments about any of the above:_____

_____

_____

_____

_____

CHILD'S STRENGTHS:

In school setting:_____

_____

In social setting:_____

_____

In home setting:_____

_____

Special Interests/Hobbies:_____

_____

Prevail Counseling Group, PLLC
6893 139th LN, NW
Ramsey, MN 55303
Phone 763-427-2590 / Fax 763-427-2579

CLINICAL RECORD REQUEST / RELEASE AUTHORIZATION

Section 1

Client Name: _____ Client ID #: _____

Date of Birth: _____

Section 2

[ ] I authorize Prevail Counseling Group, PLLC to send information to:

[ ] I authorize Prevail Counseling Group, PLLC to receive information from:

Name of Agency _____

Address _____
Street, City, State, Zip Code

Phone _____ Fax _____

Contact Person _____

Section 3

Description of Information to be Disclosed

_____ Diagnostic Assessment/Evaluation
_____ Progress Notes
_____ ARMHS Functional Assessment & Treatment Plan
_____ Chemical Dependency Evaluation Notes
_____ All Mental Health Information-Dates of Service _____
_____ Any and all medical records (including billing records and secondary records, mental health, chemical dependency/drug or alcohol abuse treatment records)
_____ Other-specify _____
_____ Treatment Plan or Summary
_____ Billing Records
_____ Psychological/Psychiatric Assessment
_____ Other Facilities/Lab Reports

Section 4

The Purpose of this Disclosure of information:

[ ] Ongoing Care [ ] Consultation [ ] Collateral Evaluation [ ] Family/Support Group Contact [ ] ARMHS

[ ] Outcomes Management Survey [ ] Other – Specify _____

Section 5

I understand that I have a right to revoke this authorization at any time, in writing, but that the revocation will not have any effect on the information released prior to notification of cancellation. If I refuse to sign this consent, treatment will not be withheld. A photocopy of this authorization will be treated in the same manner as the original. I understand that this consent ***expires ONE YEAR*** *from the date I sign it unless I request an earlier expiration in writing.*

I release Prevail Counseling Group, PLLC from any and all liability resulting from disclosure. I do not authorize re-release of this information to anyone. I have read this consent prior to signing and I understand its contents.

Signed _____ Date _____
Signature of Client or *Legal Guardian/Responsible Party if under 18

*Relationship to Client _____

Witness _____ Date _____

Prevail Counseling Group, PLLC Office Use Only

[ ] Faxed [ ] Mailed [ ] Picked Up Date: _____ Time of Day: _____ Initials: _____

CONSENT TO PROVIDE SERVICE TO A MINOR

(A minor is any client age 17 years old and under)

Client _____

Client ID # _____ Date of Birth _____

"I, _____, _____
Print Name of Responsible Party Relationship to Minor

Hereby authorize PREVAIL COUNSELING GROUP, PLLC to provide treatment to the above name client – minor.

As a parent, I understand that I have the right to information concerning my minor child in therapy, except where otherwise stated. I also understand that this therapist believes in providing a minor child with private environment in which to disclose him/her to facilitate therapy. I therefore give permission to this therapist to use his/her discretion, in accordance with the professional ethics and state and federal laws and rules, in deciding what information revealed by my child is to be shared with me.

_____ _____
Signature of Responsible Party Date

_____ _____
Witness Date

PREVAIL COUNSELING GROUP, PLLC
CHILD AND ADOLESCENT HEALTH AND DEVELOPMENTAL QUESTIONNAIRE

"Please answer all the questions. Honest answers will allow the therapist to have a better understanding of your child and family. Feel free to ask questions if you need assistance."

Today's Date:_____ Child's Name: _____

Child's Address: _____
(Street Address) (City, State, Zip Code)

Child's Date of Birth: _____ Child's Current Age: _____

Child's Gender: Male [ ] or Female [ ] Child's Social Security Number: _____

Home Phone: _____ May we leave a message? [ ] Yes or [ ] No

Work Phone: _____ May we leave a message? [ ] Yes or [ ] No

Cell Phone: _____ May we leave a message? [ ] Yes or [ ] No

Who referred you to Prevail Counseling Group ? _____

Race: [ ] African/American [ ] Asian [ ] Hispanic [ ] Native/American [ ] Caucasian [ ] Other

Are there ethnic/cultural/lifestyle/gender/religious considerations you would like us to be aware of during your care?
[ ] Yes or [ ] No

If yes, please describe: _____
_____

What do you think your child needs help with at this time? _____
_____
_____

Are there any legal or custody issues, including who has legal custody, physical custody? Please explain: _____
_____
_____
_____

Section 1 – Developmental History

Were there any problems during pregnancy or delivery? (Such as medications, alcohol/drug or cigarette use, early labor, high blood pressure, diabetes, accidents, cord around neck, blue appearance, lack of oxygen, intensive care).

As a baby, were there any:
____ Feeding problems, colic, food allergies
____ Problems forming a close relationship between mother and child
____ Baby sleeping too much or too little

As a toddler or small child, were there any:
____ Problems with activity level
____ Absence or odd speech
____ Problems relating to others
____ Unusual repetitive behaviors

Please describe any issues marked above: _____
_____
_____
_____

Section 2 – Developmental Milestones

Please check the most appropriate box regarding your child's developmental activity.

Activity	Normal Range	Early	On Time	Late	Don't Know
Crawling	3-6 Months				
Walk Alone	11-15 Months				
First Words & Sentences	8-18 Months				
Toilet Trained (Bladder)	2-3 Years				
Toilet Trained (Bowel)	**2-3 Years**				

Were/are there any problems with bed wetting or soiling? _____
_____

Section 3 – Chemical / Alcohol History

Are there any chemical use issues for your adolescent? [ ] Yes or [ ] No If yes, check all that apply below.

_____ Tobacco Use
_____ Alcohol
_____ Cocaine/Crack
_____ Heroin
_____ Sleeping Pills
_____ Diet Pills
_____ LSD/Acid/Angel Dust
_____ Marijunana
_____ Methamphetamine
_____ Other

Do you think anyone else in your family has a chemical / alcohol use / addiction problem? Please explain: _____
_____
_____

Section 4 – Current / Previous Mental Health Services

Name of current Psychiatrist or Clinic: _____

Name of County Social Worker: _____

- Name of Prior Psychiatrist: _____ Years Treated: _____

  Medications: _____

- Name of Prior Therapist: _____ Years Treated: _____

  Issues: _____

- Most recent psychiatric hospitalization: _____ Hospital Name: _____

  Approximate number of psychiatric hospitalizations: _____

If members of your family have been treated for a mental illness, please indicate relationship to child and diagnosis: ____
_____
_____
_____
_____

Section 5 – Medical History

Child's Primary Care Physician and / or clinic name: _____

Address of Physician and / or clinic name: _____

Please list all prescription and over the counter medications your child takes on a regular basis: _____
_____
_____

Has your child ever had a problem with any of the following?

____ Allergies to Medications	____ Other Allergies	____ Asthma
____ Diabetes	____ Vision Problems	____ Heart Murmur or Heart Problems
____ Hearing Loss	____ Seizures (staring spells)	____ Head Injury, Concussion, Knocked Out
____ Surgery (What Kind)	____ Anorexia	____ Bulimia
____ Suicide Thoughts or Attempts	____ Self Injury	____ Other

Please explain: _____
_____
_____
_____
_____

Are there any **blood relatives** of your child who have any other following problems?

____ Depression	____ Learning Disabilities	____ Suicide Thoughts or Attempts
____ Thyroid Disease	____ Bipolar	____ Heart Disease
____ Eating Disorder	____ Seizures Disorder	____ Schizophrenia
____ ADHD	____ Anxiety Disorder	____ Other

Section 6 – Preschool / Daycare History

Did or does your child attend preschool or daycare? [ ] Yes or [ ] No

Were or are there any problems with his or her behavior? [ ] Yes or [ ] No

Please describe any of those problems or behaviors: _____
_____
_____
_____
_____
_____

Did your child have problems separating from parent(s) for more than the first few days? [ ] Yes or [ ] No

Please describe any of those problems or behaviors: _____
_____
_____
_____
_____
_____

Section 7 – School History

Name of Child's School: _____ Grade Level: _____

Are there any behavior or academic concerns for your child? [ ] Yes or [ ] No

Please explain those behavior or academic concerns: _____
_____
_____

When were these problems **first** noticed by parent(s) or school? _____

Check problems that apply to your child:

____ Fighting ____ Stealing ____ Arguing with Teachers ____ Refusing to Do School Work

____ In School Suspension, Suspended or Expelled ____ Police or Court Involvement because of Behavior Problems

____ Truancy, Unexcused Absences, Skipping – If Yes, How much school has your child missed? _____

Is your child receiving special educations services? [ ] Yes or [ ] No Accelerated/Gifted Services? [ ] Yes or [ ] No

Please explain: _____
_____
_____

Section 9 – Peer Relationships

Please answer the following regarding your child:

____ Is shy or timid ____ Is bossy or controlling ____ Gets upset if she or he doesn't get her or his own way

____ Has many friends ____ Has few friends ____ Has no friends

Any other relationship issues you are concerned about with your child? _____
_____

Is your child old enough to be employed? [ ] Yes or [ ] No

If yes, what is his or her experience: _____
_____

Section 10 - Stressors

Has your child experienced any of the following and at what age was your child?

____ Death of Parent	____ Age	____ Death of a Close Friend or Relative	____ Age
____ Death of a Pet	____ Age	____ Parental Separation or Divorce	____ Age
____ Accident or Serious Injury	____ Age	____ Prolonged Separation from Parent(s)	____ Age
____ New Person in Household	____ Age	____ Recent Move or Change in School	____ Age
____ Physical Abuse	____ Age	____ Sexual Abuse	____ Age
____ Emotional Abuse	____ Age	____ Witnessed Violence towards Family Members	____ Age
____ Other Stressful or Traumatic Experience	____ Age		

Chart Number: _____

Client Name: _____

PREVAIL COUNSELING GROUP, PPLLC HIPPA ACKNOWLEDGMENT & AUTHORIZATION

"I hereby acknowledge that I have received a copy of the HIPPA & Privacy documents from PCG, PLLC."

PLEASE REVIEW & CHECK THE FOLLOWING STATEMENTS ACCEPTING RESPONSIBILITY

[ ] I grant authorization to Prevail Counseling Group, PLLC to release PHI to my third party payer and any prior authorization that is necessary for billing or to process any claims for services provided by PCG, PLLC.

[ ] I accept full responsibility for notifying PCG, PLLC **IMMEDIATELY** of any changes in my insurance coverage or third party payer while receiving care. Failure to do so will result in my being responsible for any unpaid claims.

[ ] I understand that **I AM** responsible for my bill.

[ ] I authorize my therapist to act as my agent in assisting me in obtaining payment from my insurance company or third party payer.

[ ] I authorize my insurance company or third party payer to send payment directly to Prevail Counseling Group, PLLC for all services provided.

[ ] I will pay my co-payment and/or co-percentage **and** any outstanding balances owed to PCG, PLLC **BEFORE** each visit.

CONSENT AND AUTHORIZATION GRANTED

PRINT YOUR NAME – FIRST, MI, LAST

First _____ MI _____ Last _____

Signature _____ Date _____

IF CLIENT IS MINOR: CONSENT & AUTHORIZATION GRANTED AS CLIENT'S REPRESENTATIVE

PRINT YOUR NAME – FIRST, MI LAST

First _____ MI _____ Last _____

Signature _____ Date _____

Relationship to Minor _____

INSURANCE / THIRD PARTY PAYER / SELF PAY

[ ] _____

[ ] _____

[ ] _____

[ ] I request **NOT** to use my insurance benefits and understand I will **SELF-PAY** the cost of services provided by PCG, PLLC.

AUTHORIZATION GRANTED TO PCG, PLLC TO DISCUSS BILLING RECORDS, ADMN QUESTIONS, GENERAL QUESTIONS WITH THESE PEOPLE

[ ] SPOUSE _____ PHONE # _____

[ ] PARENT _____ PHONE # _____

[ ] OTHER _____ PHONE # _____

OFFICE USE: PCG Copy of Acknowledgment & Authorization to Client: Date: _____ Initials: _____

Side 1

Prevail Counseling Group, PLLC

HIPAA & PRIVACY DOCUMENTS

"Welcome to our practice. We continually work to provide you with appropriate, high quality services. We believe that a client who understands and participates in his/her care will achieve better results. We have the responsibility to respect your rights, provide you the best possible care and acknowledge your rights as a client. The following has been prepared to inform you of your rights and responsibilities."

NOTICE OF PRIVACY PRACTICES

During treatment at Prevail Counseling Group, PLLC (PCG, PLLC) therapists gather information about your psychiatric, medical history and health. The information that identifies you and relates to your past, present, future physical or mental health is referred to as your PROTECTED HEALTH INFORMATION (PHI). This notice describes how your PHI may be used and disclosed and how you can gain access to this information. Please review this notice carefully.

Clients of PCG, PLLC are both adults and children. When we refer to "you" or "your" in this notice, we refer to the client. When we refer to types of disclosures of information to "you", we mean disclosures of the client, the client's guardian, or the person legally authorized to receive information about the client.

Please note, after you have read this notice, you will be asked to sign a separate consent form. Signing this form will allow us to use and disclose your PHI in the following ways:

- **Treatment:** We will use your information to provide, coordinate and manage care and treatment. For example, a therapist may consult with another health care provider, including PCG, PLLC clinicians regarding the case or a referral.
- **Payment:** We will use information to receive payment for the services we provide. For example: we will disclose information in order to submit claims to insurance companies, third party payers, Medicare or Medicaid.
- **Health Care Operations:** We will use the information for certain activities related to the functioning of PCG, PLLC. For example, we may use or disclose information for quality assurance activities.
- **When Required by Law:** Applicable law and ethical standards permit us to disclose information about you without your authorization when required by law. PCG, PLLC may disclose or use PHI when necessary to:
  - ✓ Report suspected abuse or neglect of a child or vulnerable adult
  - ✓ Comply with mandatory government agency (such as psychology board or health department) audits or investigation
  - ✓ Comply with court order
  - ✓ Report possible professional or sexual misconduct by a named health care professional
  - ✓ Prevent or lessen a serious and imminent threat to the health and safety of you or another person. If such information is disclosed, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat. If it is to ensure your safety, information may be disclosed to others such as family members, other health care professionals, and/or law enforcement officials.

Side 2

USES AND DISCLOSURES THAT REQUIRE SPECIFIC AUTHORIZATIONS

We will need your written permission to use your information for any purpose other than those listed above. If you do sign an authorization form that allows using or disclosing your PHI, you can revoke that permission, in writing at any time.

MINORS - PRIVACY AND CONFIDENTIALITY

Parents and legal guardians have a right by law to information in their children's files. Exceptions are minors who are married or have born a child and those who are living independently and managing their finances.

PRIVACY RIGHTS

- **Right to Inspect and Copy:** You have the right, which may be restricted only in exceptional circumstances, to inspect and obtain a copy of your PHI. You must make this request in writing. We will respond to your request within three business days. Your right to inspect and copy PHI will be restricted only in those situations in which there is compelling evidence that access would cause serious harm to you. If your request to inspect (or obtain) a copy of) your record is denied, you have the right to have the denial reviewed by a health care professional. We will act upon your request within 30 days. We may charge you a reasonable, cost-based fee for copies.
- **Right to Amend:** If you feel that the information we have about you is incorrect or incomplete, you may ask us to amend the information. If you request is denied, you can write a statement of disagreement with the denial that we will keep with your medical information.
- **Right to Request Restrictions:** You may request that PCG, PLLC not use medical information for treatment, payment or health care operations. You may also request that PCG, PLLC not provide medical information to certain people. However, PCG, PLLC has the right to refuse your request.
- **Right of Accounting Disclosures:** You may ask us to provide you with information about disclosures of your PHI we made in the past. Requests for accountings will not be made prior to September 5, 2006. Your request can go back six years after September 5, 2006.
- **Right to Request Confidential Communication:** You may request that PCG, PLLC provide you with your medical information in a confidential manner. For example, you can request we send bills and other mailing to a different address or that we notify you of this kind of information in another way, such as by a telephone call. You must make this request in writing and specify another address or means of communication. We must agree to your written request. You may also ask you to give us information about how you will pay for your bills.
- **Right to File a Complaint:** If you feel your medical information privacy rights have been violated, you may file a complaint with the Secretary of Health and Human Services and/or your PCG, PLLC privacy official, who is your therapist. Filing a complaint will not affect the quality of the services you receive from PCG, PLLC and you will not be retaliated against for filing a complaint.

Side 3

The effective date of this notice is May 20, 2008. PCG, PLLC is required by law to maintain the privacy of PHI and provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new notice of Privacy Practices will be effective for all PHI that we maintain at the time. We will provide you with a copy of the revised notice by sending a copy to you in the mail upon request or providing one to you at your next appointment.

NOTICE OF NON-DISCRIMINATION / CONFIDENTIALITY STATEMENT

PCG, PLLC does not discriminate in access to treatment services due to race, color, national origin, sex, creed, handicap or sexual preferences.

POLICY REGARDING MINOR CLIENTS (AGES 17 AND UNDER)

In order to best meet the needs of minor clients and their families, it is our policy to require the presence of a parent or appropriate care provider at the initial appointment of a minor. If a minor resides in a foster home or a residential treatment facility, a written report of developmental history, pertinent information, and reason for referral must be forwarded by the referral resource (usually a county social worker) prior to the initial appointment. Additionally, the minor must be accompanied by a foster parent, social worker, or residential staff person who is knowledgeable about the child and available for consult during the session.

A parent or responsible adult must remain in the building during therapy sessions of any child age 15 and under. During the initial session, the therapist will discuss parental (foster parent or staff) participation in subsequent sessions. We strongly recommend that other siblings do not accompany the parent to the sessions since their presence in the interview may inhibit the sharing of pertinent information or distract from the needs of the minor client. Because we believe that these expectations are in the best interest of minor clients, we may not be able to provide services to minor s unless these guidelines are met.

Reminding parents and responsible caregivers of the following:

- Children age 15 and under or any child regardless of age who needs adult supervision should not be left unaccompanied in the reception space.
- A parent or responsible adult must remain on-site for any child 15 years or younger while the child is in session.

GRIEVANCE PROCEDURE NOTICE

Clients receiving outpatient mental health services have the right to complain if they feel their treatment has not been adequate and/or civil and legal rights have been infringed upon.

You have the right to obtain legal counsel if you feel your civil and legal rights have been denied you.

Complaints regarding the quality and type of treatment you have received should be brought to the attention of the therapist you are working with. If you are unable to resolve the conflict at this point, you have the right to present your complaint to the governing board

who licensed the therapist assigned you.

If you continue to feel dissatisfied, you have the right to obtain legal counsel to aid in resolving the complaint.

Minnesota Board of Social Work
2829 University Ave SE, Suite 340
Mpls, MN 55414-3239
Ph) 612-617-2100

Minnesota Board of Psychology
2829 University Ave SE, Suite 320
Mpls, MN 55414-3237
Ph) 612-617-2230

Minnesota Board of Marriage and Family Therapy
2829 University Ave SE, Suite 330
Mpls, MN 55414-3222
Ph) 612-617-2220

CLIENT RIGHTS AND RESPONSIBILITIES

PCG, PLLC and staff are committed to quality and professional mental health services; you have the responsibility and right:

- **To Be Honest:** You are responsible for being honest about everything that relates to you and your care. Please tell your therapist how you are feeling about what is happening in your life.
- **To Understand Your Treatment Plan:** Together with your therapist, the most appropriate treatment diagnosis and individual treatment plan will be developed for your care. You have the responsibility to understand your treatment goals to your own satisfaction. If you do not understand, please ask your therapist. Understanding your treatment plan is important for the success of your treatment. You are responsible for following your treatment plan and informing your therapist of whether or not you can and/or want to follow your plan.
- **To Keep Appointments:** Because your appointment time has been reserved for only you, we expect you will put a priority on keeping appointments. If is necessary to have at least 24 hour notice se we can offer the time to another client. If an emergency requires less than a 24 hour notice, please inform your therapist at the time of cancellation. Not showing for an appointment will result in the cancellation of future scheduled appointments.
  => If a pattern of TWO or more appointment are no shows or non- emergency late cancellations occur, it may result in services being discontinued and a referral made elsewhere for services.
- **Guidelines Regarding Children in Sessions:** We have an expectation that you will find appropriate care for minor children during your therapy appointment time. Having young children in your sessions may inhibit the sharing of pertinent information and distract you and/or your therapist. While we understand that children may need to accompany you occasionally, it may side tract or divert attention from you and your therapeutic goals.

THERAPIST RIGHTS AND RESPONSIBILITIES

1. A therapist shall limit practice to the areas of competence in which proficiency has been gained through education and training or experience.
2. A therapist shall accurately represent areas of competence, education, training, experience and professional affiliations of the therapist to PCG, PLLC, the public and colleagues.
3. In cases in which an new service, technique or specialty is developing, a therapist shall engage in ongoing consultation with other therapists or similar professionals as skills are developed in the new area and shall seek continuing education which corresponds to the new are. A client whose treatment involves the use of a newly developing service, technique or specialty shall be informed of its innovative nature and of known risks associated with it.
4. A therapist shall recognize that there are other professional, technical and administrative resources available to clients and make referrals to those resources when it is in the best interest of clients to be provided with alternative or complementary services.
5. A therapist shall safeguard the private information obtained in the course of practice, teaching, or research. In any situation in which services of a therapist are requested by one part of another party, the therapist shall inform both the requester and the receiver of the services of the responsibility of the therapist regarding the privacy of any information gained in the course of rendering the services.
6. A the beginning of a professional relationship, a therapist shall inform a client who is a minor of the limit the law imposes on the right to privacy of a minor in respect to communications of a minor with the therapist.
7. A therapist shall limit access to client records and shall inform every person associated with the agency or facility of the therapist, such as a staff member, student, volunteer or community aide, that access of client records shall be limited only to the therapist with whom the client has a professional relationship, a person associated with the agency of facility whose duties requires access, and a person authorized to have access by the informed written consent of the client.
8. A therapist shall instruct the staff to inquire of clients and to comply with the wishes of clients regarding to whom and where statement of services to be sent.
9. Case report or other clinical materials used in teaching, professional meetings or publications shall be disguised so that no identification of the individual occurs.
10. Diagnostic interviews or therapeutic sessions with a client may be observed or electronically recorded only with the informed consent of the client.
11. A therapist shall continue to maintain as private information the records of a client after the professional relationship between the therapist and the client has ceased.
12. A therapist must not undertake or continue a professional relations with a client in which the objectivity of the therapist is or would be impaired due to familial, social, emotional, economic, supervisory or political interpersonal relationship. A therapist whose objectivity becomes impaired because of the development of a listed interpersonal relationship during a professional relationship with a client shall notify the client orally and in writing that the therapist shall no longer see the

client professionally, begin termination of the relationship, and assist the client in obtaining services from another therapist.

13. A therapist must not undertake or continue a professional relationship with a client in which objectivity or effectiveness is or would be impaired due to the divorce, grief reaction, or would be impaired due to the divorce, grief reaction, severe health problem or chemical abuse or dependency of the therapist. A therapist whose objectivity or effectiveness becomes impaired during a professional relationship with a client because of such a personal problem shall notify the client orally and in writing that the therapist shall no longer see the client professionally, begin termination of the relationship and assist the client in obtaining services from another therapist.
14. A therapist has a right to expect fair and respectful treatment from the client. The therapist can refuse treatment to client who uses threats, verbal abuse or physical violence.

* EMERGENCY SERVICES *

You may contact your therapist during business hours for emergency purposes. If your therapist is not available or you are calling after hours, call one of the following 24 hour response centers:

- **CRISIS PLUS** at **612-379-6363.**
- **ANOKA COUNTY CRISIS** at **763-755-3801,** if you are a resident of Anoka County.
- Call **911** if you are in a life threatening event.

BILLING POLICIES AND FEE INFORMATION

It is your responsibility to ensure HTS; LLC has current and accurate health insurance information on file. If we do not have complete and accurate health insurance information we will bill you for the full amount of our service fee. We will forward a claim for all services rendered to your insurance company for payment by the company directly to PCG, PLLC for each visit.

Statements will be mailed monthly.

I understand that if my account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, PCG, PLLC will forward your account to our collections agency to secure payment. If legal action becomes necessary, its costs will be included in the claim and I understand that I will be responsible to pay said fees'. PCG, PLLC reserves the right to withdraw care from clients if the client or responsible party does not fulfill their financial obligation.

NSF Checks: PCG, PLLC will assess your account our bank fee associated with any checks written with insufficient funds.

INSURANCE COVERAGE: Many insurance companies provide out-patient mental health benefits under an office visit setting. Insurance coverage varies widely so it is **YOUR** responsibility to understand the provisions of your insurance plan. If we have a contractual relationship with your particular insurance plan, you will be responsible for any co-pays, co-percentages and deductibles as determined by your insurance provider. Payment is expected at the time of service with PCG, PLLC. If you are unable to pay at the time of service, we ask you to discuss this event with your therapist.

To assist you in obtaining insurance payments, you must provide us with the following information:

- Name, address and phone number of your insurance company
- Group number, Personal identification number
- Name of policyholder and their date of birth
- Relationship of the policyholder
- Copy of your insurance card, front and back

If you have health coverage, you are expected to utilize it. If you choose not to do so, you or the responsible party will be responsible and expected to pay the full cost of services prior to each session.

Out of Network
In the event that we do not participate in your insurance plan's network, you may be eligible for out of network benefits. Please refer to your insurance provider's handbook or contact your insurance carrier if you are eligible for out of network benefits.

LATE CANCELLATION NOTICES OR FAILED APPOINTMENTS
YOU, NOT your insurance company, will be charged $130 for any session you failed to attend or miss without providing a 24 hour notice **BEFORE** the scheduled appointment.

PCG, PLLC CLINICAL FEES

- $185/50 minute hour - Initial Diagnostic Assessment
- $130/50 minute hour - Individual Psychotherapy
- $130/ 50 minute hour - Family Psychotherapy
- $130/50 minute hour - Couples/Marriage Psychotherapy
- $150/full hour - Psychological Testing
- $40-$60/per session - Group
- $200/full hour - Educational Group
- $250/full hour - Court
- $130-No Show or Late Cancellation Fee without 24 hour notice
- $200 Mediation Services (Including Document Prep.)
- $50 minute - Document Preparation/Consultation Fee
- NSF (Non-sufficient Funds) Bank fees will be assessed to client account

CELL PHONE POLICY

At PCG, PLLC we value providing a safe, comforting, calming and confidential atmosphere for our clients. We ask you to refrain from cell phone use in our space and adhere to the following policy:

- Cell phones **MUST BE TURNED OFF OR SET TO VIBRATE**
- If necessary to accept a phone call, please step outside
- Please be aware of your conversation and surroundings even when outside
- PCG, PLLC reserves the right to ask anyone to leave if he/she is being disruptive to others in our office space

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Thank you for choosing to work with us. We are committed to providing quality care. Please feel free to talk with your therapist or client care advocate if you have any questions to the above information.
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PREVAIL COUNSELING GROUP, PLLC
PARENTAL CONSENT and MEDICAL LIABILITY RELEASE

CLIENT INFORMATION

Client Name: _____ Age: _____ DOB: _____

Address: _____
City, State, Zip Code

Phone Number: _____ Cell Number: _____Work Number: _____

Medical Insurance: YES _____ NO _____ Insurance Company _____

Policy Holder: _____ Policy Holder DOB: _____

Policy ID #: _____ Policy Group #: _____

Allergies or Medical Conditions & Medication(s): _____

PARENT / GUARDIAN INFORMATION

Name of Parent / Legal Guardian: _____

Address of Parent / Legal Guardian: _____
City, State, Zip Code

Phone: Day _____ Evening _____ Cell _____

EMERGENCY CONTACT INFORMATION

In case of a medical emergency should the parent or legal guardian cannot be reached.

Name: _____

Relationship to Client: _____

Address: _____
City, State, Zip Code

Phone Number: _____ Cell Number: _____Work Number: _____

CONSENT and MEDICAL LIABILITY RELEASE

I give permission for my child / client named above to participating in activities, events that may take place outside the office of Prevail Counseling Group, PLLC during any scheduled therapy session. This will include transportation driven by our clinical staff member(s). My child / client named above and I understand that SEAT BELTS SHALL BE WORN AT ALL TIMES during transportation. This authorization and consent will expire one year from this signed consent and release document.

I hereby release, indemnify and hold harmless Prevail Counseling Group, PLLC its staff members and agents from any and all liability, damage, claim of any nature whatsoever arising out of or in any way related to participating in outside events or activities during any scheduled therapy session, including transportation to and from the office of Prevail Counseling Group, PLLC.

I authorize and consent to the giving of all treatments, medications, and or emergency care should the need arise. We further authorize the use of disclosure of my personal health information should medical or emergency treatment become necessary.

_____ _____/ _____
Name of Parent / Legal Guardian (Printed) Signature of Parent / Guardian Date

Office Use Only: Copy of Signed Consent and Release given to Parent / Legal Guardian. Date: _____ Staff Initials: _____

Prevail Counseling Group, PLLC 6893 139th LN, NW Ramsey, MN 55303
Phone 763-427-2590 Fax 763-427-2579 www.prevailcounselinggroup.com

PRIMARY CARE PHYSICIAN CONTACT AUTHORIZATION

Section 1

Client Name: _____ Client ID #: _____

Date of Birth: _____

Section 2

Please indicate below whether you would like us to contact your primary care physician regarding your treatment at Prevail Counseling Group, PLLC.

[ ] I authorize Prevail Counseling Group, PLLC to contact my physician as indicated below for the purposes of continuing care and case coordination. I also authorize my physician to disclose PHI to Healing Therapeutic Services, LLC for the same purposes.

[ ] I do not have a primary care physician. I understand that I am encouraged to obtain one.

[ ] I do not authorize Prevail Counseling Group, PLLC to contact my physician.

Name of Physician_____

Address _____
Street, City, State, Zip Code

Phone _____ Fax _____

Other Information_____

Section 3

Description of Information to be Disclosed

_____ Diagnostic Assessment/Evaluation
_____ Progress Notes
_____ ARMHS Functional Assessment & Treatment Plan
_____ Chemical Dependency Evaluation Notes
_____ All Mental Health Information-Dates of Service _____
_____ Other-specify _____
_____ Treatment Plan or Summary
_____ Billing Records
_____ Psychological/Psychiatric Assessment
_____ Other Facilities/Lab Reports

Section 4

The Purpose of this Disclosure of information:

[ ] Ongoing Care [ ] Consultation [ ] Case Coordination [ ] Other – Specify _____

Section 5

I understand that information will be disclosed that is protected by Federal Laws and Minnesota Statutes. I understand that I have a right to revoke this authorization at any time, in writing, but that the revocation will not have any effect on the information released prior to notification of cancellation. If I refuse to sign this consent, treatment will not be withheld. A photocopy of this authorization will be treated in the same manner as the original. I understand that this consent ***expires ONE YEAR*** *after signature date.*

I release Prevail Counseling Group, PLLC from any and all liability resulting from disclosure. I do not authorize re-release of this information to anyone. I have read this consent prior to signing and I understand its contents.

Signed _____ Date _____
Signature of Client or *Legal Guardian/Responsible Party if under 18

*Relationship to Client _____

Witness _____ Date _____

Prevail Counseling Group, PLLC Office Use Only

[ ] Faxed [ ] Mailed [ ] Picked Up Date: _____ Time of Day: _____ Initials: _____