Therapist: _____ Diagnosis Code: _____

COUPLES INTAKE FORM

❑ Married _____ years ❑ Living together _____ years ❑ Separated _____ months

PARTNER 1'S INFORMATION

Name: _____
Birth Date: _____ /_____ /_____ Age: _____
Address: _____
_____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Permission to leave message at: Home / Work / Cell
E-mail: _____
Employer: _____
Emergency Contact: _____
Emergency Phone: _____
Previous Counseling: ❑ Yes ❑ No # Therapists: _____
Length of Individual: _____ : Length of Couples: _____
Previous Therapist's Name: _____
Previous Therapist's Name: _____
Number of Previous Marriages: _____

PARTNER 2'S INFORMATION

Name: _____
Birth Date: _____ /_____ /_____ Age: _____
Address: _____
_____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Permission to leave message at: Home / Work / Cell
E-mail: _____
Employer: _____
Emergency Contact: _____
Emergency Phone: _____
Previous Counseling: ❑ Yes ❑ No # Therapists: _____
Length of Individual: _____ : Length of Couples: _____
Previous Therapist's Name: _____
Previous Therapist's Name: _____
Number of Previous Marriages: _____

Child's Name: _____ Age: _____ ❑ Partner 1 ❑ Partner 2 ❑ Adopted
Child's Name: _____ Age: _____ ❑ Partner 1 ❑ Partner 2 ❑ Adopted
Child's Name: _____ Age: _____ ❑ Partner 1 ❑ Partner 2 ❑ Adopted
Child's Name: _____ Age: _____ ❑ Partner 1 ❑ Partner 2 ❑ Adopted
Child's Name: _____ Age: _____ ❑ Partner 1 ❑ Partner 2 ❑ Adopted
Child's Name: _____ Age: _____ ❑ Partner 1 ❑ Partner 2 ❑ Adopted
Child's Name: _____ Age: _____ ❑ Partner 1 ❑ Partner 2 ❑ Adopted

Are you currently receiving psychiatric services: Partner 1 - ❑ Yes ❑ No Partner 2 - ❑ Yes ❑ No
MD's Name: Partner 1 _____ Partner 2 _____
How did you hear about Stable Living: _____
Referred by: _____

TO BE COMPLETED BY PARTNER 1

PARTNER 1'S OCCUPATIONAL INFORMATION

Are you currently employed: ❑ Yes ❑ No If no, how long have you been out of work: _____

If yes, current employer/position: _____

If yes, are you happy at your current position: _____ Any stressors: _____

_____

PARTNER 1'S HEALTH AND SOCIAL INFORMATION

How is your physical health at present: ❑ Poor ❑ Unsatisfactory ❑ Satisfactory ❑ Good ❑ Very good

List any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc):

_____

List any current emotional stressors (e.g. loss, grief, relocation, financial, difficult family member, etc):

_____

Are you having trouble sleeping: ❑ Yes ❑ No

If yes, check where applicable: ❑ Too little ❑ Too much ❑ Poor quality ❑ Disturbing dreams ❑ Other

How many times per week do you exercise: _____ Approximately how long each time: _____

Difficulty with appetite or eating habits: ❑ Yes ❑ No ❑ Eating less ❑ Eating more ❑ Binging ❑ Restricting

Have you experienced significant weight changes in the last 2 months: ❑ Yes ❑ No

Do you regularly use alcohol: ❑ Yes ❑ No

In a typical month, how often do you have 4 or more drinks in a 24-hour period: _____

How often do you engage in recreational drug use: ❑ Daily ❑ Weekly ❑ Monthly ❑ Rarely ❑ Never

Has anyone told you they were concerned about your alcohol/drug use: ❑ Yes ❑ No

Have you had suicidal thoughts recently: ❑ Frequently ❑ Sometimes ❑ Rarely ❑ Never

Have you had them in the past: ❑ Yes ❑ No If yes, have you attempted: ❑ Yes ❑ No

Currently taking prescribed psychiatric medication (antidepressants or others): q Yes q No

If Yes, please list: _____

If no, have you been previously: ❑ Yes ❑ No If yes, please list: _____

On a scale of 1-10 (with 10 high), how would you rate the quality of your current relationship: _____

PARTNER 1'S MENTAL HEALTH HISTORY

In the last year, what significant life changes or stressors have you experienced: _____

_____

_____

HAVE YOU EVER EXPERIENCED:

❑ Yes ❑ No Extreme Depressed Mood
❑ Yes ❑ No Wild Mood Swings
❑ Yes ❑ No Rapid Speech
❑ Yes ❑ No Extreme Anxiety
❑ Yes ❑ No Panic Attacks
❑ Yes ❑ No Phobias
❑ Yes ❑ No Sleep Disturbances
❑ Yes ❑ No Hallucinations
❑ Yes ❑ No Unexplained Losses of Time/Memory Lapses
❑ Yes ❑ No Chronic Pain
❑ Yes ❑ No Alcohol/Substance Abuse
❑ Yes ❑ No Frequent Body Complaints
❑ Yes ❑ No Eating Disorder
❑ Yes ❑ No Body Image Problems
❑ Yes ❑ No Repetitive Thoughts (e.g. obsessions)
❑ Yes ❑ No Repetitive Behaviors(e.g., frequent checking, hand washing, etc.)
❑ Yes ❑ No Homicidal Thoughts
❑ Yes ❑ No Suicide Attempt

PARTNER 1'S FAMILY MENTAL HEALTH HISTORY

Have immediate family members or relatives experienced difficulties with the following: If yes, please list relationship:

❑ Yes ❑ No Difficult Family Member _____
❑ Yes ❑ No Depression _____
❑ Yes ❑ No Bipolar Disorder _____
❑ Yes ❑ No Anxiety Disorders _____
❑ Yes ❑ No Panic Attacks _____
❑ Yes ❑ No Schizophrenia _____
❑ Yes ❑ No Alcohol/Substance Abuse _____
❑ Yes ❑ No Eating Disorders _____
❑ Yes ❑ No Learning Disabilities _____
❑ Yes ❑ No Trauma History _____
❑ Yes ❑ No Suicide Attempts _____

PARTNER 1'S RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious: ❑ Yes ❑ No If yes, what is your faith: _____
If no, do you consider yourself to be spiritual: ❑ Yes ❑ No

PARTNER 1'S OTHER INFORMATION

What are effective coping strategies that you've learned: _____

What are your strengths: _____

Brief description of your experience growing up (relationship with parents/siblings, sexual or physical abuse, etc:

Is there anything else you'd like me to know: _____

I have received, read and understand the Counseling Agreement and the Notice of Privacy Rights. I authorize the release of the minimum amount necessary of my personal health information to the above referenced insurance company, and Healing Lives, LLC's billing company in order to obtain payment for services received.

Partner 1's Signature: _____ Date: _____

Therapist: _____ Diagnosis Code: _____

PARTNER 1'S TREATMENT GOALS

Please complete form as best you can. If you are unsure of your answers, bring your questions in and your therapist will help you form goals and estimate timeline.

Issues (Why I'm here): _____

_____

_____

_____

_____

Goals (What I want): _____

_____

_____

_____

_____

_____

_____

_____

_____

Indicators (How do I know that I'm making progress): _____

_____

_____

_____

_____

Estimate – Time to achieve goals: _____ (You and your therapist will determine this together)

Likelihood (0-100%) of achieving goals: _____ (You and your therapist will determine this together)

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

Review Dates: _____

TO BE COMPLETED BY PARTNER 2

PARTNER 2'S OCCUPATIONAL INFORMATION

Are you currently employed: ❑ Yes ❑ No If no, how long have you been out of work: _____

If yes, current employer/position: _____

If yes, are you happy at your current position: _____ Any stressors: _____

_____

PARTNER 2'S HEALTH AND SOCIAL INFORMATION

How is your physical health at present: ❑ Poor ❑ Unsatisfactory ❑ Satisfactory ❑ Good ❑ Very good

List any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc):

_____

List any current emtional stressors (e.g. loss, grief, relocation, financial, difficult family member, etc):

_____

Are you having trouble sleeping: ❑ Yes ❑ No

If yes, check where applicable: ❑ Too little ❑ Too much ❑ Poor quality ❑ Disturbing dreams ❑ Other

How many times per week do you exercise: _____ Approximately how long each time: _____

Difficulty with appetite or eating habits: ❑ Yes ❑ No ❑ Eating less ❑ Eating more ❑ Binging ❑ Restricting

Have you experienced significant weight changes in the last 2 months: ❑ Yes ❑ No

Do you regularly use alcohol: ❑ Yes ❑ No

In a typical month, how often do you have 4 or more drinks in a 24-hour period: _____

How often do you engage in recreational drug use: ❑ Daily ❑ Weekly ❑ Monthly ❑ Rarely ❑ Never

Has anyone told you they were concerned about your alcohol/drug use: ❑ Yes ❑ No

Have you had suicidal thoughts recently: ❑ Frequently ❑ Sometimes ❑ Rarely ❑ Never

Have you had them in the past: ❑ Yes ❑ No If yes, have you attempted: ❑ Yes ❑ No

Currently taking prescribed psychiatric medication (antidepressants or others): q Yes q No

If Yes, please list: _____

If no, have you been previously: ❑ Yes ❑ No If yes, please list: _____

On a scale of 1-10 (with 10 high), how would you rate the quality of your current relationship: _____

PARTNER 2'S MENTAL HEALTH HISTORY

In the last year, what significant life changes or stressors have you experienced: _____

_____

_____

HAVE YOU EVER EXPERIENCED:

❑ Yes ❑ No Extreme Depressed Mood
❑ Yes ❑ No Wild Mood Swings
❑ Yes ❑ No Rapid Speech
❑ Yes ❑ No Extreme Anxiety
❑ Yes ❑ No Panic Attacks
❑ Yes ❑ No Phobias
❑ Yes ❑ No Sleep Disturbances
❑ Yes ❑ No Hallucinations
❑ Yes ❑ No Unexplained Losses of Time/Memory Lapses
❑ Yes ❑ No Chronic Pain
❑ Yes ❑ No Alcohol/Substance Abuse
❑ Yes ❑ No Frequent Body Complaints
❑ Yes ❑ No Eating Disorder
❑ Yes ❑ No Body Image Problems
❑ Yes ❑ No Repetitive Thoughts (e.g. obsessions)
❑ Yes ❑ No Repetitive Behaviors(e.g., frequent checking, hand washing, etc.)
❑ Yes ❑ No Homicidal Thoughts
❑ Yes ❑ No Suicide Attempt

PARTNER 2'S FAMILY MENTAL HEALTH HISTORY

Have immediate family members or relatives experienced difficulties with the following: If yes, please list relationship:

❑ Yes ❑ No Difficult Family Member _____
❑ Yes ❑ No Depression _____
❑ Yes ❑ No Bipolar Disorder _____
❑ Yes ❑ No Anxiety Disorders _____
❑ Yes ❑ No Panic Attacks _____
❑ Yes ❑ No Schizophrenia _____
❑ Yes ❑ No Alcohol/Substance Abuse _____
❑ Yes ❑ No Eating Disorders _____
❑ Yes ❑ No Learning Disabilities _____
❑ Yes ❑ No Trauma History _____
❑ Yes ❑ No Suicide Attempts _____

PARTNER 2'S RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious: ❑ Yes ❑ No If yes, what is your faith: _____
If no, do you consider yourself to be spiritual: ❑ Yes ❑ No

PARTNER 2'S OTHER INFORMATION

What are effective coping strategies that you've learned: _____

What are your strengths: _____

Brief description of your experience growing up (relationship with parents/siblings, sexual or physical abuse, etc):

Is there anything else you'd like me to know: _____

I have received, read and understand the Counseling Agreement and the Notice of Privacy Rights. I authorize the release of the minimum amount necessary of my personal health information to the above referenced insurance company, and Healing Lives, LLC's billing company in order to obtain payment for services received.

Partner 2's Signature: _____ Date: _____

Therapist: _____ Diagnosis Code: _____

PARTNER 2'S TREATMENT GOALS

Please complete form as best you can. If you are unsure of your answers, bring your questions in and your therapist will help you form goals and estimate timeline.

Issues (Why I'm here): _____

_____

_____

_____

_____

Goals (What I want): _____

_____

_____

_____

_____

_____

_____

_____

_____

Indicators (How do I know that I'm making progress): _____

_____

_____

_____

_____

Estimate – Time to achieve goals: _____ (You and your therapist will determine this together)

Likelihood (0-100%) of achieving goals: _____ (You and your therapist will determine this together)

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

Review Dates: _____

FEE POLICY

Client: _____ Date: _____

Fee Scedule: A fee of $_____ per 55 minute session (or applicable copay if utilizing health insurance) is payable at the beginning of each session. Missed appointments or late cancellation fee of $_____ will be charged for each missed appointment or appointments cancelled with less than a 24-hour notice.

- ***The client is fully and directly responsible to check with their insurance company to determine their benefits for mental health coverage and verify that this Healing Lives therapist, is an in-network provider under their policy. The client agrees that they are fully and directly responsible to Healing Lives, LLC, for the payment of services rendered with or without insurance coverage.***
- ***The client is fully and directly responsible for additional fees which may be charged for psychological testing or phone consultation as discussed prior to testing or consulting.***
- ***The client is fully and directly responsible to pay for missed appointments or appointments cancelled with less than a 24-hour notice (except in cases of illness, emergency or severe weather).***
- ***The client is fully and directly responsible for overdue payments which will be assessed at a 5% monthly interest fee.***
- ***If fees change during the course of treatment, client will be given adequate notice of these changes.***

Please initial:

_____ ***All Clients:*** I understand agree to the current fee schedule above and my responsibility for payment of fees according to the above bullet points.

_____ ***Fee-for-Service Clients:*** I will be paying for services out-of-pocket and will not be utilizing my insurance company or be given a diagnosis at this time. I would like a receipt of payment and understand that payment is due at time of service.

_____ ***Out-of-Network Clients:*** I will be utilizing my out-of-network benefits with my insurance company and will be given a dianosis. I would like a receipt to send to my insurance company for reimbursement. I understand that payment is due at time of service and that I will file my own claims for reimbursement with my insurance company.

_____ ***In-Network Clients:*** I have verified that my therapist is an in- network provider with my insurance company and understand that I will be given a dianosis. I also understand that benefits do not guarantee payment and that I will be responsible for payment if the insurance company doe. I give my permission for my therapist and their business office, Professional Services Consultants, LLC to contact my insurance company. It is my responsibility to supply and keep up-to-date the current and accurate information for insurance and patient billing purposes, which may include, but not limited to: my legal name, correct postal mailing address, phone number(s), and insurance policy/identification number, group or policy number for insurance(s). . Healing Lives, LLC cannot guarantee the outcome of payment by the insurance company. Insurance companies determine eligibility for behavioral health treatment based on medical necessity. Initial and ongoing authorization of treatment. Even under stress or time constraints, it is extremely important to understand benefit limitations and any other insurance company requirements.

Insurance Company: _____ Employer: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____ /_____ /_____ Relationship to Client: _____

ID #: _____ Group #: _____

I hereby authorize Healing Lives, LLC to furnish the above named Insurance Company all information that said insurance company, may request concerning my present condition/illness. I hereby assign to Healing Lives, LLC insurance proceeds to be credited against total fee for service due on my account wit Healing Lives, LLC and will pay my portion of charges incurred as indicated by my insurance company. I hereby verify that all information supplied above is current and accurate. I have been given a copy of the current fee policy and understand that I will be responsible for all fees as indicated on the current fee schedule and as outlined on this payment contract. I am also aware that I may be charged a late cancel/no show charge.

Client Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

CREDIT CARD AUTHORIZATION

THIS FORM MUST BE COMPLETED BY ALL CLIENTS BEFORE SESSIONS BEGIN

This form certifies that I, _____,
request Professional Services Consultants, LLC (PSC) and/or Healing Lives, LLC to bill the below listed credit card of mine for all co-insurance for visits that have processed through insurance and appear on the statement for the current month. It also gives permission to charge my credit card for the $125 Missed Appointments/Late Cancel Fee on the day of Missed Appointment/Late Cancel session.

I further understand that I retain the right to revoke this authorization, if done so in writing and sent certified/receipt requested mail to PSC at the address below:

Professional Services Consultans, LLC
7650 Currell Boulevard, Suite 110
Woodbury, MN 55125
Phone: 651-738-8561
Fax: 651-730-6657

Type of Credit Card ❍ Visa ❍ Mastercard ❍ American Express ❍ Discover

Credit Card Number: _____

Expiration Date: _____

CSC Code: _____

Billing Zip Code: _____

Name on Card: _____

Phone Number: _____

Card Holder Signature: _____

COUNSELING AGREEMENT

This agreement is designed to help build a positive working relationship between you and your therapist. It also informs you of your rights and responsibilities in the therapy relationship. If you have any questions or concerns, please feel free to discuss them with your therapist.

1. Therapeutic Relationship

The relationship between you and your therapist is very important and is different from other relationships in your life. You are able to talk freely and openly about yourself, more than you might do in social relationships. Your therapist's responsibility is to listen, select, sort, make observations, and reflect back to you behaviors, thoughts, feelings, and values or beliefs that will enable you to understand and see yourself more clearly. The goal of this process is to gain more insight and understanding and increase adaptive thoughts, feelings, and behaviors that increase your wellbeing. This does not predict, nor guarantee, a successful outcome in therapy. While your therapist may suggest changes, only you can choose if those changes are valuable and pertinent, and only you are able to make those changes.

You and your therapist will work together to establish treatment goals for therapy that are meaningful to you. As you work towards your goals, some people can experience therapy as an intense or, at times, painful experience. This anxiety begins to reduce as the relationship between you and your therapist develops, trust builds and understanding is gained. This is not unusual in the healing process. Fortunately, most people find therapy to be a very rewarding and positive experience with life changing outcomes.

2. Appointments

Appointments are typically 55 minutes in length. You and your therapist will work together to personalize a schedule to fit your needs.

3. Cancellation Policy

If you need to cancel an appointment for any reason, it is necessary to notify your therapist via phone or email at least 24 hours in advance. You will be charged $_____ for appointments not canceled within 24 hours of scheduled session.

4. Confidentiality

Client information is kept strictly confidential and the release of information about you to anyone can only be done with your written consent. Because therapists are all mandated reporters, state law, however, places certain limitations on the right of confidentiality (see also Notice of Privacy Rights):

- *Threats of suicide*
- *Threats of harming another person*
- *Any incidence or knowledge of suspected neglect, physical, or sexual abuse of children and/or vulnerable adults*

During professional consultation, the therapist may discuss facts in a case, but the identity of the client will remain confidential.

When meeting as couples and/or families, it may be helpful to meet with your therapist individually. If individual sessions are scheduled, no confidences will be held by the therapist. Your therapist reserves the right to use his/her best judgment to share pertinent information, or will ask the individual to share the information, in the best interest of the marriage or family.

For couples and families, in order for information to be shared between a therapist at Stable Living and another individual, we require a signed release of information from both or all parties.

When children are being seen by a therapist, the custodial parent(s) will be informed of their child's progress for children under 18 years of age.

Confidentiality can not be guaranteed by Stable Living LLC if client chooses to correspond using unsecure internet email.

5. Fees

Payment of fees is expected at the time of each session. You may use cash, check, credit card or money order. Insurance coverages differ, so please check with your insurance company to determine the requirements for mental health coverage. A receipt will be provided which can be submitted by the client. Your fee per 55-minute session will be billed to health insurance at the rate of $190 for Intake and followup sessions at the rate of $175. Overdue payments will be assessed a $5.00 fee for each month the payment is overdue. Additional fees will be charged for psychological testing and there is a charge for written reports of files based on an hourly fee structure. We will give you a 30-day notice if fees change. In court cases, we encourage information to be passed on to lawyers and the court through written reports at our hourly fee rate. If we are asked to do a deposition or appear in court, our fees are $350 per hour plus a mileage fee of $.75 per mile.

6. Hours & Emergencies

After normal business hours, you will receive our voicemail system where you can leave messages. This voicemail system is available 24 hours a day and messages are retrieved regularly throughout the weekdays. If you need immediate assistance, please call:

- *211 (or 1-800-543-7709; 24-hour help to connect you to resources)*
- *Hennepin County Crisis Center at 612.347.3161*
- *Crisis Connection at 612-379-6363 (or 1-866-379-6363; 24-hour crisis counseling and suicide hotline)*
- *911, or go to the nearest hospital emergency room.*

7. Healing Lives, LLC

Healing Lives, LLC is a limited liability corporation. Therapists working under the name are contracted therapists who are covered individually with their own private liability insurance. If you have questions about Healing Lives, LLC, please contact Kathy Boisjoli, MA, LPCC, President at 651-315-5254 or kathy@healinglivescounseling.com or contact your therapist directly with questions or concerns.

8. Complaints

You are urged to discuss with your therapist any questions, concerns, or problems you may have about the therapy you receive. Often times, part of the therapeutic relationship involves working through misunderstandings or misconceptions. You also have the right to file a complaint with: Kathy Boisjoli, MA, President, 6600 France Ave S., Suite 418, Edina, MN 55435, 651-315-5254 and Minnesota Department of Health, 121 East 7th Street, St. Paul, MN 55101, 612.623.5522.

9. Therapy Session

An important aspect of therapy is the relationship that develops between you and your therapist. As with any new relationship, it takes some time to trust and feel safe. If the relationship does not develop after a reasonable amount of time (three to four sessions), you may want to talk with your therapist about it and a referral can be made. Your therapist will be happy to help with this.

The therapeutic relationship is unique in that you will be focusing on aspects of yourself that may not ordinarily receive attention. The therapeutic approach used by the therapist comes from a variety of psychological theories. As each client is different, each session varies depending on the needs of the client and the goals set by the client and therapist.

The therapist will work with the client towards healthy development, meaningful and satisfying relationships, and address conflict between mind, body, and spirit. The intention is to address relationship issues, behavioral problems, family-of-origin concerns, destructive thought patterns, trauma and/or spiritual issues. Core values and beliefs are identified and based on the issues of concern your therapist will help with insight and observations where needed. Your therapist will strive towards a safe environment in which clients can talk freely and openly about their concerns.

Therapy is a process. Initially you may feel uncomfortable, even anxious, talking about sensitive issues. Again, this anxiety begins to reduce as the relationship between you and your therapist develops and trust builds. As you learn new ways to interact with yourself and others, these new ways to interact may feel uncomfortable. Sometimes things seem to get worse before they get better. This is expected and typical of everyone making life adjustments.

One of the most growth-producing times for the client can be when he/she expresses anger with the therapist. This expression of "owning" one's feelings and having the therapist respect them often results in a very affirming experience for the client. Your therapist is open to hearing about your concerns and feelings.

It is critical to stay with the therapy even during these uncomfortable times. Once you get through this phase, and as we discuss the emotions around these issues, you should begin to feel more comfortable. During this stage, you will continue to apply the new skills and you will feel more courageous in meeting problems directly. As you near the end of therapy, you and your therapist will discuss discontinuing the therapy, with the understanding that you can choose to return any time if you feel the need.

10. Therapy Techniques

Each therapist at SHealing Lives, LLC uses a combination of psychotherapy techniques. If you have questions, please ask your therapist directly and he/she can explain things more thoroughly.

Cognitive Behavioral Therapy (CBT) is what many know as therapy addressing negative thoughts, feelings and behavior. Several therapists are trained in CBT as well as Eye Movement Desensitization and Reprocessing (EMDR) and Equine-Assisted Psychotherapy (EAP). These approaches are helpful when addressing trauma, abuse, post-traumatic stress disorder, anxiety and depression, to name a few. When using either EMDR or EAP, your therapist will outline how the therapy helps, if you are a good candidate for it, and you will be given the option to participate. For a thorough explanation of EMDR, visit the EMDR.com website. For a more thorough explanation of EAP, visit naturallifemanship.com to better understand Trauma-Focused Equine-Assisted Psychotherapy (TF-EAP).

Healing Lives, LLC • www.healinglivescounseling.com • Phone 651.315.5254 •

PRIVACY POLICY

The privacy of your medical information is important to us, with the understanding that this information is personal. Therefore, we are committed to protecting it. To comply with certain legal requirements, Stable Living, LLC creates a record of the care and services each individual receives to better provide you with quality care. This notice details the ways we may use and share medical information about you. Furthermore, we describe your rights and certain duties we have regarding the use and disclosure of medical information. This notice is effective January 1, 2017.

1. *Uses of Information Obtained From You: The information we obtain from you is used to establish diagnosis, determine your treatment plans and goals, provide the services you request, and establish your ability to pay for these services.*
2. *Our Legal Responsibility: The law requires us to keep your medical information private, give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information, and to follow the terms of the notice that is now in effect.*
3. *Patient Rights: Effective April 14, 2003, the 45 CFR Health Insurance Portability and Accountability Act (HIPAA) went into effect with rules on not only disclosure but also on the use of patient information. Under this Act clients, must be given a Notice of Privacy Practices upon the arrival of their first service. The following list of rights now apply to any patient of a health care provider:*
   a) *Right to Request Medical Records: The patient has a right to access their medical records.*
   b) *Right to Request Additional Restrictions: You may request restrictions on our use and disclosure of protected health information for treatment, payment, and health care operations. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction. If you wish to request a restriction, please make a request in writing and submit it to your therapist. We will send you a written response.*
   c) *Right to Receive Confidential Communications: You may request, and we will accommodate, any reasonable (written) request for you to receive protected health information by alternative means of communication or at alternative locations.*
   d) *Right to Inspect and Copy Your Health Information: If you desire access to your records, please make a written request to your therapist. If you request copies, there will be a $2.00 charge per page. Please note, under limited circumstances we may deny you access to a portion of your records.*
   e) *Right to Amend Your Records: You have the right to request that we amend protected health information maintained in your clinical file or billing records. If you desire to amend your records, please request in writing the amendment and submit it to your therapist. Under certain circumstances, we have the right to request to amend your records and notify you of this denial as provided by the HIPAA regulations. If your requested amendment to your records is accepted, a copy of your amendment will become a permanent part of the medical record. By "amend," your therapist is permitted to append information to the original record, as opposed to physically remove or change the original record.*
   f) *Right to Receive an Accounting of Disclosures: Upon request, you may obtain an accounting of disclosures of your protected health information other than those for which you gave written authorization or those related to your treatment, payment for services, or health care operations. The accounting will apply only to covered disclosures prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, a charge may apply. You will be informed of the cost prior to the request being filled.*
   g) *Right to Receive a Paper Copy of this Notice: Upon request, you may obtain a paper copy of this privacy notice.*
4. *Use and Disclosure of Your Medical Information With Written Consent: We are permitted to use and disclose information about you for treatment and/or services to doctors, nurses, psychiatrists, psychologists, other mental health professionals. Also included are other people in charge of your care or health care professionals assisting in your treatment. We may also use and disclose your medical information for payment purposes to insurance companies for disability payments, etc. Furthermore, we may also use information for healthcare operations that may include information disclosed to business associates such as billing software providers or transcriptionists.*
5. *Use and Disclosures Without Neither Consent Nor Authorization: According to state and federal requirements, we are mandated to report information we maintain about you to other agencies or individuals without your written consent under the following circumstances:*
   a) *If we have reason to believe there has been:*
   • abuse of a child or vulnerable adult. • victimization due to violence. • victimization due to other crimes. • potential or intention to seriously harm another person, we may have a legal obligation to warn the intended victim and/or the police. • the possibility a pregnant woman has used a controlled substance (e.g., cocaine, heroin) for a non-medical purpose during the pregnancy.
   b) *If it is court-ordered.*
   c) *If a non-custodial parent requests information, they may receive information about our services for their child, but not about services to the other parent.*
   d) *If there is an emergency, we may communicate your condition to a family member or other appropriate persons.*
   e) *If your account is delinquent, we may attempt to obtain reimbursement through small claims court or to collection agency. We may also report delinquent accounts to credit bureaus.*
   f) *Examination of records for an audit or accreditation.*
   g) *To meet federal, state, and local statistical requirements.*
   h) *If a new statute, federal law, or State Commissioner of Administration authorizes a new use of the information after you had been given this notice.*
6. *Regarding Minors: Minnesota State Law authorizes that a minor has the right to request the private data about them be kept from their parents. This request will be honored if we believe it will protect the child from physical or psychological harm.*
7. *Providing Information About You: You are not required to provide information about yourself; however, without some information we may not be able to provide the most appropriate services. If you are here because of a court order, and you refuse to provide information, that refusal may be communicated to the court.*
8. *Right to Change Terms of this Notice: We may change the terms of this notice at any time. If we change this notice, we may make the new notice terms effective for all protected health information that we maintain, including any information created or received prior to issuing the new notice. If we change this notice, we will post it in public access areas, or give you a copy of the updated notice.*
9. *Complaints: If you desire further information about your privacy and confidentiality rights, or are concerned that we have violated these rights, or disagree with a decision that we made about access to your protected health information, you may contact your therapist or Kathy Boisjoli, LPCC, Healing Lives, LLC, President at 651.315.5254. You may also file a written letter of complaint with the Secretary of the Department of Health and Human Services. We will not retaliate against you if you file a complaint.*