Greetings,

I'm reaching out to you today to inform you that your child has been identified as a student who may benefit from some additional mental health support. For your convenience, District 728 has contracted with us to provide mental health therapy to their students within the school. The district is providing the office space from which to conduct therapy sessions so that families don't need to take time out of their schedules to bring their kids to a community mental health resource to get the support they need. We bill your insurance (when available) and otherwise treat these services the same as we would if you came into our external offices, but have found that providing these services within the school allows for easier collaboration with school resources as well as added convenience for the families we serve.

Included in this packet you'll find the consent forms needed to initiate seeing you child. If you agree, **please sign and return to school** so that we can get started as we cannot see your child for therapy without your written consent. Copies of our privacy practices and service agreement can be found on our website at www.parasolwellness.com, along with additional information about each of our service providers- or this information can be provided in print from the school directly at your request. Your signature on the enclosed forms indicates that you have read and agree to these terms. Additionally, please don't hesitate to contact the provider associated with your child's school to learn more about these services.

Our aim is to help bridge the gap between school and home life for the students we serve and as such, we appreciate and encourage your involvement in this process. We hope to build a solid working relationship with you and would appreciate hearing how we can support you in your parenting efforts.

Thank you for your collaboration!

9201 Quaday Ave, Ste 205, Otsego MN 55330

763-309-1005 info@parasolwellness.com

CO-LOCATED
Release of Information

I understand that mental health therapy services, when provided within the school setting, cannot be given with the same level of confidentiality as services provided within an outpatient clinic setting. School staff assist in coordinating these services and thus at minimum are aware that students are engaged in therapy.
Additionally, I authorize Parasol Wellness Collaborative and their independent contractors to exchange health information about my child with ISD 728 staff for the purpose of collaboration in support of my child's care. This information may include diagnostic assessments and treatment plans as well as verbal conversations for the purpose of consultation/collaboration.
I understand that by signing this form, I'm consenting to the release of this information. I understand that this exchange of information is optional and can revoke my consent at any time. I understand that I have the option of accessing mental health services for my child at an outpatient clinic where coordination with the school is not necessary so that services may remain confidential. Finally, I understand that I may contact my child's provider at any time to be informed of what information about my child was released and to whom. Any questions or concerns may be directed to Parasol Wellness Collaborative at the phone number provided below.

Client Name: _______________________________________ Date of Birth: ________________________________

Legal Guardian Name: ________________________________ Relationship to Client: __________________________

Guardian Signature: __________________________________ Date: _______________________________________

CO-LOCATED SERVICES SIGNATURE FORM

By signing this form you are agreeing that you have reviewed the following documents: Bill of Rights, Professional Services Agreement, Informed Consent & HIPAA Privacy Practices forms provided to you prior to or at intake. Additionally, you agree that you discussed any questions or concerns with provider, and agree to the terms and conditions included in these documents.

Client Name: ___________________________________ Caregiver/Client Signature: ________________________

Relationship to Client: _______________________________ Date: _______________________________________

Provider Signature: _________________________________ Date: _______________________________________

Treatment plans are required as part of the psychotherapy process. These must be reviewed occasionally and created with you/your child and the provider. By signing below, you are allowing permission to the provider to electronically sign the formal treatment plan after you have discussed goals, objectives, length of treatment, and interventions with the provider.

Client Name: ___________________________________ Caregiver/Client Signature: ________________________

Relationship to Client: _______________________________ Date: _______________________________________

CO-LOCATED CHILD & ADOLESCENT INTAKE FORM

Child/Adolescent Name (First, Last, MI): ____ Today's Date:_______________________________

Date of Birth: ___________ Age: _____ Gender: _____ Ethnicity/Race: _________________________ Grade & School: _________________________________

Person Completing Form: ____ Relationship to Client: ____

Please Explain any Custody Issues (documentation may be needed for file): ____

Home Address: ____ County: __________________________ Phone(s): _____________________________

Email: ______________________________Who Referred? ________________________ Emergency Contact and Number: _______________________________

Describe any needs related to culture or faith that might help with your child's therapy: ____

List any individual or entity which a release of information may be needed: ____

Who resides with your child in their primary residence? (Names, ages and relationships) ____

Presenting Problem:

Child's current difficulties (behaviors, symptoms, etc.): ____

When were difficulties first noticed? _________________________________What has seemed to help? And make things worse? ____________________________

List any mental health support child has received (medication, therapy, hospitalization, crisis team, etc.):____

List any present stressors which may be affecting your child today: ____

Have stressors seemed to trigger any changes in mood or behavior? **Yes/No** If so, what are these? ____

Please describe your child's strengths: ____

Family & Social History:

Relationship status of parent(s): __________________________________Relationship status of client (if applicable): ______________________________________

Mother's name: ____ Age: _____ Education: _____

Occupation: ____ Work: Part-time Full-time

Father's name: ____ Age: _____ Education: _____

Occupation: ____ Work: Part-time Full-time

Co-parent's name:____ Age: _____ Education: _____

Occupation: ____ Work: Part-time Full-time

Co-parent's name:____ Age: _____ Education: _____

Occupation: ____ Work: Part-time Full-time

Other Caregivers: ____

Any siblings not at home? (If so, please list with ages):____

Describe any legal issues with parent/caregiver and child ____

www.parasolwellness.com
info@parasolwellness.com
9201 Quaday Ave, Ste 205, Otsego MN 55330

p. 763-309-1005 f. 651-222-9727

Probation Officer:____ Social Worker:____

Describe child's peer relationships/friendships: ____ What types of activities does child enjoy? _________________________________

Developmental History

List any complications during labor, delivery or at birth? (eg.stuck in birth canal, NICU, etc.): ____

List any complications during pregnancy? (parent chemical use, nutrition, dom. violence, illness, etc.): ____

List any major illnesses, medical problems/procedures or injuries? ____

List any development delays during early childhood (toileting, speech, social, feeding, sleep, sensory regulation, movement): ____

Describe any caregiver separation issues child has displayed or experienced: ____

List any significant trauma? *(This can include falls off bikes, assault, bullying, witnessing violence, discrimination, bodily harm, etc.):* ______________________________________

List any significant losses? (death, divorce, loss of pet, etc.) ____

Are you concerned that your child is being-or has been-abused (sexually, verbally, physically or emotionally)? **Yes/No** If so, please explain: _______________________________

Describe any sleeping or eating concerns: ____

Educational History

Is your child getting extra support through school? **Yes/No** If yes, please explain?____

Describe any changes in school settings: ____

Has your child been held back in any grade? **Y/N** If yes, what grade and why? ____

Child's grades before this year: ____________ How does your child get along with teachers? ____

Medical Information

Name of clinic or doctor:_________________________________ Phone: ____________________ Date and reason of last doctor's visit:_________________________________

Please list any major medical problems and allergies? (chronic illness, seizures, etc): ____

Current Medications (include prescribed, over-the-counter and herbal medicines)

Medicine Name	*Dose/How Often*	*Reason*	*Doctor who prescribed it*

Family Medical History

List any major medical issues experienced by immediate family and relationship to child: ____

List any mental health issues experienced by immediate family and relationship to child: ____

List any chemical use issues experienced by immediate family and relationship to child: ____

Other Information

In your own words, describe your child: ____

Is there anything else that you would like your child's Counselor to know? ____

Thank you for providing this essential information about your child and family. Please let your provider know if there is anything that was not included on this form that you would like to share.

CO-LOCATED INSURANCE FORM

Primary Insurance
Insurance Company:________________________________ ID#:_______________________________________

Group #:____Policy Holder:________________________________

Place of Employment:_______________________________ Policy Holder Phone:__________________________

Insurance Phone: __________________________________ Client's Relationship to Policy Holder:_____________

Copay/Deductible %: ________________________________Policy Holder Date of Birth: ____________________

Secondary Insurance
Insurance Company:________________________________ ID#:_______________________________________

Group #:____Policy Holder:________________________________

Place of Employment:_______________________________ Policy Holder Phone:__________________________

Insurance Phone: __________________________________ Client's Relationship to Policy Holder:_____________

Copay/Deductible %: ________________________________Policy Holder Date of Birth: ____________________

I grant Parasol Wellness Collaborative and the identified client's provider permission to speak with insurance representatives regarding claims and authorization as well as file a claim on my behalf to the insurance commissioner should it be necessary. I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or other benefits to the party who accepts assignment. I authorize payment of medical benefits to Parasol Wellness Collaborative. I understand that limited information will be disclosed to the insurance company in order for the insurance claims to be processed. I understand that I am responsible for any claims not paid by insurance and that it is my responsibility to confirm coverage with my insurance plan before starting services. If I do not pay my entire balance, I may be subject to added collection fees and relevant information will be given to the collecting party. I am the policyholder or the responsible party for the identified client utilizing services. I will maintain a credit card on file to secure my account, and my credit card may be charged for outstanding balances over 30 days old.

BY SIGNING BELOW, I AGREE TO AND UNDERSTAND THE ABOVE STATEMENTS REGARDING BILLING AND INSURANCE

Client Name: _________________________________ Date: ______________________________________

Name of Person Completing Form (printed):____

Relationship to Client:_________________________ Signature: __________________________________

Credit Card Authorization Form

My signature below allows Parasol Wellness Collaborative to keep my signature on file and to charge the credit card listed below for any balance that is due. I understand that Parasol Wellness Collaborative routinely runs cards on file for copayments, coinsurances, deductibles, fee for service charges and no show/cancellation charges. As a courtesy, it is our practice to send paper invoices for charges that are a result of an insurance denial so that our clients may have the opportunity to work with their insurance company to get charges covered before the credit card on file will be charged.

Credit/Debit Card Information:

( ) Visa ( ) Mastercard ( ) Discover ( ) American Express ( ) HSA/FSA

Cardholder

Name: ____

Billing

Address:_____________________________________ City:___________________________

State:______ Zip Code:_________________________

Credit Card #:____

Expiration Date:___/_________ Billing Zip: ________________________

Security Code (the last 3 digits near the signature block on back of card): ______________

X____ __/___/____________
Cardholder Signature **Date**

___ Please send me an email alerting me of any transactions at: ___________________________

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CHILD BEHAVIOR CHECKLIST

CHILD'S NAME:______________________________

Each of the statements below describes a behavioral symptom.
Circle the response that best matches your concern.

1 = No Problem 2 = Present 3 = Concerned 4 = Very Concerned 5 = Severe Concern

ATTENTION

DATE SYMPTOMS BEGAN: ________	1 = No Problem				5 = Severe
Careless mistakes	1	2	3	4	5
Poor attention span	1	2	3	4	5
Doesn't listen	1	2	3	4	5
Doesn't finish tasks	1	2	3	4	5
Avoids tasks requiring concentration	1	2	3	4	5
Loses needed items	1	2	3	4	5
Difficulty organizing tasks/activities	1	2	3	4	5
Easily distracted	1	2	3	4	5
Forgetful	1	2	3	4	5
Fidgets, squirms	1	2	3	4	5
Leaves seat when required to sit	1	2	3	4	5
On-the-go, seems driven	1	2	3	4	5
Runs, climbs excessively or is restless	1	2	3	4	5
Talks excessively	1	2	3	4	5
Problems waiting for a turn	1	2	3	4	5
Interrupts	1	2	3	4	5

OPPOSITIONAL BEHAVIORS

DATE SYMPTOMS BEGAN: ________	1 = No Problem				5 = Severe
Touchy, easily annoyed	1	2	3	4	5
Often loses temper	1	2	3	4	5
Argues	1	2	3	4	5
Refuses to comply with adult request	1	2	3	4	5
Angry	1	2	3	4	5
Tantrums	1	2	3	4	5
Bothers others deliberately	1	2	3	4	5
Spiteful / Mean	1	2	3	4	5
Blames others for own mistakes	1	2	3	4	5

CONDUCT

DATE SYMPTOMS BEGAN: ________	1 = No Problem				5 = Severe
Bullies, threatens others	1	2	3	4	5
Starts fights	1	2	3	4	5
Used a weapon in a fight	1	2	3	4	5
Physically cruel to people/animals	1	2	3	4	5
Forcibly stolen from victim	1	2	3	4	5
Stolen without confronting victim	1	2	3	4	5
Forces sexual activity	1	2	3	4	5
Deliberately sets fires to cause damage	1	2	3	4	5
Deliberately destroys property	1	2	3	4	5
Broken into private property	1	2	3	4	5
Lies or cons	1	2	3	4	5
Run away from home	1	2	3	4	5
Doesn't follow curfew	1	2	3	4	5
Truant from school	1	2	3	4	5

COMMENTS:

MOOD

DATE SYMPTONS BEGAN: ________	1 = No Problem				5 = Severe
Child has been without symptoms for two or more months this year	1	2	3	4	5
Weight changes, appetite changes	1	2	3	4	5
Energy level changes	1	2	3	4	5
Sleep disturbances	1	2	3	4	5
Concentration problems	1	2	3	4	5
Crying spells	1	2	3	4	5
Loss of interest, pleasure	1	2	3	4	5
Hopeless feelings	1	2	3	4	5
Isolates self/ withdrawn	1	2	3	4	5
Low self-esteem	1	2	3	4	5
Gives things away	1	2	3	4	5
Wishes to be dead	1	2	3	4	5
Injures self	1	2	3	4	5
Thinks about death/violence often	1	2	3	4	5
Rage outbursts	1	2	3	4	5
Bizarre behavior, hallucinations	1	2	3	4	5
Rapid, hard to follow speech, thoughts	1	2	3	4	5
Thinks he/she is smartest, best person in the world	1	2	3	4	5

ANXIETY / WORRY

DATE SYMPTOMS BEGAN: ________	1 = No Problem				5 = Severe
Worries terrible things will happen to self/others	1	2	3	4	5
Frequently refuses or is reluctant to go somewhere because of fear of separation	1	2	3	4	5
Frequently fearful to sleep without someone close by	1	2	3	4	5
Avoids being alone, clingy	1	2	3	4	5
Nightmares/ sleep disturbance	1	2	3	4	5
Physical somatic complaints	1	2	3	4	5
Worries about parent(s) leaving	1	2	3	4	5
Ruminating thoughts/ Can't let things go	1	2	3	4	5
Avoids social situations	1	2	3	4	5
Irritability/ restlessness	1	2	3	4	5
Intense fears or phobias	1	2	3	4	5
Obsessive or compulsive behavior or rigid rituals	1	2	3	4	5
Extreme fear of new places or situations	1	2	3	4	5

CHILD STRENGTHS

AT SCHOOL:
IN SOCIAL SETTINGS:
AT HOME:
SPECIAL INTERESTS & HOBBIES:

PHQ-9: Modified for Teens

Name ____

Clinician ______________________________________ Date ____________________

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the ***past year*** have you felt depressed or sad most days, even if you felt okay sometimes? ☐ Yes ☐ No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Has there been a time in the past month when you have had serious thoughts about ending your life? ☐ Yes ☐ No

Have you ***ever,*** in your ***whole life,*** tried to kill yourself or made a suicide attempt? ☐ Yes ☐ No

For Office Use Only | Score ____________

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original document included as part of *Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit.* Copyright © 2010 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and in no event shall the AAP be liable for any such changes.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all __________
Somewhat difficult _________
Very difficult _____________
Extremely difficult _________

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

CO-LOCATED INFORMED CONSENT

Counseling clients and caregivers have certain rights and responsibilities when consulting a therapist for treatment and evaluation services for themselves or those they care for. This form should be carefully read prior to the first session. By you signing the attached signature form you affirm the following:

1. Prior to commencement of therapy, I was given adequate information to understand the process of Counseling. This information included, but was not limited to: the professional identity and qualifications of the Counselor, the potential risks and benefits of Counseling, confidentiality and its limits, alternative treatment options, and financial responsibilities.
2. I agree that I have sought and consent to have myself or my child participate in the therapy process. This will include the development of treatment goals and a treatment plan. I agree to be involved in the process and regularly review the treatment progress and process in person or via phone. I understand that the Counselor will continue the treatment process, if my child is engaged in therapy, even if I do not engage in therapy sessions. Reasonable attempt will be made to contact me, by the Counselor, in attempts to engage me and/or the family in therapy process.
3. I understand that I have the right to discontinue treatment and/or request a referral to another Counselor within Parasol Wellness Collaborative, or elsewhere.
4. I understand that there are no guarantees regarding the results of the therapy process and at times symptoms or behaviors may increase.
5. Contracted providers are obligated to follow their code of ethics related to their specific licensure. They are also mandated reporters. I understand that this means me and my child’s safety and well-being is kept in mind with every interaction. The Therapist/Counselor may need to make reports to outside agencies or instigate increased level of care for my child or myself should my personal safety, others’ safety, or my child’s well-being seem to be at risk. I understand that I may or may not be notified if outside reports are made. The provider or other involved parties will make best attempts to connect if increased level of care or support is recommended or needed. (See privacy practices for any concerns related to confidentiality).
6. I understand that Parasol Wellness Collaborative is not liable for the actions of the contracted Therapists/Counselors. I understand that each contracted therapist at Parasol Wellness Collaborative is liable for their own actions and behaviors throughout the therapy process.
7. I understand that any financial obligations are my responsibility. I understand that payments towards balances are to be made in a timely manner or services may be discontinued and a collection process put into place. The definition of “a timely manner” is determined by the Counselor/Therapist providing services to your child.
8. I understand that play or art may/can be used during the therapy process. Play and art have been proven as effective therapeutic methods, therefore serve a significant purpose in Counseling/Therapy sessions.
9. I understand that a therapy animal may/can be used during therapy sessions. This will only be the case with verbal permission from you and/or the client. Therapy animals are up-to-date with shots and veterinarian recommendations. Use of therapy animals has been proven an effective method in Counseling practices.
10. I understand that Counselors/Therapists make best attempts to deter any physical contact with clients, however, on occasion, children may ask for hugs, high-fives, or other age appropriate ways of connecting. Counselors/Therapists will maintain appropriate boundaries with and refer to their code of ethics as needed. To protect both the Counselor and child, providers are encouraged to document any physical interactions between selves and clients they support.

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CO-LOCATED PROFESSIONAL SERVICES AGREEMENT

This document contains important information about the professional services at Parasol Wellness Collaborative (PWC) and business policies. Please read carefully and write down any questions you might have so that we can discuss them at our next meeting.

MENTAL HEALTH SERVICES

Psychotherapy is not easily described in general terms. It varies depending on the personalities of the therapist and client and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. There are no guarantees of what you will experience. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work may include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up another meeting with another mental health professional.

PROFESSIONAL FEE DISCLOSURE

Professional Fees

PWC charges fees based on 30-55 minute appointments. We will break down the cost based on time spent in session. Out-of-pocket service costs typically range from $120.00 to $220.00. Examples of other services which may require payment are listed in the "Additional Service Charges" portion of this document. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time, even if I am called to testify by another party. Because of the difficulty of legal involvement, PWC charges $250.00 per hour fee for preparation for and attendance at any legal proceedings; this includes report writing, meetings with any relevant professionals, transportation and wait time. I will require a $1000.00 retainer fee prior to starting any services pertaining to court related tasks.

Appointment Cancellation fees

PWC requires 24 hour cancellation notice. However, we understand that life circumstances may not always offer this opportunity. Should cancellations consistently occur without 24 hour notice, you will be required to pay half of your session fees for every cancellation. If you do not provide communication regarding your cancellation, and do not show up for your scheduled appointment, you will be charged a no show fee which reflects the type of services you were scheduled for. This cannot be billed to insurance. If cancellations and/or no shows become detrimental to your therapy progress, I may close your file and/or refer you elsewhere for services.

Additional Service Charges

You will be charged for various services provided by myself or any other professional at or affiliated with PWC that are not part of face to face appointments. These charges may include administrative materials and time spent. These services may include, but are not limited to:

- Letters, reports, medical records, form completion for other entities.
- Telephone calls or meetings with clients, parents/caregivers, or other professionals lasting longer than 10-minutes.
- Court testimony and reports required for legal proceedings. This also includes any reviewing of videotapes.
- Transportation time to and from any meetings pertaining to your care.
- A flat records request fee will be charged at the rate of $15 plus $1 per page.

Insurance Reimbursement

At this time, PWC offers reimbursement through some insurance companies. Not all providers at PWC offer the same insurance reimbursement. Under those circumstances, out of network reimbursement or fee for services may be an option, if you are not involved with a Minnesota Healthcare plan. We have limited access to what insurance providers will compensate for services. Therefore, we encourage you to be well informed about your insurance and what services/providers they will reimburse forYou are responsible for any fees not covered by your insurance plan.

Billing and Payments
If you are paying fee for services, you will be expected to pay for each session at the time it is held, prior to the session beginning, unless you have an agreed upon arrangement with provider. PWC accepts cash, check or credit/debit cards. We typically require you complete a credit card authorization form at intake. This is an agreement between you and Parasol, allowing us to automatically pay your fees through a delegated account. In the event that a payment/check is returned a $25.00 service charge will be added to your bill and your privilege to write checks will be denied. Under those circumstances, cash or credit payment options will be available to you. Payment schedules for other professional services will be agreed upon and put into writing when they are requested. In circumstances of unusual financial hardship, PWC may be willing to negotiate a payment installment plan. A sliding-fee scale is also available for those whom it applies. If your account has not been paid for more than 60 days and arrangement for payment has not been agreed upon, we have the option of using other means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such action is necessary, costs may be included in the claim. In most collection situations, the only information released regarding the client's treatment is his/her name, the nature of the services provided, and the amount due. If there are any caregiver custody issues, one caregiver will be delegated as the responsible party for billing needs, unless otherwise agreed upon.

PROFESSIONAL RECORDS
The laws and standards require that PWC keeps treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted by/and or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Your records may also be accessible to you via a secure electronic medical records system. Please know that we are allowed to omit portions of your records, should we deem them inappropriate/unsafe for sharing.

MINORS
Minors Consent for HealthCare Act offers that minors 16 years and older may initiate mental health services without caregiver consent under the following conditions: Professional deems services are "emergency treatment", they request "voluntary institutional treatment", or if minor is "living apart from parents, managing own financial affairs" (Minnesota Statutes: 144.344; 253B.03 & 253B.04; & 144.341. If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. I ask that caregivers and their children agree that I will only provide caregivers with general information about our work together; unless I feel there is a high risk that you will seriously harm yourself or someone else or that you are at risk for abuse or neglect. In this case, I will notify them or other appropriate parties of my concern. I may also provide them with information which can be useful to increase treatment progress at home. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections that you may have about what I am prepared to discuss.

CONFIDENTIALITY & CUSTODY ISSUES
In general, federal and state law protects the privacy of most communications between a client and therapist. I can release information about our work to others only in certain instances and with your written permission. More detailed confidentiality notice and custody stipulations may be found in the client Bill of Rights or Privacy Practices documents provided prior to or at your intake session. In the area of parental custody or guardianship rights, it is important you know that PWC does not offer parenting assessments or services related to litigation. Each parent/legal caregiver is obligated to receive records, share information with whom they deem appropriate, and cancel or schedule appointments as needed, based on legal documentation and verbal agreement.

CO-LOCATED HIPPA & PRIVACY PRACTICES

THIS FORM DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW CAREFULLY.

DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for health care is considered “Protected Health Information” (PHI). Parasol Wellness Collaborative (PWC) along with independently contracted providers are required to extend certain protections to your PHI, and give you this notice about our privacy practices that explains how, when and why we may use or disclose you PHI. Expect in specified circumstances, we must use or disclose only the minimum necessary PHI to accomplish the intended purpose related to the use or disclosure. Providers are required to follow privacy policies described in this notice though we reserve the right to change our privacy practices and the terms of this notice at any time. PWC providers must abide by Minnesota and federal HIPAA regulations regarding your PHI. If alterations are made, you may request a copy of the new notice from your provider.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

PWC providers may use and disclose Personal Health Information for a variety of reasons. Providers have a limited right to use and/or disclose your PHI for purposes of treatment, payment and for our health care operations. For uses beyond that, written authorization must be obtained.

USES AND DISCLOSURES RELATING TO TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

Generally, PWC providers may use or disclose you PHI as follows: For treatment: we may disclose your PHI to doctors, nurses, and other health care personnel who are involved in your health care team. Your PHI may also be shared with ancillary services relating to your treatment such as for crisis related services, consultation purposes and/or community mental health agencies involved in the provision and coordination of your care. To obtain payment: we may use/disclose your PHI in order to bill or collect payment for your health care services. For health care operations: We may use/disclose your general PHI in the course of operating our facility. Appointment reminders & correspondence: Unless you provide us with alternative instructions, we may send appointment reminders to your personal devices or other materials to your home address.

USES AND DISCLOSURES OF PHI REQUIRING AUTHORIZATION

For uses and disclosures beyond treatment, payment and operations purposes, PWC providers are required to have your written authorization, unless the use or disclosure falls within one of the exceptions described above. Authorizations can be revoked at any time to stop future uses/disclosures except to the extent that we have already undertaken an action reliant upon your authorization.

USES AND DISCLOSURES OF PHI FROM MENTAL HEALTH RECORDS NOT REQUIRING CONSENT OR AUTHORIZATION

The law provides that PWC providers may use/disclose your PHI from mental health records without consent or authorization in the following circumstances: When required by law: we may disclose PHI when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. Providers must also disclose PHI to authorities that monitor compliance with these privacy requirements. To avert threat to health or safety: in order to avoid serious threat to health or safety, we may disclose PHI as necessary to law enforcement and other persons who can reasonably prevent or lessen the threat of harm to self or others. For specific government functions: your provider may disclose PHI to government benefit programs relating to eligibility and enrollment, and for national security reasons.

USES AND DISCLOSURES OF PHI- FROM ALCOHOL AND OTHER DRUG RECORDS-NOT REQUIRING CONSENT OR AUTHORIZATION

When required by law: we may disclose PHI when a law requires that your provider report information about suspected child abuse and neglect, or when a crime has been committed on the program premises or against a program personnel, or in response to a court order. For research and audit purposes: In certain circumstances, PWC providers may disclose PHI for research, audit, or evaluation purposes.

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To avert threat to health or safety: In order to avoid serious threat to health and safety, we may disclose PHI to law enforcement when a threat is made to commit a crime on the program premises or against program personnel.

USES AND DISCLOSURES REQUIRING YOU TO HAVE AN OPPORTUNITY TO OBJECT

In the following situation, your provider may disclose a limited amount of your PHI if we inform you about the disclosure in advance, and you do not object, as long as the disclosure is not otherwise prohibited by law. To families, friends or others involved in your care: we may share with these people information directly related to their involvements in your care, or payment for your care.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights relating to your protected health information: To request restrictions on uses/disclosures: You have the right to ask that PWC providers limit how we use or disclose your PHI. PWC providers will consider your request, but are not legally bound to agree to restriction(s). To the extent that your provider does agree to any restriction on our use/disclosure of you PHI, we will put the agreement in writing and abide by it except in emergency situations. PWC providers cannot agree to limit uses/disclosures that are required by law. To choose how we contact you: You have the right to ask that we send any information to an alternative address or by an alternate means. We must agree to your request as long as it is reasonably easy for me to do so. To inspect and request a copy of your PHI: Unless your access to your records is restricted for clear and documented treatment purposes, you have a right to see your PHI upon written request. Restrictions may be imposed if record disclosure may be determined as detrimental to yours or other's wellbeing. We will respond to your request within 30 days. If you want copies of your PHI, a charge for preparation may by imposed. You have the right to choose what portions of your information you want copied and to have prior information regarding the cost of copying. To request amendment of your PHI: If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that your provider correct or add to the record. We will respond within 30 days of receiving your request. This request may be denied if it is determined that the PHI is 1) correct and complete; 2) not created by your provider and/or not part of PWC provider's records, or; 3) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights along with any statement in response that you provide. This will be added to your PHI. If your provider approves the request for amendment, we will change the PHI; informing you and others that need to know about the change in the PHI. To find out what disclosures have been made: You have a right to get of list of when, to whom, for what purpose, and what content your PHI has been released other than instances of disclosure: for treatment, for payment, and operations; to you, your family, of the facility directory, or pursuant to your written authorization. The list will also not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or disclosures made before October 2014. PWC providers will respond to your written request for such a list within 30 days of receiving it. Your request can relate to disclosure going back as far as ten years, if applicable.

YOU HAVE THE RIGHT TO RECEIVE THIS NOTICE

You have the right to receive a paper copy of this Notice and/or an electronic copy by e-mail upon request. You may also access on our website for your convenience.

HOW TO COMPLAIN ABOUT PRIVACY PRACTICES

If you think that PWC or their providers, may have violated your privacy right, or you disagree with a decision we have made about access to your PHI, you may file a written complaint with PWC. You may file a complaint with your provider's supervisor and/or licensing board. This information can be found on your Bill of Rights. PWC providers will take no retaliatory action against you for making complaints.

For further information about Federal or State confidentiality regulations you may consult www.health.state.mn.us or www.hhs.gov

*Please note that school staff may follow different privacy guidelines than Mental Health Professionals/Practitioners.

Mental Health Professionals/Practitioners will abide by HIPAA standards, even when providing services in the school setting.