Cashman Center MINOR Client Registration & Treatment Contract

Client Information

Client Name: _____ Gender: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship:_____ Phone: _____

Parent/Guardian _____
Phone: _____ Email: _____
Address: _____

Parent/Guardian _____
Phone: _____ Email: _____
Address: _____

Custody Arrangement* (if applicable): _____

**Please bring proof of custody arrangement to first appointment*

Insurance Information

Insurance Company: _____ Phone Number: _____

ID # _____Group # _____ Policy # _____

Effective Date: _____ Co-pay/ deductible: _____

Policy Holder Information

Insured Person: _____ Date of Birth: _____

Relation to Client: _____ Employer: _____

Secondary Insurance

Insurance Company: _____ Phone Number: _____

ID # _____Group # _____ Policy # _____

I assign all benefits from insurance or other third-party coverage to the provider of service. I understand that by signing this form, I acknowledge that if my insurance carrier or I-IB/IO/PPO does not cover certain services, I will pay for them in full. I authorize the release of any medical information necessary to process any claim for services provided by provider or its independent contractors. A photocopy of this authorization may be honored.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Client Health Data

How did you hear about Cashman Center? _____

If referred, who referred you here? _____

Please briefly describe your presenting problem: _____

_____

_____

Current Physician: _____

Physician's Clinic: _____

Address: _____

Phone: _____ Fax: _____

Date of most recent physical: _____

Please list your current medications: _____

_____

_____

Please list any vitamins, herbs or supplements that you currently use: _____

_____

Please list any allergies or drug sensitivities: _____

_____

Are you currently or have you in the past been diagnosed and/or treated for? *(please check all that apply)*

___ stroke ___ seizures ___ migraines ___ liver damage ___ cardiac problems

___ anemia ___ chronic fatigue ___ diabetes ___ chronic pain ___ thyroid problems

___ asthma ___ hepatitis ___ tuberculosis ___ eating disorder ___urinary tract infection

___ cancer ___ hypertension ___menopause ___ perimenopause ___communicable diseases

___ mental illness ___ persistent flu-like symptoms ___ poly-cystic ovarian syndrome

___ Other: _____

Provider Contract/Release of Information

Given our strong commitment to your holistic health, it is important to have a close working relationship with your physician, psychiatrist, and/or other health care providers. Please complete a release of information to allow us to communicate with your other caregivers. If you have more than one provider, we will provide additional forms. We will be happy to answer any of your questions or respond to your concerns regarding this matter.

Please choose one of the following options:

1. **___ Yes, please communicate information about my care with my primary care physician and other health care providers. I will complete releases of information with my Cashman Center provider.**
    a. I understand that I may sign a release of information at any time for a specific provider and Cashman Center will initiate communication with that provider.
    b. I understand that Cashman Center is unable to guarantee protection of information by the HIPPA Privacy Rule upon disclosure to third parties authorized by a signed release of information.

2. **___ No, I do not want Cashman Center to communicate with other providers (see disclaimer below).**
    a. Please note that by selecting this option, your provider will be unable to provide documentation to support third party requests (ie legal provider, disability services, insurance claims). Should you require documentation but are unwilling to sign a release for the applicable third party, your provider reserves the right to discuss whether continued services at Cashman Center are appropriate.

Signature of Client _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

No-Show/ Late Cancellation Policy

This policy has been established to provide the highest level of care to all our clients who receive Cashman Center Integrated Health and Wellness Services. It has been proven that consistent attendance provides the greatest opportunity for success. By providing us notice of a cancellation, we may be able to accommodate other clients with your appointment slot. We would like to remind you of our office's policy regarding missed appointments.

- Clients must call 24-hours prior to their scheduled appointment time, when they knowingly are unable to make their appointment. Cancellations within 24-hours of your appointment will be considered a late cancellation. We do understand that emergencies arise and that it may not be possible to give such a notice. Any potential exceptions to the No-Show/Late Cancellation policy will be determined by your provider.

- Clients should plan to arrive on time for scheduled appointments. We will allow a 5-minute grace period for 30minute appointments and a 10-minute grace period for 60-minute and 90-minute appointments. Beyond the grace period listed, your provider reserves the right to cancel your appointment and charge a late fee, Fees for No-Shows or Late Cancellations start at $80.00.

- Continuation of Services
  - Cashman Center reserves the right to discontinue services after **THREE** No-Show/or Late Cancellations. Because we are an integrated care team, a No-Show and/or Late Cancellation for an appointment with any of our clinicians will be included in determination of ongoing care.
  - Medicare and Medicaid plans prohibit us from charging you for No-Show and Late Cancellations, and Cashman Center will abide by those prohibitions. Therefore, clients with Medicare or Medicaid insurance policies will be discharged from treatment and all future appointments will be cancelled after **TWO** No-Show and/or Late Cancellations.
  - If extenuating circumstances have contributed to missed appointments, all clients have the right to appeal the discontinuation of services by writing a letter explaining such circumstances.

Thank you for providing our office and our clients with this courtesy. Signing below indicates you understand and agree to the terms of this policy.

Signature of Client _____ Date _____

Signature of Provider _____ Date _____

Cashman Center
Therapies for Mind & Body

Credit Card Authorization

Cashman Center requires you to provide your credit/debit card information on file with us so we can charge any co-pays, co-insurance, deductible amounts, and professional service charges such as late cancelation or missed appointment charges. It is the client's responsibility to keep cards accurate and up to date. We store financial information and other protected health information in an encrypted, HIPAA compliant site.

Payment is required at the time of service. We provide regular statements for your account balance via mail. You may pay your balance in session with your therapist, online via our website, or by check or cash. If balance accrues and no payment is received within 45 days of service, we reserve the right to seek payment by any means, including using the credit/debit information we have on file, retaining a collection agency, etc. Cashman Center allows you to work out payment plan with us that includes a reasonable period for resolving the balance. If the client's balance remains unpaid, we reserve the right to suspend services until the balance is paid in part or in full.

Client Name _____ Client Number_____

Card type _____ Visa _____ Master Card _____ Discover _____ AmEx _____ Other _____

Name on card _____

Credit card number_____

Expiration Date _____ Security code _____ Billing Zip code _____

Is this card linked to Health Savings Account (HSA) or Flexible Spending Account) (FSA)? _____

Your signature below indicates that you have read and understood our credit/debit card and delinquent account policy. You are authorizing Cashman Center to charge the above credit card. You are aware that your information will be saved on file for a future transaction on your account.

Signature _____Date _____

Telehealth Services Informed Consent Form

I _____, consent to engaging in telehealth with Cashman Center as part of the therapy process and my treatment goals. I understand that telehealth psychotherapy may include mental health evaluation, assessment, consultation, treatment planning, and therapy. Telehealth will occur primarily through HIPPA compliant interactive audio and video communications.

I understand I have the following rights with respect to telemedicine:

1) I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.
2) The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
3) I understand there are risks and consequences from telehealth including but not limited to the possibility, despite reasonable efforts on the part of Cashman Center that, the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons.
4) In addition, I understand that telehealth-based services and care may not be as complete as in-person services. I understand that if my therapist believes that I would be better served by other interventions I may be referred. I also understand that there are potential risks and benefits associated with any form of mental health treatment, and that despite my efforts and the efforts of my therapist, my condition may not improve, or may have the potential to get worse.
5) By signing this document I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer-based psychotherapy services. If I am in crises or in an emergency, I should immediately call 911 or go to the nearest hospital or crisis facility. By signing this document I understand that emergency may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if I am in a life threatening or emergency situation, and/or if I am abusing drugs or alcohol and are not safe. By signing this document, I acknowledge that I have been told that if I feel suicidal, I am to call 911, local county crisis agencies or the National Suicide Hotline at 1-800-784-2433.

_____ _____

Signature of Client/Parent/Guardian Date

_____ _____

Printed Name Relationship *(if applicable)*

Client Receipt of Information

I have read, understand, and agree to abide by the policies given to me in the Client Registration and Treatment Contract Handbook. I understand all center information provided to me within these documents; should I have concerns about any policies, I will discuss with my treatment provider. The information I received includes:

- Client Registration
- Crisis Coverage
- Notice of Health Information and Privacy Practices
- Responsibilities of Cashman Center
- Bill of Rights
- Client Responsibilities
- Cashman Center is an integrative care clinic, which means consultation occurs across providers on the same case to facilitate care. Providers will disclose the minimal necessary information to protect client privacy.

Signature of Client _____ Date _____

Please return forms to Cashman Center.

Email to: cashmanforms@therapysecure.com *(please note, private information may not be secure by email)*

Fax: 952-224-8991

Or mail to: 2970 Judicial Road Suite 100, Burnsville, MN 55337

Phone: 952-224-8990 Fax 952-224-8991
2970 Judicial Road, Suite 100, Burnsville, MN 55337

Cashman Center
Therapies for Mind & Body

Consent for Release of Information (Optional)

This authorizes Cashman Center to use and disclose the specific health information described below concerning:

Client: _____ Date of Birth: _____
Cashman Center Clinician: _____

This will authorize Cashman Center to release to/obtain from:

Name: _____
Relationship to Client_____
Address: _____City: _____State: _____ Zip: _____
Phone: _____Fax:_____

Information from the medical record maintained from (please list dates such as "all", or 1/16 to 2/17):_____

The information to be disclosed is (please check all info that you are willing to have exchanged):

- ☐ History and Intake Information
- ☐ Consultation Notes/Progress Reports
- ☐ Treatment Plan, Goals, and Results
- ☐ Chemical dependency abuse or diagnosis, history and treatment *(protected by Federal and State regulations 42 CFR Part 2 and ORS 430.399(5), 179.505)*
- ☐ Social/Psychological/Medial Reports
- ☐ Court or Probation Records
- ☐ Medications used in treatment
- ☐ Other (specify)

The purpose of the information release is (please check all that apply):

- ☐ Diagnosis and Evaluation
- ☐ Treatment Planning
- ☐ To Facilitate Treatment
- ☐ Other (specify)

If we are requesting the Authorization from you for our use and disclosure or to allow another health care professional or entity to disclose information: (1) You have the right to inspect a copy of the protected information to be used or disclosed; (2) You may refuse to sign this authorization; and (3) We must provide you with a copy of the signed authorization at your request. You may revoke this consent at any time. This authorization lasts for one year after the date you sign it unless you enter a different date of expiration here:_____

By signing this authorization, you may be directing us to disclose your health information to a person or organization that does not have the same obligations to protect privacy required of health care practitioners under state and federal law. The disclosure of the information specified above may carry with it the potential for unauthorized disclosure of your protected health information and loss of protection under state and federal law. You may request that we require the recipient of your protected health information to sign a Confidentiality Agreement in which the recipient agrees to limit its use and disclosure of your information as specified by the confidentiality agreement. If the intended recipient refuses to sign the confidentiality agreement you request, we will not release the information.

I have reviewed and understand this Authorization. I understand that the information used or disclosed under this Authorization may be subject to redisclosure by the recipient and may no longer be protected under federal privacy law.

Signature of Client_____ Date_____