CLEARLIFE INTAKE FORM

Date: _____ Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Separated ❑ Other

Name: _____ Tel: (H) _____ Cell _____ (W) _____

Address: _____ email address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Date of Birth: _____ Age: _____

Religion while growing up: ❑ None ❑ Jewish ❑ Protestant ❑ Catholic ❑ Other: _____

Education: ❑ Some High School ❑ High School Graduate ❑ Post High School Training ❑ College ❑ Graduate Work

Name of Spouse or Domestic Partner: _____

Children: (first name/age) _____

_____

Please check if you have ever had a: ❑ Child Die ❑ Stillbirth ❑ Pregnancy Terminated ❑ Child Adopted

Are you in counseling now?: ❑ Yes ❑ No If yes, with whom?: _____

Name of Medical Doctor: _____

Address: _____

When was your last medical physical?: _____ Please explain any unusual circumstances/outcome of the exam: _____

_____

Are you currently on medications?: ❑ Yes ❑ No If yes, for what reason?: _____

Medication prescribed by: ❑ Psychiatrist ❑ Other Medical Doctor

Type of medication?: _____ Dosage?: _____

Name of Psychiatrist/Doctor: _____

Address: _____

Please list a person whom we could contact in an emergency:

Name/Relationship to You: _____ Telephone: _____

By whom were you referred?: _____

PROBLEM AREAS

Please check your response:	Not a Problem	Mild Problem	Moderate Problem	Severe Problem
Financial Problems	❑	❑	❑	❑
Physical heath and/or handicap	❑	❑	❑	❑
Misuse of drugs or alcohol	❑	❑	❑	❑
Spiritual concerns	❑	❑	❑	❑
Sexual concerns	❑	❑	❑	❑
Problems between parents/children	❑	❑	❑	❑
Physical abuse/violence	❑	❑	❑	❑
Problems with aging	❑	❑	❑	❑
Communication Problems	❑	❑	❑	❑
Problems with pregnancy	❑	❑	❑	❑
Separation or divorce	❑	❑	❑	❑
Problems between husband/wife	❑	❑	❑	❑
Trouble relating to others	❑	❑	❑	❑
Career problems	❑	❑	❑	❑
Legal difficulties	❑	❑	❑	❑
Lack of self-esteem	❑	❑	❑	❑
Food/body image issues	❑	❑	❑	❑
Other: _____	❑	❑	❑	❑

Rate your overall level of distress:

❑ Mild

❑ Moderate

❑ Severe

How long have you been experiencing these problems?

❑ Under 3 Months

❑ 3-6 Months

❑ 6-12 Months

❑ 1-2 Years

❑ 3-4 Years

❑ 5 or More Years

What symptoms have you been feeling (Please check ALL that apply)?:

- ❑ Numb
- ❑ Depressed
- ❑ Hopeless
- ❑ Confused
- ❑ Disappointed/Let Down
- ❑ Empty
- ❑ Sad
- ❑ Fearful
- ❑ Panic Attacks
- ❑ Anxiety
- ❑ Nervousness
- ❑ Tense
- ❑ Anger
- ❑ Hostile/Violent
- ❑ Resentful
- ❑ "Used"/Put Upon
- ❑ Embarrassed
- ❑ Shameful/Inadequate
- ❑ Lonely
- ❑ Guilty
- ❑ Trapped
- ❑ Fatigue
- ❑ "Wired"/Unable to Slow Down
- ❑ Sleep Problems
- ❑ Too much sleep
- ❑ Not enough sleep/interrupted sleep
- ❑ Nightmares
- ❑ Flashbacks
- ❑ Headaches
- ❑ Worry
- ❑ Racing Thoughts/Obsessive Thoughts
- ❑ Compulsive Behaviors (specify): _____
- ❑ Weight Gain
- ❑ Weight Loss
- ❑ Memory Impairment
- ❑ Trouble Concentrating
- ❑ Hallucinations Voice/Visual
- ❑ Other: _____

How long have you been experiencing these symptoms/feelings?:

- ❑ Under 3 Months
- ❑ 3-6 Months
- ❑ 6-12 Months
- ❑ 1-2 Years
- ❑ 3-4 Years
- ❑ 5 or More Years
- ❑ All My Life

PREVIOUS THERAPY HISTORY

Please list all previous counseling, psychotherapy or treatment. Include outpatient and inpatient hospital stays. Begin with your earliest experience and work forward to present.

1. WHEN (year)_____ from _____ to_____ Weekly or_____ ❑ Individual ❑ Couple ❑ Family ❑ Group

WHERE (Name of therapist/clinic/hospital):

Name:_____ City:_____ State:_____

Reason for seeking therapy:_____

What did you learn about yourself?:_____

Was medication prescribed during this time?: ❑ Yes ❑ No

If yes, what medication _____ Dosage:_____ Prescribed for what:_____

Are you still taking the prescribed medication ❑ Yes ❑ No If not, for how long did you use?_____

2. WHEN (year)_____ from _____ to_____ Weekly or_____ ❑ Individual ❑ Couple ❑ Family ❑ Group

WHERE (Name of therapist/clinic/hospital):

Name:_____ City:_____ State:_____

Reason for seeking therapy:_____

What did you learn about yourself?:_____

Was medication prescribed during this time?: ❑ Yes ❑ No

If yes, what medication _____ Dosage:_____ Prescribed for what:_____

Are you still taking the prescribed medication ❑ Yes ❑ No If not, for how long did you use?_____

3. WHEN (year)_____ from _____ to_____ Weekly or_____ ❑ Individual ❑ Couple ❑ Family ❑ Group

WHERE (Name of therapist/clinic/hospital):

Name:_____ City:_____ State:_____

Reason for seeking therapy:_____

What did you learn about yourself?:_____

Was medication prescribed during this time?: ❑ Yes ❑ No

If yes, what medication _____ Dosage:_____ Prescribed for what:_____

Are you still taking the prescribed medication ❑ Yes ❑ No If not, for how long did you use?_____

NOTE: Please use a separate sheet of paper for additional space if needed.

BACKGROUND

IDENTIFY AREAS OF CONCERN THAT APPLY TO YOU OR A FAMILY MEMBER
Write in self, mother, father, brother, sister, spouse, lover in the space provided.

❑ Smoker_____
❑ Alcohol Abuse_____
❑ Dependent_____
❑ Other Drug Abuse_____
❑ Drug Dependent_____
❑ Too Religious_____
❑ Helpless/Victim_____
❑ Pleaser_____
❑ "Picture Perfect"_____
❑ Too Positive_____
❑ Too Negative_____
❑ Rageaholic_____
❑ Compulsive Cleaner_____
❑ All Rational/Non-Feeling_____
❑ Compulsive Gambler_____
❑ Other_____

Food/Eating Disorders
❑ Compulsive Eater_____
❑ Bulemic_____
❑ Anorexic_____
❑ Exercise Addict_____
❑ Sexual Addict_____
❑ Numerous Affairs_____
❑ Sexually Abusive_____
❑ Emotionally Abusive_____
❑ Physically Abusive_____
❑ Panic/Anxiety Attacks_____
❑ Too Dependent_____
❑ Too Independent_____
❑ Depression_____
❑ Workaholic_____
❑ Chronic Mental Illness/Diagnosis_____
❑ Chronic Physical Illness/Disease_____

How would you describe yourself as a child?:_____

Who raised you as a child?:_____

Were your parents separated, divorced, or did one parent die when you were growing up? Please explain:_____

How many brothers and sisters do you have?:_____

What number child are you? ❑ Only ❑ First ❑ 2nd ❑ 3rd ❑ _____

How were you disciplined as a child?:_____

Which parent were you closer to as a child?: ❑ Mother ❑ Father ❑ Both the Same

Were you sexually abused by anyone as a child or adolescent? ❑ Yes ❑ No ❑ Not Sure, Please explain:_____

Were you emotionally abused by anyone as a child or adolescent? ❑ Yes ❑ No ❑ Not Sure, Please explain:_____

Were you physically abused by anyone as a child or adolescent? ❑ Yes ❑ No ❑ Not Sure, Please explain:_____

Have you been physically beaten, emotionally battered or sexually abused/raped by a spouse or anyone else as an adult?

❑ Yes ❑ No ❑ Not Sure, Please explain:_____

Are you currently being physically beaten or emotionally battered?: ❑ Yes ❑ No ❑ Not Sure, Please explain:_____

Have you sexually abused a child, adolescent or an adult? ❑ Yes ❑ No ❑ Not Sure, Please explain:_____

Have you emotionally abused a child, adolescent or an adult? ❑ Yes ❑ No ❑ Not Sure, Please explain:_____

Have you physically abused a child, adolescent or an adult? ❑ Yes ❑ No ❑ Not Sure, Please explain:_____

CURRENT HISTORY

Are you feeling suicidal?: ❑ Yes ❑ No

Have you ever had suicidal thoughts?: ❑ Yes ❑ No If yes, how recently?: _____

Have you ever made a plan to commit suicide?: ❑ Yes ❑ No If yes, please explain:_____

_____

Have you ever attempted suicide?: ❑ Yes ❑ No If yes, state when and what happened:_____

_____

Why are you seeking therapy?:_____

_____

What symptoms are you experiencing?:_____

_____

What do you hope to gain from therapy?:_____

_____

Do you know what some of the defenses are that keep you "stuck"? Please explain:_____

_____

_____

How might you sabotage yourself/your therapy work? Please explain:_____

_____

_____

How satisfied are you with:

Your work/career?:_____

Your social life/friendships?:_____

Your intimate life? (spouse/lover):_____

Your sexuality?:_____

Please include any other information that you think would be helpful for us to know about you:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I certify the information on this Intake Form is correct and complete:

Signature:_____ Date:_____

Return to Friel Associates PO BOx 270250 St. Paul, MN 55127 or use Electronic Fax 651.628.0220

or if agreed upon beforehand, bring to your first therapy session or next therapy session

Friel Associates/Lifeworks/ClearLife® PO Box 270250 St. Paul, MN 55127 651/628-0220

Signature Page For *Agreeing With* Minnesota Psychotherapist-Patient Services Agreement and Receipt of HIPAA Statement

NOTE! I HAVE READ AND AGREE TO ABIDE BY THE POLICIES REGARDING CANCELLATION OF APPOINTMENTS. I UNDERSTAND THAT A 50-MINUTE APPOINTMENT REQUIRES CANCELLATION AT LEAST 24 HOURS (NOT 23 HOURS) PRIOR, TO AVOID BEING CHARGED. LONGER APPOINTMENTS HAVE LONGER CANCELLATION TIMES. TO BE LEGALLY BINDING, CANCELLATIONS MUST BE MADE BY TELEPHONE

APPOINTMENTS) REQUIRE PRIOR CANCELLATION OF 48 HOURS, 96 HOURS,

ETC. TO AVOID BEING CHARGED FOR A MISSED APPOINTMENT.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE *RECEIVED*, *READ*, AND *AGREE* TO THE TERMS OF THE 6-PAGE "MINNESOTA PSYCHOTHERAPIST-PATIENT AGREEMENT" AND THAT YOU HAVE RECEIVED THE HIPAA NOTICE STATEMENT

_____	_____	_____
Signature of Client #1	Date of Birth	Date
_____	_____	_____
Signature of Client #2	Date of Birth	Date
_____	_____	_____
Signature of Parent Or Guardian	Date of Birth	Date

ClearLife®

Friel Asociates

Reno: 5421 Kietzke Ln.
Minneapolis: 1409 Willow St.

Mpls Tel: 651.628.0220
Electronic Fax: 651.628.0220
Reno Tel: 775.337.0299

John C. Friel, Ph.D.
MN Lic Psychologist LP0504
NV Lic Psychologist PY0370
Linda D. Friel, M.A.
MN Lic Psychologist LP0724

All Mail Goes To:
PO Box 270250
St. Paul, MN 55127

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

CLIENT NAME_____ DATE OF BIRTH_____

ADDRESS_____
street city state zip

TELEPHONE__H_____w_____CELL_____

E-MAIL_____

I/WE_____AUTHORIZE THE EXCHANGE OF THE FOLLOWING LISTED INFORMATION **BETWEEN** MY DOCTOR/THERAPIST/ETC
(NAME)_____

ADDRESS_____
street city state zip

TELEPHONE_____FAX_____

___**AND**____ (YES NO) JOHN C. FRIEL, PH.D (YES NO) LINDA D. FRIEL, M.A.

INFORMATION WHICH MAY BE EXCHANGED...

T**HE LIMITATIONS TO THIS AUTHORIZATION ARE...**

WITH THE EXCEEPTION OF THE ABOVE LIMITATIONS, THE ABOVE-NAMED PROFESSIONALS ARE AUTHORIZED TO EXCHANGE INFORMATION REGARDING AND AND ALL ACADEMIC, SOCIAL, MEDICAL, AND PSYCHOLOGICAL RECORDS IN THEIR POSSESSION, WHICH MAY INCLUDE TREATMENT FOR SUBSTANCE ABUSE AND/OR HIV/AIDS TEST RESULTS OR DIAGNOSES

THE PURPOSE OF THIS AUTHORIZATION IS....

I UNDERSTAND THAT ANY ELECTRONIC TRANSMISSION OF THIS INFORMATION, WHETHER BY CELL PONE, E-MAIL,OR FAX MACHINE POSES A POTENTIAL RISK TO MY PRIVACY, AS THESE DEVIDES ARE NOT SECURE AND THERE IS NO CONTROL OVER INFORMATION ELEASED INTO CYBERSPACE.

I FURTHER UNDERSTAND THAT THIS AUTHORIZATION MAY BE REVOKED BY MYSELF, IN WRITING, AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN IN RELIANCE THEREUPON.

THE TERMINATION DATE OF THIS AUTHORIZATION IS... (specify date) _____

_____ _____
signature of client, parent, or guardian/s date

_____ _____
witness date

ClearLife **Clinic** Therapist Release Form

TO: Therapists with Clients Registered for the ClearLife Clinic

CLIENT NAME: _____ CLINIC DATE: _____

The ClearLife Clinic is a special 3.5-day program designed to help discover and work through the roots of self-defeating patterns of living. As we practice old learned habits over the years, we may find that they no longer work for us, so that we ultimately try harder to be happy but feel less comfortable as time passes. These habits can eventually interfere with our quality of life so that we experience depression, feelings of loneliness and emptiness, troubles in our intimate relationships, and compulsive or addictive behaviors. In the end, we may discover that we have unconsciously held onto patterns that only lead to more of the same unhappiness.

The ClearLife Clinic is a therapy process designed to help identify and explore early patterns and habits that may have been usful in childhood but that are now causing problems in adulthood, so that participants can begin to acquire emotional, behavioral, and cognitive tools to begin leading a more satisfying life in the present.

This program is especially helpful for those who are:

1. Seeking a deeper, fuller, more conscious identity.
2. Struggling with relationship issues, and
3. Concerned about depression, anxiety, compulsive or addictive behavior, or the impact of childhood pain in their lives.

If there is any information about your client that you would like us to have prior to the Clinic, or if there is any way that we can facilitate your work with your client after the Clinic, please call or write to us.

ACKNOWLEDGMENT

I am aware that _____ will be attending the ClearLife Clinic in Minneapolis, MN and have discussed processing his/her work following the Clinic:

Therapist Signature: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone:(_____) _____ - _____

I hereby authorize Friel Associates to release and/or exchange information from the records maintained while I am a client in the ClearLife Clinic with the above listed therapist.

Client Signature: _____ Date: _____

For those not in therapy at this time: Please provide us with the name and address of a therapist in your area that you would be available to see if you should desire follow up care.

Therapist Name: _____ Phone:(_____) _____ - _____

Therapist Address: _____

City: _____ State: _____ Zip: _____

For information about the program or inquiries, please contact Friel Associates 651-628-0220 Electronic Fax 651-628-0220 revised 2/2015

ClearLife®

Friel Associates
PO Box 270250
St. Paul, MN 55127
http://www.clearlife.com

Reno: 5421 Kietzke Ln
Minneapolis: 1409 Willow St.

Tel: 651.628.0220
Electronic Fax: 651.628.0220
Reno: 775.337.0299

John C. Friel, Ph.D.
MN Psychology Lic LP0504
NV Psychology Lic PY0370
Linda D. Friel, M.A.
MN Psychology Lic LP0724

2015 Men's Group Rules/Contract

These ground rules are offered out of respect for all group participants. Ground rules model clean, structured boundaries and provide a clear understanding between therapists and group members that if left unclear lead to avoidable misunderstandings.

If a group member will not be able to attend a given session, he is expected to call and leave a voice message at 651.628.0220 prior to the beginning of that day's group. An uninformed absence causes all of us to wonder and/or worry about your well-being, and can be a distraction from the group work that day.

Each client agrees to be respectful of self and others, and to give clear notice to us of the decision to terminate membership in the group. After notice has been given, it is expected that you will attend one last time to say "goodbye" and get closure with the group. This can be one of the more important aspects of a group process, especially given that people growing up in dysfunctional families often have a hard time giving or getting that kind of respectful closure.

The fee for each 2-hour group is $70. Each group member is financially responsible for each regularly scheduled group session, whether or not the session is attended. In other words, you are buying a "season ticket" or "season pass" for group. There are two (2) excused absences per calendar year for which you will not be billed, and all the rest are your responsibility. The charge for group is payable at each session. By signing below, you are agreeing to pay for each group except for the two mentioned above, and you give us permission to bill your credit card for the full amount due, or to send your bill to a collection agency or court to attempt to get payment.

The schedule for men's group sessions is posted on our web site at http://www.clearlife.com. Go to the bottom of the main page and click on the link there. Should there be extreme extenuating circumstances (8 feet of snow, a 7.5 earthquake, etc.), I will leave a notice on my voicemail at 651.628.0220 to cancel group.

A request for a leave of absence will be treated the same as a termination in most cases. A person may re-enter the group as an opening comes up. Former group members who would like to return to work on additional issues in the future are welcome to come back as openings come up. We look forward to working with you.

_____ _____

Signature Date

ClearLife®

Friel Associates
PO Box 270250
St. Paul, MN 55127

Tel: 651/628-0220
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John C. Friel, Ph.D.
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MN Lic 0724
Licensed Psychologists

MINNESOTA NOTICE FORM

Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Patient's 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.

I. 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 my 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.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or 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 or health care operations, we will obtain an authorization from

you before releasing this information. We will also need to obtain an authorization before releasing your 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.

Please remember that if your spouse or significant other calls our office to ask if you made it to your appointment, or if you are still in therapy, or for any other reason, we can only say that we cannot comment about whether or not someone is our client. This holds even if the two of you are in couple therapy with us. Please do not contact our office and attempt to get any information **from** us about a client. If you have information to **share with us** about a friend, acquaintance, or loved one whom you believe to be in therapy with us, please feel free to do so. But remember that we cannot share anything in return.

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.

III. Uses and Disclosures with Neither Consent nor Authorization

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

- **Child Abuse:** If we know or have reason to believe a child is being neglected or physically or sexually abused, or has been neglected or physically or sexually abused within the preceding three years, we must immediately report the information to the local welfare agency, police or sheriff's department.

- **Adult and Domestic Abuse:** If we have reason to believe that a vulnerable adult is being or has been maltreated, or if we have knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, we must immediately report the information to the appropriate agency in this county. We may also report the information to a law enforcement agency.

  "*Vulnerable adult*" means a person who, regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:
  - (i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and
  - (ii) because of the dysfunction or infirmity and the need for assistance, the individual has an impaired ability to protect the individual from maltreatment.

- **Health Oversight Activities:** The Minnesota Board of Psychology may subpoena records from us if they are relevant to an investigation it is conducting.

- **Judicial and Administrative Proceedings**: If you are involved in a court proceeding and a request is made for information about the professional services that we have provided you and/or the records thereof, such information is privileged under state law and we must not release this information without written authorization from you or your legally appointed representative, 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**: If you communicate a specific, serious threat of physical violence against a specific, clearly identified or identifiable potential victim, we must make reasonable efforts to communicate this threat to the potential victim or to a law enforcement agency. We must also do so if a member of your family or someone who knows you well has reason to believe you are capable of and will carry out the threat. We also may disclose information about you necessary to protect you from a threat to commit suicide.

- **Worker's Compensation**: If you file a worker's compensation claim, your prior approval and/or a release of information is not required in order for us to release your records to your employer, insurer, and the Department of Labor and Industry.

IV. Patient's Rights and Psychologist'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. However, we are not required to agree to a restriction your request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications 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. On 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. This request must be in writing, dated, and signed. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial 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 me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of my 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 provide you with a revised notice by e-mail, U.S. Mail, or in person at a therapy session.
-

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the Minnesota Board of Psychology, 2829 University Avenue S.E., #320, Minneapolis, MN 55414-2240, 612/617-2230.

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.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice by e-mail, U.S. Mail, or in person at a therapy session.

revised 2/2015

ClearLife®

Friel Associates
PO Box 270250
St. Paul, MN 55127

Tel: 651/628-0220
Electronic Fax: 651.628.0220

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MN Lic 0724
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MINNESOTA PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Welcome to Friel Associates/Lifeworks/ClearLife®. This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail.

The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully before our first session; or, if you are an ongoing client, before our next session. We can discuss any questions you have about the procedures then. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time, except for the portions of it pertaining to appointment cancellation notification times, billing and payments, and insurance reimbursement.. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. **You should be aware that, except for the exceptions noted above, this Agreement will be in effect for one year from the date of signing unless you specifically request that it remain in effect for a shorter time. This contract, or any provision of this contract, can be revoked by you at any time, except to the extent that we have relied on it.**

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with us. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

INTAKE PROCEDURES SESSIONS POLICY REGARDING MISSED APPOINTMENTS

During the first 1-4 hour blocks of time, we can each decide if I am the best person to provide the services you need in order to meet your treatment goals. As part of the initial evaluation, you will be asked to complete and sign an Intake Form. When psychotherapy starts, we may schedule one or two 50-minute sessions (one appointment segment of 50 minutes duration) to begin with, although in the case of our couple intensives, this session length may be up to 12 segments in length (12 x 50 minutes = 600 minutes). Individual, group, and couple sessions may vary in length depending on the therapist and the situation..

Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation, by calling our office at 651/628-0220 or 775.337.0299. We will call you back within 8 hours to confirm your cancellation. We will keep a recording of your telephone message or text or email with its date and time stamp if we deem it necessary. With sessions longer than 50-minutes this notice time will increase accordingly, by day. 48 hours for a 2-hour session, 72 hours for a 3-hour session, etc., up to 10 days for a weekend couple intensive of 8-12 segments. A non-refundable deposit may also be required in the case of these longer intensives. There are very few reasons for missing an appointment that will not fall under this rule, and we must both agree that you were unable to attend due to circumstances beyond your control. "Forgetting " does not meet this criterion. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. Please also note that if you miss your scheduled appointment, it may take up to 2-3 weeks to get in to see us again.

PROFESSIONAL FEES

Our hourly fee for **individual, couple, or family therapy** is **$175**, our fee for men's **group therapy is $70, and $85 for women's group,** and the fee for the MMPI-2 or Millon-III is **$100**. There is a **$25** charged for any checks returned N.S.F. In addition to weekly appointments, we charge **$175** per hour for other professional services you may need, though we will break down the hourly cost if we work for periods of less than one hour.

Other services include report writing, **telephone conversations lasting longer than 5 minutes**, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of us. If you become involved in legal proceedings that require our participation, you will be expected to pay for all of our professional time, including preparation and transportation costs, even if we are called to testify by another party. Because of the difficulty of legal involvement, we charge **$500 per hour** for preparation and attendance at any legal proceeding. **We do psychotherapy. If you believe that you will need a psychologist to do legal work for you, please let us know in the beginning, and we will try to find another professional with whom you can work. We do not typically do forensic work.**

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, by either check, Visa, Mastercard, or cash. Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than **60 days** and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court, which will require me to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

Assignment of Benefits/Overpayments: Should there be an unpaid balance due on your account, you hereby authorize your insurance carrier to assign benefits to the provider, Friel Associates—that is, to pay us directly rather than paying you. Should there be an overpayment to us on your account, a refund will be promptly sent to you by us.

INSURANCE REIMBURSEMENT

We are not on <u>any</u> insurance panels, we do *<u>not</u>*** file insurance forms, and we do not guarantee insurance coverage. We will ***<u>not</u>*** code your claim for couple therapy as individual therapy, which would be considered insurance fraud. If we are seeing you as an *individual client* and ask you to bring in your significant other for a session or two, as an adjunct to your individual therapy, then it will still be coded as individual therapy.** We will send you a statement at the end of each month with the **appropriate** procedure code and diagnosis code, which you can then submit to your insurance carrier if you would like. As noted elsewhere, we expect payment at the time of service, which can be made by check, cash, VISA, or MasterCard. Individual insurance policies, even within companies, vary widely. It is very important that you find out exactly what mental health services your insurance policy covers. We are both Licensed Psychologists, and the work you do with us is either outpatient individual or group psychotherapy.

You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we can provide requested information to your carrier.

CONTACTING US

We are often not immediately available by telephone. Our telephone is answered by voice mail that we monitor frequently. Our voicemail service sends us an email as soon as you leave a message, so we efectively receive it instantly. But we are often in session for several consecutive hours, so we will make every effort to return your call within 24 hours, but please remember that unless you are in a life-threatening crisis, it is part of therapy to learn to handle personal difficulties until your next scheduled appointment. If you are difficult to reach, please inform us of some times when you will be available, and please provide a cell phone number to reach you. If you are unable to reach us and feel that you can't wait for us to return your call, contact your family physician or the nearest hospital emergency room and ask for the psychologist or psychiatrist on call, or dial 911.

If we will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, we can only release information about your treatment to others if you sign a written **Authorization Form** that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- we may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our patient. The other professionals are also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together. We will note all consultations in your Clinical Record (which is called "PHI" in our Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

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- You should be aware that we employ limited administrative staff whom we have known for many years. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. As psychologists, we are both bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of one of us.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where we are permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services we provided to you, such information is protected by the psychologist-patient privilege law. We cannot provide any information without your, or your legal representative's, written authorization, or a **court order**. **If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.**

- If a government agency, pursuant to their lawful authority, is requesting the information for health oversight activities, we may be required to provide it for them.

- If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend ourselves.

- If a patient files a workers compensation claim, we must, upon appropriate request, disclose information related to the claim to appropriate individuals, which may include the patient's employer, the insurer, or the Department of Labor and Industry.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a patient's treatment. These situations seldom occur in our practice.

- If we know or have reason to believe a child is being neglected or physically or sexually abused or has been neglected or physically or sexually abused within the preceding three years, the law requires that we file a report immediately with the appropriate government agency, usually the local welfare or social services agency. Once such a report is filed, we may be required to provide additional information.

- If we have reason to believe that a vulnerable adult is being or has been maltreated or if we have knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, the law requires that we file a report immediately with the appropriate government agency, usually an agency designated by the county. Once such a report is filed, we may be required to provide additional information.

- If we believe that you present a serious and specific threat of physical violence to another, we may be required to disclose information necessary to take protective actions. These actions may include notifying the potential victim, contacting your family or others who can help provide protection, contacting the police, or seeking your hospitalization.

If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit our disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, we keep Protected Health Information about you in two sets of professional records. One set constitutes your **Clinical Record**. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents. In certain situations, we may charge a copying fee of 75 cents per page. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.

In addition, we also keep a set of **Psychotherapy Notes**. These Notes are for our own use and are designed to assist us in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, our analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to us that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your signed, written Authorization. **Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal to authorize release of your**

Psychotherapy Notes. You may examine and/or receive a copy of your Psychotherapy Notes unless we determine that the information they contain is detrimental to your physical or mental health, or is likely to cause the patient to harm another. If we deny your request to examine your Psychotherapy Notes, you may select an **appropriate** third party to whom these notes will be forwarded. This individual may choose to disclose these notes to you. In this event, we recommend that you select another mental health provider to perform this task.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes our policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, we will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. We will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's **Authorization**, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

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