2375 University Ave W #160
St. Paul, MN 55114

G Zachariah White, PsyD
Licensed Psychologist

Phone: (612) 208-9739
Fax: (612) 643-3479

CLIENT INFORMATION PACKET

This packet will help acquaint you with my office procedures as well as provide information about your rights and responsibilities with regard to consultation. You will also find information about your rights, the Health Insurance Portability and Accountability Act (HIPAA), and your Protected Health Information (PHI). If you have any questions about this information, please discuss them with me at any time. Reading and completing these forms will allow us to get right to work on your concerns.

THE IMPORTANT INFORMATION AND FORMS INCLUDED FOR YOU TO READ, COMPLETE, AND SIGN PRIOR TO THE FIRST SESSION BEGINNING ARE:

- Client Information Packet
- Insurance and Payment Information and Authorization Form
- Confidentiality Agreement Form
- Client Rights Form
- Confidential Individual/Family Questionnaire

DIRECTIONS TO MY ST. PAUL OFFICE

My office is located within the New Light Specialty Clinic, 2375 University Ave W, Suite 160, St. Paul, MN 55114. Parking is accessible from Charles Ave. behind the building. Please check my website for a map at www.sexfromthecenter.com.

By Car. If you are traveling east on University Ave. toward St. Paul, turn left onto Raymond Ave. If you are traveling west on University Ave. out of St. Paul, turn right onto Raymond Ave. From Raymond Ave, take the 1st right onto Charles Ave. The parking lot is on the right, after the U.S. Bank parking lot. There are three parking spots by the back door reserved for Suite 160. Upon entering the building from the parking lot, proceed to the bottom of the ramp. Suite 160 will be on your right. Please have a rest, help yourself to tea or water, and I will greet you at your appointment time.

By Metro Transit. My office is accessible from the 16, 63, 67, and 87 bus lines and the METRO Green Line. Get off at the University Ave & Raymond Ave stop. The building is next door to the U.S. Bank building. Enter the building from University Ave and proceed to the rear of the building. Suite 160 will be on your left. Please have a rest, help yourself to tea or water, and I will greet you at your appointment time.

PROFESSIONAL RELATIONSHIP

Professional consultation (another name for therapy) varies depending on the personalities of the consultant and client and the particular concerns you are experiencing. There are many different methods I may use to deal with the concerns that you hope to address. Consultation is not a passive experience. Instead, it calls for a very active effort on

your part. It might even include other important people in your life. Consultation can be more successful as you work on goals and strategies at home that we've talked about during our sessions.

Consultation can have benefits and risks. Since consultation may involve discussing unpleasant experiences of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, consultation has also been shown to have many benefits. Successful consultation can lead to more satisfaction in relationships, new possibilities for addressing specific problems, or reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs and goals. By the end of the evaluation, we will be able to discuss your first impressions of what our work could include and a potential plan to follow, if you decide to continue with consultation. It is important to evaluate this information along with your own opinions of whether you feel comfortable working together. Since consultation involves a commitment of time, money, and energy, it is important to be selective about the consultant you select. If you have questions about my procedures, we can discuss these whenever they arise. While we co-create possible solutions, you maintain the right to implement them or to decide against implementing any or all of them.

MEETINGS & PROFESSIONAL FEES

Our initial intake session ranges from 45-60 minutes and is $250. Following the intake session is an evaluation period that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your goals. I will usually suggest one 45-50 minute consultation per week at a time we agree on, although some sessions may be longer, or more or less frequent. We will work together to determine how often and for what length of time we meet. Standard fees for 2015 are as follows:

- Initial consultation (45-60 minutes): $250
- Therapy 16-37 minutes: $125
- Therapy 38-52 minutes: $175
- Therapy 53-67 minutes: $225
- Therapy more than 67 minutes: $25 plus $200/hour
- Group session (90-120 minutes): $75 per person

Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. It is important to note that most insurance companies do not provide reimbursement for cancelled sessions and you must pay for the time reserved for your session. New sessions may not be scheduled without payment.

I reserve a limited number of hours for services at a reduced fee. If you have no insurance to cover services, you may qualify for a discount based on your annual income and family size.

ADDITIONAL PROFESSIONAL FEES

In addition to weekly appointments, I charge $200 per 60 minutes for other professional services you may need, though I will pro-rate the hourly cost if I work for periods of less than 60 minutes. Other services include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. These services may not be covered by insurance. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. I charge $400 per hour (2 hours minimum) for preparation and attendance at any legal proceeding including travel time to and from the location.

CONTACTING ME

Because I do not answer the phone when I am with a client, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I can also be reached by email at gzwhite@sexfromthecenter.com. I will make every effort to respond to your message within 24 hours, with the exception of weekends and holidays. In your message, please inform me of some times when you will be available and the best way to contact you.

If you are unable to reach me and feel that you cannot wait for me to respond to your message, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call or you can contact the Crisis Connection at (612) 379-6363 or (866) 379-6363 or your local emergency services at 911. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact should the need arise.

BILLING, PAYMENTS AND SCHEDULING SESSIONS

You will be expected to pay the full fee or copayment for each service as it is rendered. You may use cash, check, or major credit card. **Follow up sessions may not be scheduled until you are paid in full in order to avoid you or the clinic incurring a debt or financial difficulty.** If for some reason, your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I may use legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is their name, the nature of services provided, and the amount due. If such legal action is necessary, interest and its costs will be included in the claim. If you cannot afford therapy with me, you will be referred to another service for care.

INSURANCE REIMBURSEMENT

You should be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above (unless prohibited by contract). I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

Please call the number on the back of your insurance card to know what your coverage is. You must bring your insurance card to the session. Please do not submit your claims unless I instruct you to do so as this might interfere with my claim. I process all insurance claims on your behalf. It is your responsibility to inform me of any changes to your insurance coverage.

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Preferred Name: _____ Preferred Gender/Pronoun Use: _____

INSURANCE AND PAYMENT INFORMATION AND AUTHORIZATION

Your insurance provider may require the following information in order to process insurance claims on your behalf:

Legal Name: _____ Birth Date: _____

Legal Gender: _____ Relationship Status: _____ SS#: _____

Home Address:_____ Preferred Phone: _____

City: _____ State: _____ Zip: _____ Email address: _____

It is okay to contact me about my care by (check all that apply): ___ Phone ___ Email ___ Regular mail

Employer(s) (if applicable): _____ Work Phone: _____

Guardian Name (if applicable): _____

Guardian Address:_____ Phone: _____

City: _____ State: _____ Zip: _____

Physician: _____ Phone: _____

Primary Insurance Company or Paying Party: _____

Subscriber/Policy Holder: _____ Employer (if applicable): _____

Subscriber ID#: _____ SS#: _____Group#: _____

Complete only if asked.

Claims Mailing Address (usually on back of card):_____

City: _____ State: _____ Zip: _____

Contact Person: _____ Insurance Phone: _____

Secondary Insurance Company: _____

Subscriber/Policy Holder: _____ Employer (if applicable):_____

Subscriber ID#: _____ SS#: _____Group#: _____

Claims Mailing Address: (usually on back of card): _____

City: _____ State: _____ Zip: _____

Contact Person: _____ Insurance Phone: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release of any medical information or other information necessary to process insurance claims and to coordinate with my physician if necessary. I agree that a reproduced copy of this authorization is as valid as the original.

Signature: _____Date: _____

AUTHORIZATION TO PAY BENEFITS TO PROVIDER OF SERVICE

I authorize and request payment of medical benefits to the provider or supplier of services by insurance or myself. I understand charges include appointments I fail to cancel 24 hours in advance (full fee), sessions that my insurance company fails to authorize (full fee) or phone calls, report writing, and other work you may request in excess of 10 minutes (prorated). I understand that I am responsible for all non-covered charges.

Signature: _____ Date: _____

CONFIDENTIALITY AGREEMENT

By law, information about clients and their families is confidential with some of the following main exceptions:

1) Authorization by the client and/or family (valid authorization form).
2) Therapist's duty to warn another in the case of potential suicide, homicide or threat of imminent, serious harm to another individual.
3) Therapist's duty to report suspicion of abuse or neglect of children or vulnerable adults.
4) Therapist's duty to report prenatal exposure to cocaine, heroin, phencyclidine, methamphetamine, and amphetamine or their derivatives.
5) Therapist's duty to report the misconduct of mental health or health care professionals.
6) Therapist's duty to provide a spouse or parent of a deceased client access to their child or spouse's records.
7) Therapist's duty to provide parents of minor children access to their child's records. Minor clients can request, in writing, that particular information not be disclosed to parents. Such a request should be discussed with the therapist.
8) Therapist's duty to release records if subpoenaed by the courts.
9) Therapist's obligations to contracts (e.g. to employer of client, to the paying agency or person, to an insurance carrier or health plan).
10) Therapist's duty to offer a detailed HIPPA Notice of Privacy Practices of Protected Health Information. A copy is also available upon request.

As a licensed psychologist, Therapist consults with other trusted clinical therapists. The purpose of this consultation is to obtain additional insight, further therapeutic skills, and ensure the highest possible service to clients. Therapist will make every effort to provide only those details necessary to gain feedback.

My signature indicates I understand the above limits of confidentiality.

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Client Signature or Parent/Guardian for minor Date

As a client, you have the right to know and inquire about the following:

1) The cost of therapy, time frame for payment, access to billing statements, billing procedure for missed appointments, and any issues related to insurance coverage.

2) When the therapist is available and where to call during off hours in case of emergency.

3) The manner in which the therapist conducts sessions concerning intake, consultation, and termination. Clients may take an active role in the process by asking questions about relevant consultation issues, specifying goals, and renegotiating goals when necessary.

4) The nature and perspective of the therapist's work, including techniques used, and alternative methods of consultation.

5) The purpose and potential negative outcomes of therapy. Clients may refuse any intervention or strategy.

6) The anticipated length and frequency of treatment and limitations that may arise due to difficulties in financing.

7) The liberty of clients to discuss any aspect of their therapy with others outside the consultation situation, including consultation with other professionals.

8) The status of the therapist, including the therapist's training, credentials, and years of experience.

9) The maintenance of records, including security and length of time they are kept, client's rights to access personal records, and release policies.

10) The right to request a referral and the right to require the current therapist to send a written report regarding services to the qualified referred clinician or organization upon the client's written authorization.

11) The procedure followed in the event of the therapist's death or illness.

I consent to therapy and have read and understand my rights listed above.

_____ _____
Client Signature Date

_____ _____
Guardian Signature (if applicable) Date

In case of an emergency, please contact the following persons:

Name: _____ Relationship: _____

Cell/Home: _____ Work: _____

Name: _____ Relationship: _____

Cell/Home: _____ Work: _____

Your signature below indicates that you have read the entire 8 pages of this document and agree to abide by its terms during our professional relationship. Your signature also serves as an acknowledgement that you have received the CLIENT INFORMATION PACKET (pages 1 – 4) and that you have been offered and are aware of the detailed HIPPA Notice of Privacy Practices regarding protected health information available from your therapist.

_____ _____

Client Signature or Parent/Guardian for minor Date

_____ _____

Client Signature or Parent/Guardian for minor Date

_____ _____

Client Signature or Parent/Guardian for minor Date

_____ _____

Client Signature or Parent/Guardian for minor Date

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CONFIDENTIAL INDIVIDUAL/FAMILY QUESTIONNAIRE 1

Name: _____ DOB: _____ **Date:** _____

Relationship to Concerned Person (If Not Yourself):_____

Directions: The purpose of this questionnaire is to help me understand the problem(s) and its effects. Please answer the following questions from your personal perspective. Use the back of the form to complete answers if needed. It is best if each person completes their own form to get their perspective and advice.

1. Who referred you to the center?

_____

2. What is the main concern or problem that brought you to the center at this time?

_____

_____

_____

_____

3. Who is the Person/Issue you are most concerned about and why?

_____

_____

_____

_____

PROBLEM LIST

Listed below are possible challenges for you or your family. Please rate each according to **your** degree of concern by circling the scale number and explain briefly why it is a concern at this time?

1. Depression/Sadness? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Why? _____

_____

_____

2. Suicidal Thoughts/Actions? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Why? _____

_____

_____

3. Worry/Anxiety? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Why? _____

_____

_____

4. Family/Relationship Conflict? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Why? _____

_____

_____

5. Verbal Abuse/Behavior? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Why? _____

_____

_____

6. Sexual Abuse/Behavior? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Why? _____

_____

_____

7. Physical Abuse/Behavior? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Why? _____

_____

_____

8. Legal/Financial Problems? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Why? _____

_____

_____

9. Sexual Health/Functioning Concerns? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Why? _____

_____

_____

10. Gender Identity Concerns? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Why? _____

_____

_____

11. Alcohol/Chemical Health Concerns? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Why? _____

_____

_____

12. Gambling Concerns? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Why? _____

_____

_____

13. Spiritual/Faith Concerns? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Why? _____

_____

_____

14. Medical Problems/Conditions? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Why? _____

_____

Current medications: _____

15. Other Problem/Behavior? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Why? _____

_____

_____

DIMENSIONS OF IDENTITY AND CULTURE

Dimensions	**How important is this dimension to you and your main concerns?**
What is your age and generation?	(Low) 1 2 3 4 5 6 7 8 9 10 (High) Why?
What is your disability status?	(Low) 1 2 3 4 5 6 7 8 9 10 (High) Why?
What is your religion or spiritual orientation?	(Low) 1 2 3 4 5 6 7 8 9 10 (High) Why?
What is your ethnicity or race?	(Low) 1 2 3 4 5 6 7 8 9 10 (High) Why?
What is your socioeconomic status or class?	(Low) 1 2 3 4 5 6 7 8 9 10 (High) Why?
What is your sexual orientation?	(Low) 1 2 3 4 5 6 7 8 9 10 (High) Why?
What is your indigenous heritage? (Where are your ancestors from?)	(Low) 1 2 3 4 5 6 7 8 9 10 (High) Why?
What is your national origin?	(Low) 1 2 3 4 5 6 7 8 9 10 (High) Why?
What is your gender?	(Low) 1 2 3 4 5 6 7 8 9 10 (High) Why?

This section adapted from Hays, P. A. (2008). Addressing cultural complexities in practice: Assessment, diagnosis, and therapy. (2nd ed.). Washington: American Psychological Association.

ASSESSMENT

Why do **you** think these concerns are present for you or your family?

_____

_____

_____

_____

_____

_____

PROBLEM SOLVING

What is the main goal or need **you** have for today's session?

_____

_____

_____

What are your ideas on how that goal can be accomplished?

_____

_____

_____

_____

_____

_____

What attempts have you made in the past to deal with these concerns?

_____

_____

_____

_____

_____

_____

Thank you.

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NARRATIVE INFORMATION AND INFORMED CONSENT FORM

The intention of this information sheet is to help you and people you care about know some ideas and practices I, and people who have consulted me in the past, have found helpful. My intention is to invite you and them into new and creative approaches to the problems or concerns that bring you here.

Narrative Approaches

I use Narrative ideas and approaches as the foundation of my work. Sometimes called Narrative Therapy, they are a growing set of ethically based and innovative therapy ideas that recognize that people use narrative, or story, to make meaning of their lives and identity. Using these ideas, people can re-author their stories.

I will ask you questions about your life and concerns to facilitate what I hope is a meaningful conversation of re-authoring your life according to your intentions, purposes, values, beliefs, hopes, dreams, visions, and commitments to ways of living. I want to creatively consult some of the personal and professional stories, resources, and ideas you may or may not have fully considered in the hope that they might provide new possibilities and ways to address the concerns that brought you here. And I invite you to creative express yourself through writing, words, art, music, movement, logic, etc. In addition, I am trained in and may suggest other possibly helpful collaborative and research-informed therapy approaches and ideas.

Some Ideas and Practices that I Find Helpful in my Work

Your Knowledge and Values are Respected

I see people as knowledgeable in their own lives and view problems as separate from people. Narrative Therapy assumes that people have many skills, competencies, beliefs, values, commitments, and abilities that will assist them to reduce the influence of problems in their lives.

The Person is Not the Problem

I avoid thinking or speaking of those I consult with or their loved ones as the "Problem." Rather, the Problem is the Problem, and I strive, with compassion and understanding, to ally with people to help them stand up to or change their relationship to problems and reclaim their lives from each problem's influence.

Externalized Conversation

As someone consulting with me, you might notice that if you say, "I am depressed," I might ask, "How did you notice Depression first influencing your life?" This is an example of separating the person from the problem. This can help move from what we call problem-saturated identities toward more rich and full descriptions of life and can help put problems in their broader contexts.

Life is Multi-storied

Just as one's preferred identity may be rendered invisible by problems, so also one may look back at life and see little except a problem-saturated, hopeless history. I may ask unusual, exceptional, and curious questions that may help you put in words often thinly described, hidden stories of richer understanding, strength, possibility, and hope. In this way, we find people can often creatively reclaim or construct, with the help and support of others, what we call preferred realities and identities.

Therapist: Influential, but De-Centered
I strive to be "influential but de-centered," striving to keep central you and your ideas and preferences. I strive to be a responsible collaborator and co-author with those I work with, rather than pretending to be an all knowing expert to tell you how to live your life. While I may share some of my ideas, resources, and experiences regarding some ways a problem can influence a life, based on what others have told me, I prefer to first acknowledge and build on your unique story, wisdom, and resources. I view the "therapist as an anthropologist or archeologist" respecting and making more visible your own preferred words, ideas, theories, and practices of life.

Collaborative: The Particular Context
I have found that problems can isolate us and make it hard to find options, possibilities, and connections in our lives. I ask you, with your full approval and understanding, to sign release forms to allow me to collaborate with key family members, relatives, friends, associates, and involved professionals, who may be helpful or concerned. Any requested assessment, report, diagnosis, letter, or test is reviewed with you. I strive to collaborate in sensitive, responsible, ethical, legal, diplomatic, and creative ways.

The Background Context
The background of many problems can be a history or experience of injustice and cultural difficulty. We may spend some of our time considering such socially constructed, taken for granted stories of family, gender, culture, ethnicity, sexuality, economics, faith, etc., and their influences in your life and identity. This can help make such influences more visible and may help you decide more clearly if those ideas and practices may fit with what you want in your life and relationships.

Questions, Concerns, Complaints, Suggestions
Please feel free, at any time, to express any questions, concerns, complaints, or suggestions. And please give me your thoughts on our work together. I continue to develop from the suggestions and feedback of the many people and professionals I have worked with and, as such, continue to improve.

Signed Permission to Conduct Narrative Therapy, Research, Evaluation, and Follow-up
Your signature below confirms you have read this handout and give your legal consent to Narrative Therapy and to complete brief therapy evaluations to help inform my work and provide professional accountability, training, and development. You also give me legal permission to contact you by phone, email, or mail to check up on how things went or are going as part of my follow-up care and research.

Thank you.

Signed: _____ Date: _____

Signed: _____ Date: _____

Signed: _____ Date: _____

WHODAS 2.0
WORLD HEALTH ORGANIZATION DISABILITY ASSESSMENT SCHEDULE 2.0
36-item version, self-administered

Name: _____
DOB: _____
Date: _____

This questionnaire asks about difficulties due to health/mental health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

In the past 30 days, how much difficulty did you have in:

Understanding and communicating		None	Mild	Moderate	Severe	Extreme or Cannot Do
D1.1	Concentrating on doing something for ten minutes?	1	2	3	4	5
D1.2	Remembering to do important things?	1	2	3	4	5
D1.3	Analyzing and finding solutions to problems in day-to-day life?	1	2	3	4	5
D1.4	Learning a new task, for example, learning how to get to a new place?	1	2	3	4	5
D1.5	Generally understanding what people say?	1	2	3	4	5
D1.6	Starting and maintaining a conversation?	1	2	3	4	5
Getting around		None	Mild	Moderate	Severe	Extreme or Cannot Do
D2.1	Standing for long periods such as 30 minutes?	1	2	3	4	5
D2.2	Standing up from sitting down?	1	2	3	4	5
D2.3	Moving around inside your home?	1	2	3	4	5
D2.4	Getting out of your home?	1	2	3	4	5
D2.5	Walking a long distance such as a mile?	1	2	3	4	5
Self-care		None	Mild	Moderate	Severe	Extreme or Cannot Do
D3.1	Washing your whole body?	1	2	3	4	5
D3.2	Getting dressed?	1	2	3	4	5
D3.3	Eating?	1	2	3	4	5
D3.4	Staying by yourself for a few days?	1	2	3	4	5
Getting along with people		None	Mild	Moderate	Severe	Extreme or Cannot Do
D4.1	Dealing with people you do not know?	1	2	3	4	5
D4.2	Maintaining a friendship?	1	2	3	4	5
D4.3	Getting along with people who are close to you?	1	2	3	4	5
D4.4	Making new friends?	1	2	3	4	5
D4.5	Sexual activities?	1	2	3	4	5

(continued…)

Life activities—Household		None	Mild	Moderate	Severe	Extreme or Cannot Do
In the last 30 days, how much difficulty did you have in:						
D5.1	Taking care of your household responsibilities?	1	2	3	4	5
D5.2	Doing most important household tasks well?	1	2	3	4	5
D5.3	Getting all of the household work done that you needed to do?	1	2	3	4	5
D5.4	Getting your household work done as quickly as needed?	1	2	3	4	5

Life activities—School/Work		None	Mild	Moderate	Severe	Extreme or Cannot Do
If you work (paid, non-paid, self-employed) or go to school, complete questions D5.5–D5.8, below. Otherwise, skip to D6.1.						
Because of your health condition, in the past 30 days, how much difficulty did you have in:						
D5.5	Your day-to-day work/school?	1	2	3	4	5
D5.6	Doing your most important work/school tasks well?	1	2	3	4	5
D5.7	Getting all of the work done that you need to do?	1	2	3	4	5
D5.8	Getting your work done as quickly as needed?	1	2	3	4	5

Participation in society		None	Mild	Moderate	Severe	Extreme or Cannot Do
In the past 30 days:						
D6.1	How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	1	2	3	4	5
D6.2	How much of a problem did you have because of barriers or hindrances around you?	1	2	3	4	5
D6.3	How much of a problem did you have living with dignity because of the attitudes and actions of others?	1	2	3	4	5
D6.4	How much time did you spend on your health condition or its consequences?	1	2	3	4	5
D6.5	How much have you been emotionally affected by your health problems?	1	2	3	4	5
D6.6	How much has your health been a drain on the financial resources of you or your family?	1	2	3	4	5
D6.7	How much of a problem did your family have because of your health problems?	1	2	3	4	5
D6.8	How much of a problem did you have in doing things by yourself for relaxation or pleasure?	1	2	3	4	5

H1	Overall, in the past 30 days, how many days were these difficulties present?	Record number of days ____
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	Record number of days ____
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	Record number of days ____

CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

Permission for use granted by Richard Brown, MD.

G Zachariah White, MFA, PsyD, LP
Notice of Privacy Practices

Our Commitment

The privacy of your health information is important to us. We are required by Health Insurance Portability And Accountability Act (HIPAA) to protect the privacy of your health information. We must give you notice of our legal duties and privacy practices concerning "protected health information" or "PHI" including:

- We must protect PHI that we have created or received about your past, present, or future health conditions, health care we provide to you, or payment of your healthcare
- We must notify you about how we protect PHI about you.
- We must explain how, when and why we use and/or disclose PHI about you
- We may only use and/or disclose PHI as we have described in the notice.
- We must abide by the terms of this notice.

We reserve the right to change the terms of this Notice and to make new notice provisions effective for all PHI that we maintain. We will post a revised notice in our offices, make copies available to you upon request and post the revised notice on our website.

Minnesota Patient Consent for Disclosures
For most Disclosures of your health information we are required by State on Minnesota Laws to obtain a written consent from you, unless the disclosure is authorized by Law. This consent may be obtained at the beginning of you treatment, during the first delivery of health care service, or at a later point in your care, when the need arises to disclose your health information to others outside of our organization.

Uses and Disclosures
A. For Purposes of Treatment, Payment and Health Care Operations.

Heath Care Treatment. We may use and disclose PHI about you to provide, coordinate and manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing the delivery of health services with others. For example, we may use and disclose PHI about you when you need a physician's evaluation, prescription, or other health care services. In addition, we may use and disclose PHI about you when referring you to another health care provider.

Payment. We may use and disclose your medical information to others to bill and collect payment for the treatment and services provided to you. For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used. Before you receive scheduled services, we may share information about these services with your health plan(s). Sharing information allows us to ask for coverage under your plan or policy and for approval for payment before we provide the services. We may also share portions of your medical information with the following: 1) Billing departments; 2) Collections departments and agencies; 3) Insurance companies, health plans and their agents which provide you coverage; 4) Utilization review personnel that review the care you received to check that it and the costs associated with it were appropriate for your illness or condition; and 5) Consumer reporting agencies (e.g., credit bureaus).

Health Care Operations. We may use and disclose PHI in performing business activities, which we call "health care operations." For example: Members of our staff such as the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually the quality and effectiveness of the healthcare and service we provide.

- ***Our Business Associates.*** There are some services provided in our organization through contacts with business associate such as our billing

service, Paragon Billing, or consultants as needed. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your third party payer for service rendered. So that your health information is protected, however, we require the business associate to sign a contract ensuring their commitment to protect your PHI consistent with this Notice and to appropriately safeguard your information.

B. Requiring Your Authorization.

In addition to your use of your health care information for treatment, payment or healthcare operations, you may give us written authorization, different from the Minnesota Patient Consent, to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted be your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

- *Research/Evaluation:* We may disclose information to internal or external researchers with your authorization, which we will attempt to collect in a manner consistent with applicable state laws.
- *Marketing:* We will not be able to use or disclose your name, contact information, or other PHI for purposes of marketing without your written authorization. This does not include informing you about treatment alternatives or other health related products or services that may be of interest to you.

C. Require Your Opportunity to Agree or Object

In the following instances we will provide you the opportunity to agree or abject to a use or disclosure of your PHI:

- *Notification:* We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.
- *Communication with Family:* Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

If you would like to object to our use or disclosure of PHI about you in the above circumstances, please call our contact person listed on the cover page of this notice.

D. Authorized by Law that Do Not Require Your Consent, Authorization or Opportunity to Agree or Object.

Under certain circumstances we are authorized to use and disclose your health information without obtaining a consent or authorization from you or giving you the opportunity to agree or object. These include:

- When the use and/or disclosure is authorized or required by law. For example, when a disclosure is required by federal, state or local law or other judicial or administrative proceeding.
- When use and/or disclosure is necessary for public health activities. For example, we may disclose PHI about you if you have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.
- When the disclosure relates to victims of abuse, neglect, or domestic violence.
- When the use and/or disclosure is for health oversight activities. For example, me may disclose PHI about you to a state or federal health oversight agency which is authorized by law to oversee our operations.
- When the disclosure is for judicial or administrative proceedings. For example, we may disclose PHI about you in response to an order of a court or administrative tribunal.
- When the disclosure is for law enforcement purposes. For example, we may disclose PHI in order to comply with laws that require to reporting of

certain types of wounds or other physical injuries.

- When the use and/or disclosure relates to decedents. For example, we may disclose PHI about you to a coroner or medical examiner, consistent with applicable laws, to carry out their duties.
- When the use and/or disclosure relates to products regulated by the Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events in respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacements.
- When the use and/or disclosure relates to cadaver organ, eye or tissue donation purposes. Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.
- When the use and/or disclosure relates to Worker's Compensation information: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
- When the use and/or disclosure is to avert a serious threat to health or safety. For example, we may disclose PHI about you to prevent or lessen a serious and eminent threat to the health and safety of a person or the public.
- When the use and/or disclosure relates to specialized government functions. For example, we may disclose PHI about you if it relates to military or veterans' activities, national security and intelligence activities, protective services for the President, and medical suitability or determinations of the Department of State.
- When the use and/or disclosure relates to correctional institutions and in other law enforcement custodial situations. For example, in certain circumstances, we may disclose PHI about you to a correctional institution having lawful custody of you.

Your Individual Rights

A. To Request Restriction on Uses and Disclosures of PHI.

You have the right to request that we restrict the use and disclosure PHI information about you. We are not required to agree to your requested restrictions. However, even if we agree to your request, in certain situations your restrictions may not be followed. These situations include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, and uses and disclosures described in subsection 4 of the previous section of this Notice. You may request a restriction by submitting your request in writing to us. We will notify you if we are unable to agree with your request.

B. To Request Communications via Alternative Means or to Alternative Locations

Periodically, we will contact you by phone, email, postcard reminders, or other means to the location identified in our records with appointment reminders, results of tests or other health information about you. You have the right to request that we communicate with you through alternative means or to alternative locations. For example, you may request that we contact you at your work address or phone number or by email. While we are not required to agree with your request, we will make efforts to accommodate reasonable requests. You must submit your request in writing.

C. To See and Copy PHI

You have the right to request and see a copy of PHI obtained in clinic, billing and other records used to make decisions about you. Your request must be in writing. We may charge you related fees. Instead of providing you with a full copy of the PHI, we may give you a summary or explanation of the PHI about you, if you agree in advance to the form and cost of summary or explanation. There are certain situations in which we are not required to comply with your requests. Under these circumstances, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of your denial.

D. To Request Amendment of PHI

You have the right to request that we make amendments to clinical, financial and other health-related information that we maintain and use to make decisions about you. Your request must be in writing and must explain the reason(s) for the amendment and, when appropriate, provide supporting documentation. We may deny your request if: 1) the information was not created by us (unless you provide the creator of the information is no longer available to amend the record); 2) the information is not part of the records used to make decisions about you; 3) we believe the information is correct and complete; 4) you would not have the right to see and copy the record as described in paragraph 3 above. We will tell you in writing the reasons for the denial and describe your rights to give us a written statement disagreeing with the denial. If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, including persons you name who have received PHI about you and who need the amendment.

E. To Request and Accounting of Disclosures of PHI.

You have the right to a listing of certain disclosures we have made of your PHI. You must request this in writing. You may ask for disclosures made up to six (6) years before the date of your request (not including disclosures made prior to April 14, 2003). The list will include the date of the disclosure, the name (and address, if available) of the person or organization receiving the information, a brief description of the information disclosed, and the purpose of the disclosure. If, under permitted circumstances, PHI about you has been disclosed for certain types of research projects, the list may include different types of information. If you request a list of disclosures more than once in 12 months, we can charge you a reasonable fee.

F. To Receive a Copy of This Notice.

You have the right to request and receive a paper copy of this Notice at any time. We will provide a copy of this Notice no later than the date you first receive service from us (except for emergency services or when the first contact is not in person, and then we will provide the Notice to you as soon as possible). We will make this Notice available in electronic form and post it on our website.

Questions or Complaints

If you want more information about our privacy practices or have questions or concerns, please contact our Privacy Official. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at an alternative location, you may file a complaint with out Privacy Official. You can also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

Privacy Office Contact Information
G Zachariah White, MFA, PsyD, LP
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