Minnesota CarePartner
393 N Dunlap St. #300 St. Paul, MN 55104
P: 612-289-5656 F: 651-925-0278

Minnesota CarePartner Mental Health Bill of Rights

Client Name:____

Client Date of Birth:____________________________________

Person Signing this form is: ☐ Client ☐ Parent/Guardian

Name of Person Signing this Form:____

As a Minnesota CarePartner client, you have a right to:

- Receive respectful treatment
- Refuse treatment or a particular intervention strategy
- Ask questions at any time
- Know how available the counselor is to see you or what the waiting period is
- Have full information about fees, method of payment, and insurance reimbursement
- Have full information regarding the counselor's qualifications to practice, including licensure or registration, training and experience
- Have full information regarding the counselor's areas of specialization and limitations
- Have full information about the counselor's therapeutic orientation and any technique which is routinely used
- Have full information regarding your diagnosis if your counselor uses one
- Choose a counselor with whom you feel you can work
- Experience a safe setting, free from physical, sexual, or emotional abuse
- Agree to a written contract of counseling goals and treatment plan
- Request that the therapist evaluate the progress of counseling
- The right to be allowed access to records and written information from records in accordance with the State of Minnesota Statutes, section 144.335
- Require the therapist to send a report regarding your therapy with your written authorization
- Confidentiality regarding records and transactions, unless you have signed and authorized, in writing, a release of records, or as otherwise required by law
- Information regarding other services that may be available in the community and the freedom to change provider of service
- Coordinated transfer when there has been a change in provider of services
- To assert the client's rights without retaliation
- Complaints can be made to:
  - Minnesota Board of Social Work 612-617-2100
  - Office of Ombudsman (BHP referrals), 612-296-0382 or 800-657-5391
  - United States Department of Health and Human Services, 877-696-6775

As a recipient of services from a Licensed Marriage and Family Therapist, you have a right:

1. to expect that a therapist has met the minimal qualifications of education, training, and experience required by state law;
2. to examine public records maintained by the Board of Marriage and Family Therapy that contain the credentials of a therapist;
3. to report complaints to the Board of Marriage and Family Therapy;
4. to be informed of the cost of professional services before receiving the services;
5. to privacy as defined and limited by rule and law;
6. to be free from being the object of unlawful discrimination while receiving services;
7. to have access to their records as provided in Minnesota Statutes, sections 144.291 to144.298, except as otherwise provided by law or prior written agreement;
8. and to be free from exploitation for the benefit or advantage of a therapist.

As a recipient of services from a licensee of the Minnesota Board of Behavioral Health and Therapy, you have a right to:

1. expect that the provider meets the minimum qualifications of training and experience required by state law;
2. examine public records maintained by the Board of Behavioral Health and Therapy that contain the credentials of the provider;
3. report complaints to the Board of Behavioral Health and Therapy;
4. be informed of the cost of professional services before receiving the services;
5. privacy as defined and limited by law and rule;
6. be free from being the object of unlawful discrimination while receiving counseling services;
7. have access to their records as provided in sections 144.92 and 148F.135, subdivision 1, except as otherwise provided by law;
8. be free from exploitation for the benefit or advantage of the provider;
9. terminate services at any time, except as otherwise provided by law or court order;
10. know the intended recipients of assessment results;
11. withdraw consent to release assessment results, unless the right is prohibited by law or court order or was waived by prior written agreement;
12. a nontechnical description of assessment procedures; and
13. a nontechnical explanation and interpretation of assessment results, unless this right is prohibited by law or court order or was waived by prior written agreement.

Attestation to Contents of and Orientation to Bill of Rights

☐ **I have read and understand the Mental Health Bill of Rights**

Demographic Information

Client Name:____

Client Date of Birth:____________________________

Person Signing this form is: ☐ Client ☐ Parent/Guardian

Name of Person Signing this Form:________________________________

Age

☐ 0-10 ☐ 11-20 ☐ 21-30 ☐ 31-45 ☐ 46-55 ☐ 55+

How do you identify ethnically?

☐ African-American
☐ Asian-American
☐ Native-American
☐ Latino-Hispanic
☐ Somal
☐ Hmong
☐ Caucasian/White
☐ Multiracial-Other
☐ Prefer not to say

What services are you currently receiving?

☐ Psychotherapy
☐ ARMHS – Adult Skills
☐ CTSS Children's Skills
☐ Rule 25 Assessment
☐ Supervised Visitation
☐ Parenting Assessment
☐ Diagnostic Assessment
☐ Roots Substance Use Treatment
☐ Other Services

Gender:

☐ Female
☐ Male
☐ Non-Binary
☐ Other
☐ Prefer Not to Say

In which county do you reside?

☐ Hennepin
☐ Ramsey
☐ Chisago
☐ Isanti
☐ Dakota
☐ Other

Sexual Orientation:

☐ Heterosexual/Straight
☐ Homosexual/Gay
☐ Bisexual
☐ Other
☐ Prefer Not to Say

Who referred you to us?

☐ Self
☐ Child Protection Social Worker
☐ Mental Health Social Worker
☐ Doctor
☐ Other

What type of insurance do you have?

☐ State Medical Assistance Plan or PMAP ☐ Commercial/Employer ☐ Medicare ☐ No Insurance

Your Privacy Rights

Client Name:____

Client Date of Birth:______________________________

Person Signing this form is: ☐ Client ☐ Parent/Guardian

Name of Person Signing this Form:__________________________________

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

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future mental and/or physical health is referred to as Protected Health Information (PHI). "Protected information" is individually identifiable information. We are committed to protecting the privacy of your health information by complying with applicable federal and state privacy and confidentiality laws. You have privacy rights under the Minnesota Government Data Practices Act, the federal Health Insurance Portability and Accountability Act (HIPAA) and other state and federal laws, rules and regulations. These laws protect your privacy but also allow us to give information about you to others if the law requires or permits it. We are required by law to abide by the terms of this Notice of Privacy Practice and to provide you with this notice. We reserve the right to change the terms of this notice and apply any changes to all present and future information that we collect about you.

This Notice of Privacy Practices describes how we may use or disclose your protected information, with whom that information may be shared, and the safeguards we have in place to protect it. It also describes your rights regarding how you may gain access to and amend your protected information. You have the right to approve or refuse the release of specific information except when the release is required or authorized by law or regulation.

WHY DO WE ASK FOR PRIVATE INFORMATION?

We provide a number of mental health and other services. We may ask you for information so we can:

- tell you from other persons by the same name or similar name,
- determine service eligibility
- make reports, do research, audit, and evaluate our programs,
- collect money for payment
- communicate with insurance companies,
- collect money from the county, state or federal government for help we give you
- coordinate with the county social service agency who contract with us to provide your service

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED INFORMATION

Following are examples of permitted uses and disclosures of your protected information. These examples are not exhaustive. We may tell you before we release your information but are not required to in these instances.

Required Uses and Disclosures

By law, we must disclose your information to you unless it has been determined by a competent medical authority that it would be harmful to you. We must also disclose information to the Minnesota Department of Health and Human Services and the Secretary of the Department of Health and Human Services (DHHS) for investigations or determinations of our compliance with laws on the protection of your information.

Treatment/Services

Treatment is when we provide, coordinate, or manage your health care and other services related to your care. This includes the coordination or management of your care with an allowed third party. An example of treatment would be when we consult with another health care provider, such as your family physician. In emergencies, we will use and disclose your protected information to provide the treatment you require.

Payment

Payment is when we obtain reimbursement from insurance companies or other agencies/counties for your services. Your protected information will be used, as needed, to obtain payment for your services. This may include certain activities the County might undertake before it approves or pays for the services recommended for you such as determining eligibility or coverage for benefits.

Health Care/ Human Services Operations

Operations are activities that relate to the performance and operation of our practice. Examples are quality assessment and improvement activities, program eligibility determination, and care coordination, along with business-related matters such as audits and administrative services, licensing inspections and government regulation requirements, investigations, and financial management of the organization. We may use or disclose, as needed, your protected information to support the daily activities related to health and human services care. We share your protected information with third-party "business associates" who perform various activities (for example; billing, referral sources). The business associates are also required to protect your information.

Required by Law

We may use or disclose your protected information if law or regulation requires the use or disclosure.

Legal Proceedings

We may disclose protected information during any judicial or administrative proceeding in response to a court order or subpoena.

Research

We may disclose your protected information to researchers/evaluators when authorized by law.

EXCEPTIONS TO PRIVACY AND CONFIDENTIALITY

In general, the law protects the privacy of communication between a client and a therapist. We only can release information about your treatment to others if you sign a release of information form. You can revoke any such authorization at any time in writing. However, in the following situations your authorization is not required for us to release information:

- duty to warn a specific other in the case of potential suicide, homicide or threat of imminent, serious harm to another
- duty to report suspicion of abuse or neglect of children or vulnerable adults.
- duty to report pregnant client exposure to cocaine, heroin, phencyclidine, methamphetamine, amphetamine or their derivatives, THC, and abuse of alcohol.
- duty to report the misconduct of mental health or health care professionals.
- duty to release records if subpoenaed by the courts.
- duty to provide legal guardian/parents of minor children access to their child's records. Minor clients can request, in writing, that particular information not be disclosed to parents.

Please discuss any questions or concerns you have about confidentiality with your provider at any time. If you have specific legal questions about the law regarding confidentiality, the exceptions and how it may relate to your situation, please seek formal legal advice from an attorney.

YOUR RIGHTS REGARDING PROTECTED INFORMATION

Right to Inspect and Copy

You may inspect and obtain a copy of your protected information for as long as we are required to maintain it.

This right does not include inspection and copying of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected information that is subject to law that prohibits access to protected information.

Right to Request Restrictions

You may ask us not to use or disclose any part of your protected health information for treatment, payment, or health care operations. In your written request, you must tell us:

- what health information you want restricted,
- what use or disclosure you want to restrict
- to whom you want the restriction to apply,
- an expiration date

If we cannot reasonably accommodate the request, we are not required to agree. If the restriction is mutually agreed upon, we will not use or disclose your protected health information in violation of

that restriction, unless it is needed to provide emergency treatment. You may revoke a previously agreed upon restriction, at any time, in writing.

Right to Request Alternate Communications

You may request that we communicate with you using alternative means or at an alternative location. We will accommodate reasonable requests, when possible.

Right to Request Amendment

If you believe that the information we have about you is incorrect or incomplete, you may request an amendment to your protected information as long as we maintain this information. While we will accept requests for amendment, we are not required to agree to the amendment.

Right to An Accounting of Disclosures

You may request that we provide you with an accounting of the disclosures we have made of your protected health information. This right applies to disclosures made for purposes other than services, treatment, payment or operations as described in this Notice of Privacy Practices. The disclosure must have been made after April 14, 2003, and no more than 6 years prior to the date of request. This right excludes disclosures made to you or others you authorized to receive information regarding your care.

FURTHER QUESTIONS OR COMPLAINTS

If you have any questions about the information we have about you, you may ask a staff person to tell you about it, or talk with your parent, guardian, or case manager.

You can contact Minnesota Care Partner's Privacy Officer Katy Armendariz, CEO, 612.289.5656

You may also contact: Data Privacy Office, MN Dept. of Human Services, 4th Floor, Centennial Building, St. Paul, MN 55155. Phone # 651-297-3173.

ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE

We ask that you sign this form. Our intent is to make you aware of the possible uses and disclosures of your protected information and your privacy rights. If you decline to provide a signed acknowledgment, we will continue to provide you services, and will use and disclose your protected information for treatment, payment, and operations as disclosed in this notice.

Your signature is proof that you have received this form and understand what it says. If you have a guardian, they will be asked to sign for you. This notice about collecting and sharing information about you applies to all contacts we have with you when you are in our program, whether these contacts are in person, on the phone, electronic, or by mail.

Attestation to Review and Understanding of Privacy Rights

- ☐ **I have received and reviewed the privacy rights.**
- ☐ **The privacy rights have been explained to me.**

Minnesota CarePartner Mental Health Services & Financial Agreement

Client Name:____

Client Date of Birth:_________________________________

Person Signing this form is: ☐ Client ☐ Parent/Guardian

Name of Person Signing this Form:______________________________________

A. PERMISSION FOR TREATMENT

I agree to permit employees and interns of Minnesota CarePartner to provide services to me. I understand that Minnesota CarePartner can make no guarantees about the outcome of my treatment, but that I can expect to receive services that are ethical and professional. I understand that Minnesota CarePartner agrees to comply with all privacy laws and respects my right to confidentiality. As a client, I agree to attempt to be honest and to disclose information to assist the MNCP staff in providing appropriate services.

1. I agree to attend scheduled appointments or notify service providers if I need to reschedule an appointment.
2. I agree to participate in required treatment planning.

☐ Under the above conditions, I provide my consent to receive services from Minnesota CarePartner

B. FINANCIAL AGREEMENT

1. I authorize Minnesota CarePartner to correspond with my insurance company as I have indicated, and with any insurance company with which I will be covered in the future to which I will ask Minnesota CarePartner to submit claims. I understand that it is my responsibility to know the benefits and limits of my insurance. I request payment of authorized insurance benefits be made to Minnesota CarePartner for any services furnished to me by any provider employed or contracted by this agency. I authorize Minnesota CarePartner to release to Minnesota Health Care Programs, its agents, or any insurance company, any information needed to process claims, determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize Minnesota CarePartner to release all information necessary to secure the payment.
2. **Insurance claims will be handled as follows:**

   ☐ I do not want Minnesota CarePartner to file claims to my insurance company and I will pay fees in full upon receipt of an invoice for services.

☐ I do not have insurance to cover services performed by Minnesota CarePartner and will pay fees in full upon receipt of an invoice for services or prior to services as required.

☐ Minnesota CarePartner will file claims to the insurance I have indicated and I will pay any balance not paid by insurance. If my insurance is discontinued I will pay fees in full upon receipt of invoice for services.

3. If my insurance company sends me payment for services performed by Minnesota CarePartner and I have not yet paid my balance in full, I will make payment of at least the amount received from insurance within five working days.
4. This form also authorizes the release of any medical information necessary to process this claim. I understand that I am financially responsible for charges not covered by this authorization.
5. I hereby request and authorize direct payment of benefits specified under my policy or any policy paying benefits to: Minnesota CarePartner

Minnesota CarePartner Mental Health Cancellation Agreement

Client Name:____

Client Date of Birth:______________________________

Person Signing this form is: ☐ Client ☐ Parent/Guardian

Name of Person Signing this Form:________________________________

1. Minnesota CarePartner is committed to providing all of our patients with exceptional care. When a service recipient cancels without giving enough notice, they prevent another patient from being seen.
2. Please call your Provider on the day prior to your scheduled appointment to notify them of any changes or cancellations. If arriving late to a scheduled appointment, your late arrival will require that the session end at the scheduled time, meaning your session will unfortunately be shorter.
3. If prior notification is not given, you will be given three opportunities (no call/no show/ late cancellation) before your Provider decides on the continuation of services.

Intake Forms Acknowledgement

Client Name:____

Client Date of Birth:_______________________________

Person Signing this form is: ☐ Client ☐ Parent/Guardian

Name of Person Signing this Form:______________________________

I attest that I have reviewed and understand the forms in this document, as listed below:

- **Minnesota CarePartner Mental Health Bill of Rights**
- **Minnesota CarePartner Privacy Rights**
- **Minnesota CarePartner Mental Health Services and Financial Agreement**
- **Minnesota CarePartner Cancellation Policy**

I agree to the information contained in each form to which I have attached my initial, attestation or signature.

SIGNATURE:

Client or Parent/Guardian: ______________________ **Date:** __________

MNCarePartner Staff: ______________________ **Date:** __________