

Education: Highest grade completed _____ Post secondary 1 2 3 4 5 6

Degree(s) earned _____ Other training _____

Employment: Occupation _____ Employer _____

Occupation of Spouse _____ Employer _____

Military: Were you ever in military service? Yes ____ No ____

Emergency contact person: _____ **Phone:** _____

Insurance Company Name: _____

Medical: Name of doctor _____ Date last seen _____

Reason for needing to be seen? Medications _____ Therapy _____

Are you taking medication now? ____ What medication(s)? _____

Have you had previous psychiatric care or professional counseling? Yes ____ No ____

If yes, where and when? _____

Have you had a previous diagnostic assessment or mental health evaluation? Yes ____ No ____

If yes, where and when? _____

FAMILY: In your family, are you: (circle one)

NATURAL ADOPTED FOSTER or STEPCHILD

- Please complete the following information about your birth family:

RELATIONSHIP	FULL NAME	ADDRESS	AGE	EDUCATION	OCCUPATION
FATHER					
MOTHER					
SIBLING					

Others living in your home when you were a child: _____

- Please complete the following information about your current family:

RELATIONSHIP	FULL NAME	ADDRESS	AGE	EDUCATION	OCCUPATION
SPOUSE/SIGNIFICANT OTHER					
CHILD					

Others living in your home at the present:

Who referred you to the Mental Health Center? _____

With whom have you talked about your problems? _____

What are your problems? _____

PRIVACY STATEMENT FOR CLIENTS OF THE FREEBORN COUNTY MENTAL HEALTH CENTER

- A. Federal and State laws require this center to keep all personal information about you strictly private. We will not release this information to anyone without your written consent except under the legally prescribed conditions below.
- B. All information we request will be used for one or more of the purposes stated below:
- To evaluate your need for care;
 - To plan the types of care that will help you the most;
 - To let this center collect payment from a private or government agency for the care we give you;
 - To see if you are eligible for public assistance, should you request it;
 - To fulfill state, federal and local demands for reports and statistics.
- A. You are not required to provide any information to this mental health center. If you choose not to give us information about yourself, that will make it more difficult for us to help you, and may require us to ask you to return to the agency that sent you here.
- B. Information about the type, the amount, the dates, the cost, the outcome and the evaluation of the treatment given will be available to local, state, and federal workers and to people at this center who need such information to keep records.
- C. NO ONE BUT THE STAFF AT THIS CENTER WILL HEAR OR SEE TRANSCRIPTS OF ANYTHING YOU SAY IN COUNSELING OR THERAPY SESSIONS UNLESS YOU GIVE YOUR PERMISSION WITH THE EXCEPTION OF ADMISSIONS OF CHILD OR VULNERABLE ADULT ABUSE, WHICH THE PROFESSIONAL STAFF ARE REQUIRED BY LAW TO REPORT. COURT ISSUED SUBPOENA OF CLINIC RECORDS IS A POSSIBILITY IN WHICH CASE THE COURT TAKES RESPONSIBILITY FOR CONFIDENTIALITY OF THESE RECORDS.
- D. You may request in writing to see all data about you. You will be shown this data unless it is used to investigate an illegal action or if a professional believes that it will be harmful to you or others. You may have the information explained to you and have corrected any information you think is wrong and this center finds to be wrong. If you consider incorrect any information which this center finds to be correct, you may attach your own explanation.

E. Acknowledgment:

I have read and understand this Privacy Statement.

Signed _____

Date _____

FEE POLICY

The Freeborn County Mental Health Center primarily serves residents of Freeborn County. The Center will serve residents of other counties who are involved in a treatment program within Freeborn County and for whom fees are paid in full.

There is a charge for all services provided by this Center including testing and evaluation, psychotherapy (including individual, family and group sessions), chemotherapy management, consultations, reports and in-service training. Fees are charged for services whether you are self-referred, referred by another agency/individual or court-ordered.

A schedule of fees is available for anyone upon request. The full fee will be charged for all persons having medical insurance and/or any other third party coverage (including group or individual policies, Medicare, VA, Medical Assistance, General Assistance Medical Care, Workmen’s Compensation, etc.). The client, parent or guardian is expected to provide verification of coverage at the time of appointment as well as complete all necessary insurance and authorization forms. The following policies apply for payment of services:

1. Following application of insurance benefits, the client, parent, or guardian is responsible for any remaining balance. Any insurance co-payments are due at the time of your appointment.
2. Persons without third party coverage will be charged according to a sliding fee scale based upon family income, size, and cost of service. Sliding fee payments are due at the time of your appointment.
3. By Federal and State law Medical Assistance (MA) and General Assistance Medical Care (GAMC) payments are considered payment in full.
4. If anyone chooses not to utilize health insurance, other medical benefits, or to disclose gross income for fee determination, the client then becomes responsible for full payment.
5. The fee schedule is subject to annual revision. Client fees may be modified due to a change in financial status.
6. Unfulfilled obligations are subject to normal recovery procedures and may be basis for termination of service.
7. Any client experiencing difficulty in paying their fee should discuss it with the staff member being seen. Any request for extension of payment terms or other modifications needs to be submitted in writing to the Center within 30 days of the first billing.

If there are any questions regarding the Center’s fees and policies, anyone can phone (507) 377-5400 and ask for the Accounting Department.

I understand the above stated policies concerning service fees.

Please **PRINT** your name: _____

Signature _____ Date _____



Mental Health Center

203 West Clark Street
P.O. Box 1246
Albert Lea, MN 56007-1246

General Information	507-377-5440
Fax	507-377-5505
Warm Line	800-337-2460
Crisis Line	507-377-5499 or 877-402-3743

To Whom It May Concern:

Insurance information and/or private payment arrangements is needed by the time of the first appointment for Freeborn County Mental Health Unit. If you have any questions regarding your coverage please contact your insurance company. Thank you for your cooperation in handling this promptly to avoid billing problems.

I understand that if I do not provide insurance and/or payment arrangement information I will be responsible for full payment of services.

Name (please print)

Signature

Date

Your Privacy Rights

This sheet tells you about your rights under the **Minnesota Government Data Practices Act** and the **Health Insurance Portability and Accountability Act**. These Acts protect your privacy but also lets us give information about you to others if a law requires it and we tell you before we do it. This sheet tells why and when we will ask for and give information about you. It applies to all future contacts you have with our Department. Those contacts may be in person, by mail, via audio/video conferencing, or on the telephone. Your worker can explain any additional requirements.

A. Why Do We Ask You For Information?

We may ask you for information so we:

- ❖ Tell you from other persons by the same or similar name.
- ❖ Decide if you can get money or services from us and what or how much you can get.
- ❖ Help you get the medical, mental health, financial or social services.
- ❖ Collect money from the state or federal government for help we give you.
- ❖ Decide if you can pay for any help you get.
- ❖ Make reports, do research, audit and evaluate our programs.
- ❖ Investigate reports of people who may lie about the help they need.
- ❖ Decide about out-of-home care and in-home care for you or your children.
- ❖ Collect money from other agencies, like insurance companies, if they should pay for your care.
- ❖ Decide if you or your family needs protective services.

B. Do You Have To Answer The Questions We Ask?

Generally the law does not say you have to give us information. Federal laws require that you give us your Social Security number if you want financial help or child support enforcement services.

C. What Will Happen If You Do Not Answer The Questions We Ask?

We need information about you to tell if you can get help from any program. Without some information, we may not be able to help you. It may be that we can help you, but the help may be late or not enough. Giving us wrong information on purpose may result in investigating and charging you with fraud.

D. Who May We Share The Information About You With?

We may give information about you to any of the following agencies, if they need it for investigations or to help you or help us help you. This does not mean we always share information about you with these organizations. It only says that there is a law that says we may share data with these organizations (sometimes the law says we must share certain information.) If you have any questions about when we give these organizations information, ask your worker.

Federal Organizations

- | | | |
|---|---------------------------------|----------------------------|
| *U.S. Department of Agriculture | *Social Security Administration | *Attorney General |
| *U.S. Department of Health & Human Services | *U.S. Department of Labor | *Internal Revenue Services |
| *Immigration & Naturalization Services | *Center for Medicaid Services | |

State Organizations

- | | |
|--|--|
| *Minnesota Department of Human Services | *Regional Treatment Centers |
| *Minnesota Department of Public Safety | *Minnesota Department of Labor & Industry |
| *Minnesota Department of Revenue | *Minnesota Department of Economic Security |
| *Minnesota Department of Veteran Affairs | *Minnesota Department of Human Rights |
| *Minnesota Historical Society | *Ombudsman for mental health & retardation |
| *Minnesota Department of Health | *Minnesota Office of State Auditor |

County Organizations

- | | |
|---|---|
| *County Social Service Boards | *Other County Social Service Offices (Crime Victims Crisis Center & Domestic Abuse Program) |
| *County Attorney | |
| *County Housing & Redevelopment Authority | *County Child & Adult Protection Teams |

Other Organizations

- | | | |
|---|---|----------------------|
| *Mental Health Centers | *City Attorney | *School districts |
| *Hospital & medical clinics | *People who investigate child & adult protection | *Creditors |
| *Member agencies of a local collaborative | *Employees or volunteers of any Social Srv agency | *Court officials |
| *Higher education coordinating board | *Fraud prevention and control units | *Credit Bureaus |
| *Law enforcement officials | *Others who may pay for your care | *Insurance companies |
| | *Ombudsman for families | |

- *Community food shelves or surplus food programs
- *School & other institutions of higher education
- *Guardians, conservators or power of attorneys
- *Anyone else who the law requires us to

- *Collection agencies
- *American Indian tribes
- *Coroners & Medical examiners
- *Local health departments

E. You Have The Right To Copies Of Information We Have About You

You may ask if we have any information about you. If we have information about you, you may ask for copies. Unless we get special written permission from you, we will only use your health information for the purpose listed. You may have to pay for the copies. You may give other people permission to see and have copies of private data about you. If the information is unclear, you may ask to have it explained to you. You may question the accuracy of any information we have about you. You also have the right to ask us to share health information with you in a certain way or in a certain place. For example, you may ask us to send health information to your work address instead of your home address. You must make this request in writing. You do not have to explain the basis for your request. You may also ask us to restrict uses or disclosures of your information. Your request must be in writing and be specific to what information you want to restrict from being disclosed and to whom you want these restrictions to apply. You have the right to receive a record of the people or organizations that we have shared your health information with. We must keep a record of each time we share your health information for six years from the date it was shared. This record will be started on April 14, 2003. It will NOT include those times when we have shared your information in order to treat you, pay or bill for your health care services, or to run our programs. If you want a copy of this record, you must send a request in writing to our Privacy Official.

F. What Are Our Responsibilities Under This Notice?

We may change our privacy policy in the future. We might do this, for example, because privacy laws change and require us to change our practices.

G. What If You Believe The Information We Have About You Is Wrong?

Send your concerns in writing, telling us why the information is not accurate or complete. You may send your own explanation of the facts you disagree with. Your explanation will be attached any time that information is shared with another agency.

H. How Do You Appeal If You Think Information Is Not Accurate Or Complete?

Your objection must be in writing and be sent to the Director of this agency. You must tell us why the information is not accurate or complete. You may send your own explanation of the facts you disagree with. Your explanation will be attached any time that information is shared with another agency. For more information on how to do this, ask your worker.

I. What Privacy Rights Do Children Have?

If you are under 18, your parents may see data about you and authorize others to see this data, unless you have asked that this information not be shared with your parents. You must make this request in writing and say what data you want withheld and why. If the agency agrees with you that not sharing the data would be in your best interests, we will not share the data with your parents. If we don't agree with you, the data may be shared with your parents if they ask for it.

J. What Happens With Immigration Information?

Immigration information given as part of this application is private and confidential. Information will only be used for eligibility determination and program administration. If you are applying for emergency services, you do not need to give us information about your immigrations status. Non-immigrant or undocumented people who are pregnant, under age 18, age 65 and over, or people with disabilities, may also be eligible without providing immigration information.

K. What If You Believe Your Privacy Rights Have Been Violated?

You may complain if your privacy rights have been violated. You cannot be denied service or treated badly because you have made a complaint. If you believe that your medical privacy was violated by your doctor or clinic, a health insurer, a health plan, or a pharmacy, you may send a written complaint either directly to that organization or to the federal office of Civil Rights at U.S. Department of Health and Human Services, Office for Civil Right-Region V, 233 North Michigan Avenue, Suite 240, Chicago, Illinois, 60601; (312) 886-2359 (voice); (312) 353-5693 (TTY/TDD); (312) 886-1807 (FAX). Complaints can also be filed with the Department of Humans Services, Appeals Unit, 444 Lafayette Road, St. Paul, Minnesota, 55155-3815. If you think that Freeborn County Human Services has violated your privacy rights you may send a written complaint to Freeborn County Human Services, Privacy Official, Suzi Nerison, 203 West Clark Street, Albert Lea, Minnesota, 56007-1246. If you have any questions about the information on this form, you may ask your worker to have it explained to you. You can ask Freeborn County Human Services for another copy of this notice.

Client Signature

Date

Agency Representative Signature

Date

Client name: _____

Please print

Freeborn County Mental Health Center No-Show Appointment Policy

Thank you for entrusting Freeborn County Mental Health Center with serving your mental health needs. We take the responsibility of providing mental health services very seriously. We pride ourselves on providing excellent care to all of our clients. As a result of this goal, we have established a new “no show” policy to help us serve you better.

When an appointment is made and then there is a “no show”, it takes an available appointment away from someone else who may need the appointment. No shows delay the delivery of mental health care to other people and financially impact our mental health center.

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you need to provide at least 24 hours' notice.

- A “no show” is missing a scheduled appointment or cancelling an appointment without calling us to cancel within 24 hours of an office appointment.
- Clients who miss three consecutive appointments in six months without notifying the mental health center 24 hours in advance will only be allowed to schedule their next appointment three months after the most recent “no show” appointment.
- We understand that you may have unavoidable situations that arise or personal reasons for missing your appointment. We also understand that emergencies and illness occur and we ask that you communicate any issues as soon as possible. If you cannot make an appointment in person, a telehealth appointment can be arranged by contacting the scheduling unit at Freeborn County Mental Health Center.

To cancel or reschedule an appointment, please call Freeborn County Mental Health Center at (507) 377-5440 and ask to speak to the scheduling unit in the mental health center.

Refill Policy

Prescriptions will not be refilled until an appointment is scheduled. However, at the discretion of the psychiatric provider, refills on prescriptions may be approved prior to the time of your next scheduled appointment.

Notice of Service Termination Due to Relocation

Our services will terminate 90 days after you move out of the service area. Therapy services are available to Freeborn County residents only. Psychiatric and medication management services are available to Freeborn County residents as well as residents who live within the 10 County South Central Community Based Initiative service area. The 10 counties are: Blue Earth, Brown, Sibley, Le Sueur, Faribault, Freeborn, Martin, Nicollet, Rice, and Watonwan.

We appreciate your understanding of our policies.

Thank you for choosing Freeborn County Mental Health Center for your mental health care.

I have read these policies, understand them, and agree to follow them.

Signature Name: _____

Please print

Signature

Date



Mental Health Center

203 West Clark Street
P.O. Box 1246
Albert Lea, MN 56007-1246

General Information 507-377-5440
Fax 507-377-5505
Warm Line 800-337-2460
Crisis Line 507-377-5499 or 877-402-3743

Freeborn County Mental Health Center is requesting that you sign the enclosed Telehealth Informed Consent Form whether you wish to see your mental health provider in person face to face or virtually.

-If you want to be seen virtually, we need you to sign the form providing consent to participate in telehealth (virtual) appointments.

-If you want to be seen in person face to face, we ask that you sign the form providing consent to participant in telehealth appointments on very rare occasions such as when the weather is inclement and you or your mental health provider cannot travel to the mental health center. In this rare situation, you may be given the option to see your mental health provider virtually. As such, we are requesting that you sign the form,

Please do not hesitate to call Freeborn County Mental Health Center at 377-5440 should you have any questions.

Thank you,

Freeborn County Mental Health Center

Freeborn County Mental Health Center
203 West Clark Street
Albert Lea, Minnesota 56007
(507) 377-5440

Telehealth Informed Consent

1. I agree to participate in telehealth services for the purposes of psychiatric evaluation and treatment and/or for individual psychotherapy.
2. I understand that the only difference between an appointment occurring via telehealth is that I will not be in the same room as my mental health provider.
3. I understand that I have the right to withdraw consent at any time without affecting my right to future care or services or program benefits to which I would otherwise be entitled.
4. I understand that there are potential risks to this technology, including but not limited to, disruption of transmission by technology failures, interruption, breeches of confidentiality by unauthorized persons, and limited ability to respond to emergencies. I understand that my mental health provider or I can discontinue the telehealth appointment if it is thought that the videoconferencing connections are not adequate for the situation or for any clinical reason.
5. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
6. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the telehealth session other than my mental health provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained.
7. I understand that I have the option to refuse telehealth services at anytime without affecting my right to future care or treatment.
8. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth unless an exception to confidentiality applies (i.e. mandating reporting or child, elder or vulnerable adult abuse, danger to self or others)
9. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate and a higher level of care is required.
10. I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at (507) 377-5440 to discuss since we may need to reschedule.

I have read the statements in this document, understand the risks and benefits of telehealth services and have had my questions regarding these procedures explained. I consent to participate in telehealth under the terms described herein.

Client Signature

Date

Guardian/Legal Representative Signature

Date



203 West Clark Street
P.O. Box 1246
Albert Lea, MN 56007-1246

Mental Health Center

General Information 507-377-5440
Fax 507-377-5505
Warm Line 800-337-2460
Crisis Line 507-377-5499 or 877-402-3743

Mental Health Care Bill of Rights

This Mental Health Care Bill of Rights is provided by law to persons receiving mental health services in the State of Minnesota. Its purpose is to protect the rights and enhance the well-being of clients, by informing them of key aspects of the clinical relationship.

1. To be treated with courtesy and respect for your individuality by employees of or persons providing service in our mental health center.
2. To receive appropriate mental health care based on your individual needs.
3. To be given, in writing, the name, business address, telephone number, and specialty, if any, of the physician, advanced practice registered nurse, or physician assistant responsible for coordination of your care
4. If you receive services from an outside provider, you shall be entitled, upon request, to be told the identity of the provider.
5. To be given complete and current information concerning your diagnosis, treatment, alternatives, risks, and prognosis. This information will be in terms and language you can reasonably be expected to understand.
6. You shall have the right to participate in the planning of your health care.
7. If you are competent, you have the right to refuse care based on an understanding of the risks, benefits and alternatives to treatment, etc.
8. To be cared for with reasonable regularity by your mental health provider.
9. You have the right to be free from maltreatment.
10. You have the right to respectfulness and privacy as it relates to the mental health care you receive at this mental health center.
11. You have the right to be assured confidential treatment of your personal and medical records, and may approve or refuse their release to any individual outside the agency.
12. You have the right to a prompt and reasonable response to your questions and other requests.
13. You have the right to every consideration of your privacy, individuality, and cultural identity as related to your social, religious, and psychological well-being.
14. To be encouraged and assisted, during the course of your treatment, to understand and exercise your rights. You may voice grievances and recommend changes in policies and services to our staff and others of your choice, free from restraint, interference, coercion, discrimination, or reprisal, including the threat of discharge.
15. To obtain information regarding the provision(s) for emergency coverage.

Signature

Date

CONSENT FOR THE RELEASE OF PRIVATE INFORMATION TO AN INSURER

**FREEBORN COUNTY MENTAL HEALTH CENTER
P.O. Box 1246
Albert Lea, Minnesota 56007
(507) 377-5440**

****Please provide copy of insurance card with this release****

RE: _____

DOB: _____ **Social Security Number:** _____

I hereby authorize the Freeborn County Mental Health Center to disclose to:

(Medical insurance provider)

the following information:

- Date first consulted us for service
- Name of referring physician or other source
- Dates of hospitalization if related to charges for services
- Name and address of facility where services rendered
- Acknowledgment of lab work outside our office (yes, no, unknown)
- Date and place of service
- Procedure code and description (description and length of time)
- Diagnosis
- Charges
- Amounts paid by client and/or other insurance carrier or third party source
- Patient account number
- Provider's name, complete address, telephone number, employer I.D. number, authorized signature and date
- Therapist name and degree (if applicable)
- Treatment records (if required by insurer to process claim)

The organization receiving this information will use it for determination of medical benefits payable for services as described on completed claim forms submitted.

Direct payment is authorized to the Freeborn County Mental Health Center for medical benefits otherwise payable to me for services provided.

I understand that no other uses will be made of this information, except for those previously communicated to me or as otherwise authorized by law, and that access to it will be limited to persons whose work assignments reasonably require access to accomplish the purposes stated above. I understand that I may revoke this consent at any time and that, in any event, it expires automatically, within one year of this date or when the purposes for which it was granted have been accomplished, whichever occurs first.

Signature of Client

Date

If client is a minor or incompetent,
signature of parent or guardian

Witness

**Authorization to Share Information
With Primary Care Physician**

It is generally considered to be good practice for mental health providers to coordinate care with your primary care physician and/or any specialty physician with whom you have an ongoing treatment relationship. Please list the name and address of your physician or primary care clinic below. (If you do not have a regular doctor, write "none" in space below, and sign this form where indicated.)

Client name: _____ Date of Birth: _____

Physician/Clinic name: _____

Physician/Clinic Address: _____

Indicate if you are willing to permit us to share clinical information about you with this physician or clinic, including dates of service, diagnosis, treatment plan, and your response to treatment by checking the appropriate statement below.

_____ I *give permission* for Freeborn County Mental Health Center to share my clinical information with the physician or clinic named above.

_____ I *do not give permission* for sharing clinical information with the physician or clinic named above.

I understand that I may revoke this consent at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of cancellation. I also understand that this consent will automatically expire one year from the date of my signature without my expressed revocation.

I understand that this information will be treated as confidential to the extent allowed by law and used only by professional persons interested in my welfare. I agree that a photocopy of this consent form has the same validity as the original.

X _____
Signature

Relationship (if signed by parent or guardian)

Date



Authorizations and Service Terms

Form content retained in medical record.
Route to HIMS Scanning.

(complete fields or place patient label here)

Patient Name (First Middle Last)	
Birth Date (mm-dd-yyyy)	Room Number (if applicable)
Mayo Clinic Number	

**TO BE
SCANNED**

Authorizations

Authorization for Treatment: I consent to the rendering of medical care which may include routine diagnostic procedures and such medical treatment as my attending physician(s) or other Mayo Clinic* (Mayo) medical staff consider to be necessary. I may be offered medical services via telemedicine systems that involve the delivery of healthcare by electronic communication with a provider who is at a different physical location. I consent to initiating and/or receiving technology-based communications with my providers, including consulting services from a specialist performed virtually. I agree to be responsible for any charges that insurance does not pay. I understand that my medical care and treatment may be provided by physicians, including fellows and residents, medical and allied health students, physician assistants, nurses and other healthcare providers. I have read and understand this Authorization for Treatment and understand that no guarantee or assurance has been made as to the results that may be obtained.

Consent to Process and Share Medical Information:** I consent that as a Mayo patient, my Medical Information will be used, processed, and disclosed in accordance with U.S. law and as outlined in Mayo Clinic's Notice of Privacy Practices (mayoclinic.org/npp). Furthermore, I authorize Mayo to use, process, or disclose my Medical Information:

- To provide me with treatment and to coordinate my care;
- To bill for and collect payment for services, which may include communications to my Payer(s)*** and Billing Addressee/Guarantor;
- For healthcare operations as described in the Mayo Clinic Notice of Privacy Practices;
- For quality improvement and to coordinate my care. This may include sharing my past, current and future health, treatment and patient account records with my insurer(s) and other care providers;
- To accrediting and quality organizations, regulatory agencies, and public health reporting agencies;

Authorization to Assign Benefits and Release Information: I authorize my Payer(s) to pay directly to Mayo any benefits due under the terms of my healthcare plan(s), for services provided by Mayo. I understand Mayo reserves the right to refuse or accept assignment of medical benefits. If my healthcare plan(s) will not allow direct payment to Mayo or if Mayo chooses not to accept assignment of medical benefits, I agree to pay Mayo all healthcare payments I receive for services. I authorize Mayo to contact my Payer(s) to obtain all pertinent financial information concerning coverage and payments made under my healthcare plan(s) and for my Payer(s) to release such information to Mayo. I hereby give Mayo

authorization to appeal on my behalf for services provided at Mayo. I understand that this may waive my insurance appeal rights as a member when appealing the insurance denial. By signing this form, I understand that future appeal and adjudication rights for services may be exhausted according to the provisions of my plan.

Service Terms

Statement of Financial Responsibility: I acknowledge I am responsible for all charges for services provided, including any amount not paid by my healthcare plan(s), or an out of state workers' compensation payer, other than billing terms and restrictions under a government program or as prescribed by law in the state where medical services are provided. I authorize Mayo to apply any credit balance on my account to any amounts that I may owe to one or more Mayo entities. I agree that Mayo may obtain financial information, including consumer credit reports to determine eligibility for financial assistance and/or payment options. Information on financial assistance is available by calling 844-217-9591, or at mayoclinic.org or mayoclinichealthsystem.org.

Dispute Resolution: I agree that any dispute (including personal injury claims) related to healthcare services rendered by Mayo is subject to the exclusive jurisdiction of the appropriate court in the state where the provider of the disputed services is physically located when the services are rendered and the law of that state. Any state court action must be venued in the county where the provider of the disputed services is physically located when the services are rendered. These agreements also apply to my legal representatives and next of kin.

Calling/Texting/Emailing: I agree that if I provide phone numbers or email addresses to Mayo, you may use them to text, email, or call me about my healthcare which includes, but is not limited to, appointment or prescription reminders, discharge planning, billing, research opportunities, your products and services, treatment alternatives, my general health or to provide regulatory notice in lieu of first class mail. These communications may use automated phone dialing and/or synthetic voices or prerecorded messages. I understand that when contacted in this manner, I will be given the opportunity to opt out of similar future communications. To learn more about opting out, visit mayoclinic.org/npp.

Notice of Privacy Practices: I acknowledge I have been presented with the Mayo Notice of Privacy Practices, which can be viewed at: mayoclinic.org/npp. I can request a paper copy during my visit or by contacting the Privacy Office.

Notice of Nondiscrimination: I acknowledge I have been presented with the Mayo Notice of Nondiscrimination, which can be viewed at: mayoclinic.org/non. I can request a paper copy during my visit or by contacting the Compliance Office.

Signature

Attention: This is a legal document. Changes will not be accepted on this form. Questions or requests for alterations must be made by calling 507-284-3350. By signing, I agree that I understand and accept the terms on this form. I understand I have the right to revoke the authorizations on this form at any time by notifying Mayo in writing, except to the extent that Mayo has already taken action in reliance upon them. These authorizations will remain valid until I revoke them in writing.

- If the patient is 18 years of age or older, the patient must sign and date the form.
- If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Indicate your legal authority and include documentation of your relationship:
 - Legal Guardian or Conservator
 - Healthcare Agent (Healthcare Power of Attorney)
 - Other Legal Representative
- If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Indicate your relationship: Parent Legal Guardian

Signature (required)	Date (mm-dd-yyyy)	Time (hh:mm)	<input type="checkbox"/> am <input type="checkbox"/> pm
Printed Name of Person Signing (if not patient) (First Middle Last)			

* For purposes of this form, Mayo refers to Mayo Clinic in Arizona, Florida, Rochester, Mayo Clinic Health System and all affiliated clinics, hospitals, and entities, including employees, business associates, and agents.

** Medical information includes, but is not limited to, photographs taken for identification purposes, information related to psychologic, psychiatric, sickle cell anemia, HIV/AIDS, communicable diseases, genetic testing, and alcohol and drug abuse diagnosis and treatment.

*** For purposes of this form, Payer(s) includes, but is not limited to, insurance carriers, health-plan administrators, or any other payers including the Centers for Medicare & Medicaid (CMS) and their agents or review agencies.





Authorization to Release Protected Health Information to a Third Party

Form content retained in medical record.
Route to HIMS Scanning.

**TO BE
SCANNED**

Instructions: This form is to be used by a patient or legal representative to authorize the release of information to a third party (other than a family member or friend) such as an insurance company, employer, or for legal purposes, etc. Print clearly; each section needs to be completed to be valid.

1. (complete fields or place patient label here)

Patient Name (First, Middle, Last)	
Birth Date (mm-dd-yyyy)	Room Number (if applicable)
Mayo Clinic Number	

Staff Use Only

<input type="checkbox"/> ROI to Send Records	<input type="checkbox"/> Scan to Chart
<input type="checkbox"/> Information Released by LAN ID	Date (mm-dd-yyyy)

2. Additional Patient Information

Previous or Maiden Name (if applies) (First, Middle, Last)	Daytime Phone	<input type="checkbox"/> Check this box if patient is deceased.
Patient Address (Street, City, State, ZIP Code)		

3. Release Purpose

Check appropriate box or write in other purpose.

Continuing care Disability Forms completion Insurance Legal Workers' compensation

Other, specify _____

4. Release Information FROM

Check one box and complete if applicable.

Mayo Clinic
Includes all Mayo Clinic and Mayo Clinic Health System locations

Other, specify organization, department, or individual (complete each line below)

Street _____

City _____

State _____ ZIP Code _____

Phone _____

Fax _____

5. Release/Send Information TO

Check one box and complete each line for box checked.

Mayo Clinic
Dept. _____ Attn. _____
Fax _____

Other, specify organization, department, or individual (complete each line below)

Freeborn County Mental Health Center

Street 203 W. Clark Street

City Albert Lea

State MN ZIP Code 56007

Phone 507-377-5400

Fax 507-377-5505

This authorization will expire in 1 year from date of signature *unless another date is specified*: _____

By checking this box I allow the ongoing exchange of information between the above parties until this authorization expires or is revoked.

By checking this box I also authorize the release of records for future visits or stays after the date of my signature until this authorization expires or is revoked.

6. Delivery of Information

Preferred Method <input type="checkbox"/> Written copy (may include completed forms) <input type="checkbox"/> Verbal only	Date Information Needed by (mm-dd-yyyy)
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Written information will be mailed unless an alternate method is checked.

Patient Portal – Mayo Clinic Patient Online Services

Fax (number listed above in section 5)

Email address _____

Pick-up at a Mayo Clinic location, specify _____

CD/DVD

USB flash/thumb drive

Other, specify _____

Authorization to Release Protected Health Information to a Third Party (continued)

(complete fields or place patient label here)

Patient Name (First, Middle, Last)
Birth Date (mm-dd-yyyy)
Mayo Clinic Number

7. Records or Reports to Be Released

Timeframe to Be Released		
Date(s) _____ or Year(s) _____ <small>(mm-dd-yyyy) (yyyy)</small>		
Document/Note(s) (check all that apply)		
<input type="checkbox"/> Behavioral health/Mental/Psychological notes	<input type="checkbox"/> Emergency department/Urgent care notes	
<input type="checkbox"/> Operative/Procedure notes	<input type="checkbox"/> Provider notes	
<input type="checkbox"/> Therapy notes (physical, occupational, speech)	<input type="checkbox"/> Other, specify _____	
I understand the information to be released may include behavior and/or mental health care, and HIV test results.		
Additional Records (check all that apply)		
<input type="checkbox"/> Allergy list	<input type="checkbox"/> Laboratory results	<input type="checkbox"/> Pathology report(s)
<input type="checkbox"/> Immunizations	<input type="checkbox"/> HIV lab test results	<input type="checkbox"/> EKG(s)/Cardio/Echo
<input type="checkbox"/> Medication list	<input type="checkbox"/> Genetic testing	<input type="checkbox"/> Radiology report(s)
<input type="checkbox"/> Billing information for records checked		<input type="checkbox"/> Radiology image(s), specify exam(s)/body part(s)
Substance Abuse and Addiction Treatment Records (check all that apply)		
<input type="checkbox"/> Assessment/Evaluation	<input type="checkbox"/> Family participation invitation	<input type="checkbox"/> Treatment plans
<input type="checkbox"/> History and physical exam	<input type="checkbox"/> Questionnaires	<input type="checkbox"/> Other, specify _____
<input type="checkbox"/> Multidisciplinary notes	<input type="checkbox"/> Treatment/Discharge summary	
Other , specify if applicable _____		

8. Signature and Date The patient or legal representative must sign and date this authorization.

<ul style="list-style-type: none"> This authorization may be revoked at any time by providing a written notice of revocation to the Health Information Management Services (HIMS) Release of Information (ROI) department at the facility releasing the information, except to the extent that the Providers have already taken action in reliance on it. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law (42 CFR Part 2) (HIPAA). I understand that Mayo Clinic will not condition treatment on whether I sign this authorization. I may request a copy of the signed authorization. I may be charged for copies in accordance with state law. I have a right to inspect and receive a copy of the material to be disclosed. 	
Note: A patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Specific situation(s) may require minor's authorization.	
Signature (required) ▶	Date (required) (mm-dd-yyyy)
Printed Name of Person Signing (if not patient) (First, Middle, Last)	
Relationship if Not Patient (legal documentation of the right of access by the signing individual may be required)	
<input type="checkbox"/> Parent <input type="checkbox"/> Stepparent <input type="checkbox"/> Legal guardian <input type="checkbox"/> Foster parent <input type="checkbox"/> Health care power of attorney/agent <input type="checkbox"/> Other _____	

HIMS* Release of Information Contact Information

Arizona 13400 East Shea Boulevard Scottsdale, AZ 85259 Phone 480-301-4211 Fax 480-301-7282	Florida 4500 San Pablo Road Jacksonville, FL 32224 Phone 904-953-2022 Fax 904-953-2242	Rochester 200 First Street SW Rochester, MN 55905 Phone 507-284-4594 Fax 507-284-0161	MCHS MN 1025 Marsh Street Mankato, MN 56001 Phone 507-594-2621 Fax 507-422-0902	MCHS WI 1400 Bellinger Street Eau Claire, WI 54703-5211 Phone 715-838-6395 Fax 715-838-3058
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Reminder: If sending records **TO** Mayo Clinic, fax records to number indicated in section 5 on page 1.

*Health Information Management Services