CLIENT INFORMATION

Welcome

Making the decision to seek behavioral healthcare services is not made easily, and it is our hope that we have provided a comfortable environment where you can receive confidential assistance in resolving the issues for which you are requesting our professional help.

We welcome any feedback you wish to offer regarding your care so we can continue to improve our services to all clients.

Providing quality, caring and confidential services is of primary importance to all of us at LMHC.

Thank you for selecting LMHC to work with you.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

YOUR RIGHTS:

- The right to quality and respectful care, without discrimination, regardless of race, ethnicity, national origin, gender, sexual orientation, religion, personal values, age, disability and economic or veteran status.
- The right to confidential and considerate care, respecting privacy and dignity, in a safe non-threatening environment.
- The right to request transfer to another provider within LMHC.
- The right to consent or refuse services before they are provided.

Copy of Medical Record:

- The right to inspect and receive a paper or electronic copy of PHI (Protected Health Information), as applicable. We will provide a copy or a summary of your health information, usually within 30 days of your request..
- You may see all data about you unless it was developed under a Court Order, or for Social Security, or if a therapist believes that the data may be harmful to you or others. You may have the information explained to you and have corrected any information you believe is incorrect and we find to be incorrect as well. If you consider any information incorrect which we find to be correct, you may still attach your own explanation.
- The right to revoke a consent for release of information by written notice at any time except when legal action prevents revocation (probation, parole, court confinement), or when requested by your insurance company, as the law provides your insurer the right to contest a claim under your policy.

Right to Amend Medical Record:

- The right to amend PHI, as applicable. You can ask us to correct health information about you that you think is incorrect or incomplete. We may say 'no' to your request, but we will notify you within 60 days.

Request Confidential Communication:

- The right to receive confidential communications of PHI, as applicable. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say 'yes' to all reasonable requests

Request to Limit Use/Sharing of TPO:

- The right to request restrictions on certain uses and disclosures of PHI. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may also say ‘no’ if it would affect your care.

List of Those With Whom We’ve Shared Information:

- The right to restrict certain disclosures of PHI to a health plan. If you pay for a service of healthcare item out-of-pocket in full, you can ask us not to share that information for the purpose of payment for our operations with your health insurer. We will say ‘yes’ unless a law requires us to share that information.
- The right to receive an accounting of disclosure of PHI, as applicable. You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and healthcare operations, and certain other disclosures (such as any you asked us to make).

Copy of This Privacy Notice:

- The right to obtain a paper copy of this Notice from LMHC upon request. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.

File A Complaint-Grievance:

- 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. If you feel your rights have been violated in receiving services at LMHC, you are first encouraged to discuss your concerns with your Clinician. If you feel that your concerns are yet unresolved, you may complete a grievance form. Grievance forms will be forwarded to the Program Supervisor to which you will receive a written response. If you continue to feel that your concerns

have not been addressed, you may request the grievance be forwarded to the Regional Operating Officer to which you will also receive a written response. If your concern continues to be unresolved, you may request your grievance be forwarded to the Chief Executive Officer and/or Board of Directors. There will be a response received containing LMHC's official response to this step of the grievance process. While we feel confident that our grievance process will adequately address your concerns, if you feel your concern is still not resolved in a satisfactory manner you may notify:

Minnesota Department of Human Services
Licensing Division
PO Box 64242
St. Paul, MN 55164-0242
Phone: 651-431-6500
Fax: 651-431-7673

US Department of Health and Human Services
For Office of Civil Rights
200 Independence Ave SW
Washington, DC 20201
Phone: 800-368-1019
www.hhs.gov/ocr/privacy/hippa/complaints

YOUR CHOICES:

Request Us Not To Share:

For certain health information, you can tell us your choices about what we share.
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us NOT to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation

We Will Never Share Without Permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes
- MN law also requires consent for most other sharing purposes.
- We do not share your PHI information for fundraising activities.

Our Uses and Disclosures:

We typically use or share your health information in the following ways. We need your consent before we disclose protected health information for treatment, payment and operations purposes, or the disclosure is for a medical emergency and we are unable to obtain your consent due to your condition or the nature of the medical emergency.

- For treatment - we can use your health information and share it with other professionals who are treating you. (example, multidisciplinary team case consultation)
- For Payment - We can use and share your health information to bill and get payment from health plans or other entities. (Examples - determining insurance eligibility or coverage, obtaining prior authorization from an insurance company for a service, or billing an insurance for a service provided).
- For healthcare options - We can use and share your health information to run our practice, improve your care, and contact you when necessary. (example - outcomes, evaluation, or quality assessment activities)
- Substance Use records are covered under a more strict regulation (45 CFR Part 2). You will be required to sign additional documents when receiving care under our Chemical Health Program.*

Public Health and Safety:

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence. (Clinicians are required by law to report even if the information was received in confidence.)
- Preventing or reducing a serious threat to anyone's health or safety

Research:

- We can use or share information for health research, if you do not object and we receive your general written authorization.

Comply With The Law:

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Medical Examiner:

- We can share health information with a coroner and medical examiner when an individual dies. (We need consent to share information with a funeral director.)

Workers' Comp, Law Enforcement and Government:

We can use or share health information about you:

- For Workers' compensation claims
- For law enforcement purposes or with a law enforcement official with your consent, unless required by law. (MN Stat 144.293, subd. 2)
- With health oversight agencies for activities authorized by law,
- For special government functions such as military, national security, and presidential protective services with your consent, unless required by law. (MN.Stat.144.293 subd.2)

Respond to Legal Actions:
Response to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.
    - MN may require a court order
- Your records will be available to the court if you are evaluated by County or District Court Order. If you are involved in any other court action, your records may be subpoenaed. By law, if your records are involved in any investigative action, information about you may be exchanged with the Commissioner of Human Services.

Other State Law:

- We will never share any substance abuse treatment records without your written permission
- If State of Minnesota Data Privacy Laws are more restrictive than HIPAA requirements, state laws will be followed.
- If you are a minor (under 18 years of age), you have the right to request that data about you be kept from your parents. This request must be in writing and both explain the reasons for withholding data from your parents and show that you understand the consequences of doing so. In a few cases, the law permits us to withhold data from your parents without a request from you if the data concerns the treatment of drug abuse or venereal disease, or if you are married.
- At the age of 18, the record becomes the property of the person on whom the data was gathered.

OUR RESPONSIBILITIES:

- To provide non-discriminatory clinical services.
- To provide clinical services in a professional and ethical manner
- To provide a safe environment for their clients and themselves.
- To refer clients to another professional when applicable for appropriate ethical, professional or personal reasons.
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy and security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of This Notice of Privacy Practice

We can change the terms of this notice and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

EFFECTIVE DATE OF NPP NOTICE: 9-13, 3-19, 10-21, 11-22, 1-30-23

Tennessen Warning

The law requires that we inform you that the information you provide will be kept private and that it is used by our staff in determining the best care for you. Without this information, we cannot effectively help you. This information may be reviewed by other professionals at LMHC who may become jointly involved in your care.

Notice to Clients

Your clinician will explain the recommendations for the care you may need. Please feel free to ask whatever questions you may have about these recommendations, including treatment alternatives, possible outcomes and potential side effects. If appropriate treatment is not available at LMHC, your clinician will assist you in locating another community resource to meet your needs. You may be eligible for a fee reduction. Please contact your clinician for details.

It is the policy of LMHC to destroy client records when there has been no contact with the client for a period of ten (10) years. Minor clients' records will be destroyed ten (10) years following the age of 18 when there has been no contact during that time.

Your bill will reflect the time spent with the clinical staff member(s), the professional time required to interpret psychological tests, write reports and progress notes, or consult with others you have authorized us to contact.

Please call the respective LMHC office as soon as you know you may be unable to keep your appointment so that this time may be rescheduled for another client needing care. A minimum of 24-hour notice is required. If repeated appointments are failed without prior notification, special clinical care requirements may be implemented before appointments are re-scheduled with your therapist.

LMHC does not allow any audio or video recording. Services will be terminated following any violation of this standard. A case by case approval may be considered, but must be approved prior to any video or audio recording being done.

Credit Policy

LMHC will file a claim to your insurance if we are provided a copy of your current insurance card and you sign our authorization form at the time of service. If you do not provide us with this information at the time of service, you will be responsible to pay for all charges incurred. We will not file past charges until you provide us with a copy of the card and sign an authorization. Some insurances have a timely filing requirement so it is important to provide us your insurance card and information to meet these requirements. LMHC will

not file claims that have a date past the filing limit for your insurance. You will be asked at each visit to show your insurance card. LMHC requests that you pay all co-pays on the day the service is provided. If you do not pay your copay at the time of the service and it is not paid within 30 days after you receive our statement, we will require payment of that co-pay as well as the current co-pay on your next visit.

LMHC accepts credit card payments.

LMHC requires all balances to be paid by the 20th of the month the statement is received. If the balance in full cannot be paid, payment arrangements must be made with our office. Failure to pay the balance within 90 days or not keeping payment arrangements will result in your account being placed in collection with our collection agency. Once the account has been placed in collection, it is the patient's responsibility to work out details with the said agency. Payments made to LMHC after the account is in collection will be applied to the remaining account balance held at LMHC and secondly to the balance at the collection agency. If your account becomes 90 days past due and no payments are made for 90 days, or your account is turned over to collection; current and future appointments will be suspended until your account is brought to a current status (current status means balance at collection agency is zero).

LMHC is not responsible for knowing your insurance policy. You must obtain this information directly from your insurance company before service is given. All insurance policies are not alike and do not cover all of the same things. We cannot guarantee coverage for your services.

LMHC reserves the right to bill you for any services not covered by insurance. If your insurance states that you have a primary clinic or provider and LMHC is not the primary provider, you will be responsible for contacting your primary provider for a referral and will be responsible for charges not covered by insurance.

Please read carefully before signing below.

Consent For Release of Private Information to Insurer and Assignment of Benefits.

In Connection with treatment received by me at Lakeland Mental Health Center (LMHC), Inc.;

By signing below, I authorize LMHC to release any medical or other information necessary to process claims submitted to my insurance company. I request and authorize payment of medical benefits from either a government or non-government source to LMHC. I understand and agree that I am responsible for payment of any bill that I incur at LMHC which includes co-insurance, deductibles, co-payments and any services not covered by government agencies, intermediaries, insurance companies and third party carriers unless otherwise specified by my insurance company. I am also responsible for any finance charges on the unpaid portion of my account and I will be subject to LMHC's collection policy if my account is not paid in a timely manner. I understand I am required to provide LMHC with a copy of my current insurance card(s) at the time of each service. Insurances have a timely filing requirement so it is important to provide a current insurance card(s) and information on the date of service to help meet these requirements. LMHC does not file claims that have a date past the filing time limit and I understand that I am responsible for any claims if I have failed to provide accurate and timely information. I understand that I may be seen by a provider who is not credentialed for my insurance and that this provider will be supervised. Billing will be submitted to my insurance under that credentialed supervisor. I understand that I need to communicate and work with my insurance company(s) to be able to utilize my insurance policies. If my insurance policy will not process my claims due to information on my part I have not given them, I am responsible for the cost of services. This consent for release of private information to an insurer and assignment of benefits will automatically expire one year from the date signed below.

I certify that I have read and understand the information above regarding billing practices as well as the privacy and confidentiality of my medical information.

_____ _____

Client Name (PRINT) Client ID

_____ _____

Client Signature Date

_____

Parent/Legal Guardian (PRINT)

_____ _____

Parent/Legal Guardian Signature Date