truenorth
TREATMENT CENTER

(775) 870-5027
3740 Lakeside Drive #202, Reno, NV. 89509
www.tntcreno.com

CLIENT INFORMATION – INTAKE FORM

Client's name_____Age_____Date of Birth_____

Name of person filling this form out,_____Relationship_____

Street Address_____

City, State, Zip_____

Occupation or School attending_____Employer or Grade_____

Family physician_____How did you hear about us?_____

FINANCIALLY RESPONSIBLE PARTY (GUARANTOR)

Guarantor's Name_____Date of Birth_____

Street Address_____

City, State, Zip_____

Employer_____ Contact phone_____

Relationship to Client_____

PRIMARY INSURANCE

Or we can make a copy of your card

Policy Name_____Policy #_____

Group #_____

Insurance phone (customer service #)_____

Insurance Street address_____

City, State, Zip_____

Insured's name_____Relationship to client_____

Insured's date of birth_____ Employer_____

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CONTACT INFORMATION

Your email address: _____

Your cell phone number: _____

Where would you like to receive appointment reminders? (check one)

_____ Via a text message on my cell phone (normal text message rates will apply)

_____ Via an email message to the address listed above

_____ Via an automated telephone message to my home phone

_____ None of the above. I'll remember my appointments on my own.
(Missed appointment fees will still apply)

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

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As a condition of reserving/scheduling sessions, True North Treatment Center **requires** a credit or debit card be kept on file. This information is kept on an encrypted, offsite server and is made part of your medical record.

Please document a card number for True North Treatment Center to keep on file below. This number will only be used to collect fees related to late cancelations and/or "no show" appointments and/or fees, coinsurance, deductibles or other monies due during and/or after services are rendered/completed. Another form of payment may be used during treatment as an adjunct or in place of this credit/debit card. If you dispute a charge with your credit card company and it is determined by them that you did owe this money you will be charged a $30 charge for each disputed charge, to cover our costs.

Name on Card_____ Billing Zip Code_____

Card Number _____

Expiration Date: _____ CVV Number (3 or 4 digit code): _____

I have read and understand the sections above, including those on HIPAA, Privacy, Confidentiality, Client Rights and Responsibilities, Attendance and Cancelation Policy, Credit/Debit Card on File Policy, and the Professional Services Agreement of True North Treatment Center and can request a copy of this agreement now or any time in the future, with a written request.

Parent/ Guardian or Client (if 18 or older)

Printed Name_____

Signature & Date_____

If/when a couple presents for services:

Partner Printed Name_____

Partner Signature & Date_____

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Notice of Privacy Practices, Payment, and Expectations

This notice describes how medical information about you may be used by True North Treatment Center and disclosed and how you can get access to this information. **Please read this carefully, there is important information that you will be responsible for.**

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form are kept properly confidential. HIPAA gives you the right to understand and control your *protected health information* (PHI). There are penalties when PHI is misused.

True North Treatment Center is required to maintain the privacy of your health information and can release PHI only for the purposes of treatment, payment, or health care operations. Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. Payment means obtaining reimbursement for services, confirming coverage, billing and collections, and utilization review. Heath Care Operations includes conducting quality assessments and improving activities, auditing, cost management analysis, and customer service. True North Treatment Center may also release PHI for law enforcement or other legitimate reasons.

We may also create and distribute de-identified health information by removing all references to PHI. We may contact you to provide appointment reminders via email, phone or text, information about alternative treatments, health-related benefits and services, and fundraising communications that may be of interest to you.

Disclosure of PHI will be made following written authorization from you. This may include disclosure of psychotherapy notes, marketing materials, sales of PHI under HIPAA, or other disclosures not included in this notice. You can revoke such authorization and we will abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You have the right to request restrictions on certain uses and disclosures of PHI, including those related to family members, other relatives, personal friends, or any others identified by you.

You have the right to reasonable requests to receive confidential communications of PHI by alternative means and locations. You have the right to copy and inspect your PHI. You have the right to request to amend your PHI. You have the right to receive an accounting of disclosures of your PHI. You have the right to obtain a paper copy of this notice upon request. You have the right to be advised of your unprotected PHI that is disclosed.

If you pay for services privately, you have the right to request that we do not disclose PHI related to your health plan. We will accommodate this request, except where required to disclose by law.

This notice is effective as of January 1, 2016 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms and to make the new notice provision effective for PHI that we maintain. ----If you feel that handling of your PHI has been violated, you have the right to file a formal, written complaint with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Confidentiality in Therapy

Professional ethics and state laws prevent therapists from telling anyone else what is shared in therapy without written permission. There are exceptions to this rule, when therapists must break confidentiality. These exceptions are outlined below for your review.

When you or other individuals are in physical danger, we must report this. Specifically, we will report if we believe:

- You are threatening serious harm to another person.
- You are seriously threatening to harm yourself. And/or your life or health is in grave danger.
- You may be abusing a child, an elderly person, or a disabled person or being abused. "Abuse" means to neglect, hurt, or sexually molest another person.

If you become involved in a court case or proceeding, you can prevent me from testifying in court about what you have told me. However, there are some situations where a judge or court may require me to testify:

- Child custody or adoptions proceedings, where your fitness as a parent is questioned or in doubt.
- In cases where your emotional or mental condition is important information for the court's decision.
- During a malpractice suit filed against me or another professional.
- In a civil commitment hearing to decide if you will be admitted to or continued in a psychiatric hospital.
- When you are seeing me for court-ordered evaluations and treatment.
- If you were sent to me for an evaluation by worker's compensation or Social Security disability.

In terms of insurance, money, and confidentiality:

- If you use your health insurance to pay part of our fees, the insurance company, managed care organization, or your employer's benefits office can require us to provide information about your functioning in many areas of your life, your social and psychological history, and your current symptoms. We will also be required to provide a treatment plan for your problems and information about your progress in therapy.
- It is against the law for insurers to release information about our office visits to anyone without your written permission. We cannot control who sees this information after it leaves our office.
- If you have been sent to me by your employer's employee assistance program, the program's staffers may require some information. We cannot control who sees this information after it leaves our office.
- If your account with us is unpaid and we have not arranged a payment plan, we can use legal means to get paid. The only information we will give to the court, a collection agency, or a lawyer will be your name and address, the dates we met for professional services, and the amount due.

Children, families and couples have some special considerations:

- When we treat children under the age of 12, we tell their parents or guardians whatever they ask us. As children get older, they assume more rights. Between the ages of 12-18, most of the details will be treated as confidential. However, parents or guardians do have the right to general information, including therapy progress. We may also have to tell parents or guardians information about others that I am told, especially if we are concerned about harm to the child.
- When we treat several members of a family, confidentiality can become very complicated. At the start of treatment, we must all have a clear understanding of our purpose and our roles. Then we can further discuss confidentiality.
- If you tell us something your spouse does not know, and knowing this could harm him or her, we cannot promise to keep it confidential.
- If you and your spouse have a custody dispute, we will need to know about it. Our professional ethics prevent us from doing both therapy and custody evaluations.
- If you are seeing us for marriage counseling, you must agree at the start of treatment that if you eventually decide to divorce, you will not request our testimony for either side. The court, however, may order us to testify.
- In couple's treatment, the medical record "belongs" to the member whose chief complaint brought the couple to treatment. This member has primary control over the contents of the record and who may or may not have access to its contents.
- **In regard to substance use, we have to follow Federal Law 42CFR which states many things including any one 12 and older must sign a release of information to disclose substance use information to anyone, including a parent. If the substance use becomes a safety issue, of imminent risk, this will be treated as such.

There are a few other things you should know about confidentiality:

- We may sometimes consult with another professional about your treatment. The other individual is also required to keep your information confidential. Likewise, when your therapist is out of town or unavailable, another therapist will be available to help clients. In these situations, we must give the individual some information about the client.
- I am required to keep records of your treatment.
- Confidentiality in group therapy is a special situation because members involved in the group are not therapists. They do not have the same ethics and laws, so you cannot be certain that they will not share information you say in a group setting.
- If you want us to send information about our therapy to someone else, you must sign a "Release of Information" form.
- Cell phones and email are less secure forms of communication. If you choose to use these forms of communication to communicate with our practitioners, we cannot assure your privacy as well as via "landline" based communication or fax (which of course also have risks).

  The rules of confidentiality are complicated! Please keep in mind that I am not able to give you legal advice. If you have special or unusual concerns, and so need special advice, I strongly suggest that you speak with a lawyer to protect yourself.

Client Rights and Responsibilities

In the course of care, a patient has both rights and responsibilities. Patients have the right to:

- Be treated with respect and recognition of their dignity and right to privacy.
- Receive care that is considerate and respects their personal values and belief system.
- Personal privacy and confidentiality of information.
- Receive information about their insurance carrier's services, practitioners, clinical guidelines, quality improvement program and consumer rights and responsibilities.
- Reasonable access to care, regardless of their race, religion, gender, sexual orientation, ethnicity, age, or disability.
- Participate in an informed way in the decision-making process regarding their treatment planning.
- A candid discussion with their treating professionals about appropriate or medically necessary treatment options for their condition regardless of cost or benefit coverage
- Have parents/ guardians participate in treatment planning.
- Individualized treatment, including
    - Adequate and humane services regardless of the sources (s) of financial support
    - Provision of services within the least restrictive environment possible.
    - An individualized treatment or program plan.
    - Periodic review of the treatment or program plan
    - An adequate number of competent, qualified, and experienced professional clinical staff to supervise and carry out the treatment or program plan.
- Designate a surrogate decision maker if they are incapable of understanding a proposed treatment or procedure or are unable to communicate their wishes regarding care.
- Be informed, along with their family, of their insurance carrier's rights in a language they understand.
- Voice complaints or appeals about their insurance carrier, their provider of care or privacy practices
- Make recommendations regarding their insurance carrier's rights and responsibility policies.
- Be informed of the reason for any utilization management adverse determination including the specific utilization
  review criteria or benefits provision used in the determination.
- Have utilization management decisions based on appropriateness of care. Their insurance carrier does not reward practitioners or other individuals conducting utilization review for issuing adverse determinations for coverage or service.
- Request access to their Protected Health Information (PHI) or other records that are in the possession of their insurance carrier.
- Request to inspect and obtain a copy of their PHI, to amend their PHI or to restrict the use of their PHI, and to receive an accounting of disclosures of PHI.

Patients are responsible for:

- Providing (to the extent possible) their treating clinician and their insurance carrier with information needed in order to receive appropriate care.
- Following plans and instructions for care that they have agreed on with their treating clinician.
- Understanding their health problems and participating, to the degree possible, in developing, with their treating clinician, mutually agreed upon treatment goals.

Professional Services Agreement

Treatment Expectations

True North Treatment Center values your trust in our services and we value building a strong, healthy relationship between our clientele and our practitioners. In order to maintain this trust and to build this foundation, we believe in maintaining *full transparency and accountability*. We also recommend that you have a primary care physician (PCP) and will provide you with referrals if you do not have one. The following expectations are clarified in order to maintain a strong working relationship and avoid misunderstandings and potential conflict in our relationship.

Professional Fees and Billing:

All fees are expected at the time services are rendered. True North Treatment Center accepts cash, check, and credit cards for payment. A receipt is available for your records and may be printed or sent electronically through email. True North Treatment Center is able to keep a credit card on file for billing purposes and bill services automatically for your convenience. The below rates are billed to insurance. *"In Network" rates are typically lower, as these rates are negotiated with each insurance carrier and vary by insurance company.*

- Psychotherapy

Initial Consultation	$200
Substance Use Evaluations	$225
45-50 Minute Individual/Family Session	$150
Group Session	$50/group

- Psychiatry

Initial consultation	$325
Follow up	$125

Please note that there is an administrative fee of $.60 per page, plus postage and handling, for copies of medical records, other than those sent to other health practitioners for coordination of care purposes. Furthermore, there are "add on" codes that are occasionally used in treatment, such as "Interactive Complexity" that is billed in addition to our per-session fees for cases involving the use of additional resources, time and/or effort, such as those that require contact with outside practitioners (e.g. Probation Officers for example) or individuals other than the client (e.g. parental involvement that is required due to communicative deficits of a child). There are also crisis billing codes or others that may be used.

Insurance Reimbursement:

Most True North Treatment Center practitioners are contracted with insurance carriers as "in network" providers. If and when this is the case, we will attempt to verify benefits at the time of your initial appointment. However, it is ultimately the *client's responsibility* to understand the limitations of insurance reimbursement. ***Any amount denied by the client's insurance carrier would be the financial responsibility of the client. If and when a collections agency becomes involved due to non-payment for services, a 40% "collections fee" may be assessed and forwarded with your statement to said collections agent.***

If True North Treatment Center is not contracted with your insurance, your practitioner is able to provide you with a superbill that you may submit to your insurance carrier for "out of network" reimbursement.

Insurance Credentialing and Billing:

Some of our practitioners' bill through their own NPI and/or professional license, whereas others bill insurance through their supervisor and/or our group practice. At times, Explanation of Benefits (EOB's) may come from your insurance company with a rendering provider name being our group practice name and/or

one of our supervising clinicians. If and when this causes concern or is confusing, please contact our office for clarification.

Contact Outside of Session:
True North Treatment Center may be contacted outside of regularly scheduled sessions by phone, mail, or email. True North Treatment Center practitioners strive to be available within a reasonable timeframe, which we define as within 24 business hours (e.g. during the traditional M-F workweek, during daytime hours, and closed for major holidays). Emergencies that cannot wait for a return call should be directed to the Crisis Call Center at 800-273-8255, West Hills Hospital at 775-323-0478, or 911. True North Treatment Center does not have members "on call" outside of regular hours, typically weekdays from 8am to 6pm.

Excessive contact or requests for significant out of session support services beyond a 10-minute time obligation will lead to the expectation for reimbursement at a prorated rate of $2 per minute, which may not be covered by insurance, and at the discretion of each practitioner. If requested for legal consultation, evaluation, the expected reimbursement rate is $300/hour, plus travel expenses beyond 25 miles. This hourly rate is for records review, discovery, report preparation, revisions, examinations, calls, emails, letters, affidavits, research, consultation, forms, deposition and travel to and from the TNTC office. Court appearances and depositions reimbursement rate is $500/ hour.

Attendance and Cancelation Courtesy Policy:
True North Treatment Center values your time and we strive to be available for as many members of our community as possible. In order to do this, *we hold a high standard for our staff and our clientele as it relates to attendance and cancelations.*

True North Treatment Center expects clientele to be present for services as agreed and in a timely manner. For treatment to move forward and be viable, consistent attendance is necessary and will be determined as part of the treatment planning process. Treatment and adherence is always "at will" and voluntary, however, effective treatment is at the discretion of each practitioner and their treatment plan is expected to be followed accordingly in order to attain positive results.

*A minimum of 24 hours' notice is expected for ALL cancelations or rescheduled appointment*s
No more than 3 "late cancelations" per 6-month period OR 2 concurrent late cancelations in any time period may occur, or termination of services may be considered. If *excessive cancelations* occur, as defined in the preceding sentence, payment may be expected for each service at the time of scheduling. Excessive cancelations will lead to the termination of services. If and when this is the case, a termination letter or email or phone call may be sent to the address on record and referrals will be provided for continuation of care.

When an appointment is scheduled with True North Treatment Center, you are holding a time on a clinician's calendar that *cannot be used in treating another person*. This is *time reserved for you* and it is expected this time will be well utilized. "No Shows" to appointments impact our ability to serve others well and will not be tolerated.

A reminder contact will be attempted 1-2 days prior to appointments via email, text or phone and clientele are expected to be available for services when scheduled. "No Shows" are billed a fee of $100, which will either be charged to a credit card on file or billed accordingly. If you cancel within 24 hours, before your session, you will be charge $50. If the therapist has availability and you reschedule within the same week, this fee will be reduced by $50%. If a client presents more than 15 minutes late to services, the session may

be considered canceled and billed the "No Show" rate, specified above. If this agreement is complete and on file *prior* to your initial appointment and you fail to present for services, you will be responsible for this fee.

Credit/Debit Card on File:

When an appointment is made with a True North Treatment Center clinician, this time is set aside and reserved solely for you and your family.

Please, note that the reason behind this policy is to protect the provider's time, and other possible clients, not to penalize you financially. If you are wondering why you should pay for the services you have not received, please, consider the fact that when you make an appointment with the provider, you are booking the provider's time that is no longer available for scheduling. Your session time is reserved/booked for you. We are rarely able to fill a cancelled session unless we know in advance. If you late-cancel a session or no-show, True North will charge you for the lost time unless we are able to fill it. Please, note that your insurance will not cover this charge.

As a condition of reserving/scheduling sessions, True North Treatment Center **requires** a credit or debit card be kept on file. This information is kept on an encrypted, offsite server and is made part of your medical record.

Please document a card number for True North Treatment Center to keep on file below. This number will only be used to collect fees related to late cancelations and/or "no show" appointments and/or fees, coinsurance, deductibles or other monies due during and/or after services are rendered/completed. Another form of payment may be used during treatment as an adjunct or in place of this credit/debit card. If you dispute a charge with your credit card company and it is determined by them that you did owe this money you will be charged a $30 charge for each disputed charge, to cover our costs.

Name on Card_____ Billing Zip Code_____

Card Number _____

Expiration Date: _____ CVV Number (3 or 4 digit code): _____

I have read and understand the sections above, including those on HIPAA, Privacy, Confidentiality, Client Rights and Responsibilities, Attendance and Cancelation Policy, Credit/Debit Card on File Policy, and the Professional Services Agreement of True North Treatment Center and can request a copy of this agreement now or any time in the future, with a written request.

Parent/ Guardian or Client (if 18 or older)

Printed Name_____

Signature & Date_____

If/when a couple presents for services:

Partner Printed Name_____

Partner Signature & Date_____

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Safety Acknowledgments

At True North, one of our main concerns is your safety. As we see people from a variety of setting and for a variety of reasons, we recognize that some people may not be in treatment for the same reasons regarding safety. However, we have created this list of some important things to be aware of, to further promote safety. Please let us know if you have any questions.

Medication

- If you (or your child) is taking prescribed or over the counter medication, please:
- Take medications as prescribed. Do not change the dose, time or method of administration unless directed by your physician.
- Report any medication side effects to your physician immediately.
- Managing medications may be difficult when distracted, angry or confused.
- I understand that I should not use drugs, alcohol, medications that are not currently prescribed to me. If I am pregnant, please consult with our doctor.
- I am aware that any medication can be dangerous and may need to be safely secured.

Safety

- I understand that driving can be dangerous if I am not fully alert and oriented. I will not drive if I feel impaired.
- I understand that if I feel lonely, unsafe (towards self or others), etc., I will talk to a supportive person and/or my parent/guardian (if client is a minor). I can also create a list of numbers to call in a crisis, call the crisis call center @211 or text "ANSWER" to 839863. Finally, I can call 911 or go to the nearest emergency room.

Safety Plan for Weapons/ Firearms/ other means

- I understand that True North's position is that firearms must be safely disposed of, stored in a safe, or secure location, away from the home. Having firearms, weapons or other means of self-harm in the home, or access to them, increases the chances of an individual harming or killing themselves.
- I am aware that there are many ways for a person to harm themselves or someone else. Some (but not all of these include): razor, knife, rope, high places, moving vehicles, etc.
- Please bring up any concerns that you may have with your therapist, or to have a more in-depth safety plan.

Client/Parent/Guardian Signatures:		
Client Signature: ****Client only needs to sign if 12 or older**		
Parent/Guardian: signature and printed		
Parent/Guardian Signature:		

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TREATMENT CENTER

AUTHORIZATION TO RELEASE OF PROTECTED HEALTH INFORMATION

Client Name: _____DOB: _____ Phone #: _____

I authorize the exchange of information Between

True North Treatment Center
3470 Lakeside Drive Ste #202
Reno, NV 89509
Phone #: 775-870-5027
Fax # 775-507-4020

Name of Person or Entity: _____
Address: _____
Phone #: _____
Fax # _____

Information that may be released: (*Must be checked to authorize release*):

_____ Medical Record ____ Psychiatric Evaluation ____ Consultation Reports ____ Psychological Testing

____ Physician Progress Note ____ Discharge/Continuing Care Plan ____ Discharge Summary ____Verbal Communication

Purpose for which Information is being used:

_____Continuing Care ____ School ____Disability Benefits ____Legal ____Personal ____employment condition

AUTHORIZATION:

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Revocation must be in writing. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure. Refer to the Notice for Privacy Practices regarding authorized disclosures. A legible copy of the Authorization or my signature thereon may be used with the same effectiveness as an original.

OTHER CONDITIONS:

This information has been disclosed to you from records whose confidentiality may be protected by Federal Law: "Federal regulation (42 CFR, Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." [RM 203, 7.2] Rev. 4-12-04

This consent expires one year from the date below unless otherwise specified: (not to exceed one year)_____

Patients age 11 and younger require parent/guardian signature only; Based on services provided, signature of both patient and parent/guardian may be required for patients age 12-17; patients age 18 and older must sign exclusively unless there is a legal guardian.

_____
Signature of Client and Date

_____
Signature of Parent/Guardian, if applicable, and Date