Katie A. Benson, MSW, LCSW
2755 10th Ave N.
Grand Forks, ND 58203-2136
Phone: (701) 738-0888
Fax: (701) 757-1431
Email: katie@thezonegf.com

Forms for New Patients of Katie A. Benson, MSW, LCSW

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Please print and fill out all forms completely, signing pages 2, 3, 11, & 12.

Katie A. Benson, MSW, LCSW

Child and Family Therapist
2755 10th Ave N.
Grand Forks, ND 58203-2136
Phone: 701-738-0888
Fax: 701-757-1431
Email: katie@thezonegf.com

Please complete all information correctly and legibly or **you will be responsible for the bill.**

PATIENT INFORMATION:

Last name: ___________________________ First Name:___________________________ M.I. ______

SSN: ______-____-______ Birth date: _____/_____/_______ Medication Allergies: ____________

Sex: M or F Patient's marital status: ______________ Patient's Spouse's Name:_______________

Address: ______________________________ City: _________________ State: _____ Zip: _______

Phone: home ____________________ work ____________________ cell ____________________

Referring Doctor: _________________________ Primary Doctor: ____________________________

RESPONSIBLE PARTY (if other than patient):

Last name: ___________________________ First Name:___________________________ M.I. ______

Address: ______________________________ City: _________________ State: _____ Zip: _______

Phone: home ____________________ work ____________________ cell ____________________

Employer's Name: ______________________________ City: _________________ State: _________

INSURANCE INFORMATION:

Primary Insurance

Card Holder _______________________________

Birth Date _________________________________

SSN ______________________________________

Address (if different) ________________________

____

Phone # __________________________________

Employer _________________________________

Insurance Company _________________________

Policy ID # (begins with a letter)

____

Group # ______-______

Secondary Insurance (if applicable)

Card Holder _______________________________

Birth Date _________________________________

SSN ______________________________________

Address (if different) ________________________

____

Phone # __________________________________

Employer _________________________________

Insurance Company _________________________

Policy ID # (begins with a letter)

____

Group # ______-______

BILLING INFORMATION – Read and sign:

1. I authorize Katie A. Benson, MSW, LCSW to release medical and other information concerning this or related claims to government agencies including Social Security Administration and its intermediaries, insurance companies and carriers who may be responsible for payment of benefits.
2. I authorize Katie A. Benson, MSW, LCSW, to release my medical records and billing information to my Primary Care and Referring Physician.
3. I authorize my insurance benefits to be paid to Katie A. Benson, MSW, LCSW.
4. If a requested insurance claim is filed, I will receive a bill each month if my account has a balance due. I am responsible for any charges not paid by insurance.
5. I understand that if I do not provide the above insurance information, I will be responsible for my bill, regardless of whether or not I have insurance.
6. I understand that I am responsible for providing a referral to my insurance company if they require it.
7. I understand I am responsible for payment of my bill beyond insurance coverage.
8. I understand that my scheduled time slot will be forfeited if I miss three scheduled sessions without contacting the provider and per the provider's discretion.

Name of person completing this form (please print) ____

Signature of person completing this form____________________________________ Date: __________

Relationship to Patient: ____

AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL RECORDS & INFORMATION

Patient Name: ____

Date of Birth: ______________________ **Phone:** ___________________________

I authorize: Circle One
Katie A. Benson, MSW, LCSW
Diane K. Baumbach, MSW, LCSW, BCD
Jessica L. Hermanson, MSW, LCSW

To release and exchange with:
1. Clinicians who provide services at the Zone (listed at the left)
2755 10th Ave N.
Grand Forks, ND 58203-2136
Ph: (701) 738-0888, fax: (701) 757-1431

Clinicians at The Zone operate independently but share office space.

Items to be released:
X Diagnostic Information x Acknowledgement of Care
X Therapy & Progress Information (not to include progress notes)

I authorize verbal and/or written exchange of my medical information.
The information is to be used for:

X Office work related to Management of Care
X Supervision
X Referral
___ Other ____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OF FEDERAL LAW I SPECIFICALLY AUTHORIZE THE RELEASE OF INFORMATION RELATE TO:

1. Substance Abuse
2. Mental Health (includes psychological testing)
3. HIV-Related Information (AIDS related testing)
4. Developmental Disabilities
5. Adoptee/Adopting Parents
6. Physical Abuse

This release of information consent form remains in effect for 12 months or until the patient or legal guardian shall revoke this authorization. However your revocation will not be effective to the extent that action that relied on the authorization of this consent and was obtained as a condition for insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to the authorization may be subject to re-discloser by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Clinician's policy for release of medical records:

a) No charge for medical records released to physician(s) or other health care providers.
b) A fee schedule is applicable for medical records released directly to patient(s) or nonmedical related parties.

Copying fee: $____________

Signature: ____ **Date:** ____________

Relationship to client________________________________

Witness: ____ **Date:** ____________

Name ____________________________ Date ________

BIOPSYCHOSOCIAL HISTORY

PRESENTING PROBLEMS

Presenting problems	**Duration** (months)	**Additional information**:
____________________	______________	________________________
____________________	______________	________________________
____________________	______________	________________________

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

None = This symptom not present at this time • **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate = Significant impact on quality of life and/or day-to-day functioning • **Severe** = Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
depressed mood	[ ]	[ ]	[ ]	[ ]	bingeing/purging	[ ]	[ ]	[ ]	[ ]	guilt	[ ]	[ ]	[ ]	[ ]
appetite disturbance	[ ]	[ ]	[ ]	[ ]	laxative/diuretic abuse	[ ]	[ ]	[ ]	[ ]	elevated mood	[ ]	[ ]	[ ]	[ ]
sleep disturbance	[ ]	[ ]	[ ]	[ ]	anorexia	[ ]	[ ]	[ ]	[ ]	hyperactivity	[ ]	[ ]	[ ]	[ ]
elimination disturbance	[ ]	[ ]	[ ]	[ ]	paranoid ideation	[ ]	[ ]	[ ]	[ ]	dissociative states	[ ]	[ ]	[ ]	[ ]
fatigue/low energy	[ ]	[ ]	[ ]	[ ]	circumstantial symptoms	[ ]	[ ]	[ ]	[ ]	somatic complaints	[ ]	[ ]	[ ]	[ ]
psychomotor retardation	[ ]	[ ]	[ ]	[ ]	loose associations	[ ]	[ ]	[ ]	[ ]	self-mutilation	[ ]	[ ]	[ ]	[ ]
poor concentration	[ ]	[ ]	[ ]	[ ]	delusions	[ ]	[ ]	[ ]	[ ]	significant weight gain/loss	[ ]	[ ]	[ ]	[ ]
poor grooming	[ ]	[ ]	[ ]	[ ]	hallucinations	[ ]	[ ]	[ ]	[ ]	concomitant medical condition	[ ]	[ ]	[ ]	[ ]
mood swings	[ ]	[ ]	[ ]	[ ]	aggressive behaviors	[ ]	[ ]	[ ]	[ ]	emotional trauma victim	[ ]	[ ]	[ ]	[ ]
agitation	[ ]	[ ]	[ ]	[ ]	conduct problems	[ ]	[ ]	[ ]	[ ]	physical trauma victim	[ ]	[ ]	[ ]	[ ]
emotionality	[ ]	[ ]	[ ]	[ ]	oppositional behavior	[ ]	[ ]	[ ]	[ ]	sexual trauma victim	[ ]	[ ]	[ ]	[ ]
irritability	[ ]	[ ]	[ ]	[ ]	sexual dysfunction	[ ]	[ ]	[ ]	[ ]	emotional trauma perpetrator	[ ]	[ ]	[ ]	[ ]
generalized anxiety	[ ]	[ ]	[ ]	[ ]	grief	[ ]	[ ]	[ ]	[ ]	physical trauma perpetrator	[ ]	[ ]	[ ]	[ ]
panic attacks	[ ]	[ ]	[ ]	[ ]	hopelessness	[ ]	[ ]	[ ]	[ ]	sexual trauma perpetrator	[ ]	[ ]	[ ]	[ ]
phobias	[ ]	[ ]	[ ]	[ ]	social isolation	[ ]	[ ]	[ ]	[ ]	substance abuse	[ ]	[ ]	[ ]	[ ]
obsessions/compulsions	[ ]	[ ]	[ ]	[ ]	worthlessness	[ ]	[ ]	[ ]	[ ]	other (specify) ___________	[ ]	[ ]	[ ]	[ ]

EMOTIONAL/PSYCHIATRIC HISTORY

[ ] [ ] Prior outpatient psychotherapy?
No Yes If yes, on _______occasions. Longest treatment by ______________ for _____ sessions from ____/_______ to _____/_______
Provider Name Month/Year Month/Year

Prior provider name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?
______________	_________	_____	_________	_________	______________	______________
______________	_________	_____	_________	_________	______________	______________

[ ] [ ] Has any family member had outpatient psychotherapy? If yes, who/why (list all):________________________________
No Yes ____

[ ] [ ] Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?
No Yes If yes, on _______occasions. Longest treatment at ____________________________ from ___/_______ to _____/_______
Name of facility Month/Year Month/Year

Inpatient facility name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?
______________	_________	_____	_________	_________	______________	______________
______________	_________	_____	_________	_________	______________	______________

[ ] [ ] Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder? If yes,
No Yes who/why (list all):____

Name ______________________________ Date ________

[ ] No [ ] Yes **Prior or current psychotropic medication usage?** If yes:

Medication	Dosage	Frequency	Start date	End date	Physician	Side effects	Beneficial?
________	______	________	________	______	____________	_________	____________
________	______	________	________	______	____________	_________	____________

[ ] No [ ] Yes **Has any family member used psychotropic medications?** If yes, who/what/why (list all):____________________________

____

FAMILY HISTORY

FAMILY OF ORIGIN

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	[ ]	[ ]	[ ]
father	[ ]	[ ]	[ ]
stepmother	[ ]	[ ]	[ ]
stepfather	[ ]	[ ]	[ ]
brother(s)	[ ]	[ ]	[ ]
sister(s)	[ ]	[ ]	[ ]
other (specify)	[ ]	[ ]	[ ]

____

Parents' current marital status:

[ ] married to each other
[ ] separated for ___ years
[ ] divorced for ___ years
[ ] mother remarried ___ times
[ ] father remarried ___ times
[ ] mother involved with someone
[ ] father involved with someone
[ ] mother deceased for ___ years
age of patient at mother's death ___
[ ] father deceased for ___ years
age of patient at father's death ____

Describe parents:

	Father	**Mother**
full name	____________	____________
occupation	____________	____________
education	____________	____________
general health	____________	____________

Describe childhood family experience:

[ ] outstanding home environment
[ ] normal home environment
[ ] chaotic home environment
[ ] witnessed physical/verbal/sexual abuse toward others
[ ] experienced physical/verbal/sexual abuse from others

Special circumstances in childhood:____

____

____

IMMEDIATE FAMILY

List all persons currently living in patient's household:

Name	Age	Sex	Relationship to patient

List children not living in same household as patient:

____

____

____

Frequency of visitation of above: ____

Describe any past or current significant issues in immediate family relationships: ______________________________

____

____

____

MEDICAL HISTORY (check all that apply for patient)

Describe current physical health: [ ] Good [ ] Fair [ ] Poor

____

List name of primary care physician:

Name ______________________ Phone ______________

List name of psychiatrist: (if any):

Name ______________________ Phone ______________

List any medications currently being taken (give dosage & reason):

____

____

____

Is there a history of any of the following in the family:

[ ] tuberculosis
[ ] heart disease
[ ] birth defects
[ ] high blood pressure
[ ] emotional problems
[ ] alcoholism
[ ] behavior problems
[ ] drug abuse
[ ] thyroid problems
[ ] diabetes
[ ] cancer
[ ] Alzheimer's disease/dementia
[ ] mental retardation
[ ] stroke
[ ] other chronic or serious health problems ______________

____

Name ______________________________ Date ________

List any known allergies: ________________________

List any abnormal lab test results:
Date ___________ Result ____________________
Date ___________ Result ____________________

Describe any serious hospitalization or accidents:
Date ________ Age _____ Reason ____________________
Date ________ Age _____ Reason ____________________
Date: ________ Age _____ Reason ____________________

SUBSTANCE USE HISTORY (check all that apply for patient)

Family alcohol/drug abuse history:

[ ] father [ ] stepparent/live-in
[ ] mother [ ] uncle(s)/aunt(s)
[ ] grandparent(s) [ ] spouse/significant other
[ ] sibling(s) [ ] children
[ ] other __________________

Substance use status:

[ ] no history of abuse
[ ] active abuse
[ ] early full remission
[ ] early partial remission
[ ] sustained full remission
[ ] sustained partial remission

Substances used:

(complete all that apply)	First use age	Last use age	Current Use (Yes/No)	Frequency	Amount
[ ] alcohol	________	________	______	_______	______
[ ] amphetamines/speed	________	________	______	_______	______
[ ] barbiturates/owners	________	________	______	_______	______
[ ] caffeine	________	________	______	_______	______
[ ] cocaine	________	________	______	_______	______
[ ] crack cocaine	________	________	______	_______	______
[ ] hallucinogens (e.g., LSD)	________	________	______	_______	______
[ ] inhalants (e.g., glue, gas)	________	________	______	_______	______
[ ] marijuana or hashish	________	________	______	_______	______
[ ] nicotine/cigarettes	________	________	______	_______	______
[ ] PCP	________	________	______	_______	______
[ ] prescription___________	________	________	______	_______	______
[ ] other________________	________	________	______	_______	______

Treatment history:

[ ] outpatient (age[s]______________)
[ ] inpatient (age[s]_______________)
[ ] 12-step program (age[s]_________)
[ ] stopped on own (age[s]_________)
[ ] other (age[s]__________________
describe:_____________________

Consequences of substance abuse (check all that apply):

[ ] hangovers [ ] withdrawal symptoms [ ] sleep disturbance [ ] binges
[ ] seizures [ ] medical conditions [ ] assaults [ ] job loss
[ ] blackouts [ ] tolerance changes [ ] suicidal impulse [ ] arrests
[ ] overdose [ ] loss of control amount used [ ] relationship conflicts
[ ] other ____

DEVELOPMENTAL HISTORY (check all that apply for a child/adolescent patient)

Problems during mother's pregnancy:

[ ] none
[ ] high blood pressure
[ ] kidney infection
[ ] German measles
[ ] emotional stress
[ ] bleeding
[ ] alcohol use
[ ] drug use
[ ] cigarette use
[ ] other

Birth:

[ ] normal delivery
[ ] difficult delivery
[ ] cesarean delivery
[ ] complications _____
____
birth weight ____lbs ___oz.

Infancy:

[ ] feeding problems
[ ] sleep problems
[ ] toilet training problems

Childhood health:

[ ] chickenpox (age _________) [ ] lead poising (age ________)
[ ] German measles (age _____) [ ] mumps (age ___________)
[ ] red measles (age _________) [ ] diphtheria (age _________)
[ ] rheumatic fever (age ______) [ ] poliomyelitis (age _______)
[ ] whooping cough (age _____) [ ] pneumonia (age _________)
[ ] scarlet fever (age _________) [ ] tuberculosis (age ________)
[ ] autism [ ] mental retardation
[ ] ear infections [ ] asthma
[ ] allergies to ____
[ ] significant injuries ____
[ ] chronic, serious health problems ______________________________
____

Name ______________________________ Date ________

Delayed developmental milestones (check only those milestones that did not occur at expected age):

[ ] sitting
[ ] rolling over
[ ] standing
[ ] walking
[ ] feeding self
[ ] speaking words
[ ] speaking sentences
[ ] controlling bladder
[ ] other ______________________________
[ ] controlling bowels
[ ] sleeping alone
[ ] dressing self
[ ] engaging peers
[ ] tolerating separation
[ ] playing cooperatively
[ ] riding tricycle
[ ] riding bicycle

Emotional / behavior problems (check all that apply):

[ ] drug use
[ ] alcohol abuse
[ ] chronic lying
[ ] stealing
[ ] violent temper
[ ] fire-setting
[ ] hyperactive
[ ] animal cruelty
[ ] assaults others
[ ] disobedient
[ ] repeats words of others
[ ] not trustworthy
[ ] hostile/angry mood
[ ] indecisive
[ ] immature
[ ] bizarre behavior
[ ] self-injurious threats
[ ] frequently tearful
[ ] frequently daydreams
[ ] lack of attachment
[ ] distrustful
[ ] extreme worrier
[ ] self-injurious acts
[ ] impulsive
[ ] easily distracted
[ ] poor concentration
[ ] often sad
[ ] breaks things
[ ] other ____________
____

Social interaction (check all that apply):

[ ] normal social interaction
[ ] isolates self
[ ] very shy
[ ] alienates self
[ ] inappropriate sex play
[ ] dominates others
[ ] associates with acting-out peers
[ ] other ___________________

Intellectual / academic functioning (check all that apply):

[ ] normal intelligence
[ ] high intelligence
[ ] learning problems
[ ] authority conflicts
[ ] attention problems
[ ] underachieving
[ ] mild retardation
[ ] moderate retardation
[ ] severe retardation

Current or highest education level ________________________________

Describe any other developmental problems or issues: ____
____

SOCIO-ECONOMIC HISTORY (check all that apply for patient)

Living situation:

[ ] housing adequate
[ ] homeless
[ ] housing overcrowded
[ ] dependent on others for housing
[ ] housing dangerous/deteriorating
[ ] living companions dysfunctional

Financial situation:

[ ] no current financial problems
[ ] large indebtedness
[ ] poverty or below-poverty income

Social support system:

[ ] supportive network
[ ] few friends
[ ] no friends
[ ] distant from family of origin

Legal history:

[ ] no legal problems
[ ] now on probation
[ ] court ordered this treatment

describe last legal difficulty: ______
____

Cultural/spiritual/recreational history:

cultural identity (e.g., ethnicity, religion): ______________________
____

describe any cultural issues that contribute to current problem: ______
____

currently active in community/recreational activities? Yes [ ] No [ ]
formerly active in community/recreational activities? Yes [ ] No [ ]
currently engage in hobbies? Yes [ ] No [ ]
currently participate in spiritual activities? Yes [ ] No [ ]
if answered "yes" to any of above, describe: ____________________
____

SOURCES OF DATA PROVIDED ABOVE: [ ] Patient self-report for all [ ] A variety of sources (if so, check appropriate sources below):

Presenting Problems/Symptoms
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) ________________

Family History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) ____________________

Developmental History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) ____________________

Emotional/Psychiatric History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) ________________

Medical/Substance Use History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) ____________________

Socioeconomic History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) ____________________

NOTICE OF PRIVACY PRACTICES

Please read this notice and **sign and date** the attached acknowledgement.

Katie A. Benson, MSW, LCSW
Child and Family Therapist
2755 10th Ave N.
Grand Forks, ND 58203-2136

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at ________________________:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at ______________________ or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 2013.

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:____
DOB: ____
SSN:____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Katie A. Benson's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Katie A. Benson at 701-738-0888.

____
Signature of Patient/Client **Date**

____
Signature or Parent, Guardian or Personal Representative * **Date**

____
* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

☐ **Patient/Client Refuses to Acknowledge Receipt**:

____
Signature of Staff Member **Date**

PERMISSION TO TREAT A MINOR

I, ______________________________, hereby authorize Katie A. Benson, MSW, LCSW to provide psychotherapy to ____, a minor.

I attest to the fact that I have the legal authority to grant this permission.

Signature: ____

Date:___________________________

Relationship to child: ____Parent ____Legal Guardian ____Court appointed Custodian

Agency Representation: ____

Date: __________________________