14665 Galaxie Ave., Suite 210, Apple Valley, MN 55124
Phone: (952) 431-6033 Fax: (952) 431-3225
www.oakridgecenter.org

Important Information, Our Financial Policy, & Your Rights

OUR FINANCIAL POLICY

Welcome to Oak Ridge Center. We appreciate you choosing us to provide your behavioral health services. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy.

Missed or Late Cancelled Appointments

Our policy is that a 48 hour notice be given when you cancel an appointment. For example, please notify us 9 am Monday morning to cancel a 9 am Wednesday appointment. For a 9 am Monday appointment please notify us by 9am Friday.

A charge for up to the full amount of the appointment may be applied to your account for any missed or late cancelled appointment less than 48 business hours. Charges for "emergency" cancellations will be considered. This charge is not billable to your insurance and will be billed to you as your responsibility. Please help us serve you better by keeping scheduled appointments. Clients with two or more late cancelled or missed appointments are subject to termination of care and appropriate referrals given.

Payments

- **ALL COPAYS ARE DUE AT THE TIME OF YOUR SESSION**
- We accept cash, checks, and credit cards

Insurance

We accept assignment of insurance benefits. The balance is your responsibility whether your company pays it or not. We cannot bill your insurance company unless you provide us with all of your current insurance information. Your insurance policy is a contract between you and your insurance company. We are not a third party to that contract. In the event we do accept assignment of benefits and your insurance has not paid your balance in full within 60 days, the balance will be automatically transferred to your responsibility. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance. Contact your employer or insurer if you have questions. All copays and self-pay charges are due at the time of your session. In the event your insurance plan changes, it is your responsibility to notify us of the change. If your new plan is one for which we are not participating providers, you are responsible for the charges in full. Any follow up or reporting to third parties that become necessary due to unpaid balances on your account, shall not be considered breach of confidentiality. **You must notify us in advance of your first appointment if you intend to use an Employee Assistance Program (EAP and provide the authorization number.** Once services have been provided under insurance, we will not bill your EAP. While Oak Ridge Center or clinicians of Oak Ridge Center may be listed as a network provider for your insurance, this is not a guarantee of coverage. Should your insurance company reject a claim or pay at an out of network rate, you will be held responsible for the balance due.

Service & Finance Charges

- A monthly finance charge of 1.5% will be assessed on all balances exceeding 30 days.
- Past due accounts may be reported to a collection agency. If for any reason you are unable to pay your account within 30 days, it is imperative that you contact our office immediately. Payment plans may be available for those with unpaid balances.
- A $20 fee will be charged for returned checks

Fee Schedule

A discount may be available to clients choosing not to use insurance and who pay in full at the time of service.

The following are the most commonly billed services:

Diagnostic Interview: More than one diagnostic session may be needed. In this case, each session is billed at the rate below.

Masters/Doctoral Professional...$260-285
MD.... $431.25
CNP...$362.50

Psychotherapeutic Sessions:
Fees are based on length and type of psychotherapeutic session provided.

Group Therapy Fees... $40-60 depending on the group

Medication Management:
Fees are based on the type of service provided each session.

Psychological Testing:
Psychological testing is performed by a Masters or Doctoral Professional at $175 per Unit. The number of units needed to complete the testing varies and should be discussed with the provider.

Additional fees for reports, letter, and review of collateral information, phone consultations and therapy groups may apply. Some or all of the above services may not be covered by your insurance. Please consult your clinician with any questions.

IMPORTANT INFORMATION

The following is some important information about your care at Oak Ridge Center.

Prescription Refill Policy
Typically, your provider will provide you with enough prescription refills to adequately last until your next scheduled appointment. In order to avoid running out of your medication, you should schedule your next follow up appointment immediately after you have seen your provider. If you need a refill before your next appointment, please contact your pharmacy 7 days prior to running out of your medication to ensure that your treatment is not interrupted and refills may be authorized if needed. **Medication refill requests will only be processed on the days your provider is in the office.**

Controlled Substances:
Some medications are considered controlled substances and may require you to turn in a paper prescription each month to your pharmacy. Lost or stolen prescriptions will not be replaced or refilled early. It is your responsibility to make sure that you are placing these in a secure place at all times.

Confidentiality

Most of the information a clinician collects about you will be classified as confidential. However, when insurance is involved, Oak Ridge Center does not have control over and cannot insure its client's confidentiality. That means employees of the insurer and employees of contracted organizations of the insurer have access to your chart. This information is provided in the insurance policy between you and your insurance company.

The client record is legally the property of Oak Ridge Center. However, clients may have access to information contained in the file, except in those cases where the release of such information may be deemed harmful to the client's wellbeing. Information can be released to others only upon written informed consent of the client.

In a few cases, information is unavailable to the client. Certain confidential data may be available only to the clinician and particular government agencies. Classified material falling into this category might deal with adoption, civil or criminal investigations, some medical data and the names of persons who report suspected abuse of children or vulnerable adults.

Exceptions to Privacy

All members of the staff of Oak Ridge Center will hold information confidential except under the following circumstances:

- If a client threatens to harm someone (including self), a staff person must, by law, take appropriate action to ensure safety.
- If a client engages in irresponsible sexual activity while HIV positive.
- If a client uses recreational drugs or alcohol while pregnant.
- If a clinician suspects that a client is physically or sexually abusing a child or vulnerable adult, the clinician is required by law to report concern to the proper authorities.
- If a client is the age of 18 and the clinician judges it is in the best interest of the client to share information.
- Requests from your insurance company.

Oak Ridge Center Professionals may meet in consultation with other mental health providers within this clinic. During those meetings, your situation may be reviewed. Mental health professionals seeing members of the same family or significant others may discuss your situation. If you have questions or concerns with this, please speak to your clinician.

Children Visiting Our Facility

If the patient is a minor or has a legal guardian, the parent or legal guardian must be present at the initial appointment. For safety purposes, children cannot be left unattended in the waiting room.

Emergencies

Listed below are some phone numbers you may want to keep with you in case of an emergency when your clinician is not immediately available.

- Dakota County Crisis Intervention: 952-891-7171
- Scott County Crisis Intervention: 952-442-7601
- Ramsey County Crisis Intervention: 651-266-7900
- Hennepin County Acute Psychiatric Services: 612-873-2222
- United Way First Call For Help: 612-335-5000
- Crisis Connection: 612-379-6363
- Behavioral Emergency Center, University of Minnesota Medical Center: 612-672-6600

Clients Rights

Bill of Rights

Consumers of mental health services have the right:

1. To expect that the professional consulted has met minimal qualifications of training and experience commensurate with service requirements and in accordance with professional and/or disciplinary standards.
2. To be informed of the credentials of those by whom they are served.
3. To be informed of the cost of professional services prior to receiving those services.
4. To privacy as defined by rule and law.
5. To be free from being the subject of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.
6. To have access to their records as provided in the Minnesota Statutes, section 144.335 subdivision 2.
7. To be free from exploitation for the benefit or advantage of a clinician.

Professional Boundaries

Clinicians must not, under any circumstances be involved with their clients in a sexual way. They may not "date" or behave with their clients in a "dating" manner. They are not to be involved in social relationships/functions with their clients. This prohibits going to lunch/dinner with clients.

Complaints

If you are dissatisfied with the services you are receiving, please immediately discuss your concerns with your clinician. A clinician needs honest feedback to be most effective. However, if you feel uncomfortable confronting your clinician about your concerns, or if you are not satisfied with the result when you express your concerns, please contact our Clinical or Medical Director regarding these concerns.

In the case you feel it is necessary to contact a professional group outside of Oak Ridge Clinic, it is your right to do so. Professional associations interested in promoting high quality services and professional ethics are:

- Minnesota Psychological Association
- Minnesota Psychiatric Association
- Minnesota Board of Psychology
- Minnesota Board of Medical Examiners
- Minnesota Board of Marriage and Family Therapy
- Minnesota Board of Social Workers
- Minnesota Board of Nursing
- Minnesota Psychiatric Society
- Minnesota Board of Nursing
- Department of Human Services

14665 Galaxie Ave., Suite 210, Apple Valley, MN 55124
Phone: (952) 431-6033 Fax: (952) 431-3225
www.oakridgecenter.org

Notice of Privacy Practices

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

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- **Get an electronic or paper copy of your medical record:** You can ask to see a copy of your medical record and other health information we have about you. Ask us how we do this. We will provide a copy or summary of your health information within a reasonable time. We may also charge a reasonable, cost-based fee.
- **Ask us to correct your medical record:** You can ask to correct your health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- **Request confidential communication:** You can ask us to contact you in a specific way. (For example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests. Unless you tell us otherwise, we will call and mail to your home.
- **Ask us to limit what we use or share:** You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- **Get a list of those with whom we've shared information:** You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we have shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).

We'll provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

- **Get a copy of this privacy notice:** You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- **File a complaint if you feel your rights are violated:** You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us what NOT to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Clinic's Uses and Disclosures:

We typically use or share your health information in the following ways. We need your consent before we disclose protected health information for treatment, payment, and operations purposes, unless the disclosure is to a related entity, or the disclosure is for a medical emergency and we are unable to obtain your consent due to your condition or the nature of the medical emergency.

- **Treat you:** We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
- **Run our organization:** We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*
- **Bill for services:** We can use and share your health information to bill and get payment from health plans and other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways-usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

- **Help with public health and safety issues:** We can share health information about you for certain situations such as:
    - ❖ Preventing disease
    - ❖ Helping with product recalls
    - ❖ Reporting adverse reactions to medications
    - ❖ Reporting suspected abuse, neglect, or domestic violence
    - ❖ Preventing or reducing a serious threat to anyone's health or safety
- **Do research:** We can use or share your information for health research.
- **Comply with the law:** We will share information about you if the state or federal law requires it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy laws.
- **Respond to organ and tissue donation requests:** We can share health information about you with organ procurement organizations.
- **Work with a medical examiner or coroner:** We can share health information with a corner and medical examiner when an individual dies.
- **Address workers' compensation, law enforcement, and other government requests:** We can use or share health information about you:
    - ❖ For workers' compensation claims
    - ❖ For law enforcement purposes or with a law enforcement official
    - ❖ With health oversight agencies for activities authorized by law
    - ❖ For special government functions such as military, national security, and presidential protective services
- **Respond to lawsuits and legal actions:** We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Minnesota Patient Consent for Disclosures

For most disclosures of your health information we are required by the State of Minnesota Laws to obtain a written consent from you, unless the disclosure is authorized by Law, court ordered or subpoena, or for public health purposes throughout the Minnesota Department of Health Activities. This consent may be obtained at the beginning of your treatment, during the first delivery of health care service, or at a later point in your care, when the need arises to disclose your health information to others outside of our organization.

Our Clinic's Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breech occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. You must let us know in writing if you change your mind.

Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

Effective 3/1/2014

If you have any questions regarding your privacy rights or the information in this notice, please contact Oak Ridge Center.

Privacy Official: Kari Benolkin, Clinic Manager
Address: 14665 Galaxies Ave, Suite 210, Apple Valley, MN 55124
Phone Number: 952-431-6033

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Oak Ridge Center

14665 Galaxie Ave., Suite 210, Apple Valley, MN 55124 (952) 431-6033 Fax: (952) 431-3225

The following information will be used for our Patient Portal within your electronic health record. In addition, some of the information below will be used for appointment reminder notifications. This information will not be shared with any outside entities unless you have already consented to this.

Patient Name____

Date of Birth____

Email Address____

Primary Telephone Number______________________________________

Secondary Telephone Number____________________________________

Preferred Language____

Race____

Ethnicity

- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Declined to specify

Preferred Method of Contact for Appointment Reminder Notification

- ☐ Text Message Notification
  Cell Phone Number______________________________________
  By checking the box above, I agree to receive text notifications for my appointment reminders. Carrier message and data rates may apply to each message sent and are my responsibility.

- ☐ Email Message Notification to the email address listed above
- ☐ Automated Phone Call
  Phone Number____

Signature___________________________________ Date____________

Relationship to Patient_______________________________________

Oak Ridge Center

Phone: 952-431-6033

Date ____________________

Patient Information

Patient Name (Last – First – Middle)	Gender M F	Date of Birth	Race
Address	Primary Phone		Secondary Phone
City, State, Zip	Employer		Work Phone
In Case of Emergency, Notify	Emergency Contact's Phone		
Family Physician	Physician's Phone		
Whom May We Thank for referring You To Us?	Email address		

Insurance Information

We cannot guarantee insurance coverage by your insurance carrier. The information below will assist us in determining if some of the expenses are reimbursable by your HMO or insurance carrier. **Please provide insurance card to be copied.**

Primary Insurance	ID#	Group #	Social Security Number
Policy Holder	Relationship to Insured	Date of Birth	Gender M F
Address	Primary Phone		Secondary Phone
City, State Zip	Employer		Occupation
Secondary Insurance (If applicable)	ID#	Group #	Social Security Number
Policy Holder	Relationship to Insured	Date of Birth	Gender M F
Address	Primary Phone		Work Phone
City, State, Zip	Employer		Occupation

Authorization and Release

I certify the above information is true and correct to the best of my knowledge. I certify that I (or my dependent) have insurance coverage and assign directly to Oak Ridge Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand and agree that I am ultimately responsible for payment – and that at this time services rendered *may not* be covered by my insurance. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand this authorization will remain in effect until I revoke it in writing.

I authorize the release of all information necessary including copies of pertinent medical records to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that billing is done by a third-party and that I may contact them with questions regarding my account. I understand this authorization will remain in effect until I revoke it in writing.

____________________ Signature of Responsible Party

____________________ Relationship

____________________ Date

____________________ Print Name of Responsible Party

REV 1/1/15

Oak Ridge Center

14665 Galaxie Ave., Suite 210, Apple Valley, MN 55124 Ph: (952) 431-6033 Fax: (952) 431-3225

RELEASE OF INFORMATION FOR PRIMARY CARE PHYSICIAN

Client Name:____**DOB:**__________________

Do you currently have a Primary Care Physician (circle one) YES NO
*If you circled NO, please just sign and date below *If you circled YES, please complete

What is Coordination of Care? A collaborative effort between Oak Ridge Center and you Primary Care Physician to provide optimal treatment for your overall health.

What is the Coordination of Care Letter? A letter that is sent after your initial appointment and periodically throughout your treatment to your Primary Care Physician which may include the following information:

- Oak Ridge Center Provider(s)
- Appointment History
- Treatment Plan
- Diagnosis(es)

Please initial what protected health information you authorize Oak Ridge Center to disclose to your Physician:

______ I do **NOT** want Oak Ridge Center to coordinate care/disclose information to my Primary Care Physician

______I authorize **ONLY** the coordination letter to be sent to my Primary Care Physician

______I authorize the Coordination of Care letter **AND** exchange of the information initialed below by mail, fax, or verbally:

______Complete Record ______Initial Evaluation ______Progress Notes ______Testing

______Other (please Specify): ____

Primary Care Provider:____

Clinic Name:____

Address:____

Phone:______________________________ Fax:___________________________________

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in compliance of this consent. This authorization will be effective for medical/treatment records generated to the date of the signature, and the release of medical records created after the date of the signature until the expiration date or the release is revoked by myself in writing. If revocation is not received, authorization will be considered valid for a period of time not to exceed one year.

____ ______________________
Patient/Parent/Legal Guardian Signature Date

____ ______________________
Print Patient/Parent/Legal Guardian Name Relationship to Patient Date

14665 Galaxie Ave., Suite 210, Apple Valley, MN 55124 (952) 431-6033 Fax: (952) 431-3225

Required Signatures

Client Name: ________________________________ **Client DOB:** _______________

____

Print Parent/Guardian's Name **Relationship to the Client**

Financial/Missed Appointment Policy

My signature below indicates that that I have been provided with a copy of the Financial Policy and Missed Appointment Policy. I understand that I am financially responsible for all appointments, unless cancelled with at least 48 hours' notice. If I fail to give the 48 hour notice to cancel an appointment, I may be responsible for up to the full amount of the appointment, which is NOT billable to my insurance.

Billing and Payment Policy (please initial which one applies to you)

_____ Self-pay at the time of service

_____ I am covered by a participating insurance plan and will pay all copays at the time of service.

_____ I have an insurance plan that has a deductible instead of a copay. I am aware that I need to pay all amounts indicated by my insurance company. If I have not met my deductible, I understand that I may be asked to make a $75 down payment at the time of each session until my deductible has been met.

_____ These #______ visits are covered by an Employee Assistance Program (EAP). After these visits have been utilized, my insurance will be billed (Please check number 1-3 from above that applies).
Name of EAP Company____

Authorization Number____

Important Information

My signature below indicates that I have been provided with a copy of the Important Information form.

Assignment of Benefits

I hereby authorize direct payment to Oak Ridge Center of any medical benefits otherwise payable to me for services completed by a provider affiliated with Oak Ridge Center.

Records Release for Insurance Purposes

I hereby authorize Oak Ridge Center to release my records to my insurance company for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payer.

Pharmacy Release

I authorize Oak Ridge Center to communicate with my pharmacy regarding my care if needed, which may include my diagnosis, or other health care information.

Notice of Privacy Practices

My signature below indicates that I have been provided with a copy of the Notice of Privacy Practices.

Contact Information

Oak Ridge Center considers your e-mail address and other contact information to be confidential and will not disclose it to other outside entities.

Oak Ridge Center Staff Release

In the event that multiple Oak Ridge Center staff are involved in my care, I authorize the release of my records between clinicians.

These forms have been explained to me, and I have been given the opportunity to ask questions about them.

X____

Signature of Client/Parent/Legal Guardian   Date

14665 Galaxie Ave., Suite 210, Apple Valley, MN 55124 (952) 431-6033 Fax: (952) 431-3225

CONSENT FOR TELEHEALTH SERVICES

By signing this form, I consent to receive telehealth services at Oak Ridge Center.

I understand that if at any point during my treatment at Oak Ridge Center, that my insurance company does not cover telehealth services, I will be responsible for the charge in full.

Patient Name____

Patient Signature____

Date____

Parent/Guardian Name if Applicable

____

Parent/Guardian Signature____________________________________

Date____