

NEW PATIENT INFORMATION SHEET

Patient Information

Name: (Last) _____ (Use N/A if Not Applicable) (First) _____ (MI) _____
Date of Birth: _____ Age: _____ Sex: • M • F Marital Status: • S • M • W • D
Address:(street) _____
City, State, Zip _____
Phone #: _____ Social Security #: _____ Driver's License #: _____
Employer: _____ Work #: _____
Employer's Address: _____
Primary Care Provider(PCP): _____ Address _____
I authorize communication between Bluestem and my PCP for quality of care (please sign) _____

Parents, Spouse or Responsible Party

Name: _____ Relationship to Patient: _____
Address: _____
City, State, Zip: _____ DOB: _____
Phone #: _____ Social Security #: _____ Driver's License #: _____
Employer: _____ Work #: _____
Employer's Address: _____
Friend or Relative Not Living with You: _____ Phone #: _____

Primary Insurance Information

Insurance Co: _____ Phone #: _____
Insurance Address: _____
Group #: _____ Certificate or ID #: _____
Medicare #: _____ Medical Assistance #: _____
Insured's Name: _____ Relationship to Patient: _____
Insured's Address: _____
Insured's Social Security: _____ Date of Birth: _____ Sex: • M • F

If the patient is covered by another insurance policy, please complete the following information for the coordination of benefits. This information will enable your insurance company to process your claim more quickly. Thank you!

Secondary Insurance Information

Insurance Co: _____ Phone #: _____
Insurance Address: _____
Group #: _____ Certificate or ID #: _____
Medicare #: _____ Medical Assistance #: _____
Insured's Name: _____ Relationship to Patient: Self Spouse Dependent
Insured's Address: _____
Insured's Social Security: _____ Date of Birth: _____ Sex: • M • F

I hereby assign, transfer, and set over to Bluestem Center all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature: _____ Date: _____
(or Guardian's Signature, if minor)

Policies of Bluestem Center for Child and Family Development:

1. **Minnesota state law mandates that any suspected abuse be reported.** It is the policy of Bluestem Center for Child and Family Development to discuss this with families in detail if this concern arises. It is the policy of Bluestem Center for Child and Family Development to take whatever steps are required to ensure the safety of patients and others in the event of suicide or homicide risk.
2. **Confidentiality** is important in child psychotherapy, just as it is for adults. Psychotherapy is not secret, however. Parents should expect that children will be reluctant to talk about therapy sessions because they are very personal, and this should be respected. Our therapy work with children may include frequent contact and participation by parents. Medication monitoring visits are more like visits to a doctor's office than therapy appointments and parents are often present throughout the appointment, until patients are in their teen years.
3. Bluestem Center for Child and Family Development operates a multidisciplinary **group practice**. Patients are considered patients of the practice, and not of a specific professional. This means that all treatment team professionals share the same patient record, including assessment and therapist notes. Staff meetings are held at which difficult diagnostic or treatment issues are reviewed regularly. These staffings are upon request of the staff – patients are not notified in advance, but the results of staffings are often shared with the patient as part of treatment planning. Several professionals may be involved with a family, but one professional is identified as the case manager and should be the main contact person for the family.
4. The **after hours telephone service** operates out of our homes. This is a convenience for our patients who may sometimes need to reach us after hours. Appointments, inquiries about bills, and ordinary medication refills should be handled during normal business hours. Emergencies should be handled through community emergency services if our staff is not immediately available for consultation.
5. **If an emergency occurs** prior to the patient being seen at Bluestem Center for Child and Family Development, they should contact the professional currently working with them or go to a community emergency care facility.
6. **No prescriptions** are written before the patient meets with a physician or nurse at Bluestem Center for Child and Family Development. Refills should be obtained from the previous physician until then.
7. **Financial Charges and No Show Charges** are the patient responsibility and not billed to insurance. Accounts not paid within 30 days of due date are subject to a 1.5% monthly finance charge. A no show charge of \$60 per missed appointment without at least a prior notice of 24 hours will be applied to the account.

I have received a copy of the Patient Information Brochure, and the Bluestem Center for Child and Family Development Financial Policy. I understand the policies of Bluestem Center for Child and Family Development regarding confidentiality, fees and payment, and after-hours coverage.

Signature

Date

Professionals Initials _____

AUTHORIZATION FOR TREATMENT OF MINORS

It is in the best interest of minors to be treated with full knowledge of their parents or guardians. This means that except in the case of life-threatening emergency, or in cases of abuse, the following procedures will be followed.

1. Minors should be accompanied to every appointment by their parent or caregiver.
2. Unaccompanied minors will not be seen for an initial visit. Unaccompanied minors may be seen for follow-up visits if arrangements have been made between the professional and the caregiver.
3. In the cases of minors who are in protective custody, a signed "authorization of treatment" is required before the patient will be seen.
4. In the cases of minors who are brought to an appointment by staff of a residential treatment program, a signed "authorization of treatment" form is required. In the absence of this form, a copy of a signed residential facility contract specifying use of outside treatment providers may be substituted.

A copy or facsimile of this form shall be regarded as valid.

Minor's Name:

Date of Birth:

Name of Parent or Guardian:

Contact Number:

County:

My child, _____, may be evaluated and treated as his/her condition requires by the staff of Bluestem Center. This agreement shall remain in force unless terminated by either party.

Signature: _____

Date: _____

BLUESTEM CENTER
FORM 23000

NOTICE OF PRIVACY PRACTICES

BLUESTEM CENTER

EFFECTIVE DATE OF THIS NOTICE: 04 / 01 / 2003

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Pledge And Legal Duty To Protect Health Information About You.

The privacy of your health information is important to us. We are required by federal and state laws to protect the privacy of your health information. We refer to this information as "protected health information," or "PHI". We must give you notice of our legal duties and privacy practices concerning PHI, including:

- We must protect PHI that we have created or received about your past, present, or future health condition, health care we provide to you, or payment for your health care.
- We must notify you about how we protect PHI about you.
- We must explain how, when and why we use and/or disclose PHI about you.
- We may only use and/or disclose PHI as we have described in this Notice.
- We must abide by the terms of this Notice.

We are required to abide by the terms of this Notice. We reserve the right to change the terms of this Notice and to make new notice provisions effective for all PHI that we maintain. We will post a revised notice in our offices, make copies available to you upon request and post the revised notice on our website.

Minnesota Patient Consent for Disclosures

For most disclosures of your health information we are required by State of Minnesota Laws to obtain a written consent from you, unless the disclosure is authorized by Law. This consent may be obtained at the beginning of your treatment, during the first delivery of health care service, or at a later point in your care, when the need arises to disclose your health information to others outside of our organization.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

A. Uses and Disclosures of Your Protected Health Information for Purposes of Treatment, Payment and Health Care Operations.

Health Care Treatment. We may use and disclose PHI about you to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing the delivery of health services with others. For example, we may use and disclose PHI about you when you need a prescription, lab work, an x-ray, or other health care services. In addition, we may use and disclose PHI about you when referring you to another health care provider.

Payment. We may use and disclose your medical information to others to bill and collect payment for the treatment and services provided to you. For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used. Before you receive scheduled services, we may share information about these services with your health plan(s). Sharing information allows us to ask for coverage under your plan or policy and for approval of payment before we provide the services. We may also share portions of your medical information with the following: 1) Billing departments; 2) Collection departments or agencies; 3) Insurance companies, health plans and their agents which provide you coverage; 4) Utilization review personnel that review the care you received to check that it and the costs associated with it were appropriate for your illness or injury; and 5) Consumer reporting agencies (e.g., credit bureaus).

Health Care Operations. We may use and disclose PHI in performing business activities, which we call "health care operations". For example: Members of our staff such as the risk or quality improvement manager, or members

of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Our Business Associates. There are some services provided in our organization through contacts with business associates. Examples include physician services in the Emergency Department and Radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third party payer for services rendered. So that your health information is protected, however, we require the business associate to sign a contract ensuring their commitment to protect your PHI consistent with this Notice and to appropriately safeguard your information.

C. Uses and Disclosures of Your Protected Health Information that Require Your Authorization.

In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization, different from the Minnesota Patient Consent, to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

- *Research:* We may disclose information to external researchers with your authorization, which we will attempt to collect in a manner consistent with applicable state laws.
- *Marketing:* We will not be able to use or disclose your name, contact information or other PHI for purposes of marketing without your written authorization. This does not include informing you about treatment alternatives or other health related products or services that may be of interest to you.

D. Uses and Disclosures of Your Protected Health Information that Require Your Opportunity to Agree or Object.

In the following instances we will provide you the opportunity to agree or object to a use or disclosure of your PHI:

- *Notification:* We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.
- *Communication with Family:* Health professionals, using their best judgement, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

If you would like to object to our use or disclosure of PHI about you in the above circumstances, please call our contact person listed on the cover page of this Notice.

E. Use And Disclosure Authorized by Law that Do Not Require Your Consent, Authorization or Opportunity to Agree or Object.

Under certain circumstances we are authorized to use and disclose your health information without obtaining a consent or authorization from you or giving you the opportunity to agree or object. These include:

- When the use and/or disclosure is authorized or required by law. For example, when a disclosure is required by federal, state or local law or other judicial or administrative proceeding.
- When the use and/or disclosure is necessary for public health activities. For example, we may disclose PHI about you if you have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.
- When the disclosure relates to victims of abuse, neglect or domestic violence.
- When the use and/or disclosure is for health oversight activities. For example, we may disclose PHI about you to a state or federal health oversight agency which is authorized by law to oversee our operations.
- When the disclosure is for judicial and administrative proceedings. For example, we may disclose PHI about you in response to an order of a court or administrative tribunal.
- When the disclosure is for law enforcement purposes. For example, we may disclose PHI about you in order to comply with laws that require the reporting of certain types of wounds or other physical injuries.
- When the use and/or disclosure relates to decedents. For example, we may disclose PHI about you to a coroner or medical examiner, consistent with applicable laws, to carry out their duties.
- When the use and/or disclosure relates to products regulated by the Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.
- When the use and/or disclosure relates to cadaveric organ, eye or tissue donation purposes. Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

- When the use and/or disclosure relates to Worker's Compensation information: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
- When the use and/or disclosure is to avert a serious threat to health or safety. For example, we may disclose PHI about you to prevent or lessen a serious and eminent threat to the health or safety of a person or the public.
- When the use and/or disclosure relates to specialized government functions. For example, we may disclose PHI about you if it relates to military and veterans' activities, national security and intelligence activities, protective services for the President, and medical suitability or determinations of the Department of State.
- When the use and/or disclosure relates to correctional institutions and in other law enforcement custodial situations. For example, in certain circumstances, we may disclose PHI about you to a correctional institution having lawful custody of you.

YOUR INDIVIDUAL RIGHTS

A. Right to Request Restrictions on Uses and Disclosures of PHI.

You have the right to request that we restrict the use and disclosure of PHI about you. We are not required to agree to your requested restrictions. However, even if we agree to your request, in certain situations your restrictions may not be followed. These situations include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, and uses and disclosures described in subsection 4 of the previous section of this Notice. You may request a restriction by submitting your request in writing to us. We will notify you if we are unable to agree to your request.

B. Right to Request Communications via Alternative Means or to Alternative Locations.

Periodically, we will contact you by phone, email, postcard reminders, or other means to the location identified in our records with appointment reminders, results of tests or other health information about you. You have the right to request that we communicate with you through alternative means or to alternative locations. For example, you may request that we contact you at your work address or phone number or by email. While we are not required to agree with your request, we will make efforts to accommodate reasonable requests. You must submit your request in writing.

C. Right to See and Copy PHI.

You have the right to request to see and receive a copy of PHI contained in clinical, billing and other records used to make decisions about you. Your request must be in writing. We may charge you related fees. Instead of providing you with a full copy of the PHI, we may give you a summary or explanation of the PHI about you, if you agree in advance to the form and cost of the summary or explanation. There are certain situations in which we are not required to comply with your request. Under these circumstances, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of our denial.

D. Right to Request Amendment of PHI.

You have the right to request that we make amendments to clinical, financial and other health-related information that we maintain and use to make decisions about you. Your request must be in writing and must explain your reason(s) for the amendment and, when appropriate, provide supporting documentation. We may deny your request if: 1) the information was not created by us (unless you prove the creator of the information is no longer available to amend the record); 2) the information is not part of the records used to make decisions about you; 3) we believe the information is correct and complete; or 4) you would not have the right to see and copy the record as described in paragraph 3 above. We will tell you in writing the reasons for the denial and describe your rights to give us a written statement disagreeing with the denial. If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, including persons you name who have received PHI about you and who need the amendment.

E. Right to Request and Accounting of Disclosures of PHI.

You have the right to a listing of certain disclosures we have made of your PHI. You must request this in writing. You may ask for disclosures made up to six (6) years before the date of your request (not including disclosures made prior to April 14, 2003). The list will include the date of the disclosure, the name (and address, if available) of the person or organization receiving the information, a brief description of the information disclosed, and the purpose of the disclosure. If, under permitted circumstances, PHI about you has been disclosed for certain types of research projects, the list may include different types of information. If you request a list of disclosures more than once in 12 months, we can charge you a reasonable fee.

F. Right to Receive a Copy of This Notice.

You have the right to request and receive a paper copy of this Notice at any time. We will provide a copy of this Notice no later than the date you first receive service from us (except for emergency services or when the first contact is not in person, and then we will provide the Notice to you as soon as possible). We will make this Notice available in electronic form and post it in our web site.

QUESTIONS OR COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact our Privacy Official. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may file a complain with our Privacy Official. You can also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Office Contact Information

Address: 124 Elton hills Lane NW Rochester, MN 55901

Telephone: 507-282-1009

Fax: 507-282-0932

ACKNOWLEDGEMENT OF RECEIPT

My signature below indicates that I have been provided with a copy of the Notice of Privacy Practices.

Signature of Patient/Client or Personal Representative

Date

If signed by personal representative, relationship to patient: _____

Distribution:

- *Original signed to provider*
- *Copy to patient*

Bluestem Center for Child and Family Development Financial Policy

Bluestem considers acceptance of this policy and patient payment a part of the treatment plan.

Patient Financial Responsibility (parent or guardian, if patient is a minor)

The patient is responsible for all service fees. Insurance may cover most/some fees. Normally the patient is responsible for the co-payment (required by an insurance company for a service), services provided that are not covered or not considered medically necessary by the insurance company.

The patient co-payment must be paid at the time of the appointment. Bluestem accepts cash, check or Visa/MasterCard. If the co-payment is not received, you will be asked to reschedule your appointment. A parent or guardian accompanying a minor patient is responsible for the co-payment at the time of the appointment. If a minor is accompanied by an adult other than a parent or guardian, or the minor is unaccompanied; charges may be pre-authorized to an approved credit plan, charged to an existing Visa/MasterCard on file, or paid by cash or check at the time of the appointment.

If the patient insurance coverage changes, it is the patient's responsibility to notify Bluestem. If the new plan is not one Bluestem is not a participating provider, the patient is responsible for the charges applied on the account at the time the insurance change is effective.

Patient Insurance

An insurance policy is a contract between the patient and their insurance company. **Patient insurance information is required to bill the insurance company and must be provided to Bluestem at the time the first appointment is scheduled.** Bluestem will bill the patient's insurance company after each service. If payment from the insurance company is not received after 60 days, the balance will be the patient's responsibility. If an insurance payment is received after patient payment, that amount will be refunded or applied to the patient's account. It is the patient's responsibility to contact their employer or insurer if there are questions.

Missed Appointments

An office fee of \$60.00 may be charged to your account for an appointment that is missed or cancelled within a 24 hour notice. This charge is not payable by insurance and will be the patient's responsibility. (Exceptions: Late cancellation due to illness, bad weather or school closure may not be charged, but it is up to you to notify Bluestem Center of cancellation) Repeated missed appointments or late cancellations may result in termination of services.

Additional Service Charges (usually not covered by insurance)

- Letter to school (IEP, 504 Plan, Child Study Team Evaluation)
- Letter, report, form completion or telephone call to non-medical professional to coordinate care (teacher, social worker, juvenile justice, attorney)
- Copy and/or summary of records the patient requests for other professionals, when not required for patient care (legal services)
- Telephone call lasting longer than 10 minutes
- Record review required for case care and coordination
- Parenting Assessments
- Participation (telephone or in person) in meeting (school, social services, juvenile justice)
- Letter or report required for government service
- Court testimony and reports required for legal proceedings must be discussed in advance and are billed at full hourly fee, including transportation and wait time. A fee estimate may be requested prior to contracting for legal work
- Other requests not listed above may incur a fee; check with Bluestem billing

Finance Charges

- A monthly finance charge of 1.5% will be charged on a balance exceeding 30 days.
- An unpaid account exceeding 90 days will be sent to a collection agency, unless other arrangements have been made with the Bluestem Business Office
- A returned check will incur a \$25.00 service fee

If you have questions concerning charges or billing statements, or need to make payment arrangements, contact the billing office at 507-282-1009. The billing office is open Monday - Friday, 8:00 a.m. - 5:00 p.m.

Patient Information and Policies

This information is designed to assist you in setting up your first appointment, scheduling future appointments, understanding our billing policy, fee and payment schedules, and our after hours services.

ABOUT BLUESTEM CENTER

Bluestem Center is a physician-directed group practice. This means when you or your family member are a patient of one of the professionals at Bluestem, you are a patient of the practice.

You may be referred to meet with a pediatrician, psychologist, nurse, family therapist, social worker, or individual therapist.

We are proud to be recognized as a training center. With your approval, a trainee could observe or be involved in your session.

SCHEDULING AN APPOINTMENT

Initial Appointment – You will be asked to complete questionnaires about your symptoms. Please bring your insurance card to the first appointment. If you have worked with other therapists or doctors in the past, you may be asked to sign a release of information form for each. Both parents/guardians should accompany a child who is a minor to the first appointment.

If special accommodations are required, please inform the receptionist beforehand.

Future Appointments can be scheduled at the office or by calling our office during regular business hours (8 a.m.-5 p.m., Monday-Friday). Appointments for Owatonna can also be made for select providers.

Children – Our practice is designed to meet the needs of children. However, you may find it necessary to have younger children accompany you to the appointment. Please arrange for another adult to come with you to watch the child in the waiting room so you can work with the staff member in privacy.

Cancellation/No Show – We require at least 24 hours advance notice for all cancellations or rescheduling. Bluestem Center reserves the right to bill our regular fee for missed appointments if they are not canceled in advance. The same policy will apply for a “no show” appointment. These charges will be the sole responsibility of the patient or the patient’s guarantor, and are not reimbursable by insurance carriers.

CONFIDENTIALITY

Confidentiality means that information about you and your family is kept private.

Release of Information forms are kept at the front desk if you want us to share information with another professional or agency. We ask you to sign a release if we need to obtain records from another agency.

Questions about confidentiality and how it applies to our work with children are common. Please feel free to discuss any concerns with your child’s therapist.

Patient files are available to all professional staff involved with a patient.

We are required by law to report any episode in which there is a suspicion of abuse. We will discuss this with you if it becomes a concern.

If a patient tells us they plan to harm themselves or someone else, we will take steps to see that people are safe.

We comply with HIPAA.

All information regarding HIPAA can be obtained at the front desk upon request.

FEES

Bluestem Center will provide a statement of our fees upon request. Fees are determined by the complexity of the problem, the type of services provided, the professional training of the staff member, the length of appointment, and who was present.

Some of our services are not covered by insurance carriers. Examples are meetings with school personnel and some assessment tools. You are responsible for payment for services rendered on you or your child's behalf.

You will be notified on your statement if your account is past due. We ask that you contact the office manager and come in for a conference regarding payment of your bill.

If arrangements are not made, and your account remains past due, it will be turned over to a collection agency.

Finance charge of 1.5% monthly will be assessed on all patient accounts that are 30 days past due.

PAYMENT

You are responsible for payment for all services rendered whether or not they are covered by insurance.

Your co-payment is required at the time of the appointment. Your insurance company will be billed before you receive a billing statement of our services. Please keep our office informed if you or your employer changes insurance.

When parents are divorced and jointly liable for medical bills, they sometimes disagree on payment of services. As a general rule, we consider the parent who schedules the appointment and brings the child for the initial evaluation to have contracted for services and will be considered responsible for payment.

If you have concerns about being able to pay for services, please discuss this with the office manager.

LATE PAYMENT

You will be notified on your statement if your account is past due. We ask that you contact the office manager and come in for a conference regarding payment of your bill.

If arrangements are not made, and your account remains past due, it will be turned over to a collection agency.

Finances charges will be assessed on all patient accounts that are 30 days past due. Accounts not paid in full within 30 days are subject to a 1.5% monthly finance charge

AFTER HOURS SERVICE

We provide after hours telephone access for established patients of Bluestem Center.

The office phone (507-282-1009) is forwarded to a staff member's home at 5 p.m. and is forwarded back to the office at 8 a.m. the next morning.

In an emergency, please contact the local emergency room and coordinate with your professional later.