FREEBORN COUNTY MENTAL HEALTH CENTER
NEW CLIENT INFORMATION

Name ____ **Date** __________
First   Middle Initial   Last

Address ____
Street   City   State   Zip Code

Phone: Home______________________ Work __________________________

May we contact you by phone, if necessary, at home _________? **work _________?**
YES/NO **YES/NO**

May we leave a message (person, answering machine), at home _________? **work _________?**
YES/NO **YES/NO**

Birth date ______/_______/______ **Sex**: Male _____ Female _____

Social Security Number:__________-_____________-________________

Race/Ethnic background: Caucasian _____African-American ____Hispanic ____
Native American _____Asian ____Other ______________________________

Resides with _________________________________ **County of Residence:** _____________
Name and Relationship

Marital status: ____Single ____ Married ____Divorced ____Widowed ____ Separated
If currently married, have you been married before? **Yes** **No**

Previous Last Name(s): ____

Religious preference: ____

Education: Highest grade completed _____ Post secondary 1 2 3 4 5 6
Degree(s) earned __________ Other training ____________________

Employment: Occupation _________________ Employer ____________________________

Occupation of Spouse ________________ Employer ____________________________

Military: Were you ever in military service? ____ Yes ____ No

Medical: Name of doctor ________________________________ Date last seen __________

Insurance Company Name: ____

Are you taking medication now? ____ What medication(s)? ____________________________

Emergency contact person _________________________ Phone _______________________

Have you had previous psychiatric care or professional counseling? ____ Yes ____ No
If yes, where and when? ____

FAMILY: In your family, are you: (circle one)

NATURAL ADOPTED FOSTER or STEPCHILD

- Please complete the following information about your birth family:

RELATIONSHIP	FULL NAME	ADDRESS	AGE	EDUCATION	OCCUPATION
FATHER					
MOTHER					
SIBLING					
SIBLING					
SIBLING					
SIBLING					
SIBLING					

Others living in your home when you were a child: ______________________________

- Please complete the following information about your current family:

RELATIONSHIP	FULL NAME	ADDRESS	AGE	EDUCATION	OCCUPATION
SPOUSE/SIGNIFICANT OTHER					
CHILD					
CHILD					
CHILD					
CHILD					

Others living in your home at the present:

____

Who referred you to the Mental Health Center? ______________________________

____

With whom have you talked about your problems? ______________________________

____

What are your problems?______________________________

____

____

____

PRIVACY STATEMENT FOR CLIENTS OF THE FREEBORN COUNTY MENTAL HEALTH CENTER

A. Federal and State laws require this center to keep all personal information about you strictly private. We will not release this information to anyone without your written consent except under the legally prescribed conditions below.

B. All information we request will be used for one or more of the purposes stated below:

- To evaluate your need for care;
- To plan the types of care that will help you the most;
- To let this center collect payment from a private or government agency for the care we give you;
- To see if you are eligible for public assistance, should you request it;
- To fulfill state, federal and local demands for reports and statistics.

C. You are not required to provide any information to this mental health center. If you choose not to give us information about yourself, that will make it more difficult for us to help you, and may require us to ask you to return to the agency that sent you here.

D. Information about the type, the amount, the dates, the cost, the outcome and the evaluation of the treatment given will be available to local, state, and federal workers and to people at this center who need such information to keep records.

E. NO ONE BUT THE STAFF AT THIS CENTER WILL HEAR OR SEE TRANSCRIPTS OF ANYTHING YOU SAY IN COUNSELING OR THERAPY SESSIONS UNLESS YOU GIVE YOUR PERMISSION WITH THE EXCEPTION OF ADMISSIONS OF CHILD OR VULNERABLE ADULT ABUSE, WHICH THE PROFESSIONAL STAFF ARE REQUIRED BY LAW TO REPORT. COURT ISSUED SUBPOENA OF CLINIC RECORDS IS A POSSIBILITY IN WHICH CASE THE COURT TAKES RESPONSIBILITY FOR CONFIDENTIALITY OF THESE RECORDS.

F. You may request in writing to see all data about you. You will be shown this data unless it is used to investigate an illegal action or if a professional believes that it will be harmful to you or others. You may have the information explained to you and have corrected any information you think is wrong and this center finds to be wrong. If you consider incorrect any information which this center finds to be correct, you may attach your own explanation.

G. Acknowledgment:

I have read and understand this Privacy Statement.

Signed ________________________________

Date ______________________

MHC.038 (10/97)

FEE POLICY

The Freeborn County Mental Health Center primarily serves residents of Freeborn County. The Center will serve residents of other counties who are involved in a treatment program within Freeborn County and for whom fees are paid in full.

There is a charge for all services provided by this Center including testing and evaluation, psychotherapy (including individual, family and group sessions), chemotherapy management, consultations, reports and in-service training. Fees are charged for services whether you are self-referred, referred by another agency/individual or court-ordered.

A schedule of fees is available for anyone upon request. The full fee will be charged for all persons having medical insurance and/or any other third party coverage (including group or individual policies, Medicare, VA, Medical Assistance, General Assistance Medical Care, Workmen's Compensation, etc.). The client, parent or guardian is expected to provide verification of coverage at the time of appointment as well as complete all necessary insurance and authorization forms. The following policies apply for payment of services:

1. Following application of insurance benefits, the client, parent, or guardian is responsible for any remaining balance. Any insurance co-payments are due at the time of your appointment.

2. Persons without third party coverage will be charged according to a sliding fee scale based upon family income, size, and cost of service. Sliding fee payments are due at the time of your appointment.

3. By Federal and State law Medical Assistance (MA) and General Assistance Medical Care (GAMC) payments are considered payment in full.

4. If anyone chooses not to utilize health insurance, other medical benefits, or to disclose gross income for fee determination, the client then becomes responsible for full payment.

5. In the event appointment cancellation is necessary, there will be no charge if canceled at least 24 hours before the scheduled appointment time. An administrative fee of $20.00 may be charged if cancellation occurs less than 24 hours before the appointment time or if no notice of cancellation is given.

6. The fee schedule is subject to annual revision. Client fees may be modified due to a change in financial status.

7. Unfulfilled obligations are subject to normal recovery procedures and may be basis for termination of service.

8. Any client experiencing difficulty in paying their fee should discuss it with the staff member being seen. Any request for extension of payment terms or other modifications needs to be submitted in writing to the Center within 30 days of the first billing.

If there are any questions regarding the Center's fees and policies, anyone can phone (507) 377-5400 and ask for the Accounting Department.

****

I understand the above stated policies concerning service fees.

Please ***PRINT*** your name:______________________________

Signature ____ Date __________________________

MHC.039 (05.11)

CONSENT FOR THE RELEASE OF PRIVATE INFORMATION TO AN INSURER

FREEBORN COUNTY MENTAL HEALTH CENTER
P.O. Box 1246
Albert Lea, Minnesota 56007
(507) 377-5440

RE: ____

DOB: ____________ **Social Security Number:** ____________________________

I hereby authorize the Freeborn County Mental Health Center to disclose to:

____

(Health Insurance Information)

the following information:

- Date first consulted us for service
- Name of referring physician or other source
- Dates of hospitalization if related to charges for services
- Name and address of facility where services rendered
- Acknowledgment of lab work outside our office (yes, no, unknown)
- Date and place of service
- Procedure code and description (description and length of time)
- Diagnosis
- Charges
- Amounts paid by client and/or other insurance carrier or third party source
- Patient account number
- Provider's name, complete address, telephone number, employer I.D. number, authorized signature and date
- Therapist name and degree (if applicable)
- Treatment records (if required by insurer to process claim)

The organization receiving this information will use it for determination of medical benefits payable for services as described on completed claim forms submitted.

Direct payment is authorized to the Freeborn County Mental Health Center for medical benefits otherwise payable to me for services provided.

I understand that no other uses will be made of this information, except for those previously communicated to me or as otherwise authorized by law, and that access to it will be limited to persons whose work assignments reasonably require access to accomplish the purposes stated above. I understand that I may revoke this consent at any time and that, in any event, it expires automatically, within one year of this date or when the purposes for which it was granted have been accomplished, whichever occurs first.

________________________________ ________________________

Signature of Client Date

________________________________ ________________________

If client is a minor or incompetent, signature of parent or guardian Witness

MINNESOTA GOVERNMENT DATA PRACTICES ACT, MINNESOTA STATUTE 13.05, Subd. 4
MHC.040 (11/06)

Authorization to Share Information
With Primary Care Physician

It is generally considered to be good practice for mental health providers to coordinate care with your primary care physician and/or any specialty physician with whom you have an ongoing treatment relationship. Please list the name and address of your physician or primary care clinic below. (If you do not have a regular doctor, write "none" in space below, and sign this form where indicated.)

Client name:______________________ Date of Birth:___________________

Physician/Clinic name: ____

Physician/Clinic Address:____

____

Indicate if you are willing to permit us to share clinical information about you with this physician or clinic, including dates of service, diagnosis, treatment plan, and your response to treatment by checking the appropriate statement below.

_____ I *give permission* for Freeborn County Mental Health Center to share my clinical information with the physician or clinic named above.

_____ I *do not give permission* for sharing clinical information with the physician or clinic named above.

I understand that I may revoke this consent at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of cancellation. I also understand that this consent will automatically expire one year from the date of my signature without my expressed revocation.

I understand that this information will be treated as confidential to the extent allowed by law and used only by professional persons interested in my welfare. I agree that a photocopy of this consent form has the same validity as the original.

X________________________________ ________________________________

Signature Relationship (if signed by parent or guardian)

____

Date

MHC.070 (4/03)

Mental Health Center

203 West Clark Street
P.O. Box 1246
Albert Lea, MN 56007-1246

General Information	507-377-5440
Fax	507-377-5505
Warm Line	800-337-2460
Crisis Line	507-377-5499 or 877-402-3743

To Whom It May Concern:

Insurance information and/or private payment arrangements is needed by the time of the first appointment for Freeborn County Mental Health Unit. If you have any questions regarding your coverage please contact your insurance company. Thank you for your cooperation in handling this promptly to avoid billing problems.

I understand that if I do not provide insurance and/or payment arrangement information I will be responsible for full payment of services.

____
Name (please print)

____ ____________________
Signature Date

MHC.063 (revised 10/02)

Freeborn County Human Services
203 West Clark Street
Albert Lea, MN 56007

Your Privacy Rights

This sheet tells you about your rights under the **Minnesota Government Data Practices Act** and the **Health Insurance Portability and Accountability Act.** These Acts protect your privacy but also lets us give information about you to others if a law requires it and we tell you before we do it. This sheet tells why and when we will ask for and give information about you. It applies to all future contacts you have with our Department. Those contacts may be in person, by mail, via audio/video conferencing, or on the telephone. Your worker can explain any additional requirements.

A. Why Do We Ask You For Information?

We may ask you for information so we:

- Tell you from other persons by the same or similar name.
- Decide if you can get money or services from us and what or how much you can get.
- Help you get the medical, mental health, financial or social services.
- Collect money from the state or federal government for help we give you.
- Decide if you can pay for any help you get.
- Make reports, do research, audit and evaluate our programs.
- Investigate reports of people who may lie about the help they need.
- Decide about out-of-home care and in-home care for you or your children.
- Collect money from other agencies, like insurance companies, if they should pay for your care.
- Decide if you or your family needs protective services.

B. Do You Have To Answer The Questions We Ask?

Generally the law does not say you have to give us information. Federal laws require that you give us your Social Security number if you want financial help or child support enforcement services.

C. What Will Happen If You Do Not Answer The Questions We Ask?

We need information about you to tell if you can get help from any program. Without some information, we may not be able to help you. It may be that we can help you but the help may be late or not enough. Giving us wrong information o purpose may result in investigating and charging you with fraud.

D. Who May We Share The Information About You With?

We may give information about you to any of the following agencies, if they need it for investigations or to help you or help us help you. This does not mean we always share information about you with these organizations. It only says that there is a law that says we may share data with these organizations (sometimes the law says we must share certain information.) If you have any questions about when we give these organizations information, ask your worker.

Federal Organizations

*U.S. Department of Agriculture
*U.S. Department of Health & Human Services
*Immigration & Naturalization Services
*Social Security Administration
*U.S. Department of Labor
*Center for Medicaid Services
*Attorney General
*Internal Revenue Services

State Organizations

*Minnesota Department of Human Services
*Minnesota Department of Public Safety
*Minnesota Department of Revenue
*Minnesota Department of Veteran Affairs
*Minnesota Historical Society
*Minnesota Department of Health
*Regional Treatment Centers
*Minnesota Department of Labor & Industry
*Minnesota Department of Economic Security
*Minnesota Department of Human Rights
*Ombudsman for mental health & retardation
*Minnesota Office of State Auditor

County Organizations

*County Welfare Boards
*County Attorney
*County Housing & Redevelopment Authority
*Other County Welfare Offices (Crime Victims Crisis Center & Domestic Abuse Program)
*County Child & Adult Protection Teams

Other Organizations

*Mental Health Centers
*Hospital & medical clinics
*Member agencies of a local collaborative
*Higher education coordinating board
*Law enforcement officials
*People who investigate child & adult protection
*Employees or volunteers of any welfare agency
*Fraud prevention and control units
*Others who may pay for your care
*Ombudsman for families
*School districts
*Creditors
*Court officials
*Credit Bureaus
*Insurance companies

*Community food shelves or surplus food programs
*School &other institutions of higher education
*Guardians, conservators or power of attorneys
*Anyone else who the law requires us to
*Collection agencies
*American Indian tribes
*Coroners & Medical examiners
*Local health departments

E. **You Have The Right To Copies Of Information We Have About You**
You may ask if we have any information about you. If we have information about you, you may ask for copies. Unless we get special written permission from you, we will only use your health information for the purpose listed. You may have to pay for the copies. You may give other people permission to see and have copies of private data about you. If the information is unclear, you may ask to have it explained to you. You may question the accuracy of any information we have about you. You also have the right to ask us to share health information with you in a certain way or in a certain place. For example, you may ask us to send health information to your work address instead of your home address. You must make this request in writing. You do not have to explain the basis for your request. You may also ask us to restrict uses or disclosures of your information. Your request must be in writing and be specific to on what information you want to restrict from being disclosed and to whom you want these restrictions to apply. You have the right to receive a record of the people or organizations that we have shared your health information with. We must keep a record of each time we share you health information for six years from the date it was shared. This record will be started on April 14, 2003. It will NOT include those times when we have shared your information in order to treat you, pay or bill for your health care services, or to run our programs. If you want a copy of this record, you must send a request in writing to our Privacy Official.

F. **What Are Our Responsibilities Under This Notice?**
We may change our privacy policy in the future. We might do this, for example, because privacy laws change and require us to change our practices.

G. **What If You Believe The Information We Have About You Is Wrong?**
Send your concerns in writing, telling us why the information is not accurate or complete. You may send your own explanation of the facts you disagree with. Your explanation will be attached any time that information is shared with another agency.

H. **How Do You Appeal If You Think Information Is Not Accurate Or Complete?**
Your objection must be in writing and be sent to the Director of this agency. You must tell us why the information is not accurate or complete. You may send your own explanation of the facts you disagree with. Your explanation will be attached any time that information is shared with another agency. For more information on how to do this, ask your worker.

I. **What Privacy Rights Do Children Have?**
If you are under 18, your parents may see data about you and authorize others to see this data, unless you have asked that this information not be shared with your parents. You must make this request in writing and say what data you want withheld and why. If the agency agrees with you that not sharing the data would be in your best interests, we will not share the data with your parents. If we don't agree with you, the data may be shared with your parents if they ask for it.

J. **What Happens With Immigration Information?**
Immigration information given as part of this application is private and confidential. Information will only be used for eligibility determination and program administration. If you are applying for emergency services, you do not need to give us information about you immigrations status. Non-immigrant or undocumented people who are pregnant, under age 18, age 65 and over, or people with disabilities, may also be eligible without providing immigration information.

K. **What If You Believe Your Privacy Rights Have Been Violated?**
You may complain if your privacy rights have been violated. You cannot be denied service or treated badly because you have made a complaint. If you believe that your medical privacy was violated by your doctor or clinic, a health insurer, a health plan, or a pharmacy, you may send a written complaint either directly to that organization or to the federal office of Civil Rights at U.S. Department of Health and Human Services, Office for Civil Right-Region V, 233 North Michigan Avenue, Suite 240, Chicago, Illinois, 60601; (312) 886-2359 (voice); (312) 353-5693 (TTY/TDD); (312) 886-1807 (FAX). Complaints can also be filed with the Department of Humans Services, Appeals Unit, 444 Lafayette Road, St. Paul, Minnesota, 55155-3815. If you think that Freeborn County Human Services has violated your privacy rights you may send a written complaint to Freeborn County Human Services, Privacy Official, Brian Buhmann, 203 West Clark Street, Albert Lea, Minnesota, 56007-1246. If you have any questions about the information on this form, you may ask your worker to have it explained to you. You can ask Freeborn County Human Services for another copy of this notice.

Client Signature	Date	Agency Representative Signature	Date

Client name: ______________________________

Please print

Freeborn County
Mental Health Center
Practice Disclosures

It is the goal of Freeborn County's Mental Health Center to provide quality mental health services to our consumers. Practice policies have been implemented to help us efficiently achieve this goal.

Cancelling or Rescheduling an Appointment

We ask that you notify our office at least one business day prior to your appointment if you must reschedule or cancel. Any appointments cancelled or rescheduled the day of the appointment will be considered a no-show.

No-Show Policy

A "no-show" will be documented when you fail to be present at the time of a scheduled appointment or when you cancel a scheduled appointment with less than one business days notice. If three "no-shows" are documented within a six-month period of therapy services, or within a one-year time period for psychiatric services, no further appointments will be scheduled. You will be notified of this decision by mail.

How to Cancel or Reschedule Your Appointment

To cancel or reschedule your appointment, please call our front desk at (507) 377-5493. If another appointment is not available on the date you would like to reschedule, you will have the option of choosing another date or placing your name on a cancellation list.

Refill Policy

At the discretion of the psychiatric provider, refills on medications may be approved until the time of your next scheduled appointment. Prescriptions will not be refilled until an appointment is scheduled.

I have read and understand these Practice Disclosures.

Client Name: ______________________________

Please print

______________________________ ______________

Signature Date

Authorization to Release Protected Health Information to a Third Party

TO BE SCANNED

Form content retained in medical record.
Route to HIMS Scanning.

1. *(complete fields or place patient label here)*

Patient Name *(First, Middle, Last)*	
Birth Date *(mm-dd-yyyy)*	Room Number (if applicable)
Mayo Clinic Number	

Staff Use Only

☐ ROI to Send Records ☐ Scan to Chart	
☐ Information Released by LAN ID	Date *(mm-dd-yyyy)*

Instructions: This form is to be used by a patient or legal representative to authorize the release of information to a third party (other than a family member or friend) such as an insurance company, employer, or for legal purposes, etc. Print clearly; each section needs to be completed to be valid.

2. Additional Patient Information

Previous or Maiden Name (if applies) *(First, Middle, Last)*	Daytime Phone	☐ Check this box if patient is deceased.
Patient Address *(Street, City, State, ZIP Code)*		

3. Release Purpose

Check appropriate box or write in other purpose.

☐ Continuing care ☐ Disability ☐ Forms completion ☐ Insurance ☐ Legal ☐ Workers' compensation

☐ Other, specify ____________________

4. Release Information FROM

Check one box and complete if applicable.

☐ **Mayo Clinic**
Includes all Mayo Clinic and Mayo Clinic Health System locations

☐ **Other,** specify organization, department, or individual (complete each line below)

____

Street ____________________

City ____________________

State ____________________ ZIP Code ____________________

Phone ____________________

Fax ____________________

5. Release/Send Information TO

Check one box and complete each line for box checked.

☐ **Mayo Clinic**

Dept. ____________________ Attn. ____________________

Fax ____________________

☐ **Other,** specify organization, department, or individual (complete each line below)

____

Street ____________________

City ____________________

State ____________________ ZIP Code ____________________

Phone ____________________

Fax ____________________

This authorization will expire in 1 year from date of signature *unless another date is specified:* ____________________

☐ **By checking this box** I allow the ongoing exchange of information between the above parties until this authorization expires or is revoked.

☐ **By checking this box** I also authorize the release of records for future visits or stays after the date of my signature until this authorization expires or is revoked.

6. Delivery of Information

Preferred Method ☐ Written copy (may include completed forms) ☐ Verbal only	Date Information Needed by *(mm-dd-yyyy)*

Written information will be mailed unless an alternate method is checked.

☐ Patient Portal – Mayo Clinic Patient Online Services

☐ Fax (number listed above in section 5)

☐ Email address ____________________

☐ Pick-up at a Mayo Clinic location, specify ____________________

☐ CD/DVD

☐ USB flash/thumb drive

☐ Other, specify ____________________

ENTERPRISE: Applies to Mayo Clinic locations in Arizona, Florida, Rochester and Mayo Clinic Health System.

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Authorization to Release Protected Health Information to a Third Party (continued)

(complete fields or place patient label here)

Patient Name *(First, Middle, Last)*
Birth Date *(mm-dd-yyyy)*
Mayo Clinic Number

7. Records or Reports to Be Released

Timeframe to Be Released

Date(s)________________________ *(mm-dd-yyyy)* or Year(s)________________________ *(yyyy)*

Document/Note(s) (check all that apply)

- ☐ Behavioral health/Mental/Psychological notes
- ☐ Operative/Procedure notes
- ☐ Therapy notes (physical, occupational, speech)
- ☐ Emergency department/Urgent care notes
- ☐ Provider notes
- ☐ Other, specify ________________________

I understand the information to be released may include behavior and/or mental health care, and HIV test results.

Additional Records (check all that apply)

- ☐ Allergy list
- ☐ Immunizations
- ☐ Medication list
- ☐ Laboratory results
- ☐ HIV lab test results
- ☐ Genetic testing
- ☐ Pathology report(s)
- ☐ EKG(s)/Cardio/Echo
- ☐ Radiology report(s)
- ☐ Radiology image(s), specify exam(s)/body part(s)
- ☐ Billing information for records checked

Substance Abuse and Addiction Treatment Records (check all that apply)

- ☐ Assessment/Evaluation
- ☐ History and physical exam
- ☐ Multidisciplinary notes
- ☐ Family participation invitation
- ☐ Questionnaires
- ☐ Treatment/Discharge summary
- ☐ Treatment plans
- ☐ Other, specify________________________

Other, specify if applicable________________________

8. Signature and Date The patient or legal representative must sign and date this authorization.

- This authorization may be revoked at any time by providing a written notice of revocation to the Health Information Management Services (HIMS) Release of Information (ROI) department at the facility releasing the information, except to the extent that the Providers have already taken action in reliance on it.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law (42 CFR Part 2) (HIPAA).
- I understand that Mayo Clinic will not condition treatment on whether I sign this authorization.
- I may request a copy of the signed authorization.
- I may be charged for copies in accordance with state law.
- I have a right to inspect and receive a copy of the material to be disclosed.

Note: A patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Specific situation(s) may require minor's authorization.

Signature (required) ▶	**Date** (required) *(mm-dd-yyyy)*

Printed Name of Person Signing **(if not patient)** *(First, Middle, Last)*

Relationship if Not Patient (legal documentation of the right of access by the signing individual may be required)

☐ Parent ☐ Stepparent ☐ Legal guardian ☐ Foster parent ☐ Health care power of attorney/agent ☐ Other____________

HIMS* Release of Information Contact Information

Arizona	**Florida**	**Rochester**	**MCHS MN**	**MCHS WI**
13400 East Shea Boulevard	4500 San Pablo Road	200 First Street SW	1025 Marsh Street	1400 Bellinger Street
Scottsdale, AZ 85259	Jacksonville, FL 32224	Rochester, MN 55905	Mankato, MN 56001	Eau Claire, WI 54703-5211
Phone 480-301-4211	Phone 904-953-2022	Phone 507-284-4594	Phone 507-594-2621	Phone 715-838-6395
Fax 480-301-7282	Fax 904-953-2242	Fax 507-284-0161	Fax 507-422-0902	Fax 715-838-3058

Reminder: If sending records **TO** Mayo Clinic, fax records to number indicated in section 5 on page 1.

*Health Information Management Services

MC0072-01rev0419

Authorizations and Service Terms

Form content retained in medical record.
Route to HIMS Scanning.

(complete fields or place patient label here)

Patient Name (First, Middle, Last)	
Birth Date (mm-dd-yyyy)	Room Number (if applicable)
Mayo Clinic Number	

TO BE SCANNED

Authorizations

Authorization for Treatment: I consent to the rendering of medical care which may include routine diagnostic procedures and such medical treatment as my attending physician(s) or other Mayo Clinic* (Mayo) medical staff consider to be necessary.
I may be offered medical services via telemedicine systems that involve the delivery of health care by electronic communication with a provider who is at a different physical location. I consent to initiating and/or receiving technology-based communications with my providers, including consulting services from a specialist performed virtually. I agree to be responsible for any charges that insurance does not pay. I understand that my medical care and treatment may be provided by physicians, including fellows and residents, medical and allied health students, physician assistants, nurses and other health care providers. I have read and understand this Authorization for Treatment and understand that no guarantee or assurance has been made as to the results that may be obtained.

Authorization to Release Medical Information**: I authorize Mayo to release all medical information as necessary to:

- All Payers*** for processing health care claims;
- The person(s) I designate as my Billing Addressee/Guarantor for handling the billing, payment, and health care coverage for my account;
- Accrediting and quality organizations, regulatory agencies, public health reporting agencies, or other persons or entities for health care operations;
- My other health care providers for treatment or payment purposes.
- I authorize Mayo and my insurer(s) to share my past, current, and future health, treatment and account records about services I have received from Mayo and other care providers as needed to manage or coordinate my care and to improve the quality of that care.
- A health record locator service/health information exchange (HIE) allows my health care providers to electronically access my health information held by other participating providers to provide me with better care. I authorize Mayo to access any of my health information that is available in an HIE, and Mayo will also make my Mayo health information available through HIEs in which it participates unless I opt out. If I opt out, by checking the box below, Mayo will exclude all of my Mayo health information from the HIEs in which Mayo participates.

☐ **HIE Opt Out**

Authorization to Assign Benefits and Release Information: I authorize my Payer(s) to pay directly to Mayo any benefits due under the terms of my health care plan(s), for services provided by Mayo. I understand Mayo reserves the right to refuse or accept assignment of medical benefits. If I am a Medicare beneficiary, I request payment of authorized Medicare benefits to me or Mayo on my behalf for any services furnished. If my health care plan(s) will not allow direct payment to Mayo or if Mayo chooses not to accept assignment of medical benefits, I agree to pay Mayo all health care payments I receive for services. I authorize Mayo to contact my Payer(s) to obtain all pertinent financial information concerning coverage and payments made under my health care plan(s) and for my Payer(s) to release such information to Mayo. I hereby give Mayo authorization to appeal on my behalf for services provided at Mayo. I understand that this may waive my insurance appeal rights as a member when appealing the insurance denial. By signing this form, I understand that future appeal and adjudication rights for services may be exhausted according to the provisions of my plan.

Service Terms

Statement of Financial Responsibility: I acknowledge I am responsible for all charges for services provided, including any amount not paid by my health care plan(s), or an out of state workers' compensation payer, other than billing terms and restrictions under a government program or as prescribed by law in the state where medical services are provided. I authorize Mayo to apply any credit balance on my account to any amounts that I may owe to one or more Mayo entities. I agree that Mayo may obtain financial information, including consumer credit reports to determine eligibility for financial assistance and/or payment options. Information on financial assistance is available by calling 844-217-9591, or at mayoclinic.org or mayoclinichealthsystem.org.

Dispute Resolution: I agree that any dispute (including personal injury claims) related to health care services rendered by Mayo is subject to the exclusive jurisdiction of the appropriate court in the state where the provider of the disputed services is physically located when the services are rendered and the law of that state. Any state court action must be venued in the county where the provider of the disputed services is physically located when the services are rendered. These agreements also apply to my legal representatives and next of kin.

Use of Phone: I agree Mayo, its affiliates and agents may use an automated telephone dialing system, pre-recorded messages, and texting, to contact the wireless number(s) and/or residential lines I provide to Mayo for appointment and payment purposes.

Notice of Privacy Practices: I acknowledge I have been presented with the Mayo Notice of Privacy Practices, which can be viewed at: http://www.mayoclinic.org/about-mayo-clinic/notice-of-privacy-practices. I can request a paper copy during my visit or by calling 507-266-6286.

Signature

Attention: This is a legal document. Changes will not be accepted on this form. Requests for any alterations must be made by calling at 507-284-3350.
By signing, I agree that I understand and accept the terms on this form. I understand I have the right to revoke the authorizations on this form at any time by notifying Mayo in writing, except to the extent that Mayo has already taken action in reliance upon them. These authorizations will remain valid until I revoke them in writing.

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing,** a legally authorized substitute may sign and date the form. Indicate your legal authority and include documentation of your relationship:
  ☐ **Legal Guardian or Conservator** ☐ **Health Care Agent (Health Care Power of Attorney)** ☐ **Other Legal Representative**
- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Indicate your relationship: ☐ **Parent** ☐ **Legal Guardian**

Signature (required) ▶	Date (mm-dd-yyyy)	Time (hh:mm) ☐ am ☐ pm
Printed Name of Person Signing (if not patient) (First, Middle, Last)		

* For purposes of this form, Mayo refers to Mayo Clinic in Arizona, Florida, Rochester, Mayo Clinic Health System and all affiliated clinics, hospitals, and entities; including employees and agents.

** Medical information includes, but is not limited to, information related to psychologic, psychiatric, sickle cell anemia, HIV/AIDS, communicable diseases, genetic testing, and alcohol and drug abuse diagnosis and treatment if such information exists.

*** For purposes of this form, Payer(s) includes, but is not limited to, insurance carriers, health-plan administrators, or any other payers including the Centers for Medicare & Medicaid (CMS) and their agents or review agencies.

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Mental Health Center

203 West Clark Street
P.O. Box 1246
Albert Lea, MN 56007-1246

General Information 507-377-5440
Fax 507-377-5505
Warm Line 800-337-2460
Crisis Line 507-377-5499 or 877-402-3743

Freeborn County Mental Health Center is requesting that you sign the enclosed Telehealth Informed Consent Form whether you wish to see your mental health provider in person face to face or virtually.

-If you want to be seen virtually, we need you to sign the form providing consent to participate in telehealth (virtual) appointments.

-If you want to be seen in person face to face, we ask that you sign the form providing consent to participant in telehealth appointments on very rare occasions such as when the weather is inclement and you or your mental health provider cannot travel to the mental health center. In this rare situation, you may be given the option to see your mental health provider virtually. As such, we are requesting that you sign the form,

Please do not hesitate to call Freeborn County Mental Health Center at 377-5440 should you have any questions.

Thank you,

Freeborn County Mental Health Center

An Equal Opportunity Employer

Freeborn County Mental Health Center
203 West Clark Street
Albert Lea, Minnesota 56007
(507) 377-5440

Telehealth Informed Consent

1. I agree to participate in telehealth services for the purposes of psychiatric evaluation and treatment and/or for individual psychotherapy.
2. I understand that the only difference between an appointment occurring via telehealth is that I will not be in the same room as my mental health provider.
3. I understand that I have the right to withdraw consent at any time without affecting my right to future care or services or program benefits to which I would otherwise be entitled.
4. I understand that there are potential risks to this technology, including but not limited to, disruption of transmission by technology failures, interruption, breeches of confidentiality by unauthorized persons, and limited ability to respond to emergencies. I understand that my mental health provider or I can discontinue the telehealth appointment if it is thought that the videoconferencing connections are not adequate for the situation or for any clinical reason.
5. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or requited by law.
6. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the telehealth session other than my mental health provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained.
7. I understand that I have the option to refuse telehealth services at anytime without affecting my right to future care or treatment.
8. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth unless an exception to confidentiality applies (i.e. mandating reporting or child, elder or vulnerable adult abuse, danger to self or others)
9. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate and a higher level of care is required.
10. I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at (507) 377-5440 to discuss since we may need to reschedule.

I have read the statements in this document, understand the risks and benefits of telehealth services and have had my questions regarding these procedures explained. I consent to participate in telehealth under the terms described herein.

Client Signature	Date
Guardian/Legal Representative Signature	Date