Email: j@jakevoelker.com
Phone: 651-621-0688
1000 Shelard Parkway, Ste 520
St. Louis Park, MN 55426

JMV Therapy, LLC

CLIENT INFORMATION PACKET

This booklet will help acquaint you with my office procedures, as well as provide information about your rights and responsibility with regard to therapy. You will also find updated information about your rights pursuant to the Health Insurance Portability and Accountability Act (HIPAA). If you have any questions about this information, please discuss them with me at any time.

DIRECTIONS

From the North take 169 south to Shelard Pkwy/ Betty Crocker Drive. Take Shelard Parkway to 1000 Shelard Parkway. Turn right into the parking lot, and if you park on ground level, use the main entrance to the elevators up to the fifth floor. Turn right and continue down the hall to suite 520.

From the South take 169 north to Shelard Pkwy/ Betty Crocker Drive. Take Shelard Parkway to 1000 Shelard Parkway. Turn right into the parking lot, and if you park on ground level, use the main entrance to the elevators up to the fifth floor. Turn right and continue down the hall to suite 520.

From the East take 394 west to 169 North and then exit on Shelard Pkwy/ Betty Crocker Drive. Take Shelard Parkway to 1000 Shelard Parkway. Turn right into the parking lot, and if you park on ground level, use the main entrance to the elevators up to the fifth floor. Turn right and continue down the hall to suite 520.

From the West take 394 east to Hopkins Crossroads exit and turn left to cross over 394, then take the first right (East) on N. Wayzata Blvd (frontage road) approximately six blocks to the six-story blue glass building with FOCUS FINANCIAL in white letters. Turn into the ramp and park, then take the walkway to the second floor elevators up to the fifth floor. Turn right and continue down the hall to suite 520.

Upon entering, please have a seat in the waiting room and I will come out to greet you at your appointment time. Help yourself to tea or water. If you'd prefer coffee, just let me know and I will be happy to grab you a cup and provide sugar and cream.

PROFESSIONAL RELATIONSHIP

The professional relationship is not easily described in general statements. It varies depending on the personalities of the consultant and client, and the concerns you are experiencing. There are many different methods we may employ to attend to the concerns that you hope to address. The relationship is not like a medical doctor and calls for a very active role on your part. It might even include other important people in your life.

Therapy can have benefits and some risks. Since consultation may involve discussing challenging experiences of your life, you may experience sadness, guilt, anger, frustration, loneliness, etc. On the other hand, therapy may have many benefits. Successful therapy can lead to increased satisfaction in relationships, new possibilities for addressing specific concerns, and/or reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will focus on understanding your needs, goals, and presenting concerns. After these first few sessions, we will be able to discuss your first impressions of what our work could include and then co-create a potential plan to follow if we decide to continue with therapy. It is important to evaluate this information along with your own opinions of whether you feel comfortable working together. Since therapy involves a commitment of time, money, and energy, it is important to be selective about the therapist 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 decide against implementing any or all of them.

MEETINGS & PROFESSIONAL FEES

I conduct an initial session of 50 minutes at a cost of $120. Following the initial session is an evaluation period of 2 to 3 sessions, during which we both decide if I am the best person to provide the services you need to meet your goals. The fee for these 50-minute sessions is $120. When paying out of pocket (not using insurance) I charge $120 per session. If paying with a credit card I charge a $5.00 credit card fee. Payment is due at time of service.

Periodically we are faced with the issue of raising our rates. While this is not an annual change, there have been times when the hourly rate has increased $10.00/hour. In the event of a change, we will post these changes in our individual offices at least 30 days in advance and make every effort to verbally apprise you of the changes.

CANCELLATION POLICY

Once an appointment hour is scheduled, you will be financially responsible if you were to cancel with less than a 24-hour notice. The late cancel / no show fee is $100 with less than 24 hr notice. If were unable to attend due to circumstances beyond your control, such as an unforeseen emergency, sudden illness, etc., the fee is waived.

ADDITIONAL PROFESSIONAL FEES

In addition to weekly appointments, I charge $120 per 50 minutes for other professional services you may need, though I will break down the hourly cost if I work for periods of less than 50 minutes. Other services may include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and time spent performing other services you may request. These services may not be covered by insurance.

If you become involved in any legal proceedings that require my participation, you will be expected to pay for all my professional time, including preparation and transportation costs, and any legal fees that I might incur, even if I am called to testify for another party. I charge $200 per hour for preparation and attendance, and in addition, mileage to and from any location.

CONTACTING ME

My HIPPA compliant email account is the best way to reach me. My email address is j@jakevoelker.com. Email is used to make or change appointments, or for general questions not requiring an immediate response. I check voicemail weekly. I will make every effort to return your e-mail within 24 hours, except for weekends and holidays.

EMERGENCIES

If you are experiencing an immediate crisis and are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call, Community Outreach for Psychiatric Emergencies (COPE): 612-596-1223, the St. Paul Ramsey Crisis Intervention Center at (651) 266-7900, or your local emergency services at 911. Please visit our website for additional resources. If I will be unavailable for an extended time, I will provide you the name of a colleague to contact.

BILLING AND PAYMENTS

You will be expected to make payment at the time of the session. If your account is not paid for more than 30 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure 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 his/her name, the nature of services provided and the amount due. If such legal action is necessary, its costs will be included in the claim.

CONCERNS

I urge you to discuss with me any questions or concerns you may have with the consultation you receive. If you are not satisfied with the results of that discussion, you may call the Board of Marriage and Family Therapy at 612-617-2220.

I have read and understand the content of the Client Information Packet.

_____ _____

Client Signature Date

_____ _____

Parent Signature For Minor Client Date

Registration Form

Today's Date_____

Client Name (Print)_____ **Date of Birth** _____
Last First Middle Initial

Street
Address_____City_____

State_____ Zip_____ Sex: F ○ M ○ O○ Age ____ Partner Status: Sgl___○__ Mar___○__ Div___○__ Sep___○__ Other ___○___

Cell Phone
May I Leave A Message? **Yes**○ **No**○

Work Phone
May I Leave A Message? **Yes**○ **No**○

Other Phone
May I Leave A Message? **Yes**○**No**○

Confidential Email Address: _____ May we send unencrypted confidential email? **Yes** ○ **No**○

Employer _____Occupation _____

Primary Care Physician: _____ Phone: _____ May I contact: **Yes** ○ **No**○

Insurance

Primary Insurance Company____Out of pocket - Cash pay only_____$120 per 50 minute session + $5 Credit Card fee if using a credit card.

Responsible Party (Where should the personal portion of the bill be sent, if not to the person named at the top of the page?)

Name _____ Relationship _____

Address_____Phone _____

Assignment and Release

I the undersigned, certify that I (or my dependent) are paying for services out of pocket and have agreed to pay JMV Therapy for services rendered. I understand that I am financially responsible for all charges for sessions and no show or late cancellation fees. I hereby authorize the healthcare provider (therapist) to release all information necessary to secure the payment of benefits and to mail billing statements.

_____ _____ _____
Signature of Responsible Party Relationship (self, parent, etc) Date

PAYMENT AUTHORIZATION FORM

Keeping your account up to date is effortless and worry free, simply authorize your charges to your credit card or debit card. You will be charged for any unpaid balance. An additional $5 will be charged for using a credit card.

This form will authorize Jake Voelker MA, LMFT to charge your credit or debit card for your unpaid account balance. Your personal information will be kept secure and confidential.

Payment is simple and secure whether using Health Savings account, Visa, MasterCard, American Express or Discover Card. Complete and sign this form to get started. A paid receipt will be sent via email.

Please complete all the information below:

I _____ authorize Jake Voelker, LLC to charge my credit card:

Billing Address: _____

City, State, Zip: _____

Phone: _____ Email:_____

Credit Card

○ Visa ○ MasterCard

○ Amex ○ Discover

Cardholder Name: _____

Account Number: _____ - _____ - _____ - _____

Exp. Date: _____

CVV (3-digit number on back of card) or (4 digit on the front if Am Ex) _____

Zip: _____ - _____

Receipt to be sent by Email

Signature _____ Date _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify JMV Therapy in writing of any changes to my account information. I understand that if I fail to make payments owed for attended sessions, if I fail to show for a scheduled appointment without notification, or if I cancel a session less than 24 hours from the start time of the session, and do not make the required payment(s) at the end of the month, authorized personnel at JMV Therapy has my permission to charge the card listed above accordingly. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card Company; so long as the transactions correspond to the terms indicated in this authorization form.

OTHER CONTACTS

I'm interested in others who know about the concern(s) you are facing. I've found some people may have knowledge or experience this could be useful when we discuss the impact these problems and their potential solutions. Concerned others may know of ways you have stood up to these or other challenges in the past. Feel free to list these people, so that if we both decide it would be helpful to contact them, we will have their information. Please note I will obtain your written permission *before* consulting with any of these people.

First Potential contact/resource _____Relation to You?_____

Home Phone_____Work Phone _____Mobile Phone_____

Email _____

Second Potential contact/resource_____ Relation to You?_____

Home Phone_____Work Phone _____Mobile Phone_____

Email _____

Third Potential contact/resource_____ Relation to You?_____

Home Phone_____Work Phone _____Mobile Phone_____

Email _____

EMERGENCY CONTACTS

My priority is maintaining the safety and privacy of those with whom I consult. If there comes a time when I am concerned with your safety or the safety of others in your life, I may need to contact them. I ask you provide two names of people I could call if I am concerned about your safety. If you are the parent of a client I am seeing, there may be times when I am unable to contact you immediately and need someone else to verify your child's safety. Please list these individuals below.

First Emergency contact_____ Relation to You?_____

Home Phone_____Work Phone _____Mobile Phone_____

Email _____

Second Emergency contact_____ Relation to You?_____

Home Phone_____Work Phone _____Mobile Phone_____

Email _____

Third Emergency contact_____ Relation to You?_____

Home Phone_____Work Phone _____Mobile Phone_____

Email _____

CONFIDENTIALITY AGREEMENT

Information about clients and their families is confidential with exception to the following:

1. Written 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, THC, or excessive & habitual alcohol use. (253b.02; 2007).
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 specific 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 an insurance carrier or health plan.

COMMUNICATION: EMAIL, TEXT & OTHER NON-SECURE MEANS

It may become useful during our work to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Please know that these methods, in their typical form, are not confidential means of communication and may be susceptible to a third party may be able to intercept and eavesdrop on those messages, even though we offer encrypted email. The kinds of parties that mayintercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with Jake Voelker, LLC
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

If there are people in your life you don't want to access these communications, please talk to Jake Voelker about ways to keep your communications safe and confidential.

I consent to Jake Voelker, LLC providers use of email and mobile phone text messaging when transmitting your protected health information, such as:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment
- Non-emergency related correspondence

My signature indicates I have been informed of the risks, including but not limited to my confidentiality in therapy, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement to receive therapy. I also understand that I may terminate this consent at any time.

_____ _____

Client Signature Date

_____ _____

Client Signature for Minor Date

YOU HAVE THE RIGHT TO KNOW AND INQUIRE ABOUT:

1. The cost of counseling, 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 way the therapist conducts sessions concerning intake, treatment, and termination. Clients take an active role in the process by asking questions about relevant therapy issues, specifying therapeutic goals, and renegotiating goals when necessary.

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

5. The purpose and potential negative outcomes of treatment. Clients may refuse any treatment 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 therapy situation, including consultation with another therapist.

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 therapist or organization upon the client's written authorization.

11. The procedures followed in the event of the therapist's death/illness.

12. Whether or not the therapist has a professional will

13. That an executor may take over your case or refer to another clinician in the case of my inability to continue therapy

14. That by signing they waive the right to sue your estate for abandonment

I consent to this consultation, have read and understand my rights listed above, and have reviewed the Client Bill of Rights posted in our waiting room.

_____ _____

Client Signature Date

_____ _____

Parent Signature For Minor Client Date

AS A CLIENT YOU HAVE A RESPONSIBILITY TO:

1. Ask questions and get clarification regarding your diagnosis and suggested treatment plan.

2. Be willing to be an active and collaborative partner in the therapeutic relationship.

3. Inform your therapist of any changes in your behavior and/or physical or mental health status that could affect your care, including compliance with any prescribed medication.

4. If using insurance, inform your therapist of any changes in your health insurance plan.

5. Be on time for scheduled appointments. If running late, please inform me by leaving a voice message, text, or email. Please do not text or email and drive.

6. Cancel appointments if you are unable to keep them, so others may use the time slot. Please adhere to a minimum of a 24-hour notice to cancel your appointment. Thank you!

7. Limit email communications primarily to scheduling issues (making appointments, rescheduling or canceling appointments). Email is not monitored sufficiently for therapeutic or crisis correspondence

8. Understand that for your confidentiality and to minimize the possibility of dual relationships, your therapist will not accept invitations for any social media connections (i.e., Facebook, LinkedIn, etc.).

9. Inform your therapist if you would prefer to "opt out" of text message or email appointment reminders.

10. Understand that, depending on our financial agreements, co-pays, deductible amounts or full session fees are due at the time of service. Delays may occur with insurance reimbursement, or may accrue due to unmet deductible amounts, therefore, balances on your account will be reviewed monthly. Please understand, should a balance accumulate on your account, it will be limited to $300.00, and must be paid within 45 days. If a balance remains unpaid without prior arrangement, additional fees and suspension or termination of services may result.

I have read and understand my responsibilities as a client listed above.

_____ _____

Client Signature Date

_____ _____

Parent Signature for Minor Client Date

COLLABORATING IN THERAPY

Tell Me What Works and Has Worked for You
Each person, couple, and family is unique. You can help by sharing the style and questions I use that work best for you and your partner and your family. You are not expected to run the therapy. Therapists have expertise and good reasons for doing what they are doing, and a therapist should allow some room for flexibility. If you have been in counseling before and found some aspect or method particularly helpful, let me know more about those experiences.

Let Me Know When We Do Something That Was Useful/Helpful
Therapy can be a difficult and challenging and rewarding process. We see people when they are feeling stressed, feeling hopeless and sometimes feeling impatient. We often aren't aware of the things we do that have been helpful if people don't return or when change takes some time. So, most therapists appreciate hearing when we've done something that worked or you've found helpful. This can also make your therapy experience more productive, since your therapist will have your feedback to guide him or her in future sessions.

Tell Me Your Expectations
If you attend therapy hoping to go back to your childhood to find origins or contributions to the concerns that brought you into therapy and your therapist focuses on the present, someone is bound to be frustrated if that expectation isn't brought up and discussed before you proceed. Also, you might indicate how long you had anticipated you would attend therapy, and how often, to make sure you and the therapist are on the same track.

Tell Your Therapist What Doesn't Work
Like telling your therapist your expectations and letting him/her know what has worked or is helping, as well as letting him/her know when something isn't helping is important. This includes what is happening between as well as during your therapy sessions. This gives the opportunity for mid-course corrections in the therapy process.

Tell Your Therapist Your Objections
Some people think that they shouldn't speak up about their worries or objections to their therapist's suggestions, but a free and frank discussion about any misgiving helps your therapist attend to your concerns and make any adjustments to ensure a higher likelihood of success.

Ask Questions
About the therapy process, fees, any suggestions or methods, the therapist's training and qualifications, etc. Anything you are curious about. If it gets too personal or the therapist considers the questions intrusive or inappropriate, he/she will let you know.

I have read and understand collaborating in therapy as listed above.

_____ _____
Client Signature Date

_____ _____
Parent Signature For Minor Client Date

CONFIDENTIAL QUESTIONNAIRE

RELATIONAL STATUS

Single Partnered Married Divorced Total # of marriages: _____

Length of current marriage/relationship: _____

Assessment of current relationship: Good ○ Fair ○ Poor ○

Race:_____

Religion:

_____

Ethnic/Cultural Identification:

_____

EDUCATION

Fill in All That Apply

Years of Education _____

Currently Enrolled: Yes

○ No ○ Completed: High School/GED ○ Vocational ○ College ○

Graduate School ○ Doctorate ○

Other Training

_____

Special Circumstances

_____

MILITARY

Do you have a history of serving in the military? Please explain.

YOUR REASON FOR SEEKING THERAPY TODAY

Who referred you to me?_____

May I acknowledge this referral? _____

Their email or phone number with which to acknowledge the referral _____

Briefly describe the problem or concern for which you, your child or adolescent would like addressed in counseling.

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

Why do you think these challenges are present for you or your relationship? How long have they been present?

What is the main goal(s) for today's session?

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

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

If the work that we did together was helpful or successful, how would you know? What would be different in your life?

If the work that we did together was helpful or successful, what might be different in your life and the lives of others close to you?

FAMILY CONCERNS

Please check any family concerns you may be experiencing:

☐ Fighting	☐ Feeling Distant	☐ Loss of fun	☐ Lack of honesty	☐ Physical fights
☐ Drug Use	☐ Alcohol Use	☐ Disagreeing about relatives		☐ Infidelity (Couple)
☐ Divorce	☐ Separation	☐ Remarriage (self or parent)		☐ Disagreeing about friends
☐ Education	☐ Finances	☐ Birth of a sibling		☐ Death of a family member
☐ Empty Nes	☐ In-laws	☐ Blended family concerns		☐ Leisure time
☐ Abuse	☐ Neglect	☐ Inadequate Housing		☐ Inadequate health insurance
☐ Gambling	☐ Internet Usage	☐ Employment/Underemployment		☐ Other _____

SYMPTOM CHECKLIST

Please check any of the items below that you currently or have been experiencing in the last 30 days.

Symptom	None	Mild	Moderate	Severe	Symptom	None	Mild	Moderate	Severe
Anxiety	☐	☐	☐	☐	Increased or decreased appetite	☐	☐	☐	☐
Sadness/Depression	☐	☐	☐	☐	Unplanned weight gain	☐	☐	☐	☐
Low self worth	☐	☐	☐	☐	Unplanned weight loss	☐	☐	☐	☐
Unresolved guilt	☐	☐	☐	☐	Binging/Purging	☐	☐	☐	☐
Panic attacks	☐	☐	☐	☐	Poor concentration/indecisive	☐	☐	☐	☐
Paranoid thoughts	☐	☐	☐	☐	Low energy	☐	☐	☐	☐
Spiritual concerns	☐	☐	☐	☐	Excessive worrying	☐	☐	☐	☐
Dissociation	☐	☐	☐	☐	Nausea/Acid indigestion	☐	☐	☐	☐
Irritability	☐	☐	☐	☐	Anger management problems	☐	☐	☐	☐
Crying	☐	☐	☐	☐	Decreased sex drive	☐	☐	☐	☐
Sleep disturbances	☐	☐	☐	☐	Hallucinations	☐	☐	☐	☐
Self-mutilation/cutting	☐	☐	☐	☐	Racing thoughts	☐	☐	☐	☐
Impulsivity	☐	☐	☐	☐	Porn use	☐	☐	☐	☐
Nightmares	☐	☐	☐	☐	Drug use	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐	Alcohol use	☐	☐	☐	☐
Elevated mood	☐	☐	☐	☐	Decreased creativity/productivity	☐	☐	☐	☐
Mood swings	☐	☐	☐	☐	Easily distracted	☐	☐	☐	☐
Disorganized	☐	☐	☐	☐	Hyperactivity	☐	☐	☐	☐
Anorexia	☐	☐	☐	☐	Work issues	☐	☐	☐	☐
Social isolation	☐	☐	☐	☐	Problems at home	☐	☐	☐	☐
Phobia(s)	☐	☐	☐	☐	Memories of trauma/flashbacks	☐	☐	☐	☐
Obsessive thoughts	☐	☐	☐	☐	Feel panicky/anxious	☐	☐	☐	☐
Grief	☐	☐	☐	☐	Suicidal thoughts	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	Attempts of suicide in the past	☐	☐	☐	☐
Loneliness	☐	☐	☐	☐	Other	☐	☐	☐	☐

Please provide any additional detail regarding checked boxes above that you would like Jake to know:

COUNSELING & MEDICAL HISTORY

Have you previously worked with a counselor or therapist? **Yes** ◯ **No** ◯

Yes If so, where and with whom:

Approximate dates of prior counseling?

For what reason(s) did you seek counseling?

Were you given a diagnosis? If so, what?

What did you find most helpful in counseling?

What did you find **least** helpful in counseling?

Have you utilized psychiatric services? Yes○ No○ Was it helpful? Yes○ No○

Have you taken medication for any psychological health concerns? Yes○ No○ If so, please list below:

Name of Medication	Dosage	Dates Taken	Is It Helping? (Y/N)

Other medical concerns requiring surgery, treatment, or hospitalization? Please describe:

Your signature below indicates that you have read the entire Confidential Individual Questionnaire, understand the content, and agree to abide by its terms during our professional relationship. Your signature also indicates you have had an opportunity to ask questions about this material and how it applies to my situation, and that you have been offered the HIPAA MN Notice Form (see below)

_____ _____
Client Signature Date

_____ _____
Parent Signature For Minor Client Date

HIPAA MINNESOTA NOTICE FORM
Notice of Jake Voelker, LLC
Policies and Practices to Protect the Privacy of Client Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment, and Health Care Operations"*
  – *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or a psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my [office, clinic, practice group, etc.], such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given different protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I know or have reason to believe a child is being neglected or physically or sexually abused or has been neglected or physically or sexually abused within the preceding three years, I must immediately report the information to the local welfare agency, police or sheriff's department.

- **Adult and Domestic Abuse:** If I have reason to believe that a vulnerable adult is being or has been maltreated, or if I have knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, I must

- Immediately report the information to the appropriate agency in this county. I may also report the information to a law enforcement agency.

"*Vulnerable adult*" means a person who, regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:

(i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and
(ii) because of the dysfunction or infirmity and the need for assistance, the individual has an impaired ability to protect the individual from maltreatment.

- **Health Oversight Activities:** The Minnesota Board of Marriage and Family Therapy or Board of Behavioral Health may subpoena records from me if they are relevant to an investigation it is conducting.

- **Judicial and Administrative Proceedings**: If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law and I must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case.

- **Serious Threat to Health or Safety**: If you communicate a specific, serious threat of physical violence against a specific, clearly identified or identifiable potential victim, I must make reasonable efforts to communicate this threat to the potential victim or to a law enforcement agency. I must also do so if a member of your family or someone who knows you well has reason to believe you are capable of and will carry out the threat. I also may disclose information about you necessary to protect you from a threat to commit suicide.

- **Worker's Compensation**: If you file a worker's compensation claim, a release of information from me to your employer, insurer, the Department of Labor and Industry or you will not need your prior approval.

IV. Client's Rights and Clinician's Duties

Client's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI (and psychotherapy notes) in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Clinician's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will send you a copy by mail or give you a copy in session.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact the Minnesota Board of Marriage and Family Therapy.

If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to:

Jake Voelker, LLC
1000 Shelard Parkway, Ste 520
St. Louis Park, 55426-1053

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Changes to Privacy Policy

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail or in session.

Your signature below indicates that you have read the Minnesota Notice Form, understand the content, have had an opportunity to ask questions about this material and how it applies to my situation, and that you have been offered the HIPAA MN Notice Form.

_____ _____
Client Signature Date

_____ _____
Parent Signature For Minor Client Date