Arubah
RESTORATION to SOUND HEALTH

INTAKE FORM

Phone: (612) 284-8115 Email: intake@arubahemotionalhealth.com

Client Name:
Date of Birth:
Social Security Number:
Ethnicity:
Gender:
Sexuality:

Home Address:

Email Address:
Phone Number:

Parent/Guardian/Emergency Contact #1
Name:
Contact Number:
Email Address:
Relationship to client:
Legal Custody Status:

Yes	No	N/A
☐	☐	☐

Parent/Guardian/Emergency Contact #2
Name:
Contact Number:
Email Address:
Relationship to client:
Legal Custody Status: Legal Custody Status:

Yes	No	N/A
☐	☐	☐

Referral Source (*please select one*):

- ☐ Google search
- ☐ Recommended by a friend or family member
- ☐ Insurance Company
- ☐ Social media, specifically:
- ☐ Staff memeber, specifically:
- ☐ Professional Referral, specifically:
- ☐ Partnership site, specifically:
- ☐ Other:

Primary Insurance
Name of Insurance:
Type of Insurance - Commercial ☐ **State** ☐
Subscriber ID:
Group Number:
Policy Number:

Secondary Insurance
Name of Insurance:
Type of Insurance - Commercial ☐ State ☐
Subscriber ID:
Group Number:
Policy Number:

Tertiary Insurance
Name of Insurance:
Type of Insurance - Commercial State
Subscriber ID:
Group Number:
Policy Number:

Reason for seeking treatment:

Expectations from therapy:

Have you seen a counselor, psychologist, psychiatrist or other mental health professional before?

Describe your current mental health symptoms:

Please rank the three biggest concerns:

Are you currently taking prescription medication?

Please List Medications:

Signature:

Date:

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THIS DOCUMENT IS FOR CONSENT FOR TREATMENT
PLEASE SIGN AFTER EACH SECTION.

CONSENT FOR TREATMENT

This is a general consent for treatment at Arubah Emotional Health Services.
I give my consent for services at Arubah Emotional Health Services and by associated profession staff. This consent will include
evaluation, therapy, medication management or testing (if indicated).
A treatment plan will be designed between you and your assigned therapist(s). This consent is an agreement to be involved in the
treatment planning process.
I understand that I may decline a specific treatment recommendation.

Signature

Guardian Signature

Witness Signature

Date

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THIS DOCUMENT IS FOR CONSENT FOR TREATMENT AND ACKNOWLEDGMENT OF RECEIPT OF CLIENT RIGHTS and NOTICE OF PRIVACY PRACTICES. PLEASE SIGN AFTER EACH SECTION.

ACKNOWLEDGMENT OF RECEIPT OF CLIENTS RIGHTS BROCHURE
I have received and read Arubah Emotional Health Service's description of my rights as a receipt of service, entitled "Clients Rights
and Responsibilities."

I understand that I may receive another copy of this statement at any time and that I may direct any complaints about my service to the
agency Director or owner

Signature

Guardian Signature

Witness Signature

Date

ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES
Consistent with the Health Insurance Portability and Accountability Act (1996), I have been provided with a copy of the Notice of Privacy Practices.

My signature below indicates that I have received a copy of the Notice of Privacy Practices.
Arubah Emotional Health Services strongly encourages all clients to carefully read this document.

Signature

Guardian Signature

Witness Signature

Date

Arubah

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OUR FINANCIAL POLICY

We appreciate you for choosing Arubah Emotional Health Services as your mental health provider. We have committed ourselves to ensuring the best quality service for your treatment. Our financial policy is a part of our agreement for services. The statement should be read and signed prior to treatment. By signing this form you are agreeing to the terms of this financial policy.

Full Payment for fees or co-pays is due at the time of service. Fees may be paid with cash or check. All outstanding balances are the responsibility of the client, regardless of whether or not insurance covers the services. It is imperative that client notify us of any insurance changes. Failure to do so can cause billing inaccuracies that could result in full payment responsibility to the client.

Insurance Coverage - Insurance coverage is a contract between the insurance company and the covered person. Providers of health care are NOT a part of the contract. Instead, healthcare providers accept the assignment of benefits. This assignment can only happen with a client's signed authorization. Further, if the insurance company requires a referral, the client must obtain the referral prior to receipt of any care. Fees not covered by insurance after 45 days become the responsibility of the client.

Medicare and Medical Assistance - We are an authorized provider for Medicare and Medical Assistance and accept assignment of benefits. Eligibility for Medical Assistance is verified each month. Please have your Medical Assistance card available to assist us in verifying this coverage.

Reduced Fees/Sliding scale fees - We may be able to reduce fees in certain circumstances. Please speak with your therapist. Payment plans may also be arranged.

Missed Appointments – A 24-hour notice for cancellations is required. This enables us to arrange care for another client. Failure to cancel **24-hours ahead** of a scheduled appointment will **automatically** result in charges (outlined below) regardless of reason. Your treatment provider will not be able to prevent or reverse charges for missed appointments.

Suspension of Services – Any client with an out-of-pocket balance of $500 or more will be placed on a suspension of services. This is a temporary pausing of services for up to 30 days to allow the client to bring the balance under $500. If the balance remains for more than 30 days their account will be closed. No client is banned from Arubah and payment plans are available.

Fees for Missed Appointment and Late Cancellation:
Individual, Couples and Family Sessions: $ 50.00
Group Sessions Any Length $ 50.00
PLEASE NOTE: FAILURE TO ATTEND A GROUP - is an automatic charge, regardless of notice. This is because another client cannot fill the vacancy of an absent group member.

My signature below is authorization for the release of any medical information necessary to process the claim for benefits. Any release of medical information is understood to follow the standards set by HIPAA and the Data Privacy Act. I authorize payment of all benefits directly to Arubah Emotional Health Services. I acknowledge that I have read, understand, and agree to the above Financial Policy.

Client Name: _____ DATE: _____

WHODAS 2.0

WORLD HEALTH ORGANIZATION
DISABILITY ASSESSMENT SCHEDULE 2.0

12-item version, self-administered

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

In the past 30 days, how much difficulty did you have in:						
S1	Standing for long periods such as 30 minutes?	None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme or cannot do ☐
S2	Taking care of your household responsibilities?	None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme or cannot do ☐
S3	Learning a new task, for example, learning how to get to a new place?	None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme or cannot do ☐
S4	How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme or cannot do ☐
S5	How much have you been emotionally affected by your health problems?	None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme or cannot do ☐

Please continue to next page...

WHODAS 2.0

WORLD HEALTH ORGANIZATION
DISABILITY ASSESSMENT SCHEDULE 2.0

In the past 30 days, how much difficulty did you have in:						
S6	Concentrating on doing something for ten minutes?	None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme or cannot do ☐
S7	Walking a long distance such as a kilometre [or equivalent]?	None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme or cannot do ☐
S8	Washing your whole body?	None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme or cannot do ☐
S9	Getting dressed?	None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme or cannot do ☐
S10	Dealing with people you do not know?	None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme or cannot do ☐
S11	Maintaining a friendship?	None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme or cannot do ☐
S12	Your day-to-day work?	None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme or cannot do ☐

H1	Overall, in the past 30 days, how many days were these difficulties present?	***Record number of days*** ☐☐
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	***Record number of days*** ☐☐
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	***Record number of days*** ☐☐

This completes the questionnaire. Thank you.

Arubah Emotional Health Services
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Client Name (Last, first, middle initial)

Street Address | City | State | Zip

Date of Birth | Day Phone # | Evening Phone #

INFORMATION RELEASED FROM/ EXCHANGE WITH	INFORMATION RELEASED TO/ EXCHANGE WITH
Name (Program / Individual) **Arubah Emotional Health Services**	Name (Program / Individual)
Street Address	Street Address
City State Zip	City State Zip
Telephone: Fax:	Telephone: Fax:

AUTHORIZATION TO DISCLOSE MEDICAL / BILLING INFORMATION IS LIMITED TO THE FOLLOWING: FROM: _____ TO _____

☐ Admission / Intake Summary ☐ Diagnosis & Treatment Plan ☐ Progress Notes ☐ Discharge Summary
☐ Psychiatric Assessment ☐ Chemical Dependency Evaluation /Abuse/Drug/Alcohol Treatment ☐ Psychological Assessment
☐ Prior Treatment Records ☐ Medication Management Records ☐ Medical/Physical History ☐ Education Records

☐ Progress Review ☐ HIV History ☐ Billing Records/Statements (date)_____

☐ Other _____

-OR-

☐ **The entire record** (including, if applicable, chemical dependency/drug or alcohol abuse treatment records)

AND ☐ ***including*** billing records ☐ ***excluding*** billing records ☐ ***excluding*** records from other facilities ☐ ***excluding*** HIV records

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THIS INFORMATION IS TO BE DISCLOSED FOR THE PURPOSE OF:

☐ Insurance Payment ☐ Third Party Authorization and Payment ☐ Communication regarding legal issues
☐ Coordination of Care ☐ Litigation ☐ Other _____

NOTE: A FEE MAY BE CHARGED IN ACCORDANCE WITH MN STATUTE 144.335 AND FEDERAL RULE 164.524

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. Please see your Notice of Privacy Practices for information on how to revoke this authorization. I also understand that this authorization will automatically expire one year from the date of my signature unless I revoke it earlier. Arubah Emotional Health Services will not refuse or restrict my treatment if I choose not to sign this authorization. **A photocopy / fax of this authorization will be treated in the same manner as an original.**

Further, I realize that Arubah Emotional Health Services cannot prevent the re-disclosure of records released as a result of this request and that the records may not be subject to privacy rule protections; therefore, Headway Emotional Health Services is released from any and all liability resulting from re-disclosure.

Client / Legal Representative Signature _____ Dated _____

If you are the client's legal representative, please **attach a copy** of the document that gives you the authority to act as the legal representative. **You are entitled to a copy of this document**

Electronic Communication Policy

Arubah Emotional Health Services, PA

The purpose of this policy is to clarify the use, limitations and risks of electronic communication during your time at Arubah Emotional Health Services, PA. As new technology develops there may be a need to update this policy. Clients will be notified in writing of any policy changes, and a copy of the updated electronic communications policy will be provided upon request.

Non-Secure Electronic Communication Overview

Email, text and other forms of electronic messages provide convenient methods of communication. Please be advised that these methods, in their typical form, are not confidential means of communication. Therefore, Arubah Emotional Health Services, PA prefers to use email communication and text messaging only with your permission, and only for administrative purposes unless we have made another arrangement to do so. All clinical matters must be addressed in session or over the telephone. Telephone or face-to-face context is a much more secure mode of communication. If you use the aforementioned electronic methods to communicate with your provider, there is a reasonable chance that a third party may be able to gain access to those messages.

The types of parties that may intercept these messages include, but are not limited to:

1) Those who have access to your phone, computer, or other devices that you use to read and write messages

2) Your employer, if you use your work email to communicate with us

3) Internet server administrators and others who monitor Internet traffic.

If there are people in your life that you do not want accessing these communications, please talk with your provider about ways to keep your communications safe and confidential.

Email

Email is not a confidential form of communication. Therefore, Arubah Emotional Health Services, PA chooses not to conduct counseling by email, and discourages the use of email communication between clients and providers, except for administrative purposes, such as arranging or changing appointments. There is still a possibility that your privacy may be compromised when appointment times are sent electronically.

Please read below for more information:

1. Emails sending or requesting Protected Health Information or financial information will be encrypted through Paubox, a Health Care focused HIPAA certified email platform and will come from specific accounts that identify this at the bottom of the email.

2. Arubah Emotional Health Services, PA sends appointment reminders via email. If you do not wish to receive reminders via email, please inform us of that preference.

3. Email messages become part of your counseling records and may be shared along with your record should the documents be subpoenaed by the courts, or other governing agencies.

4. When you receive a message from someone at Arubah Emotional Health Services, PA the personalized signature line clearly indicates the sender.

5. You may revoke your consent for email communication at any time.

Text Messaging

While this is an easy and convenient way to send communication, it is not a secure way of transmitting information.

Below is a list of potential risks associated with the use of text messaging:

1. Communication issues can arise when communicating in text due to the lack of access to visual or voice cues, as well as the possibility of limited space, and the chance of misunderstanding when using "shorthand" words or characters to represent meaning.

2. A lost or misplaced cell phone, or a phone simply left in an insecure location, can inadvertently communicate to others that you are receiving mental health services.

3. All text messages become part of your counseling records and as such may be subject to being shared along with your record should the documents be subpoenaed by the courts, or other governing agencies.

5. You may revoke your consent for text message communication at any time.

Third-Party Access to Communications

When you use electronic communications methods, such as email, texting, online video, etc., there are various technicians and administrators who maintain these services, and who could conceivably have access to the content of those communications.

If you use your work email to communicate electronically, your employer may have access to those communications. There may be similar issues involved in school email or other email accounts associated with organizations that you are affiliated with. Furthermore, people with access to your computer, mobile phone, or other devices may gain access to your email or text messages. It is important to contemplate the risks involved if any of these persons were to access the messages exchanged with Arubah Emotional Health Services, PA.

Acknowledgment of Receipt and Permissions

I understand that I may change or revoke any or all of my permissions at any time in the future, simply by discussing it with my clinician and signing a new Electronic Communication Policy. I have read and understand the Electronic Communication Policy. I agree to the statements herein. This document was discussed with me and any questions I had were answered fully.

_____☐ I agree _____☐ do not agree to use texting as a way to communicate with my clinician for administrative purposes only.

_____☐ I agree _____☐ do not agree to use email as a way to communicate with my clinician for administrative purposes only.

_____

Printed Name of Client

_____

Client Signature/Date

_____

Parent/Guardian Signature/Date

Informed Consent for Treatment

Arubah Emotional Health Services, PA

Please read through the following informed consent agreement. What follows is a basic understanding between you and your therapist. In general, what are listed below are the responsibilities and obligations of your therapist, and also some expectations of you as the client. Please do not sign the informed consent unless you completely understand and agree to all aspects. If you have any questions, please bring this form back to your next session, so you and your therapist can go through this document in as much detail as is needed. When you sign this document, it will represent an agreement between us.

Client Involvement: All clients are expected to show up to appointments as scheduled, on time and ready to discuss therapy goals and issues. We invite you to be open and honest and attend sessions free from the influence of mood altering chemicals so your therapist can assist you with your goals. Therapy calls for active participation from both you and your therapist in order to maximize benefit. In order for therapy to be most successful, you are encouraged to work on things we talk about both during our sessions and at home. Inconsistent attendance can negatively affect your therapy progress.

Therapist Involvement: Your therapist will be prepared at the designated time, (barring emergencies), and will be attentive and supportive in your sessions. Your therapist will do everything possible to assist you in achieving a greater sense of self-awareness and work toward helping you resolve problem areas.

If your therapist is a graduate level intern or is working toward clinical licensure, their practice is conducted under the supervision of a licensed mental health professional. The clinical supervisor's name, license type and license number will be provided to you.

Risks of Therapy: While many people find positive benefits of therapy, there is no way to guarantee results. Therapy can stimulate painful memories, lead to unanticipated changes in your life, and uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. In some cases client's symptoms become worse during the course of therapy, occasionally necessitating hospitalization. Another risk of therapy is that throughout the process of therapeutic change it is not uncommon for clients to reach a point of change where they may feel they are different and no longer able to be the same person they were upon entering therapy. At times these feelings can be unsettling.

Benefits of Therapy: The benefits of therapy can include: a higher level of functional coping, solutions to specific problems, new insights into self, more effective means of communicating in relationships, symptom relief, and improved self-esteem.

Credentials and Qualifications: Therapists at Arubah may hold a variety of degrees in the field of psychology such as: Masters or Doctoral Degrees in Psychology, Licensed Marriage and Family Therapist, Licensed Alcohol and Drug Counselor, Licensed Professional Clinical Counselor, Licensed Independent Clinical Social Worker. In each case your provider is licensed (or supervised by someone who is licensed) by the state of Minnesota to provide psychotherapy based on their training and education.

Colleague Consultation: In keeping with standards of practice, your therapist may consult with other mental health professionals regarding care and management of cases. The purpose of this consultation is to ensure quality of care. Your therapist will maintain complete confidentiality and protect your identity by not using real names or any identifying information.

Confidentiality and Privilege: The information and content shared in therapy will remain confidential, except as noted in the next section: Exceptions to Confidentiality and Privilege. Your information will not be shared with

anyone without your written consent. Your information is also privileged, which means that your therapist is free from the duty to speak in court about your counseling unless you waive that right, or a judge orders it.

Exceptions to Confidentiality and Privilege: As a mandated reporter in the state of Minnesota your therapist cannot uphold confidentiality under the following circumstances: 1) When the therapist has reason to suspect that the client has been, or is currently, involved in the abuse or neglect of child 2) When the therapist has reason to suspect that the client has been, or is currently, involved, in the abuse or neglect of vulnerable adults 3) If a client is pregnant and taking street drugs 4) If a client reports sexual misconduct by another counselor 5) If a client is a serious danger to themselves 6) If a client is a serious danger to someone else 7) If the courts order copies of records 8) Another time when confidentiality has limitations is for minor clients. Parents and guardians have legal right to access a minor client's records.

Counseling and Records for Minors: If you are under 18 years of age, please be aware that the law provides your parents the right to review your treatment records as well as obtain information from us about your diagnosis, progress, and treatment. It is our policy to request an agreement from parents that they agree to avoid unnecessary review of records and involvement in your treatment with us. If they agree, we will only provide them general information about our work together, unless we feel there is a high risk that you will seriously harm yourself or someone else. In this case, we will notify them of our concern.

Client Rights: You will be provided with a Client Bill of Rights at the onset of your therapy.

Professional Fees: A fee schedule for services can be provided at your request and is listed on our website. If you are utilizing health insurance benefits, your health plan may have a contracted rate with your therapist that differs from the usual and customary fees listed in our fee schedule.

Health Insurance: You should be aware that most insurance companies require you to authorize us to provide them with a clinical diagnosis for benefits to pay for services. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). Please keep us informed of changes in your financial status and insurance or medical assistance eligibility. You may be responsible for charges incurred if your coverage has changed or lapsed and you do not inform us in advance.

Termination: Either the client or the therapist may end therapy at any time. Your voluntary involvement allows you to discontinue at any time. If your therapist feels you are no longer benefiting from therapy or your therapist feels there is a conflict in values they may discuss termination. If you desire additional counseling your therapist will provide you with a referral competent to address your therapy concerns.

Account Balance Maximum: Whenever a client's account reaches an outstanding balance of $500 and no payments have been made or received toward the account, additional therapy services will be suspended. Services will remain suspended until client begins making payment toward their account. If no payments are made, services will remain suspended and/or clients may be referred to alternate providers for services.

Additional Considerations:

- ❑ Telehealth Services: Telehealth allows my therapist to diagnose, consult, treat and educate using interactive audio, video and/or data communication regarding my treatment. I hereby consent to participating in psychotherapy via the internet (hereinafter referred to as Telehealth).
- ❑ I understand I have the following rights under this agreement: I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or

could be accessed by unauthorized persons. In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services. I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction. I understand that I can withdraw my consent to Telehealth communications by providing written notification to Arubah Emotional Health Services, PA at any time.

❑ Informed Consent for Video/Audio Recording: Arubah Emotional Health Service PA, is requesting your permission to record our counseling session(s). Video and/or audio tapes are tools that can be valuable aids in the therapy of clients and the effective training of therapists. The purpose of the recording is to: 1) help your mental health provider serve you better and to review and evaluate counseling techniques with their clinical supervisor and/or 2) be utilized for purposes of education, teaching or consulting with other professionals within Arubah Emotional Health Services, PA . The process is focused on the clinician and their efficacy in session. No recording will be done without your prior knowledge and consent. Viewers of the video/audio file(s) will be limited to mental health providers within the agency. All viewers of the video/audio file(s) are bound by the ethical standards of the clinicians counseling board and HIPAA. The video/audio file(s) will be treated with confidentiality and stored in a password protected format. Recordings will be stored no longer than a 12-month period.

I understand that I may revoke this authorization at any time by written notification to Arubah Emotional Health Services, PA, and retain my right to have any recordings electronically erased in my presence. I am aware that I can elect to not participate in a taped or observed session and that this will not adversely affect my treatment.

By signing below, I am stating that I have read and understood the Informed Consent for Treatment in its entirety and am authorizing services for Arubah Emotional Health Services, PA.

Client Printed Name: _____

Client Signature: _____

Date _____

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Arubah Emotional Health Services, PA Grievance/Formal Complaint Process

- It is the policy of Arubah Emotional Health, PA to adhere to the client rights defined and described in MN Law and Statutes.
- A copy of the Client Bill of Rights and Grievance/Formal Complaint process shall be distributed to each client at intake or next subsequent appointment in writing or orally and to applicants upon request. In the event a client continues in services longer than one year, a copy of the Client Bill of Rights will be provided to the client annually. Agency staff will explain the client rights policy and/or provide a copy at any time upon request, and in language that is understandable to the client.
- All clients, former clients, and their authorized representatives may submit a grievance to Arubah Emotional Health Services, PA at any time during or after their time of service.
- Within three business days of receiving a client's grievance, Arubah Emotional Health Services, PA will acknowledge in writing that the client's grievance was received.
- Clients will be allowed to bring a grievance to the person with the highest level of authority in the program (Executive Director or Visionary).
- All grievances will be heard by an impartial clinician having no involvement with the client or situation that is the subject of the grievance. The procedure for hearing grievances shall include in person and/or telephone contact with the aggrieved (and/or a representative as appropriate), and as appropriate, contact with others who are the subject of the grievance.
- The resolution of grievances shall not exceed fifteen working days from its filing. Written notification of the resolution of the grievance shall be provided to the client or the aggrieved, if other than the client (with the client's permission). Written resolution of the grievance shall be sent to the aggrieved party's/parties' last known mailing address. Should the aggrieved party feel that the person hearing the grievance does not adequately resolve the grievance, an appeal may be filed with the Executive Director.
- The Executive Director shall have ten days from the filing of the appeal to further investigate the grievance and provide written resolution to the aggrieved party.
- The aggrieved may file a complaint with any or all of the several outside entities and appropriate professional licensing or regulatory agencies. Relevant addresses and telephone numbers are provided and are also attached to the Client Bill of Rights.
- Information about the grievance may be provided to these outside entities upon request. Client grievances and appeals will be recorded in a log by the Clients Rights Officer and reviewed weekly at Agency Leadership Meeting. Annually, efforts will be made to determine trends in complaints and to identify areas for performance improvement.
- Within fifteen business days of receiving a client's grievance, the client will be provided a written final response.

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Outside Agencies able to address complaints/grievances:

Ombudsman for Mental Health and Developmental Disabilities 121 7th Place E #420 St. Paul, Minnesota 55101 Phone: 651-757-1800 or 1-800-657-3506 Email: ombudsman.mhdd@state.mn.us	MN Board of Psychology 2829 University Ave. SE, Suite 320 Minneapolis, MN 55414 Phone: (612)617-2230 Hearing/Speech Relay: (800) 627-3529 Email: psychology.board@state.mn.us
MN Board of Social Work 2829 University Ave SE, Suite 340 Minneapolis, MN 55414-3239 (612) 617-2100; (888) 234-1320; FAX (612) 617-2103 Hearing/Speech Relay: (800) 627-3529 Email: social.work@state.mn.us	MN Board of Marriage and Family Therapy 2829 University Ave SE Suite 400 Minneapolis, MN 55414 (612) 617-2220 Hearing/Speech Relay: (800) 627-3529 Email: mft.board@state.mn.us
MN Board of Behavioral Health and Therapy 2829 University Ave SE, Suite 210 Minneapolis, MN 55414 (612) 528-2177 FAX (612) 617-2187 Email: bbht.board@state.mn.us	Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, MN 55164 (651) 201- 4200 Email: health.fpc-licensing@state.mn.us
MN Department of Human Services Licensing Division P.O. Box 64242 St. Paul, MN 55164 (651) 431-6500	MN Department of Human Services: Office of Health Facilities Complaints (651) 201- 4200 Email: health.fpc-licensing@state.mn.us

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MINNESOTA CLIENT BILL OF RIGHTS

- **Courteous treatment.** Clients have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.
- **Appropriate health care.** Clients shall have the right to appropriate medical and personal care based on individual needs.
- **Physician's identity.** Clients shall have or be given, in writing, the name, business address, telephone number, and specialty, if any, of the physician responsible for coordination of their care. In cases where it is medically inadvisable, as documented by the attending physician in a client's care record, the information shall be given to the client's guardian or other person designated by the client as a representative.
- **Relationship with other health services.** Clients who receive services from an outside provider are entitled, upon request, to be told the identity of the provider.
- **Information about treatment.** Clients shall be given, by their providers, complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information shall be in terms and language the Clients can reasonably be expected to understand. Clients may be accompanied by a family member or other chosen representative, or both. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending provider in a client's medical record, the information shall be given to the client's guardian or other person designated by the client as a representative. Individuals have the right to refuse this information.
- **Participation in planning treatment; notification of family members.** Clients shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative, or both. In the event that the client cannot be present, a family member or other representative chosen by the client may be included in such conferences.
- **Continuity of care.** Clients shall have the right to be cared for with reasonable regularity and continuity of staff assignment as far as facility policy allows.
- **Right to refuse care.** Clients shall have the right to refuse treatment based on the information required in Information about treatment, and to terminate services at any time, except as otherwise provided by law or court order.

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- **Experimental research.** Written, informed consent must be obtained prior to a client's participation in experimental research. Clients have the right to refuse participation. Both consent and refusal shall be documented in the individual care record.
- **Freedom from maltreatment.** Clients shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every client shall also be free from nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a client's physician for a specified and limited period of time, and only when necessary to protect that client from self-injury or injury to others.
- **Treatment privacy.** Clients shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be 2017 (MN Statute 148E.195, Administrative Rule 7200.4905) (MN Statue 144.651 subd. 1, 3 to 16, 18, 20 and 30) 5/9/2018 conducted discreetly.
- **Confidentiality of records.** Clients shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility.
- **Responsive service.** Clients shall have the right to a prompt and reasonable response to their questions and requests.
- **Grievances.** Clients shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as clients and citizens. Clients may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints.
- **Protection and advocacy services.** Clients shall have the right of reasonable access at reasonable times to any available rights protection services and advocacy services so that the Clients may receive assistance in understanding, exercising, and protecting the rights described in this section and in other law. This right shall include the opportunity for private communication between the clients and a representative of the rights protection service or advocacy service.
- **Services for the Agency.** Clients shall not perform labor or services for the agency.
- **Non-Discrimination.** Clients have the right to be free from discrimination based on race, color, nation of origin, language, religion, political beliefs, sex, marital status, age, sexual orientation, gender identity, or disability, including AIDS, AIDS-related complex, or status as HIV positive.

Additional Rights:

- Examine public data on your provider maintained by their board;
- Be informed of the provider's license status, education, training, and experience

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- To have access to your records as provided in Minnesota Statutes, sections 144.291 to 144.298; Minnesota Statutes, sections 144.291 to 144.298
- To be informed of the cost of professional services before receiving the services
- To know the intended recipients of psychological assessment results;
- To withdraw consent to release assessment results, unless that right is prohibited by law or court order or is waived by prior written agreement;
- To a nontechnical description of assessment procedures
- To a nontechnical explanation and interpretation of assessment results, unless that right is prohibited by law or court order or is waived by prior written agreement.

Complaint Options:

Ombudsman for Mental Health and Developmental Disabilities 121 7th Place E #420 St. Paul, Minnesota 55101 Phone: 651-757-1800 or 1-800-657-3506 Email: ombudsman.mhdd@state.mn.us	MN Board of Psychology 2829 University Ave. SE, Suite 320 Minneapolis, MN 55414 Phone: (612)617-2230 Hearing/Speech Relay: (800) 627-3529 Email: psychology.board@state.mn.us
MN Board of Social Work 2829 University Ave SE, Suite 340 Minneapolis, MN 55414-3239 (612) 617-2100; (888) 234-1320; FAX (612) 617-2103 Hearing/Speech Relay: (800) 627-3529 Email: social.work@state.mn.us	MN Board of Marriage and Family Therapy 2829 University Ave SE Suite 400 Minneapolis, MN 55414 (612) 617-2220 Hearing/Speech Relay: (800) 627-3529 Email: mft.board@state.mn.us
MN Board of Behavioral Health and Therapy 2829 University Ave SE, Suite 210 Minneapolis, MN 55414 (612) 528-2177 FAX (612) 617-2187 Email: bbht.board@state.mn.us	Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, MN 55164 (651) 201- 4200 Email: health.fpc-licensing@state.mn.us