Headway
Emotional Health

Client ID# _____

Date: _____

CLIENT REGISTRATION & INSURANCE INFORMATION

Please Print

CLIENT INFORMATION

Name _____
Last Name First Name Middle Initial

Address: _____
Street Apt. # City State Zip County

Sex: ☐ M ☐ F Age: _____ Birth Date: _____ Soc. Sec. # _____

Home Phone Number _____ Work Phone Number _____

Email Address: _____

As a Community Mental Health Center and a Rule 29 Clinic, Headway is required to report certain demographic information to the state and Hennepin County. All information is reported anonymously to protect your privacy.

Gross (Yearly) Household Income: ( )$ 0-$10K ( ) $10K-20K ( ) $20K-$29K ( ) 30K-39K ( ) $40K-$49K
( ) $50K-$59K ( )$60K-$69K ( ) $70K-$79K ( ) $80K-$89K ( ) $90K-$99K ( ) $100K-$119K ( ) $120K and Up

Race: ( ) African American ( ) Asian American ( ) Caucasion ( ) Hispanic ( ) Hmong ( ) Multi-Racial ( ) Native American
( ) Pacific Islander ( ) Somali ( ) Sudanese ( ) Other

RESPONSIBLE PARTY

Responsible Party if **Other Than Client**: _____

Address (if different than above): _____

Home Phone Number _____ Work Phone Number _____

Birthdate: _____ Soc. Sec. # _____ Relationship to Client: _____

Email Address: _____

PRIMARY INSURANCE

Policy Holder's Name: _____
Last Name First Name Middle Initial

Birthdate: _____ Soc. Sec. # _____ Relationship to Client: _____

Address (if different from above) _____
Street City State Zip

Home Phone Number: _____ Work Phone Number: _____

Employer: _____

Insurance Company Name: _____ Effective Date: _____

Insurance ID Number: _____ Group Number: _____

SECONDARY INSURANCE

Policy Holder's Name: _____
Last Name First Name Middle Initial

Birthdate: _____ Soc. Sec. # _____ Relationship to Client: _____

Address (if different from above) _____
Street City State Zip

Home Phone Number: _____ Work Phone Number: _____

Employer: _____

Insurance Company Name: _____ Effective Date: _____

Insurance ID Number: _____ Group Number: _____

PLEASE SEE REVERSE SIDE FOR SIGNATURE AND OTHER INFORMATION

Headway
Emotional Health

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our financial policy. An important part of keeping our services accessible is having our clients follow through with their financial obligations. Please read this policy carefully prior to agreeing to treatment.

Full Payment for fees or co-pays is due at the time of service. Fees may be paid with cash, check, or credit card. All outstanding balances are the responsibility of the client, regardless of whether or not insurance covers the services.
Client/Responsible Party Initials: _____

Insurance Coverage - Insurance coverage is a contract between the insurance company and the covered person. Providers of health care are NOT a part of the contract. Instead, healthcare providers accept the assignment of benefits. This assignment can only happen with a client's signed authorization. Further, if the insurance company requires a referral, the client must obtain the referral prior to receipt of any care. Fees not covered by insurance after 120 days become the responsibility of the client. **Clients or their responsible parties are responsible for providing Headway with accurate insurance information and for promptly alerting Headway to any changes in coverage.** Failure to do so can cause billing inaccuracies that result in full payment responsibility to the client. Client/Responsible Party Initials: _____

Medicare and Medical Assistance - We are an authorized provider for Medicare and Medical Assistance and accept assignment of benefits. Eligibility for Medical Assistance is verified each month. Please have your Medical Assistance card available to assist us in verifying this coverage. Client/Responsible Party Initials: _____

Reduced Fees - As a non-profit community mental health provider, we may be able to reduce fees in certain circumstances. Please speak with a billing representative to negotiate a payment plan or if a reduced fee is needed. **Clients who qualify for reduced fees are still responsible for paying the agreed upon fee.** Client/Responsible Party Initials: _____

Missed Appointments – A 24-hour notice for cancellations is required. This enables us to arrange care for another client. Failure to cancel **24-hours ahead** of a scheduled appointment will **automatically** result in charges regardless of reason. Your treatment provider will not be able to prevent or reverse charges for missed appointments. If you feel you have been charged in error, please request to speak with a billing representative.
32% of the Full Fee for an appointment will be charged for a missed appointment due to a late cancellation.
PLEASE NOTE: Failure to attend a group is an automatic charge, regardless of notice. This is because another client cannot fill the vacancy of an absent group member.

If you have any questions regarding our fees and your financial obligations, please contact our billing department voicemail box at 952-582-6691.

My signature below is authorization for the release of any medical information necessary to process the claim for benefits. Any release of medical information is understood to follow the standards set by HIPAA and the Data Privacy Act. I authorize payment of all benefits directly to Headway Emotional Health. **I acknowledge that I have read, understand and agree to the above Financial Policy.**

Client Signature: _____ DATE: _____

****If Client is a minor or not responsible for bill payment, please complete the following information****

Name of Responsible Party for Payment: _____

Relationship to Client: _____

Responsible Party Signature: _____ DATE: _____

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CONSENT FOR TREATMENT

I give my consent to participate in mental health treatment or related services through Headway Emotional Health. I understand that staff employed directly through Headway Emotional Health will provide this treatment. This consent may include services such as evaluations, therapy, medication management or testing (if indicated).

I understand that I may decline a specific treatment and may withdraw my consent to treatment at any time, for any reason. I understand that withdrawing consent would end my ability to continue to receive services.

All clients and/or their families will be involved in the design of a treatment plan with their service provider. I consent and agree to being involved in the treatment planning process.

_____ _____

Printed name of client Date

_____ _____

Signature of adult client or parent/guardian Date

Headway
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ACKNOWLEDGEMENT OF RECEIPT OF THE PRIVACY PRACTICES & CLIENT'S RIGHTS BROCHURES

Consistent with the Health Insurance Portability and Accountability Act-HIPAA (1996), I have been provided with a copy of the Notice of Privacy Practices. I have also been provided with a copy of the Client's Rights and Responsibilities, which provides a description of my rights as a recipient of services.

I understand that I may receive another copy of either of these documents at any time and that I may direct any complaints or concerns about the services I received to the Program Director, Clinical Director, or the Executive Director.

I understand that Headway Emotional Health encourages me to fully read each of these documents and inform my provider if I have any questions or concerns.

_____ _____
Printed name of client Date

_____ _____
Signature of adult client or parent/guardian Date

Headway
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AUTHORIZATION FOR COORDINATION OF CARE WITH MEDICAL PROVIDER

This is a release of information for Headway Emotional Health to consult with your primary medical doctor or psychiatrist. It is considered best practice for therapists to have communication with medical providers to coordinate care for clients. However, communication between Headway and your medical provider is voluntary. Please indicate below if you would like Headway to be in contact with your medical provider.

☐ I do NOT want any contact between Headway and my medical provider OR I do not have a medical provider.
☐ I would like Headway to contact my medical provider.

If you would like Headway to communicate with your medical provider, please complete this release of information. Be sure to include the **name of the clinic**, your **medical provider's name** and **phone number.**

_____
Client Name (Last, first, middle initial)

_____
Street Address City State Zip

_____
Date of Birth Day Phone # Evening Phone #

INFORMATION RELEASED FROM/ EXCHANGE WITH			INFORMATION RELEASED TO/ EXCHANGE WITH		
Name (Clinic / Provider)			Name (Program / Individual) **Headway Emotional Health**		
Street Address			Street Address		
City	State	Zip	City	State	Zip
Telephone:	Fax:		Telephone:	Fax: **(612) 861-3446**	

AUTHORIZATION TO DISCLOSE MEDICAL / BILLING INFORMATION IS LIMITED TO THE FOLLOWING:

☐ Admission / Intake Summary ☐ Diagnosis & Treatment Plan ☐ Progress Notes ☐ Discharge Summary
☐ Psychiatric Assessment ☐ Psychological Assessment ☐ Prior Treatment Records ☐ Medication Management Records
☐ Mental Health Record ☐ Medical/Physical History ☐ Progress Review
☐ Other _____

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. Please see your Notice of Privacy Practices for information on how to revoke this authorization. I also understand that this authorization will automatically expire one year from the date of my signature unless I revoke it earlier. Headway Emotional Health will not refuse or restrict my treatment if I choose not to sign this authorization. **A photocopy / fax of this authorization will be treated in the same manner as an original.**

Further, I realize that Headway Emotional Health cannot prevent the re-disclosure of records released as a result of this request and that the records may not be subject to privacy rule protections; therefore, Headway Emotional Health is released from any and all liability resulting from re-disclosure.

_____ _____
Client / Legal Representative Signature Date

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NOTICE TO CLIENTS
Supervision Notice

The Minnesota State Department of Human Services, BlueCross & BlueShield as well as United Behavioral Health/Medica all have a supervision requirement to which we must alert you.

Until a therapist has his or her own billing number, or until a therapist has an *independent* license to practice, he or she must be supervised by a therapist who is enrolled in the insurance plan for which you are covered.

If a therapist being supervised relevant to this rule provides your care, we must inform you and have you acknowledge with your signature that you have been so advised.

Headway Emotional Health believes in the importance of furthering the profession of Social Workers, Psychologists and/or Marriage and Family Therapists. We provide highly supervised internships that meet the requirements of the state, the professional licensing boards, as well as the standards set by your insurance company.

*Know that Headway Emotional Health hires **only** therapists who are licensed by the State of Minnesota to provide therapy. Having a State License means your therapist holds a Master's Degree. Further, he or she completed over 2,000 hours of supervised clinical experience just to be eligible to take the state licensing exam. Headway hires therapists who have many years of experience well after they have passed their state licensing exam. You can feel assured that the therapist to whom you are assigned is highly competent and is an approved provider for many other insurance companies. Both their licensure and experience make them eligible to participate in this new agreement.*

I have been advised of this supervisory arrangement and acknowledge being informed by my signature below.

_____ _____
Signature of Client Signature of Parent/Guardian

_____ _____
Printed Name of Client Date

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Appointment Confirmation and Client Contact Consent Form

I give my consent for Headway Emotional Health to contact me via voicemail, text message, and/or email message to remind me of an upcoming appointment or to alert me to an appointment cancellation due to inclement weather or provider illness. This will also be used to provide me things like our client satisfaction surveys.

I understand that by accepting a voicemail, text message, and/or email message appointment confirmation that the message will not be encrypted. The confirmation will include the following information:

- Patient's first name, agency name and location, date and time of the appointment

Voicemail/Text Message Confirmation:

_____ **Yes,** Headway **may** confirm my appointments by voicemail or text message to my home or mobile phone number.

Please provide a home phone number for **voicemail** only confirmation: _____
Please provide a cell phone number for voicemail or **text message** confirmation: _____

OR

_____ **No,** Headway **may not** confirm my appointments by voicemail or text message to my home or mobile phone number.

Email Message Confirmation:

_____ **Yes,** Headway **may** confirm my appointments by email message.
If yes, may we also add you to our agency mailing list so you receive our agency e-mail newsletter and information on other agency sponsored events?

_____ **Yes** _____ **No**

Please provide the email address: _____

OR

_____ **No,** Headway **may not** confirm my appointments or contact me in any way by email message.

**Headway does not share or sell text numbers or email addresses to third parties.

_____

_____ _____
Printed name of client Date

_____ _____
Signature of adult client or parent/guardian Date