NYSTROM & ASSOCIATES, LTD.
Fee and Policies Agreement

If you plan to submit your own claims to your insurance company, it is our policy that payment of the entire fee is due at the time of service. As a service to our patients, Nystrom & Associates, Ltd. (NAL) staff will submit your insurance claims. If you fail to provide active insurance information in a timely manner you will be held liable for this. Co-payments are due at the time of service. Deductibles and coinsurances will be billed to your account. In the event the undersigned is entitled to health insurance benefits of any type, insuring patient or any other party liable to the patient, their benefits are hereby assigned to this health care facility for application to the patient's account.

_____ *(Initial Here)* **Billing & Payments**

By initialing, you authorize NAL to release information, including medical records, to your insurance company or the designee of your third party payer (authorized agent) as may be necessary to determine benefits, process and pay health care claims, and perform quality of care reviews at NAL. NAL will submit charges to your insurance company whenever possible for services rendered. Payments will be applied to the oldest charge on your account. Charges are based on what occurs during your treatment with NAL. Charges associated with your appointment depend on your individual medical necessity and level of care, as determined by your treating provider.

Time billed for court appearances, court case review, report writing, letters, telephone consultation, and other charges excluded by insurance coverage are your responsibility. Charges vary based on time spent and type of service.

A service charge of 1.5% (18% annual rate), or the highest statutory amount allowed, whichever is higher, will be charged on accounts past due 28 days. If payment from insurance is not received within 90 days the account may be due and payable in full by the patient. An account 90 days past due will be subject to collection procedures and/or small claims court, and the patient agrees to be held responsible for the cost disbursement, including reasonable attorneys, collection, and court fees. NAL may use the information listed below to contact you regarding your account. There is a fee of $30 for checks returned for insufficient funds. Minnesota Care Tax will be added where applicable, and you agree to be held responsible for these fees.

_____ *(Initial Here)* **Insurance Coverage**

NAL can make no guarantee that your insurance company will provide payment for services rendered. It is your responsibility to know what is and is not covered under your policy. You are responsible for the full amount of the charge, whether or not your insurance will cover any portion. If your insurance company requires preauthorization of services you are responsible to inform us. Be aware that some insurance companies have an annual maximum benefit for outpatient mental health coverage.

_____ *(Initial Here)* **Cancellations**

NAL requires a 24-hour notice when cancelling an appointment. This will allow us to schedule the time for someone else. Please note: **IF YOU DO NOT ATTEND A SCHEDULED APPOINTMENT OR CANCEL WITH LESS THAN 24-HOUR NOTICE, YOU WILL BE CHARGED A FEE THAT CORRESPONDS TO THE SCHEDULED LENGTH OF YOUR SESSION**. Your insurance cannot be billed for missed appointments. At the discretion of NAL your services may be discontinued due to excessive failed appointments or late cancels.

_____ *(Initial Here)* **Financially Responsible Party**

The parent or guardian who signs this agreement will be considered the responsible party and will receive all billing statements and letters. Any alternative financial arrangements, including court-ordered financial arrangements, must be worked out between the parents or guardian of the children outside of this agreement.

<u>Unclaimed Refunds</u>

Please remember to read your invoices carefully and call us if you have any questions, especially if you believe there is a credit on your account. If NAL confirms that it owes you or your payer a credit refund, it will resolve that promptly. After 120 days, if a credit of less than $25 remains on the account, and no credit refund has been requested it will be removed from the account. If NAL determines that it owes you a credit refund but cannot locate you, then NAL will file an Unclaimed Property Report with the State of Minnesota. The State publishes those Reports to alert the public that NAL owes you money that you have not yet claimed. The State typically publishes your name, your address, the amount unclaimed, and the identity of who owes you the money, which would be Nystrom & Associates.

Attestation for Consent

_____ *(Initial Here)* **Coordination with Primary Care Provider**

By initialing, you authorize NAL to disclose your **psychiatric** medication management records to your primary care provider for the purpose of coordinating care for best treatment outcomes. This consent will remain in effect until you cancel it in writing to NAL.

_____ *(Initial Here)* **Electronic Signature**

By initialing, you understand that this becomes your electronic signature for the following forms: Initial Treatment Plan, Updated Treatment Plans, and the DBT Agreement Form. The provider will ask for your verbal consent after reviewing the forms with you.

_____ *(Initial Here)* **Communication from NAL about Your Care**

By initialing, you authorize NAL to contact you via mailed correspondence, phone, text message, or email regarding your payment, treatment, and healthcare operations. NAL is not financially liable for any charges you incur from your service provider. By supplying your home phone number, mobile number, email address, and any other personal contact information, you authorize NAL and your healthcare provider, or a business associate of theirs, to contact you at any numbers or email addresses using an automatic telephone dialing system, using a pre-recorded voice or other third-party automated outreach and messaging system as well as to use your protected health information, or other personal or identifying information, during such contact for any administrative or health matter. You consent to the practice, your provider, or their business associate contacting you via unencrypted email and text messages. You also agree that they may leave detailed messages on your voice mail, answering system, or with another individual, if you am unavailable at the number provided.

_____ *(Initial Here)* **Notice of Privacy Practices**

By initialing, you acknowledge that NAL's HIPAA Notice of Privacy Practices and Patient or Consumer Rights Handout, procedures for reporting alleged violations of patient's rights and grievance procedures have been made available to you.

This agreement may not be altered in any way. I have read and agree to the above and hereby guarantee payment of all charges for services with the financial arrangements of NAL.

_____ _____

PRINTED NAME OF PATIENT PATIENT DATE OF BIRTH

_____ _____

PRINTED NAME OF LEGAL GUARDIAN PHONE NUMBER OF LEGAL GUARDIAN

_____

ADDRESS OF LEGAL GUARDIAN

_____ _____

EMERGENCY CONTACT PHONE NUMBER OF EMERGENCY CONTACT

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____

EMAIL ADDRESS OF PATIENT OR LEGAL GUARDIAN

Address: _____
City / State: _____ Zip: _____
Phone: _____ Fax: _____

Nystrom & Associates, LTD.

Psychiatry & Medication Management

Primary Care Provider Release of Information

Patient Full Name: _____ **Date of Birth:** _____

Nystrom Provider: _____

☐ **Send information about my initial evaluation and treatment plan to my Primary Care Provider. Coordinate with my Primary Care Provider as necessary for care.**

(Unless otherwise specified, the option above includes all Substance Use and/or mental health related information)

☐ **Do not coordinate care with my Primary Care Provider**

☐ **I do not have a Primary Care Provider.**

I authorize Nystrom & Associates, LTD. to RELEASE to and RECEIVE from:

Primary Care Provider/Clinic: _____

Street Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

I understand the following: See 45 CFR §164.508(c)(2)(i-iii) a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released according to this authorization. b. The information released in response to this authorization may be re-disclosed to other parties. c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. d. Communications resulting from this authorization will reveal I have received services from NAL/FSSI. e. My health information is protected by federal regulations and state laws. Disclosure is only allowed with my authorization, except in limited circumstance as described in NAL/FSSI Privacy Policy. f. I have the right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws. A photocopy of this authorization will be treated in the same manner as the original. This authorization will remain valid until care is terminated with NAL or this authorization is revoked by the patient. I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use disorder Patient Records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Patient Signature: _____ **DATE**: _____

Legally authorized representative signature: _____ DATE: _____

Representative's relationship to patient (parent, guardian, etc.) _____

Name (If not signed by patient): _____

NOTE: If signed by someone other than the patient, we need written proof of authority.

DO NOT FORWARD TO ANOTHER PERSON OR AGENCY WITHOUT PATIENT CONSENT.

CHILD Health Screening Questionnaire *(to be completed by parent or guardian)*

Ages 12 and under

Date: _____ Clinician: _____

Name: _____ Birth date: _____

Please answer these questions to help our providers learn more about your child's nutrition and physical health.

Was your child premature?	Yes / No
Is your child less than the 10th percentile on the wt/ht growth chart?	Yes / No
Is your child greater than the 90th percentile on the wt/ht growth chart?	Yes / No
Does your child have trouble sleeping?	Yes / No
Is your child on a special diet? If yes, what kind of diet? _____	Yes / No
Is your child allergic or sensitive to any foods? If yes, what foods? _____	Yes / No
Is your child a "picky eater?" If yes, how so? _____	Yes / No
(CIRCLE THOSE THAT APPLY) Does your child have any problems with diarrhea, constipation, nausea, vomiting, chewing, or swallowing?	Yes / No
During a normal week, how often is your child physical active? _____ minutes per day _____ days per week	
On a scale of 1-10, how ready are you to help your child to be more physically active? _____ *(10=extremely motivated; 1=no motivation at all)*	
Does your child have any physical health issues? _____	Yes / No
Has your child experienced unintentional weight loss or weight gain? **(IF YES, CIRCLE ONE)**	Yes / No
Does your child have concerns about their body image?	Yes / No
Are you or your child currently on WIC or other food support programs? If yes, what programs? _____	Yes / No
Does your family have enough food to eat?	Yes / No
During a normal meal, is half the food on your child's plate fruits and vegetables?	Yes / No
On a scale of 1-10, how ready are you to help your child eat more fruits and vegetables? _____ *(10=extremely motivated; 1=no motivation at all)*	
Does your child eat protein with every meal?	Yes / No
Does your child drink at least 8 glasses of water a day?	Yes / No
What concerns, if any, do you have with your child's eating habits? _____ _____	
Does anyone in your child's household smoke cigarettes?	Yes / No
On a scale of 1-10, how ready are they to quit smoking cigarettes? _____ *(10=extremely motivated; 1=no motivation at all)*	
Would you like to schedule an appointment for your child with the Dietitian? *If you answer YES to this question, a Patient Care Coordinator will contact you to schedule you for nutrition services.*	Yes / No

An initial nutrition assessment is recommended to compliment the care you are already receiving here at Nystrom and Associates, LTD. Please discuss this with the Patient Care Coordinator after your initial appointment has been completed.

Nystrom & Associates, Ltd.

Psychiatric Medication Management Consent and Information Form

Thank you for choosing Nystrom & Associates, Ltd. for your care. It is important for you to read each item carefully and initial in the space provided to the left each item. By initialing you are indicating you have read, and understand the content of each item. If you have any questions about the items below, please discuss with your provider at your appointment.

General:

_____ I am consenting to be evaluated to undergo possible medication treatment for my mental illness. Medication options will be discussed with your provider. Some of these options may include antidepressants, or psychotropic medications. I may also be recommended to participate in other forms of mental health care treatment.

_____ NAL does not offer after- hours services. If you have a concern, please contact us using FollowMyHealth or by calling your clinic. Your message will first be triaged through our nursing team who will contact you within one business day.

_____ If you have an emergency, such as severe suicidal thoughts, thoughts to hurt someone else, or a severe drug reaction, you should call 911, go to your local urgent care, or go to the emergency room.

_____ Legal guardians must attend all appointments with minors and adult patients who are not their own legal guardians for treatment to occur, unless exceptions have been approved by the Office Manager prior to the appointment.

Medication Refill Requests:

_____ You should contact your pharmacy or use FollowMyHealth first for all medication refill requests.

_____ Refill authorizations can take up to 5 business days.

_____ Controlled medication refills will not be authorized more than 3 days before they are due for refill. If you have questions regarding early refills, please speak with your provider.

Appointment Scheduling and Cancelations:

_____ Appointments canceled without a 24 hour notice may be assessed a fee up to $120.00.

_____ If you arrive late to your appointment, you may not be able to be seen and may be assessed a fee up to $120.00.

_____ If you miss 3 appointments in a 12 month period with your medication provider, we will end care with you.

_____ You may be able to schedule a same day or cancelation appointment if you 1) have missed your appointment, 2) need forms completed, or 3) have other treatment concerns.

_____ Many of our providers work with medical or nursing students. You should inform your provider if you do not want a student participating in your appointments.

Turn page over

Forms:

_____ Our providers require an appointment to complete any forms. Any forms needing completion should be dropped off at the front desk. Your provider will review the forms and notify staff how long to schedule your forms appointment for. Any forms completed outside of an office visit will be assessed a fee, requiring prepayment.

Laboratory & Psychological Testing:

_____ Your provider will request you complete certain laboratory tests before initiating or continuing certain medications. Laboratory tests may include, but are not limited to: saliva, hair follicle, urine, blood serum, electrocardiograms, psychological testing, genomic testing, etc.

_____ Laboratory testing fees are your responsibility. If your insurance plan will not cover the cost for laboratory, psychological, or other testing, you will be responsible for all costs incurred.

Billing and Insurance:

_____ You are responsible for understanding your insurance coverage.

_____ Co-pays are due at the time of check-in.

_____ Your insurance will be charged for services received. You are responsible for all patient balances due to co-pays, co-insurances, deductibles, tax, billing charges, late or no show charges, laboratory and psychological testing, emergency transportation, etc.

_____ A charge for psychotherapy in addition to a medication management billing code may appear on your billing statement. Psychotherapy is a standard psychotherapy add-on code that all NAL medication providers use to reflect psychotherapy services that occur in session. Psychotherapy is defined in Current Procedural Terminology (CPT) by the American Medical Association as “the attempt to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development” (2012).

Genoa Pharmacy:

We have an on-site pharmacy at our New Brighton, Duluth, Eden Prairie and Woodbury locations to provide you with the convenience of filling all of your medications in the privacy of our clinic. However, Genoa can also fill prescriptions for you at all other locations. Genoa can specially pre-package your medication or mail them to your residence, and they will match the pricing of other pharmacies.

_____		_____
Patient’s Name		Patient’s Date of Birth
_____	_____	_____
Patient or Parent/Legal Guardian Signature	Date	Witness Signature
_____		_____
Emergency Contact Printed Name		Emergency Contact Phone Number

Nystrom & Associates, Ltd.

Controlled Medication Agreement

Controlled substance medications have potential for misuse. They are intended to improve function and/or ability to work, and are not simply to feel good.

- Our providers may not prescribe standing doses of benzodiazepines with stimulant medications.
- Our providers do not prescribe pain medication or medical cannabis.
- If you are taking narcotic pain medication, medical cannabis, or are abusing drugs or alcohol, our providers may not prescribe controlled medications to you.
- If you are pregnant or have certain medical or psychiatric conditions, controlled medications may not be appropriate for you.
- Your medication provider may request records from other medical providers, permission to talk to family members, drug screens and other laboratory tests, psychological tests, and may review the state controlled medication profile, before starting or continuing controlled medication.
- Drug screens, laboratory test, and counts of remaining pills may be requested while you are taking controlled medications, and must be completed within 24 hours.
- Our providers must follow Nystrom & Associates, Ltd. maximum dosing guidelines for controlled medications.

I have been told and understand that:

1. I may get addicted to this medication. Your risk for addiction is higher if you have a family history of alcohol or drug addiction. If I need to stop this medication, I must do it in under the direction of a medical provider, including the possible need for admission to a medical detox facility, or I may get very sick.
2. I can be found guilty of Driving Under the Influence (DUI) if taking these medications and driving, even if no alcohol has been consumed.
3. I may not be prescribed controlled medication if I am currently living in a residential chemical dependency treatment center or participating in chemical dependency treatment program. I understand I must remain sober for 12 months minimum after completing a residential or outpatient chemical dependency program before controlled medications will be considered, if at all.
4. I am responsible for scheduling my next appointment so I do not run out of medication between office visits. Stimulant refills will not be given outside of appointments, unless my provider cancels my appointment.
5. I will participate in all other types of treatments for my condition that I am asked to participate in.
6. If I am arrested or incarcerated related to illegal drug charges (including alcohol), controlled medications will be stopped and cannot be restarted during the duration of my care at Nystrom & Associates, Ltd.
7. My provider may not grant early refills for any reason (i.e. lost, stolen, damaged) for any controlled medication.
8. If I am taking medical cannabis, methadone, suboxone or other any other narcotic based medications on an ongoing basis, controlled medications will be stopped while I am taking these other medications. Taking stimulants or tranquilizers with these medications can be life threatening and cancel out their effects. If I do not tell my provider about using any drugs or controlled medications on my own or from any other providers, my care will be permanently ended.
9. If I sell, trade, share, fill early, or increase the dose of controlled medications on my own, they will be stopped and cannot be restarted during the duration of my care at Nystrom & Associates, Ltd.
10. If I have an emergency such as severe suicidal thoughts, thoughts to hurt someone else or if I am having a severe drug reaction, I will call 911 or go to the emergency room. I will notify my provider as soon as possible.
11. I will treat the staff at the office respectfully at all times. I understand if I am disrespectful (including but not limited to yelling, foul language, bullying or harassing) to any staff (office, nursing staff or providers) or if I disrupt the care of other patients, my treatment will be permanently stopped at Nystrom & Associates, Ltd.
12. I may be asked to only use one pharmacy to get my medicine. My provider may talk with the pharmacist about my medicines.
13. Drug screens requested by my provider must be completed within 24 hours or will be considered positive.
14. I will inform all my other physicians of the controlled substance medication I am receiving through Nystrom & Associates, Ltd. Likewise, I will inform my Nystrom & Associates, Ltd. medication provider of any other controlled substance medication I receive from another physician.

_____ _____ _____

Patient/Legal Guardian Signature Date Provider's Initials

NYSTROM & ASSOCIATES, LTD.
PSYCHIATRIC MEDICATION PEDIATRIC PATIENT INFORMATION FORM

Today's Date: _____

Identification:
Child's Name: _____ DOB: _____ Age: _____
Home address: _____
Home Phone: _____ Cell Phone: _____ Other: _____
Emergency Contact/Relationship: _____ Phone: _____

Guardianship:
Legal Guardian #1/Relationship: _____ Phone: _____

Legal Guardian #2/Relationship: _____ Phone: _____

Legal Custody:
- ☐ Joint
- ☐ Mother
- ☐ Father
- ☐ County
- ☐ Foster Parent
- ☐ Other: _____

Physical Custody:
- ☐ Joint
- ☐ Mother
- ☐ Father
- ☐ County
- ☐ Foster Parent
- ☐ Other: _____

Additional Custody Considerations: _____
_____
_____

Current Providers:
Medical/Primary Care Provider: _____
Clinic: _____
Phone: _____ Date of last physical: _____

Home Health Nurse or PCA: _____
Company: _____ Phone: _____

Psychologist/Therapist: _____
Clinic: _____ Phone: _____

County Social Worker/Case Manager: _____
Phone: _____ Cell/Pager: _____

Probation Officer: _____
Phone: _____ Cell/Pager: _____

Presenting Information:

1. How were you referred to this clinic for medication evaluation?

_____
_____
_____

2. In your initial meeting with your provider, what do you want to accomplish the most?

_____
_____
_____

3. Does your child have a past psychiatric diagnosis (such as ADHD, depression, etc.)? If yes, please describe.

_____
_____
_____

4. Do you know of, or suspect, your child has used or is currently using tobacco, drugs, or alcohol?

_____
_____
_____

5. Has your child had legal problems related to drug or alcohol use, curfew, stealing, fighting, etc.? If yes, please describe.

_____
_____
_____

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6 – 17

Child's Name: _____ Age:____ Sex: ☐ Male ☐ Female Date:_____
Relationship with the child:_____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS**, how much (or how often) has your child…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS**, has your child…						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS**, has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

Current Medications:

Please list **ALL current medications**, including over-the-counter & vitamins:

Medication	Dose	Directions	Date/Time of Last Dose

Does patient have any known allergies to medications of any kind (circle)? YES NO

If yes, please list medication and reaction:

_____

_____

Previous Medications:

Please list all past trials of Psychiatric Medications, dose, length of use, and reason for discontinuing:

Medication	Dose	Length of Use	Reason for Discontinuing

Family History:

1. Has anyone in the child's biological family been diagnosed or treated for a mental health problem?
   If yes, please describe:

   _____

   _____

   _____

2. Has anyone in the child's family attempted or completed suicide? If yes, please describe:

   _____

   _____

   _____

Social History:

1. Has there been any divorce/separation/remarriage/adoption/foster placement in the family?
   If yes, please describe:

   _____

   _____

   _____

Family Members	Age	Sex	Occupation	Education (Highest Level)	Religion	Living in home?
Parent/Guardian						
Parent/Guardian						
Siblings 1.						
2.						
3.						
4.						
5.						
6.						
Step-Parent(s) 1.						
2.						
Other Family						

Please indicate below if you know of, or suspect, your child has been the victim of any kind of abuse or trauma.

☐ Physical Abuse ☐ Emotional Abuse ☐ Verbal Abuse

☐ Sexual Abuse ☐ Bullying ☐ Other Trauma

Developmental/Medical History

1. Describe any known or suspected prescription medication use, alcohol use, or drug use during pregnancy:

   _____

   _____

2. Were there any complications with labor/delivery or a significant period of bed rest?

   _____

   _____

3. Please complete the table below regarding developmental milestones:

Gross Motor Development (crawling, walking)	☐ Early	☐ Average	☐ Late
Fine Motor Development (fingers/hands)	☐ Early	☐ Average	☐ Late
Communication Development	☐ Early	☐ Average	☐ Late
Self-Care	☐ Early	☐ Average	☐ Late
Social Skills	☐ Early	☐ Average	☐ Late
Education (alphabet, numbers)	☐ Early	☐ Average	☐ Late
Toilet Training	☐ Early	☐ Average	☐ Late

4. Please indicate if the child has a history of any of the following:

   ☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy ☐ Sensory Issues

5. Please indicate below if the child has a chronic medical problem:

   ☐ Diabetes ☐ Cancer ☐ Seizure Disorder

   ☐ Heart Condition ☐ Asthma ☐ Kidney or Liver Problems

   ☐ Other: _____

6. Has the child ever had surgery? If yes, please describe:

   _____
   _____

7. Has the child ever been treated for a head injury, serious accident, or lead poisoning? If yes, please describe:

   _____
   _____

School Information:

Current School: _____ Grade: _____
Address/City: _____
Contact/Title: _____
Phone: _____ Fax: _____

Please describe past and present academic work:

_____
_____
_____
_____

Does your child have an IEP/504 Plan (circle)? YES NO

Has your child ever repeated a grade? If yes, please describe:

_____
_____

Does your child have a learning disability? If yes, please describe:

_____
_____

Does your child have a history of truancy, suspension, expulsion, or detention? If yes, please describe:

_____
_____

MENTAL HEALTH RELEASE OF INFORMATION

Patient Information

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

I Authorize

Nystrom & Associates, Ltd. and Family Support Services, Inc.

Address: _____

City / State: _____ Zip: _____

Phone: _____ Fax: _____

Email Address: _____

To do the following:

☐ **Release to**
☐ **Receive from**

Agency/Name: _____ Phone: _____

Address: _____ City: _____ Fax: _____

State: _____ Zip: _____ Email Address: _____

Information to be Released

(What do you want sent or released?)

Check appropriate box(es):

Only release records checked below

- ☐ Most Recent Diagnostic Assessment
- ☐ Diagnostic Assessment, 3 Most Recent Progress Notes, and Treatment Plan
- ☐ Most Recent Treatment Plan
- ☐ Psychological Testing Interpretive Report
- ☐ Other: _____

NOTE: Unless otherwise indicated, all related records regarding Mental Health will be included. This does not include records legally defined as Psychotherapy Notes.

Or

☐ All Records Dated from: _____ to _____

☐ Any/All Medical Records
(Entire medical record may be sent)

Purpose of Release

(Why is it needed?)

Check appropriate box(es):

The purpose of this release is for coordination of care, or:

- ☐ Personal Use/Review
- ☐ Social Security appeal /disability
- ☐ Insurance payment/claim
- ☐ Litigation/legal
- ☐ Other: _____

NOTE: Purpose for release is not required if you are requesting your own records for personal use/review. Records sent to third party must identify a purpose.

Method of Communication

(How would you like your information communicated/sent?)

Check appropriate box(es):

Electronic Methods:

- ☐ Standard email (PDF)
- ☐ Secure Email (PDF)
- ☐ FollowMyHealth (Requires FollowMyHealth account)
- ☐ CD (Password Protected PDF)

NOTE: Transmission of records via standard email is not a secure method of transmission. By choosing email, I understand that I risk my information being intercepted by an unauthorized individual.

Standard Methods:

- ☐ Phone/Email Conversation
- ☐ Fax
- ☐ Pick up
- ☐ Mail

Initial Action

(What would you like done with the release?)

☐ Keep On File
For Future Use

☐ Send Records
To Agency/Name Listed Above

NOTE: ROI will be faxed out to request records

I understand the following: a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released according to this authorization. b. The information released in response to this authorization may be re-disclosed to other parties. c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. d. Communications resulting from this authorization will reveal I have received services from NAL/FSSI. e. My health information is protected by federal regulations and state laws. Disclosure is only allowed with my authorization, except in limited circumstance as described in NAL/FSSI Privacy Policy. f. I have the right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws. A photocopy of this authorization will be treated in the same manner as the original. This authorization shall be in force and effect until 1 year from date of execution at which time this authorization expires. *Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F. R. §164.524

Patient Signature: _____ **DATE**: _____

Or legally authorized representative signature: _____ DATE: _____

Representative's relationship to patient (parent, guardian, etc.) _____

Name (If not signed by patient): _____

NOTE: If signed by someone other than the patient, we need written proof of authority.

DO NOT FORWARD TO ANOTHER PERSON OR AGENCY WITHOUT PATIENT CONSENT.

For internal Use: Faxed Date: _____ Initials: _____

Guidelines for completing your Release of Information

Nystrom & Associates, Ltd. (NAL) recognizes the importance of patient confidentiality as well as the importance of coordinating care and treatment with other professionals, family, friends, and others involved in your care. Please review all items on this form and contact NAL with any questions concerning this form at the below listed offices or website.

Required Fields: In order for the release of information to be HIPAA compliant, please ensure all fields inside the bolded box are filled out. Finally, ensure the release is signed and dated.

Patient Information: Complete this entire section with clear and legible writing so the information easily identifies the patient whose information is being requested/released.

To Do the Following: Indicate clearly and legibly where or whom you wish to send/receive information from. **Be as Specific** as you can. **ALSO**, please check by either: (1) Release to, and/or (2) Receive from, If you choose only to Receive information your NAL provider **CANNOT** share any information; if you choose Release only your NAL provider can only share information; if you choose both to Release **AND** Receive they may share and take in information from the agency/name listed on the form.

Information to be Received/Released: The purpose of this section is to indicate what information you wish to be shared. Please select the appropriate box or write in date range. Selecting Any/All authorizes NAL/FSSI to share or send your entire medical record.

Method of Communication: Use this space to indicate what method you would like records transmitted. If you would only like NAL/FSSI to have verbal communicate with the identified person/agency, select the Verbal/Phone option. If you wish records to be transmitted to the person or agency, select one of the other available options. If you are requesting a copy of your own records, we encourage you to use one of the available electronic methods so you can quickly and easily get access to your records.

Purpose of Release: Identify the reason you need to release/request information. This helps NAL/FSSI appropriately provide care and track releasing confidential information. It informs us who may be responsible for the cost of medical records being released and is required on each release. * Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F. R. §164.524 (when applicable).

Authorization and Revocation: Signing this form (or having the legal guardian sign for a patient) will grant authorization to share/receive confidential information. Please sign and date this form to validate this authorization. If signed by someone other than the patient, you will be required to provide written proof of your authority. Unless otherwise noted this consent will automatically expire in one year from the date signed. The authorization can be revoked or can be edited at any time at your written direction to our organization.

Helpful Tips:

- ✓ If requesting records, please allow 7-10 business days for processing of the Release of Information. In some cases it can take up to 30 days (45 CFR §164.524(b)(2)(i).
- ✓ For questions or concerns regarding this form please contact your NAL facility.