Today's Date: _____
First Name: _____ Last Name: _____
Date of Birth: _____/_____/_____ Client ID: _____

Hiawatha Valley
MENTAL HEALTH CENTER

APPOINTMENT REMINDERS

Would you like to receive appointment reminders from HVMHC, or its representative? ☐ Yes ☐ No

If yes, preferred method of reminder: ☐ Telephone call reminder Phone #: _____-_____-_____cell / home

☐ Text message reminder Cell #: _____-_____- _____

SCHEDULING APPOINTMENTS

Can someone make arrangements for appointments on your behalf? ☐ Yes ☐ No

If yes, who? _____

VERBAL COMMUNICATION CONSENT

☐ Yes, I authorize HVMHC, or its representative to contact me regarding my care (e.g. appointment times, changes, reminders & messages left regarding your care)

☐ Home: _____ ☐ Cell: _____

☐ Decline

COORDINATION OF CARE with your HEALTH CARE PROVIDER

☐ Yes, I authorize HVMHC staff to contact my health care provider about my care at HVMHC.

Name of health care provider:_____

Address and phone number, if known: _____

☐ Decline

By signing, I acknowledge I have read and understand all of the above.

X_____ _____ X_____/_____/_____

Client or Parent/Legal Guardian Signature (18 years or older -Minn. Stat. §645.451) | Relationship to client, if applicable | Date

PLEASE CONTINUE TO NEXT PAGE

TEXTING INFORMED CONSENT

I authorize HVMHC, or its representative, to text message me regarding my care at the cell phone number listed below. I understand that standard text messaging rates may apply. I understand that this information is only as secure as I keep my phone. This means that if my phone is lost or stolen, and the messages received from HVMHC were not deleted, others may have access to the information contained in those messages. I understand that messages sent to my provider are not encrypted and there is a risk that those messages can be intercepted. I understand that messages sent to my provider will be documented in my electronic medical record. I am willing to accept these risks and to not hold HVMHC liable if such an instance would occur. I agree to use this method of communication on a limited basis and to keep all communication professional. If this use of communication is abused, HVMHC can decide to discontinue this type of communication. I understand that if I later choose to not be contacted in this manner, I will need to notify HVMHC in writing.

☐ Yes, I authorize to have text messages sent to the following cell phone number _____

☐ Decline

COMMITMENT to CARE CONSENT

Clients are responsible for all appointments scheduled. Should you need to cancel or reschedule an appointment, please notify our agency at least 24 hours in advance of your appointment. Additionally, if you 'No-Show' for THREE appointments with your therapist within a year, you will no longer be able to make appointments in advance. Instead, you will only be allowed to schedule an appointment on the same day that you call for one, subject to therapist availability. If you have questions about this or have difficulty remembering your appointments, please discuss this with your therapist. Cancellations for emergency circumstances will be taken into consideration.

☐ I hereby acknowledge that I have reviewed, and understand the Commitment to Care Consent

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TENNESSEN NOTICE

The Minnesota Government Data Practices Act states that you are not required to give any information about yourself, but we cannot provide services to you if we do not have all the necessary information. Any information you choose to give will be kept confidential. Information collected will be used only by authorized personnel of this agency for treatment, payment, and operations (TPO) and to provide the services you request. Other than TPO, no use will be made of the information without your prior written approval, unless the law specifically authorizes such use.

☐ I hereby acknowledge that I have reviewed, and understand the Tennessen Notice.

***HIPAA* CLIENT PRIVACY RIGHTS & NOTICE OF PRIVACY PRACTICES**

☐ I hereby acknowledge that I have reviewed, and understand the HIPAA Privacy Rights and Notice of Privacy Practices.

By signing, I acknowledge I have read and understand all of the above.

X_____ _____ X ____ /_____ /_____

Client or Parent/Legal Guardian Signature (18 years or older -Minn. Stat. §645.451) | Relationship to client, if applicable | Date

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PLEASE CONTINUE TO NEXT PAGE

FINANCIAL POLICY

Monthly statements are mailed to clients with an outstanding balance. **Full payment is due within 30 days of the statement date, unless other arrangements are made with the billing staff.** HVMHC accepts Visa and MasterCard in addition to personal checks with proper identification. An additional charge will be made for any returned check. To pay your bill online, please visit our website: **www.hvmhc.org**. Please be aware that upcoming appointments may be cancelled until balances have been paid and unpaid balances may be subject to collection.

Please contact our billing office at (507) 454-4341 or (800) 657-6777 for questions about your account.

For clients with medical insurance

- Insurance card(s) of the responsible party must be available at each appointment. A copy of the card(s) will be taken upon admission and again when there has been a change in insurance coverage.
- HVMHC will file any supplemental insurance when appropriate.
- Co-pays required by your insurance company must be paid at the time of service.

For clients without medical insurance

- If you do not have insurance, the total payment is due at the time of service, unless you have made payment arrangements with our billing office before your scheduled appointment.

By signing, I acknowledge I have read and understand the above financial policy. I understand that I am responsible for payment of services not covered by my insurance, in addition to any co-pays or deductibles as required by my insurance policy.

X_____ _____ X ____ /_____ /_____

Client or Parent/Legal Guardian Signature (18 years or older -Minn. Stat. §645.451) | Relationship to client, if applicable | Date

ASSIGNMENT OF BENEFITS

I hereby assign payment of authorized Medicare benefits and/or insurance benefits, to include major medical benefits to which I am entitled, to be paid to HVMHC, and to release any medical information deemed necessary to secure payment. **I understand that if I have insurance coverage, but do not give the necessary information needed for billing purposes, I will be responsible for 100% of the charges I incur.**

X_____ _____ X ____ /_____ /_____

Client or Parent/Legal Guardian Signature (18 years or older -Minn. Stat. §645.451) | Relationship to client, if applicable | Date

PLEASE CONTINUE TO NEXT PAGE

GRIEVANCE PROCESS

If you have any questions or complaints concerning any aspect of treatment, you are encouraged to discuss them with your clinician. If you do not feel that your questions or complaints have been resolved, you may contact the Clinical Supervisor. If you wish to discuss the matter further, you may contact the Executive Director. If you have been referred by your unified services agency, a copy of your complaint will be submitted to the appointed complaint investigator.

INFORMED CONSENT

In order to insure that you understand all aspects of your treatment that are important to you, please review the following issues and discuss any or all topics which pertain to you with your clinician. He/she will answer any questions or discuss any procedures, concerns, goals with you that are relevant to the following:

- Benefits of the proposed treatment
- The way the treatment is to be administered
- The expected treatment side effects, risks, or side effects from medications (specific details will be provided by the prescriber/psychiatrist).
- Alternative treatment modalities
- Probable consequences of not receiving proper treatment
- The time period for which informed consent is effective
- The right to withdraw the informed consent at any time, in writing

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CLIENT'S BILL OF RIGHTS

- The right to be informed of Client's Bill of Rights
- The right to confidentiality of conversations and medical records
- The right to prompt and adequate treatment
- The right to participate in the development of your treatment plan
- The right to the least restrictive treatment conditions necessary
- The right upon request to receive information from your clinician regarding alternative programs and/or methods of treatment
- The right to refuse treatment
- The right to terminate services at any time
- The right to refuse to be filmed or taped
- The right to file a grievance, which can be made in writing to the Executive Director
- The right to be informed of the cost of treatment

There are legal exceptions to confidentiality. Ask your provider if you have any questions.

By signing, I acknowledge I have read and been informed of the grievance process, informed consent, cost of treatment and client bill of rights. I understand the benefits of receiving treatment and probable consequences of not receiving treatment, and consent to discussing treatment and to being treated, if appropriate. I understand that this consent may be withdrawn by me at any time.

X_____ _____ X_____/_____/_____

Client or Parent/Legal Guardian Signature (18 years or older -Minn. Stat. §645.451) | Relationship to client, if applicable | Date