Northland Counseling Center, Inc.
Minor Registration Form

Client Name: _____ **Client Number:** _____

I. ADMISSION INFORMATION

Client Address: _____

City _____ State _____ Zip _____

Phone #: (home) _____ (work) _____ (cell) _____

I authorize Northland staff to contact me at the above address and phone number: Yes No

May we leave a message if you are not at home? Yes No

Birthdate: _____ **Social Security #:** _____ **Sex:** Male Female

Client's primary physician: _____

II. MINOR INFORMATION *(Signature on reverse authorizes treatment of above client)*

Parents in household: Mother _____ Father _____

What type of custody do you retain? (check all that apply)

_____ Full legal custody _____ Physical custody

_____ Joint legal custody _____ Custody not yet determined

_____ Other (please specify) _____

If joint custody or none of the above, please list name, address and phone number of other party retaining custody:

_____

(Northland is required to obtain consent to treat this minor from the above named person)

III. INSURANCE INFORMATION *(check and complete all that apply)*

_____ Primary insurance ***(attach copy of card)*** ID# _____ Group#_____

Insurance Company Name _____

Address _____

Phone Number _____

Subscriber Name _____ DOB: _____

Address _____

Relationship _____

_____ Secondary Insurance ***(attach copy of card)*** ID# _____ Group#_____

Insurance Company Name _____

Address _____

Phone Number _____

Subscriber Name _____ DOB: _____

Address _____

Relationship _____

_____ No insurance Have you applied for Medical Assistance? Yes No Pending or denied?

****PLEASE READ AND SIGN REVERSE****

IV. RELEASE OF INFORMATION

I authorize Northland Counseling Center, Inc. to release information to my insurance company regarding my treatment and I permit a facsimile or photographic reproduction of this authorization in place of the original. This could include my Social Security number, diagnosis, prognosis, dates of treatment, narrative notes, and types of treatment. This is for the purpose of validating claims submitted to stated insurance carrier. I also authorize stated insurance carrier to make payments to Northland Counseling Center, Inc. for all insurance benefits to which I or my dependents are entitled for services received. I understand that this consent will terminate one year from signature date unless I choose to revoke it earlier.

V. STATEMENT OF UNDERSTANDING

I understand that I am responsible for the charges in full if I do not maintain coverage for which I am eligible or fail to provide insurance information and/or income verification (if interested in fee reduction).

I recognize that Northland Counseling Center, Inc. cannot guarantee payment of charges by any particular insurance carrier. **If I have questions regarding coverage, I will contact my insurance company.**

In the event Northland Counseling Center, Inc. has been unable to collect payment from me for services within a reasonable period of time, the Center then reserves the right to turn the account over for collection of my bill. A 15% processing fee will be added to any account sent to collections.

I affirm that the information on reverse is accurate. I am aware of my financial responsibilities and agree to the payment terms. I authorize the release of information to my insurance carrier(s). **If my address, phone number, financial status, or insurance coverage changes, I will notify Northland Counseling Center, Inc.,** and an update of this agreement may be renegotiated.

_____ _____

Client signature Date

_____ _____

Parent/Guardian signature Date

NORTHLAND COUNSELING CENTER
215 SE 2nd Avenue, Grand Rapids, MN 55744
(218)326-1274 / Fax (218) 326-9787

Authorization For Treatment Of A Minor

Name _____ DOB _____

_____ I authorize NORTHLAND COUNSELING CENTER and its staff to administer services and/or treatment to my child.

_____ I authorize NORTHLAND COUNSELING CENTER and its staff to administer services and/or treatment to my ward.

What type of custody do you retain?

Full legal custody _____
Joint legal custody _____
Physical custody _____
Other (please specify) _____

If none of above, give name, address and phone of person with custody

_____
_____
_____

Responsible Party Print Name _____

Responsible Party Signature _____ Date _____

By signing this form I agree that all of the above statements are true and accurate.

Northland
COUNSELING CENTER, INC

Telemedicine Client Consent/Refusal Form

CLIENT NAME: _____

PURPOSE: The purpose of this form is to obtain your consent to participate in telemedicine services in connection with the following services provided by Northland Counseling Center, Inc. and all satellite offices associated within.

Services <u>may</u> include: Individual Therapy, Diagnostic Assessments, Medication Management, Psychiatric Consultations, Adult Rehabilitative Mental Health Services (ARMHS), Peer Support Services (PSS), Housing Services, Employment Services through Northern Opportunities Works (NOW), Crisis Assessments, Crisis Interventions, Crisis Stabilization, Intakes, Clinical Care Consultation, Case Management, DBT Services, Substance Use Disorder (SUD) treatment (assessments, treatment planning, individual/group services), Behavioral Health Home (BHH) and Children's Therapeutic Supports and Services (CTSS).

Service(s) if not listed: _____

INTRODUCTION: Telemedicine involves the use of electronic communications to enable office visits from a site other than Northland Counseling Center, Inc. 'Telemedicine' means using electronic systems to allow communication between a client and a provider who are in different locations.

CONFIDENTIALITY: Northland Counseling Center, Inc. utilizes Zoom, which incorporates networking software security protocols to protect confidentiality of patient identification and will include measures to safeguard data and to ensure the integrity against intentional or unintentional corruption.

Reasonable and appropriate efforts have been made to illuminate any confidentiality risks associated with the telemedicine consultation and all existing confidentiality protections under Federal and Minnesota State Law applied information disclosed while utilizing telemedicine services.

RIGHTS: You may withhold or withdraw consent to telemedicine services at any time without affecting your right to future services with Northland Counseling Center, Inc. or risk the loss or withdrawal of any program benefits to which you would otherwise be entitled.

RISKS, CONSEQUENCES and BENEFITS: In rare cases, the information transmitted may be inadequate quality or, if the equipment is not working, there could be delays in evaluation and treatment. In these cases, the visit maybe rescheduled or your provider will discuss Face-to-Face visit needs. You or your mental health provider may discontinue the telehealth visit if the connections are not adequate for the situation. Very rarely, security protocols could fail, causing a breach of privacy of medical information. Northland Counseling Center, Inc. has implemented appropriate security measures to mitigate against this rare situation.

By signing below, I indicate that Northland Counseling Center, Inc. has my permission to use a web-based video-conferencing application to facilitate my care and treatment.

- I understand the expiration date of this authorization is 1 year from today's date:_____
- I understand that my Protected Health Information (PHI) will be transmitted by a third party web-based video conferencing vendor to my provider during my telehealth visits.
- I understand that I have the right to revoke my permission at any time. I understand I must make my request in writing to Northland Counseling Center, Inc.

Signature:_____ Date:_____

If signed by someone other than the client, indicate relationship:_____

If you **<u>REFUSE</u>** to participate in telemedicine services please check this box: ☐

HEALTH QUESTIONNAIRE
(Clients 18 years and younger)

Northland Counseling Center, Inc.

215 Southeast Second Ave., Grand Rapids, MN 55744
Phone: 218-326-1274

Please complete the information below on the front and back of this form. Once completed, please give to the receptionist. Thank you.

Client's Name: _____ _____ _____
First Middle Last

Date of Birth: _____ **Age** _____ **Weight** _____ **Height** _____
(mm/dd/yyyy)

Sex of the Patient: **Female** _____ **Male** _____ **Other** _____

Names of Parents/Guardians: _____

Name/Relationship of Person Completing this Form: _____

Name of current school/program: _____

School grade: ____ **IEP/504 plan? If yes, please explain:** _____

Primary Care Physician's Name and Clinic: _____

Please state last appointment with a Primary Care Physician: _____

Preferred Pharmacy: _____

Are you currently being treated for any illness? If yes please explain:

_____

Do you have any medical and/or surgical history? If yes please explain:

_____

Are you currently taking any medications? If yes, please list name of medication and dose:

_____

Turn Over To Complete Other Side ➡

Please list all allergies and medication side effects: _____

_____

Do you, or anyone in your family, have a history of thyroid disorder___Yes___No. If yes please explain:

_____

History of head trauma: _____ Yes _____ No History of fractures: _____ Yes _____ No

If you answered yes to any of these, please explain: _____

_____

SUBSTANCE USE AND ABUSE:

Tobacco/Nicotine _____ Caffeine _____ Alcohol _____ Marijuana _____ Cocaine/Crack _____
Spice _____ Heroin _____ Hallucinogens _____Methamphetamines _____ Benzodiazepines _____
Inhalants _____ Ecstasy _____ Other: _____

If yes to any of the above, please state time of use and amount used: _____

_____

BEHAVIORAL HEALTH INFORMATION:

Please list current/previous behavioral health diagnosis: _____

Please list current/previous behavioral health treatment (Including chemical dependency treatment):

____Inpatient Dates _____ Facility _____ Location _____

____Outpatient Dates _____ Facility _____ Location _____

____Therapy Dates _____ Facility _____ Location _____

____Psychiatrist Dates _____ Facility _____ Location _____

Briefly describe your reason for consultation today: _____

_____

How long has this been a problem for you? _____

Please list current symptoms: _____

Please provide additional information you feel is important: _____

_____

_____

Strengths and Difficulties Questionnaire

P or T 4-10

* Parent to complete

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

Child's name ..... Male/Female

Date of birth.....

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

Signature ..... Date .....

Parent / Teacher / Other (Please specify):

Thank you very much for your help

Northland Counseling Center, 215 SE Second Avenue, Grand Rapids, MN 55744
218-326-1274 1-800-450-1274 Fax: 218-326-9787

Authorization for the Release of Medical Information

I, _____ **authorize**
(Name) (DOB)

Northland Counseling Center to: (Check one or both)
__x__ **Give information to**
__x__ **Receive information from**

_____
(Outside Agency or Individual's Name)

Dates or Type of service to be released by mail, telephone, or facsimile as follows:

X	Diagnostic Assessment/Psychological Evaluation	X	Psychological Testing Results
X	Treatment Plan	X	Medical Report and Medication Regimen
X	Narratives/Progress Notes		
X	Educational Information	X	Discharge Summary
X	Labs		
____	Other (specify) _ _____		

Records related to chemical dependency, mental health, sickle cell anemia, tuberculosis, and/or HIV/AIDS will be released, unless otherwise indicated by initialing here: _____

Approximate Dates of information requested: Current or most recent episode of care

Purpose of Disclosure:

X	Coordination of Care and Services	____	Legal
X	Future Referrals/References	____	Disability Claims
____	Other (specify) __		

I understand that my authorization terminates one year from the date of my signature. I understand that I have the right to revoke this authorization in writing at any time prior to the termination date. I understand that NCC cannot release information disclosed by this authorization to anyone other than listed above, and that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient only upon my written consent. I further understand that the information disclosed as a result of this authorization may no longer be protected and could be redisclosed by the recipient without my permission. NCC will not condition treatment on my signing this authorization. A copy of this authorization shall be considered as valid as the original.

_____ _____
Client/Guardian Signature **Date**

If signing as the authorized representative of the patient, I am: (please check one)
____ Court appointed guardian
____ Custodial parent of a minor
____ Other, explain_____

_____ _____
Witness **Date**

This information will be disclosed from your records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical, or other information, is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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X	Narratives/Progress Notes		
X	Educational Information	X	Discharge Summary
X	Labs		
____	Other (specify) _ _____		

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