QUESTIONS AND COMPLAINTS

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact our office manager at 701-712-6692.

If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint to our office manager at Missouri River Health, 425 E Ave C, Bismarck, ND 58501.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

EFFECTIVE DATE, RESTRICTIONS AND CHANGES TO PRIVACY POLICY

This notice will go into effect on January 1, 2021.

We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

If we revise our policies and procedures, we will notify you of these changes by mail

Missouri River Health

425 E Ave C

Bismarck, ND 58501

Telephone: 701-712-6692

Fax: 701-354-2219

Missouri River Health

Notice of Psychologists' and Other Mental Health Providers' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Missouri River Health is referred to as "we", "us" and "our" in this notice.

USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

We may *use* or *disclose* your *protected health information PHI),* for *treatment, payment, and health care operations* purposes with your *consent.* To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"* - *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  -*Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- *"Use"* applies only to activities within our practice group, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of our practice group, such as releasing, transferring, or providing access to information about you to other parties.

USES AND DISCLOSURES REQUIRING AUTHORIZATION

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing our psychotherapy notes. *"Psychotherapy notes"* are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. In most cases that require transfer of information to another healthcare provider a summary note is all that is needed.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

USES AND DISCLOSURES WITH NEITHER CONSENT OR AUTHORIZATION

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If, in our professional capacity, we gain knowledge of or have reasonable cause to suspect that a child is abused or neglected or had died as a result of abuse or neglect, we are required by law to report the circumstances to the North Dakota Department of Human Services.
- **Adult and Domestic Abuse:** If we have knowledge or reasonable cause to suspect that an adult with developmental disabilities or mental illness to whom we are providing services is being abused, neglected, or exploited, we are required by law to report the circumstances to the North Dakota Protection and Advocacy Project.
- **Health Oversight:** If the State Board of Psychologist Examiners subpoenas us, we must appear as a witness and bring copies of patient/client records.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and request is made for information about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law and we must not release your information without your written authorization or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. We will inform you in advance if this is the case.
- **Serious Threat to Health or Safety:** We may disclose your confidential information to protect you or others from a serious threat of harm by you.
- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose any information, including subsequent prognosis reports, records, bills and other information concerning mental health care services to the North Dakota Worker's Compensation Bureau.

PATIENT'S RIGHTS AND PSYCHOLOGIST'S AND OTHER MENTAL HEALTH PROVIDER'S DUTIES

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communication by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communication of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. Upon your request, we will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request we will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, We will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Psychologist's and Other Mental Health Provider's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will notify you of these changes by mail.

Missouri River Health
425 E Ave C
Bismarck, ND 58501
(701) 712-9962

Today's Date: _____

Client's Name: _____ Gender: _____

Date of Birth: _____ Social Security #: _____

Address: _____
Street Address City State Zip Code

Responsible Party: _____ Address: _____

Home Telephone Number: _____ Cell Phone Number: _____ Email Address: _____

Client's Employer: _____ Employer's Telephone Number: _____

Spouse's Name: _____ Employer and Telephone Number: _____

If Child, Father's Name: _____ Employer and Telephone Number: _____

If Child, Mother's Name: _____ Employer and Telephone Number: _____

Primary Care Physician: _____

Emergency Contact:

Name: _____ Relationship: _____

Address: _____ Telephone Number: _____

INSURANCE/PAYMENT INFORMATION: ***Please check the appropriate insurance/payment option and complete its designated section.***

***** Please note: You, the client, are responsible for knowing and understanding your insurance coverage/benefits. It is the client's responsibility to call their insurance company to verify services before services are rendered.***

Medicaid: Medicaid Number: _____ County: _____

Medicare: Medicare Number: _____

BCBS of ND: Policy Holder: _____ Date of Birth: _____
Name on Card of Policy Holder

Policy Number: _____

Other Insurance: Company Name and Address: _____

Policy Holder: _____
Name ad Date of Birth

Policy Number: _____ Group Number: _____

Self-Pay: _____ **Please note that it is required that self-pay clients pay for services prior to the services being rendered.

Authorization: I hereby authorize Missouri River Health to furnish information to insurance carriers concerning any services rendered to me or any member of my family, and I hereby assign to Missouri River Health all payments for services rendered. I understand that I am financially responsible for all charges.

Signed: _____ Date: _____

Missouri River Health, PC
Client Rights and Responsibilities

YOU HAVE THE RIGHT TO BE TREATED WITH DIGNITY AND RESPECT AS AN INDIVIDUAL WHO HAS PERSONAL NEEDS, FEELINGS, PREFERENCES, AND REQUIREMENTS.

YOU HAVE THE RIGHT TO PRIVACY IN YOUR TREATMENT, IN YOUR CARE, AND IN THE FULFILLMENT OF YOUR PERSONAL NEEDS.

YOU HAVE THE RIGHT TO BE FULLY INFORMED OF ALL SERVICES AVAILABLE TO YOU AT THE FACILITY AND OF ANY CHARGES FOR THOSE SERVICES.

YOU HAVETHE RIGHT TO BE FULLY INFORMED OF YOUR RIGHTS AS A CLIENT, FAMILY MEMBER, FRIEND AND/OR GUARDIAN AND ALL RULES AND REGULATIONS GOVERNING YOUR CONDUCT WHILE IN THIS FACILITY.

YOU HAVE THE RIGHT TO KNOW ABOUT YOUR PHYSICAL CONDITION UNLESS YOUR COUNSELOR, FOR MEDICAL REASONS, CHOOSES NOT TO INFORM YOU, AND SO INDICATES IN YOUR MEDICAL RECORDS.

YOU HAVE THE RIGHT TO PARTICIPATE IN THE DEVELOPMENT OF YOUR TREATMENT PLAN.

YOU HAVE THE RIGHT TO RECEIVE INFORMATION NECESSARY TO GIVE INFORMED CONSENT PRIOR TO THE START OF ANY PROCEDURE AND/OR TREATMENT.

YOU HAVE THE RIGHT TO REFUSE TREATMENT, TO THE EXTENT PERMITTED BY LAW AND TO BE INFORMED OF THE CONSEQUENCES OF THIS RIGHT.

YOU HAVE THE RIGHT TO BE FREE FROM PHYSICAL, CHEMICAL, AND EMOTIONAL ABUSE.

YOU HAVE THE RIGHT TO CONTINUITY OF CARE. YOU WILL NOT BE DISCHARGED OR TRANSFERRED EXCEPT FOR MEDICAL REASONS, FOR YOUR PERSONAL WELFARE, OR FOR THE WELFARE OF OTHERS. SHOULD A TRANSFER OR DISCHARGE BECOME NECESSARY, YOU WILL BE GIVEN REASONABLE ADVANCED NOTICE, UNLESS AN EMERGENCY SITUATION EXISTS.

YOU HAVE THE RIGHT TO VOICE OPINIONS, RECOMMENDATIONS, AND GRIEVANCES IN RELATION TO POLICIES AND SERVICES OFFERED BY THIS FACILITY, WITHOUT FEAR OR RESTRAINT, INTERFERENCE, COERCION, DISCRIMINATION, OR REPRISAL.

YOU HAVE THE RIGHT TO CONFIDENTIAL TREATMENT OF YOUR PERSONAL AND MEDICAL RECORDS. INFORMATION FROM THESE SOURCES WILL NOT BE RELEASED WITHOUT YOUR PRIOR CONSENT, EXCEPT IN AN EMERGENCY, OR AS REQUIRED BY LAW.

YOU HAVE THE RIGHT TO REFUSE TO PERFORM ANY SERVICE FOR THE FACILITY, OR FOR OTHER CLIENTS, UNLESS THEY ARE PART OF YOUR THERAPEUTIC PLAN OF TREATMENT, WHICH YOU HAVE APPROVED.

YOU HAVE THE RIGHT TO PARTICIPATE IN THE ACTIVITIES OF SOCIAL, RELIGIOUS, AND COMMUNITY GROUPS OF YOUR CHOICE UNLESS YOUR TREATMENT TEAM CONSIDERS SUCH ACTIVITIES CONTRARY TO YOUR WELFARE AND SO INDICATES IN YOUR MEDICAL RECORDS.

YOU HAVE THE RIGHT TO CHOOSE PERSONS WITH WHOM YOU ASSOCIATE AND COMMUNICATE, PUBLICLY AND PRIVATELY, UNLESS THE STAFF FEELS SOME OR ALL SUCH ASSOCIATIONS ARE DETRIMENTAL TO YOUR WELFARE AND SO INDICATES IN YOUR MEDICAL RECORDS.

YOU HAVE THE RIGHT TO RECEIVE INFORMATION NECESSARY TO GIVE INFORMED CONSENT PRIOR TO BEING INVOLVED IN ACTIVITIES, WHICH INCLUDE THE USE OF TAPE RECORDERS, ONE-WAY OBSERVATION MIRRORS, PHOTOGRAPHY, OR ANY OTHER SPECIAL AUDIO-VISUAL TECHNIQUES.

YOU HAVE THE RIGHT TO KNOW THAT THERE MAY BE RISKS INVOLVED IN PARTICIPATING IN SERVICES SUCH AS NOT MAKING PROGRESS OR UNDERSTANDING THAT PROGRESS MAY TAKE TIME TO ACHIEVE.

YOU HAVE THE RIGHT TO UNDERSTAND THAT FAMILY MEMBERS CAN AND, AT TIMES, ARE INVOLVED IN THERAPY PROCESS AND THAT CONFIDENTIALITY WILL BE MAINTAINED OR APPROPRIATE DISCLOSURE/CONSENT FORMS WILL BE OBTAINED.

I HAVE READ (OR HAVE HAD READ TO ME) AND UNDERSTAND THE ABOVE INFORMATION.

I HAVE READ (OR HAD READ TO ME) AND BEEN GIVEN A COPY OF MY HIPAA RIGHTS.

CLIENT SIGNATURE_____ DATE_____

PARENT/GUARDIAN SIGNATURE_____ DATE_____

Missouri River Health

OFFICE PROCEDURES AND BILLING POLICIES

Missouri River Health will submit claims to the client's insurance provider. In order to do so, a copy of client's insurance card will be made. It is the client's responsibility to notify the office of any change in address, phone number, or insurance carrier. If client **DOES NOT HAVE INSURANCE,** we require payment **prior** to receiving mental health services.

If you have a **co-payment** for visits, the **co-pay is due the day services are rendered.**

Our office will bill client the balance after insurance payments are received. Payments are expected 15 – 30 days after receipt statement. Treatment will be suspended, and no additional appointments will be scheduled until account balance is paid in full, or other arrangements have been made.

MEDICAID; SANFORD EXPANSION COPAYMENTS:
There is a $2.00 co-pay for Medicaid recipients (co-pays do not apply to children).
Co-pays are due the day services are provided. If co-pay is not received prior to the appointment, it will be charged to client's account and treatment paused until co-pay balance returns to zero.

PLEASE NOTE: COLLECTION PROCEDURES:
Client will be sent statements monthly. Client will be notified if the balance is past due. After 60 days with no payments or effort to arrange payment, services will be terminated. Overdue accounts will be turned over to our collection agency who will seek payment. If client account is turned over to collections and client requests to return for services, exception may be made; however, the commission fees paid to the collection agency will be billed back to client account.

NO SHOW POLICY:
We ask that our office be notified as soon as possible if client is unable to keep an appointment. We would prefer 24-hour notice. This allows us to reschedule other clients to access the time slot. After three consecutive cancellations and/or "no shows" services may be terminated, per discretion of the provider or business manager.

MINOR CHILDREN:
The office and employees of Missouri River Health **are not** responsible for minor children left in the waiting room area unattended.

VALUABLES:
The client is responsible for the retention of personal articles. Missouri River Health will not assume responsibility for the loss or any damage of client's personal articles (e.g. money, jewelry, eyeglasses, dentures, hearing aids, cell phones or other electronic devices, or clothing, etc.).

****** Please see back of page for additional information and required signature.***

TERMINATION OF SERVICES:

(a) Providers may terminate services when it becomes reasonably clear that the client no longer needs or no longer benefiting from the service.

(b) Provider will terminate therapy when threatened or otherwise endangered by the client or other person with whom the client has a relationship.

(c) Services will be terminated for failure to comply with billing policy.

(d) Services will be terminated if the client's outstanding balance has been turned over to collections.

(e) Services will be terminated if a client has filed bankruptcy and there is an outstanding account balance.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION & ASSIGNMENT OF BENEFITS

Missouri River Health is authorized to release confidential mental health/behavioral health/chemical dependency/protected health information to the following: third-party payers, insures, Social Security Administrators, and Medicare.

The client and individual legally obligated to pay for mental health services agrees to pay and is financially responsible for services provided.

I assign and authorize any third-party payer/insurer to make direct payment to Missouri River Health. I authorize the refund of overpaid insurance benefits to the insurance company.

I acknowledge that I have read the front and back of the office procedures and billing policies of Missouri River Health and have agreed to their terms.

_____ _____

Client Signature (or Guardian) **Print Name**

_____

Date

ACKNOWLEDGEMENT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a written copy of the Missouri River Health Notice of Privacy Practices. I also acknowledge that I have been allowed to ask questions concerning this notice and my rights under this notice. I understand that this form will be part of my record until such time that I may choose to revoke this acknowledgment. If I am not the client, I represent that I am authorized by law to act for and on the client's behalf.

_____ _____

Date Signature of Client or Authorized Agent

_____ _____

Client's Date of Birth PLEASE PRINT (Client's Name)

TO BE COMPLETED BY MISSOURI RIVER HEALTH IF NO ACKNOWLEDGEMENT CAN BE OBTAINED

Missouri River Health made a good faith effort to obtain acknowledgement from the client or client's authorized agent. The good faith efforts made, and the reason acknowledgement could not be obtained was:

Client (or authorized agent) refused to sign after being requested to do so

Notice mailed

Minor child unaccompanied by parent/legal guardian

Other: (Please describe) _____

_____

Date

_____

Signature of Missouri River Health Associate

Missouri River Health
425 E Ave C
Bismarck, ND 58501
(701) 712-9962

Missouri River Health

AUTHORIZATIONS AND RELEASES

Client Name: _____ Client Number: _____

1. AUTHORIZATION FOR EVALUATION/TREATMENT

I hereby authorize the professional in charge of the above-named client to evaluate and administer treatment necessary or advisable.

2. LIMITS OF CONFIDENTIALITY

I understand the limits of confidentiality as outlined on the reverse side of this form.

3. RELEASE OF INFORMATION FOR INSURANCE CLAIMS

Missouri River Health is authorized to release all or part of the client's medical record to any person or corporation which is or may be liable for any part of the clinic's charges, including but not limited to, hospital or medical service companies, insurers, compensation carriers, or government agencies. It is understood that photocopy of this form is a valid authorization for release.

4. ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment of any insurance benefits arising from policies insuring the client or any party liable to the client, directly to Missouri River Health. I understand that I am financially responsible for any charges not covered by this assignment.

5. **FINANCIAL RESPONSIBILITY**

In consideration of the services to be rendered to the client by the provider, the undersigned guarantees that payment of any amount due. I have read the Statement of Financial Understanding on the back of this form and I assume financial responsibility for the expenses of the above-named client.

6. **MEDICARE SIGNATURE ON FILE**

I hereby authorize payment of Medicare Benefits be made either by me on my behalf to Missouri River Health for any service furnished me by the listed provider. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the client is responsible only for the deductible, coinsurance and noncovered services.

7. **VALUABLES**

The client is responsible for retention of personal articles, Missouri River Health will not assume responsibility for the loss of client's personal articles. (e.g., money, jewelry, eyeglasses, dentures, hearing aids, clothing, and fur garments, etc.).

8. **CERTIFICATION**

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, have received a copy of the foregoing and being the client, guarantor, or being duly authorized by the client, do agree and accept its terms.

_____ _____

Client or authorized signature Relationship to Client

_____ _____

Signature of Witness Date

*Please **READ** each item, **INITIAL** each item and then **SIGN** and **DATE** on the bottom of this form.*

Missouri River Health

STATEMENT OF FINANCIAL UNDERSTANDING

BILLING POLICIES

As a service to our clients, Missouri River Health is capable and willing to assist you with filing of insurance claims and answering any billing questions. All information requested is necessary for the proper processing of claims, and to speed up the billing process. Without this information, the bill will be sent directly to you.

Missouri River Health will not accept the responsibility for collection of insurance claims or negotiate settlements in disputed claims. Please recognize that you, the client, are responsible for the bill. If problems arise in the processing of these claims, we will provide any assistance possible.

MEDICARE BENEFITS

Missouri River Health is a participant in the Medicare Program and does accept Medicare assignment. We will be happy to submit any balance following payment from Medicare to your supplemental insurance providing complete information is furnished.

WORKERS COMPENSATION

North Dakota Workers Compensation claims are submitted directly to the Workers compensation Bureau by Missouri River Health. If the Workers Compensation is through another state, the claim will be completed by our office and sent directly to you for submission to your individual Workers Compensation Insurance Fund.

NO FAULT

If your visit to the clinic is due to a motor vehicle accident, you will be asked for the name and address of the insurance company along with the claim number and date of accident. If you cannot provide this information, we will consider the balance your responsibility.

PAYMENT PROCEDURES

Benefits paid directly to Missouri River Health are credited to your account and will be notified on the statement of any balance due.

When benefits are payable directly to, you are responsible for submitting that payment to the clinic. At that time your account will be credited and you will be notified on the next statement of any balance due.

We understand there are clients who have financial difficulties and encourage them to discuss their situation with us so payment arrangement can be made.

Missouri River Health will not extend credit to a client who fails to make payments, unless you consult with our office. These accounts may be turned over to an outside agency for collections. Payment arrangement can be made by calling (701) 712-9962.

CONFIDENTIALITY

The staff of Missouri River Health does everything possible to assure your confidentiality. Your limits to confidentiality may be limited by law or regulations in some situations, such as;

1. the person who is a harm to him/herself or others;
2. disclosure of suspicion of child abuse or neglect previously unreported;
3. a court ordered request for records, or
4. access by the support staff directly providing your care or completing quality assurance activities

Other considerations:

1. in the case of a minor or child, we reserve the right to communicate with client or guardian;
2. older children, especially teens, will be allowed the same privacy as an adult; parents/guardians will be offered suggestions in enhancing their care.
3. CELL PHONES: Cellular telephones and cordless telephones are UNSECURE. Missouri River Health does not recommend using any cellular and/or cordless telephones to communicate with any of the providers regarding mental health issues. It is to be understood if you choose to communicate with any provider over any cellular telephone or cordless telephone regarding mental health issues Missouri River Health is NOT RESPONSIBLE for any over heard conversation that occurs over the electronic waves/transmission of the cellular telephone or cordless telephone.