Full Name_____ Nickname_____

Date of Birth_____ Sex _____ Gender_____

Home Address_____

City_____ State/ZIP_____

Race ❒ White ❒ Asian ❒ Hispanic ❒ Native American ❒ Black/African American

❒ Multiracial ❒ Decline to answer ❒ Other: _____

Language ❒ English ❒ Hmong ❒ Spanish ❒ Other:_____

Ethnicity ❒ Hispanic/Latino ❒ Not Hispanic or Latino ❒ Decline to answer

Education Level ❒ Less than high school ❒ High school ❒ Some college ❒ Bachelor's degree and higher

Marital Status ❒ Married ❒ Divorced ❒ Single ❒ Life partner ❒ Widowed ❒ Separated

Email_____ Home Phone _____

Cell Phone_____ Work Phone _____

MHCS contacts clients to confirm appointments.
ONLY LIST A PHONE NUMBER WHERE WE CAN LEAVE A MESSAGE.
***Please check your appointment confirmation preference**:*

❒ Cell Phone ❒ Home Phone ❒ Text message ❒ Email ❒ No appointment confirmation

If you live in a residential facility please enter the information below. If not applicable, please skip to the next section.

Residential/Group Home/Agency Name_____

Street Address_____ Home Phone _____

City/State/Zip _____ Contact Phone _____

Contact Email_____

Emergency Contact Name _____ Phone _____

Emergency Contact Relationship to Client _____

Please indicate your guardianship status: ❒ I am my own guardian

❒ My guardian's name is _____ Phone _____

Office Use Only: _____Data Entry Completed

INFORMED CONSENT FOR TREATMENT

I hereby request and consent to psychotherapy and/or other behavioral health treatments and/or mental health evaluation and/or medication management services recommended/provided by my MHCS provider. I understand other licensed professionals who may have different educational backgrounds and/or specialties in this practice may assist in providing my care.

I understand that my first few sessions will involve an evaluation of my needs. By the end of the evaluation, my mental health care provider will be able to offer me some first impressions of what work will be included and a treatment plan to follow, if I decide to continue with treatment. I understand that I should evaluate this information along with my own opinions of whether I feel comfortable working with my provider. Because mental health treatment involves a large commitment of time, money, and energy, I should be very careful about the provider I select. If I have questions about suggested therapies, procedures, or medications, I will discuss them whenever they arise. I understand I can refuse specific suggestions or stop treatment at any time. If I request, the office or my provider will help set up a meeting with another mental health professional for a second opinion.

I understand that psychotherapy is not easily described in general statements; it varies depending on the personalities involved, the issues I bring forward, and the goals I want to achieve. I realize there are many different methods my mental health care provider may use to deal with the issues that I hope to address. Psychotherapy calls for a very active effort on my part. In order for the therapy to be most successful, I will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since either often involves discussing unpleasant aspects of my life, I may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. The benefit of evaluation is it may lead to a correct diagnosis of my condition and help establish effective treatment. Psychotherapy has been shown to have many benefits: therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress, but there are no guarantees of what I will experience.

If medication management is recommended, the risks and benefits of the medications will be explained to me by my provider and we will discuss any questions or concerns I may have. I understand I may refuse specific medications or treatment altogether. I understand I must see my provider on the basis which the provider recommends in order to continue to get medications prescribed (this is generally every 3 months). To get a prescription refilled I will contact my pharmacy who will notify my provider.

If I need to contact my provider between sessions, my provider, who may not be immediately available, will discuss the best method of communication with me. I am aware I can call MHCS after hours at 612-436-0295 and someone will contact me during the next business day. In an emergency I can contact 911, the National Suicide Prevention Lifeline at 1-800-273-8255, or go to my nearest hospital emergency department. In addition, I can request a list of additional emergency resources.

I have read, or have had read to me, the above explanation of my rights. I state that I have been informed and weighed the risks involved, and I have decided that it is in my best interest to receive mental health treatment. My provider and I agree to initiate treatment and I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment at MHCS. I will continue to discuss treatment options with my provider and understand that I reserve the right, at any time, to consent to or refuse my providers' treatment recommendations.

Sign only after you understand and agree to the above.

Printed Name of Patient	Signature of Patient / Representative	Date
Printed Name of Provider	Signature of Provider	Date

PATIENT FINANCIAL RESPONSIBILITY

This office will provide insurance billing services for you, if you so desire. **Remember that you are ultimately responsible for any charges incurred in this office. It is your legal responsibility to pay any deductible amount, co-insurance, and/or any other balances not paid by your insurance carrier. MHCS will attempt to inform you of any estimated personal financial responsibility, but specific coverage questions must be directed to your health insurance company. Your signature on this document indicates that you agree to pay for any outstanding charges incurred for services rendered by this office.**

The following options are available to coordinate payment for services:

1. You can pay our regular fee schedule and we will bill insurance for you. After your insurance processes the submitted claim, we will notify you of any balance on your account, e.g. deductibles or co-insurance. If and when the deductible is met, your benefit plan will go into effect. Copays are due at the time of service.
2. You can pay our discounted private pay rate and submit claims independently to your health insurance for reimbursement. MHCS will provide any documentation necessary to assist you with this process, but if you elect this option, we will not be billing on your behalf or be responsible for the successful processing of any claims made.
3. Private pay rates are available to everyone. Since we will not need to pay staff to bill and follow up with insurance companies, we pass the savings on to you. Additionally, since no claims are being submitted, we are not required to disclose any information about your treatment with any third party. Private pay rates are due at the time of service. A written copy of our fee schedule is available upon request.

We will strive to work out feasible payment options for anyone who is in need of care. Unless other prior written agreements have been made, any outstanding balance more than 60 days old is considered delinquent. Office policy dictates that delinquent accounts may be referred to a collection agency for collection. We will do our best to communicate with you about the status of your account on a timely basis to avoid collection issues.

If your insurance denies payment for any reason, we will offer you our private pay discount (our lowest fee schedule) for any outstanding charges that are paid in full within 30 days of notice.

I authorize payment of insurance benefits directly to Mental Health Counseling Services. I also authorize the healthcare provider to release all information necessary to communicate with personal physicians, other healthcare providers, collection agencies, and payers to secure the payment of benefits or inform them of concurrent treatment. By signing below, I indicate that I have read, understand, and agree with the terms of this agreement.

Client/Representative Signature _____ **Date** _____

NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; obtain payment from third-party payers; conduct normal healthcare operations such as quality assessments and accreditation. I understand how to facilitate the release and transfer of my health information from MHCS.

Client/Representative Signature _____ **Date** _____

NOTICE OF APPOINTMENT POLICY

I have received a copy of the No-Show Policy. I understand that cancelling and rescheduling of appointments should be done with at least 24 hours' notice. When I am unable to cancel with 24 hours' notice I will provide a courtesy phone call. I understand that if I consistently miss appointments, MHCS may cancel all upcoming appointments and I may be discharged from care from the practice.

Client/Representative Signature _____ **Date** _____