ACRES FOR LIFE
Therapy & Wellness Center

Phone: 651.257.4159
info@acresforlife.org

General Information

Name (first, middle, last): _____

Preferred Name: _____

Address (street, apartment #t, city, state, zip): _____

_____

Birth Date: _____ Age: _____ Grade: _____

Gender: _____ Preferred Pronouns: _____

Parent/Guardian Name: _____

Parent/Guardian Address: _____

Email: _____

Phone: Cell: _____ Home: _____ Work: _____

OK to: Call: Yes No Call: Yes No Call: Yes No

Leave message: Yes No Leave message: Yes No Leave message: Yes No

Text: Yes No Text: Yes No Text: Yes No

Parent/Guardian Name: _____

Parent/Guardian Address: _____

Email: _____

Phone: Cell: _____ Home: _____ Work: _____

OK to: Call: Yes No Call: Yes No Call: Yes No

Leave message: Yes No Leave message: Yes No Leave message: Yes No

Text: Yes No Text: Yes No Text: Yes No

Who/if anyone, referred you to Acres for Life? _____

Primary Health Insurance (Name & ID#) _____

Secondary Health Insurance (Name & ID#) _____

Primary Policyholder (Name & DOB) _____

Secondary Policyholder (Name & DOB) _____

Emergency contact name/relationship: _____

Emergency contact address: _____ Phone number: _____

What do you hope to accomplish by coming to Acres for Life?

_____

_____

Counseling & Psychiatric History

Has your child ever been given a mental health diagnosis? ** Please explain:
____

____

Do you agree with that diagnosis? Please explain:
____

____

Type of treatment (circle one): Outpatient treatment/traditional counseling Inpatient Hospitalization IOP

Treatment Facility/Provider: ____

Date of treatment: ______________________ Length of treatment: _____________________ Was it helpful? Y N

Type of treatment (circle one): Outpatient treatment/traditional counseling Inpatient Hospitalization IOP

Treatment Facility/Provider: ____

Date of treatment: ______________________ Length of treatment: _____________________ Was it helpful? Y N

Type of treatment (circle one): Outpatient treatment/traditional counseling Inpatient Hospitalization IOP

Treatment Facility/Provider: ____

Date of treatment: ______________________ Length of treatment: _____________________ Was it helpful? Y N

Type of treatment (circle one): Outpatient treatment/traditional counseling Inpatient Hospitalization IOP

Treatment Facility/Provider: ____

Date of treatment: ______________________ Length of treatment: _____________________ Was it helpful? Y N

Type of treatment (circle one): Outpatient treatment/traditional counseling Inpatient Hospitalization IOP

Treatment Facility/Provider: ____

Date of treatment: ______________________ Length of treatment: _____________________ Was it helpful? Y N

Substance Abuse Treatment History

Has your child ever received treatment for substance abuse/dependence? Y N
If yes, please describe below:

Circle one: Outpatient Treatment Inpatient Treatment 12-step Program Other

Treatment Facility/Provider: _____

Length of Treatment: _____ Length of sobriety after treatment: _____

Circle one: Outpatient Treatment Inpatient Treatment 12-step Program Other

Treatment Facility/Provider: _____

Length of Treatment: _____ Length of sobriety after treatment: _____

Circle one: Outpatient Treatment Inpatient Treatment 12-step Program Other

Treatment Facility/Provider: _____

Length of Treatment: _____ Length of sobriety after treatment: _____

****NOTE: PLEASE BRING TO INTAKE ANY SUPPORTING DOCUMENTATION IN YOUR POSSESSION OF DIAGNOSES GIVEN/TREATMENT RECEIVED**

Health Information

Does your child currently take medications? Y N

Name/Dosage/Frequency:

_____

_____

_____

_____

_____

Has your child been prescribed any medications by a medical professional that they do not take? Y N

If yes, please explain: _____

Treatment Contract/Registration

WELCOME! The most important goal of your time here is to help you feel and do better in your life. As a client, you can help with your treatment by keeping the following information in mind throughout your time here. This is a solution-focused, goal directed approach for a wide variety of problems, from crises in daily living to ongoing mental health issues. It is especially important that you keep in close contact with family or supportive friends during a crisis and that you assume responsibilities for helping yourself. Treatment will be provided in the least restrictive environment possible.

Standard individual sessions are 50 minutes and group therapy sessions vary between 1 - 2 hours. While this can be somewhat flexible, the time frame will be maintained as much as possible to help all involved. Also this is a courtesy to others that may be waiting. You are a key part of the treatment team. We encourage you to openly discuss concerns and ideas for your treatment progress with the facilitation team. Your input and concerns are very important and talking about them often leads to beneficial results for all involved.

Confidentiality: Please understand that what you say is CONFIDENTIAL and will be discussed with other people only with your written permission (except in medical emergencies, under a court order, or as required by law, i.e. mandatory child abuse reporting, and vulnerable adult abuse reporting or for the purpose of consultation or supervision). If there is a clear intention to do serious harm to self or to another person, information will be shared in an attempt to prevent that harm from occurring. Information regarding services provided to minor children can be given to parents on request as a matter of state law. If a minor child is seen, issues regarding confidentiality will be discussed with the parents. Insurance providers often require more detailed information of your situation prior to approval of continued treatment or payment for treatment. If you wish to know the informational requirements of your insurance company, please ask. **_____Initial**

Electronic correspondence, including email and text messages, does not provide sufficient confidentiality. If you choose to email us we cannot guarantee your confidentiality. **_____Initial**

Office Hours and Cancellation Policy: Office hours vary. Session time is valuable to all involved. **Cancellations or changes of an appointment must be made at least 24 hours in advance or you will be charged for your session.** Please note that insurance companies do not pay for failed or canceled appointments. This is standard practice and is intended in part to preserve the time for those who may need it. See Late Cancellation/No Show addendum attached to this packet for details. Please ask me about any questions you may have about this policy. **You can make appointment changes by calling 651-257-4159 and leaving a message, and by calling and/or emailing your primary therapist**. In addition, if a client is late for a session the session will end at the scheduled time and you will be charged for the full session or it may need to be rescheduled and a late cancellation fee may be charged. You are responsible for paying for your session at each visit. **_____Initial**

Consultation and Supervision: To provide you with the best possible service, Acres for Life engages in ongoing supervision and consultation with other mental health professionals. When discussing clients in these forums, confidentiality is protected. **_____Initial**

Crisis Situations: Providers at Acres for Life understand that at times you may be in a psychological or life-threatening crisis. Since our facilitators are frequently in sessions with other clients and thus may not be immediately available to assist you through your crisis we ask that you follow the crisis procedures outlined below. Please discuss any questions you have about these procedures with your facilitation team. **_____Initial**

Steps to take during a crisis will depend upon the nature of the crisis. You may call your individual therapist during normal business hours. In the event that your therapist cannot be reached call the Crisis Connection at 612-379-6363 or your local county crisis center right away or after business hours, weekends and holidays. When immediate service is required for life threatening situations, please call 911 or go to the emergency department at the closest hospital. **_____Initial**

Fees, Phone Calls and Reports: Fees are as follows: $185 for individual sessions. $90 per session for group therapy (minimum 3 people for 3 hours). Day of rate for individuals $130.00. Couples and family rates available upon request. **_____Initial**

Full payment (or co-payment if services are covered by insurance and any deductible has been satisfied) is due at the beginning of the session hour. There are not fees charged for phone calls, letters and reports to facilitate scheduling, information sharing, etc. and requiring up to 10 minutes of time. Scheduling paid telephone sessions is welcome when a situation is particularly urgent or because of travel or geographical difficulties and must be cash or credit card as insurance will not pay for a phone session. Failed individual/group/family appointments or cancellations will be charged as detailed in the Late Cancellation/No Show Addendum attached to this packet. Please note: **All payment, including copays/co-insurance, late cancel/failed appointment fees and unpaid claims from your insurance company is due prior to or at the time of service or your appointment will be rescheduled for a time after payment is received.** **_____Initial**

Insurance and Bookkeeping: You may contact us at 651-257-4159 with any questions regarding billing or collections. There may be situations that we will call you directly regarding billing or collection issues. If your insurance company does not cover the services you receive, you are fully responsible for the amount due. If you have any questions about obtaining coverage, please ask. However, your insurance carrier will make a decision about any reimbursement. **_____Initial**

Collections: In case you do not pay your bill, we reserve the right to seek payment through the use of a collection agency or through other legal means. The cost of collection may be added to your bill. Return check fee is $35 and will be billed to you. Unpaid balances may incur reasonable and customary interest charges. **_____Initial**

Record-keeping, Requests from Third Parties for Records, Testifying Regarding Records, and Related Costs:
We keep very brief records including only that you have been here, interventions that happened in session and topics and goals discussed. You have a right to a copy of your file at any time. You have the right to request that we correct any errors in your file, and you may provide a copy of that file to any health care provider at any time. Our records are confidential and may not be used as evidence for litigation purposes. This includes all assessments, questionnaires, evaluations, and testing. **_____Initial**

If a child or children are involved, you or your non-health care advisors may not subpoena our documents or use as evidence in any proceeding any communication or documents related to the therapy process. Be advised that if we are somehow compelled to release documents, you as a client acknowledge and grant the right for us to give identical documents to the opposing party. **_____Initial**

If we are forced to further document or respond to information requests, meet with your representatives, or testify in court our fees are $400/hour, portal to portal, plus all expenses, half day minimum, paid in advance. Agreement to this provision is required to receive therapy services from us, and is acknowledged by your signature at the end of this document. **_____Initial**

Services NOT Offered:
We are **not qualified** and we **do not offer** the following services:

1. Custody Evaluation
2. Visitation Recommendations
3. Disability Evaluation or Recommendation
4. Services requiring testimony in legal proceedings. **_____Initial**

Note: Your treatment here is suspended when a subpoena arrives. We will attempt to legally quash a subpoena request. Treatment summarization documents for legal purposes require written client release and cost $250 per request. Copies will be sent to opposing counsel. **_____Initial**

I understand and agree to abide by the policies stated above.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

Informed Consent Minor Child

Your child is going to be participating in an **intensive therapeutically based** program using **EAGALA methods. EAGALA methods** use human interaction with horses to bring out feelings and emotions that are often hidden. Each week your child will be asked to work on a challenge with the horses. These challenges can cause feelings of frustration, anger, self-doubt, and anxiety to surface. The intent of the program is to bring out these feelings so that the participants can learn to deal with them more effectively. It is also common to experience feelings of hope, empowerment, and creative problem solving.
As your child goes through this program, you may see some of these common themes:

1. Your child may say that he or she no longer wants to come to EAGALA sessions because they are "boring," "stupid," etc. It is difficult for all of us to willingly place ourselves in situations that will bring out feelings we do not want to deal with. Your child is no exception. Your child may have thought that the program was supposed to be a fun time to play with horses and then be very disappointed when he or she realizes that this is therapy. **_____ Initial**

2. You may not see improvements in your child's behaviors right away. Due to the intensive nature of the program, your child may be experiencing the "stirring the pot" syndrome. This means that your child may be confused or overwhelmed by the feelings that are aroused by EAGALA work. The ability of EAGALA methods to bring out deeper feelings and emotions is what makes this program so powerful. Each session builds on the one before it and as the difficulty level increases the participants become better equipped to handle those feelings.
_____ Initial

3. You may be wondering what is going on in the sessions. Parents and caregivers are naturally curious about their child's sessions. Our shared goal is to create an environment of emotional and physical safety. In order to do this we ask that your child's session be just that, THEIR session. The reason for this is so children can express themselves freely without worrying about what their loved ones might think. We encourage you to let your child determine what specifics about their experiences in sessions they are willing to share. Please understand that sometimes it may be difficult for our clients to express what they are experiencing and feeling as a result of the sessions. We are happy to speak with you about our overall perceptions of your child's progress in the sessions. If you are interested in discussing progress, please call our office to schedule an appointment outside of regularly scheduled sessions. **_____ Initial**

4. Scheduling conflicts may occur. EAGALA activities are planned in advance, facilitators are called in to be available and a time slot is held for your child. When your child does not show up for their session, that time slot is not available to serve other clients. Please do your best to avoid missing sessions. In the event that this cannot be avoided, please call us as soon as you know that your child will not be attending a session. Please refer back to the cancellation policy for further information. **_____ Initial**

Adapted with permission from Desert Dove Farm

Signature: _____ Date:_____

State of Minnesota Client Bill of Rights
Complementary and Alternative Health Care Statute §146A.11

Please read this Complementary and Alternative Health Care Bill of Rights. If you have any difficulty reading it or understanding it, tell us and reasonable accommodations will be made for you. This information is given to you to help you understand our qualifications and the services we provide. If you have any questions please discuss them with us. This signed copy is required for our files, Statute §146A.11.

Name:

Acres for Life, Therapy & Wellness Center
11720 – 256th Street, Chisago, MN 55013
18323 July Ave NW, Forest Lake, MN
Practitioner information can be found on our website at www.acresforlife.org

"The State of Minnesota has not adopted any educational and training standards for unlicensed complementary and alternative health care practitioners. This statement of credentials is for information purposes only."

Under Minnesota law, an unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture practitioner or services from a physician, chiropractor, nurse, osteopath, physical therapist, dietitian, nutritionist, acupuncture practitioner, athletic trainer or any other type of health care provider, the client may seek such services at any time.

Brief Summary of theoretical approach: Our theoretical approach is that the same energy we put toward perpetuating a problem can be redirected into a solution. Through offering Equine Assisted Psychotherapy, Equine Assisted Learning, Therapeutic Coaching, Music and Art Therapy etc., to our clients we help them recognize their internal resources and strengths in a way that supports them living the life they want to - free from the fears, obstacles and limiting beliefs that have held them back. Clients are empowered to create new behaviors that serve them better.

Supervision/Mentorship: We consult with other professionals as needed. We meet at a minimum of once a week to discuss operations and session schedule etc.

Complaints: Please contact us with any questions, concerns or complaints that you have. If you feel your complaint is not appropriately addressed you may contact EAGALA directly at:

EAGALA
PO Box 993
Santaquin, UT 84655
Toll Free (in U.S.): (877) 858-4600
Phone: (801) 754-0400
Fax: (801) 754-0401

Fees: Equine Assisted Psychotherapy and Learning sessions are billed at a rate of $185/hour for individuals. Couples and family rates available upon request. Group sessions are $90/per person/per hour (minimum of 3 people for 3 hours). Beyond that, the rate varies according to length of session and number of participants.

Further, clients understand that they are responsible for payment of fees at the time services are provided unless otherwise arranged in writing. Clients understand that there is a $35.00 service charge on all returned checks.

Clients have the right to reasonable notice of changes in services and/or charges

Session Cancellation Policy: See the Late Cancel/No Show addendum attached with this packet. Please make every effort to arrive for your session as we block out the agreed upon time frame on our session calendar for your appointment and this time is not able to be filled with another client last minute. The missed appointment charges should be paid upon receipt of notice of missed appointment.

This same policy applies to late cancellations. Please make every effort to avoid canceling within twenty-four hours of your appointment, as we have set aside this time for you, and filling it with another client is usually not possible at such short notice.

Assessment/Recommendations: The client has the right to current information concerning assessment, treatment, and expected duration.

Ethical Treatment: The client has the inherent right to be treated with integrity, and the utmost respect, and courtesy as well as treatment that is free from verbal, physical and sexual abuse.

Release of Medical Information: By signing this agreement you are granting full consent for release of your provided medical information to any other Acres for Life personnel who may be involved in your treatment planning and equine therapy activities.

Confidentiality: Your records and transactions with us are confidential, unless release of these records are authorized by you in writing, or otherwise required by law. The only times a client's records may be shared without your consent are: 1) Client is in danger to self or others, 2) Therapist has knowledge of client being abused or neglected and/or 3) Disclosure is required by the court.

Emergency Policy: In case of emergency, go to the nearest hospital or call 911.

Records: Are accessible to the client in accordance with section §144.335 of Minnesota Statutes.

Other Resources: Other community resources are available and may be found in local newspapers and the yellow pages. Where and when appropriate referrals will be made to appropriately qualified health care practitioners. Following through on these referrals is the responsibility of the client. The client has the right to choose freely among practitioners and to change practitioners at any time. The client has a right to coordinated transfer in the event of a change in practitioners. The right to refuse services is honored and no retaliation will be done if you need to assert your rights.

_____

Print Name

_____

Signature Date

Please sign, date and keep a copy for your records.

Client Responsibilities

Each client has the responsibility to:

1. Refrain from physical (and other) abuse of self, others, and property. Clients are responsible for repair or replacement of any property they damage in the facility.

2. Devote reasonable energy and time to sessions. Treatment is generally "hard (emotional) work." For progress to occur, we recommend making sessions a high priority in your personal life. The facilitation team may regularly assign homework that is intended to facilitate learning, and doing homework is expected to expedite sessions and decrease costs.

3. Fulfill contracted behavior.

4. Be honest with facilitation team concerning thoughts and feelings about sessions and treatment.

5. Keep appointments as made. Appointment times are reserved for each client. Therefore, clients will be charged for the appointment unless 24 hours advance notice is given. Exceptions may be made for emergencies and other extenuating circumstances.

6. Keep current in paying fees (deductibles, co-payments, fee-for-service payments) required at the beginning of each session. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that occurred prior to the first visit to my office), session fees credited toward the deductible will be collected at the time of the session until the deductible payment is verified by the insurance company or third-party provider. Verification can be made through our billing coordinator, who will contact your insurance company to check your benefit status upon request.

7. Inform those involved in the treatment plan about any changes to physical health, insurance plan, or ability to pay for contracted services.

8. Parents or caregivers are responsible to supervise the activities of children with respect to use of facilities, material, etc.

I have read and understand my rights and responsibilities as noted above.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent/Guardian Date

Guardian/Caregiver Authorization to Work with Minor Child

The State of Minnesota allows parents the legal right to have access to a child's records.

One of the most important aspects of Psychotherapeutic Counseling is the relationship between the client and the therapist. It may take time to build a relationship of trust with a minor. Often many sessions are needed for the minor child to feel comfortable with therapy process and the therapist. Children and teens need to feel safe and trusting to be able to open up about issues that concern them.

If minor children know that parents have access to their records and will request access to their records it will hinder the therapeutic process.

A child's treatment team will not keep critical information from parents. It will be made clear in the intake process that a child's treatment team consists of mandated reporters.

Parents are asked to consider the possible implications, as outlined in this form, before requesting records in order to protect their minor child's privacy. Records will be supplied directly to courts if needed. Records will be provided to other health care professionals directly if requested on condition that they protect the records of the child as well.

I have read and understand this form and agree to have Acres for Life work with my child.

Child's Name	Child's Signature	Date
Parent/Guardian Name	Signature	Date
Parent/Guardian Name	Signature	Date

Notice of Privacy Practices

An electronic copy of the Notice of Privacy Practices is available on our website at www.acresforlife.org. Paper copies are available upon request.

I have received the Notice of Privacy Practices notice and I have been provided an opportunity to review it.

Name_____Signature_____Date_____

Consent for Release of Information

This authorizes Acres for Life to use and disclose the specific health information described below concerning:

Client:_____ Date of Birth:_____

This will authorize Acres for Life to release to/obtain information from:

Name _____

Address (Street/City/State/Zip) _____

Phone _____

Fax _____

The information to be disclosed is (please check all info that you are willing to have exchanged):

	History and intake information		Social/ Psychological/ Medical reports
	Consultation notes/ progress reports		Chemical dependency abuse or diagnosis, history and treatment (protected by Federal and State regulations 42 CFR Part 2 and ORS 430.399(5), 179.505)
	Treatment plan, goals, and results		Medications used in treatment
	Court or probation records		Other (specify)

The purpose of the information release is(please check all that apply):

	Diagnosis and evaluation		To facilitate treatment
	Treatment planning		Other (specify)

If I am requesting the Authorization from you for my use and disclosure or to allow another health care professional or entity to disclose information to me: (1) You have the right to inspect a copy of the protected information to be used or disclosed; (2) You may refuse to sign this authorization; and (3) I must provide you with a copy of the signed authorization at your request. You may revoke this consent at any time and that upon fulfillment of the above stated purposes(s) or within one year, this consent will automatically expire without express revocation.

By signing this authorization, you may be directing me to disclose your health information to a person or organization that does not have the same obligations to protect privacy required of health care practitioners under state and federal law. The disclosure of the information specified above may carry with it the potential for unauthorized disclosure of your protected health information and loss of protection under state and federal law.

You may request that I require the recipient of your protected health information to sign a Confidentiality Agreement in which the recipient agrees to limit its use and disclosure of your information as specified by the confidentiality agreement. If the intended recipient refuses to sign the confidentiality agreement you request, I will not release the information.

I have reviewed the Authorization and I understand it. I understand that the information used or disclosed under this Authorization may be subject to redisclosure by the recipient and may no longer be protected under federal privacy law.

_____ _____

Signature of Client Date

_____ _____

Signature of parent or guardian or witness Date

Liability Release

In consideration of the services Acres for Life, Lynn Moore and associates (hereinafter collectively referred to as "Acres"), I hereby agree to release, indemnify, and discharge "Acres", on behalf of myself, my children, my parents, my heirs, assigns, personal representative and estate as follows:

1. I acknowledge that horseback riding, caring for horses, and all therapeutic and learning / self-discovery activities involving or not involving horses entail known and unanticipated risks which could result in physical or emotional injury, paralysis, death, or damage to me, to property, or to third parties. I understand that such risks simply cannot be eliminated without jeopardizing the essential qualities of the activity.

   The risks include, among other things: loss of control, collisions; horses, irrespective of their previous behavior and characteristics, may act or react unpredictability based upon instinct, fright, or lack of proper control by rider or handler, latent or apparent defects or conditions in equipment, animals or property, acts of other participants in this activity, adverse weather conditions' contact with plants, insects, or animals; my own physical conditions or my own acts or omissions the conditions of remote roads, trails, waterways, or terrain, and accidents connected with their use, first-aid, emergency treatment or other services rendered; consumption of food and drink.

   Furthermore, "Acres" seeks safety, but they are not infallible. They might be unaware of a participant's fitness or abilities. They might misjudge the weather, the elements, or the terrain. They may give inadequate warnings or instructions, and the equipment being used might malfunction.

2. I expressly agree and promise to accept and assume all of the risks existing in this activity. My participation in this activity is purely voluntary, and I elect to participate in spite of the risks.

3. I hereby voluntarily release, forever discharge, and agree to indemnify and hold harmless "Acres" from any and all claims, demands, or causes of action, which are in any way connected with my participation in this activity or my use of "Acres" equipment or facilities, including any such Claims which allege negligent acts or omissions of "Acres".

4. Should "Acres" or anyone acting on their behalf, be required to incur attorney's fees and costs to enforce this agreement, I agree to indemnify and hold them harmless for all such fees and costs.

5. I certify that I have adequate insurance to cover any injury or damage I may cause or suffer while participating, or else I agree to bear the costs of such injury or damage myself. I further certify that I have no medical or physical conditions, which could interfere with my safety in this activity, or else I am willing to assume – and bear the costs of – all risks that may be created, directly or indirectly, by any such condition.

6. In the event that I file a lawsuit against "Acres", I agree to do so solely in the state of MN, and I further agree that the substantive law of that state shall apply in that action without regard to the conflict of laws rules of that state. I agree that if any portion of this agreement is found to be void or unenforceable, the remaining portions shall remain in full force and effect.

7. **PHOTO RELEASE**: During participation in Equine Assisted Therapy or Equine Assisted Learning, we may take photographs of you and/or your child(ren), or any representations that may be built. These photos may be used to recreate the representations that were built. We may also use the photos in various publicity materials. Please note that if we do use these photos, we will blur out all identifying features, as protecting your privacy is our main concern.

I _____(CLIENT / PARTICIPANT) do hereby authorize and give permission for any Acres for Life personnel to treat or transport me (or my child if minor) for medical treatment in case of accident / emergency if I am unable or in case of minor cannot be reached / unavailable.
Emergency contact name_____ Phone:_____

By signing this document, I acknowledge that if anyone is hurt or property is damaged during my participation in this activity, I may be found by a court of law to have waived my right to maintain a lawsuit against "Acres" on the basis of any claim form which I have released them herein.

I have had sufficient opportunity to read this entire document. I have read and understood it, and I agree to be bound by its terms.

Client Signature: _____Date:_____

Client -- Print Name: _____

Parent/Guardian Signature:_____Date:_____

Parent/Guardian – Print Name:_____

Address: _____

Phone Number:_____ Email Address:_____

Please check no if you do not wish to receive email from us: NO__

CONFIDENTIAL EXCHANGE OF INFORMATION FORM
THIS IS NOT A REQUEST FOR MEDICAL RECORDS

Best practice requires contracted behavioral health practitioners and facilities to coordinate treatment with other behavioral health practitioners, primary care physicians (PCPs), and other appropriate medical practitioners involved in a member's care. Please complete this form and send it to the appropriate care provider(s) treating the member.

PATIENT NAME: _____DOB:_____

A. Treating Behavioral Health Practitioner/Facility Information:
Name:_____ Phone:_____
Address:_____ Fax:_____

B. PCP/Medical Practitioner or Other Behavioral Health Practitioner/Facility Information:
Name: _____Phone:_____
Address: _____Fax:_____

C. Patient Clinical Information:
1. The patient is being treated for the following behavioral health condition(s):
_____
2. The patient is taking the following prescribed psychotropic medication(s):
_____
3. Expected length of treatment: ___3 months ___ 3-6 months ___ 6-12 months ___ >1 year
4. Coordination of care issues/Other relevant information impacting care:
_____

I hereby freely, voluntarily and without coercion, authorize the behavioral health practitioner listed above in Section A to release the information contained on this form to the practitioner/provider listed in section B above. The reason for disclosure is to facilitate continuity and coordination of treatment. This consent will last one year from the date signed. I understand that I may revoke my consent at any time.
I do not want to have information shared with:
____My PCP/Medical practitioner
____I am not currently receiving services from a PCP/ other medical practitioner
____My other behavioral health practitioner(s)
____I am not currently receiving services from any other behavioral health practitioner

_____
Patient Signature **DATE**

Parent/Guardian Signature _____

_____
Behavioral Health Practitioner/Facility Representative Signature **DATE**

For Patient Records Applicable Under Federal Law 42 CFR Part 2:To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42) CFR Part 2 prohibit you from making any further disclosure of it without the specific 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.

Date Mailed or Faxed to Other Practitioner/Facility: _____

No Show / Late Cancellation Policy:

Please note that clients who No Show for their appointment, or who late cancel within the 24 hours of their appointment, may be subject to a fee that is equal to 60% of their session rate. This amount will be charged to their credit card, or will be billed directly.

Signature: _____

Date: _____

Cardholder Name:_____

Billing Zip Code: _____

Credit Card #: _____

Expiration Date: _____

Card Type: _____

CVV/Auth code: _____

Chronic Cancellations:

I understand that if I routinely cancel my appointments, or do not show up for my appointments, that I may be subject to dismissal from the program. I understand that Acres will make a reasonable effort to contact me and see about another time that will work better for me. If I do not respond within five business days my sessions will be removed from the calendar.

Signature: _____

Date: _____

ADDITIONAL INFORMATION:

Name of the parent/guardian completing this form: _____

Presenting Situation

What do you hope to accomplish by coming to Acres for Life?

_____

_____

_____

School History

How is the child doing academically in school?

_____

_____

How is the child doing socially in school?

_____

_____

Is there any history of bullying? If so, please describe.

_____

_____

Family History

Briefly describe the home environment(s) the child spends time in (who lives in the home, how adults get along with each other, their relationship with the children in the family, how conflict in handled, etc):

_____

_____

_____

Describe how the child's primary caregivers are related to one another (marriage, dating, cohabiting, divorce, etc):

_____

_____

If divorced, please describe the child's relationship with each parent:

_____

_____

Trauma History

Please describe any traumatic events in the child's life (including: deaths, abuse, major moves, loss of a significant pet, etc):

_____

_____

_____

_____

Is there a history of suicidal ideation or self-harm behaviors? If yes, please describe.

_____

_____

_____

Additional information you would like to share?