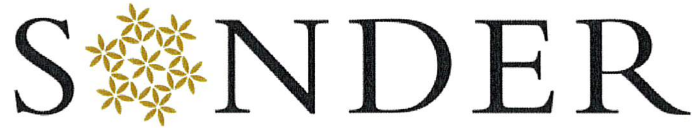

Behavioral Health & Wellness

Date: ___________

Patient Information

Patient Name ____ Date of Birth ____________
Street Address ____ Home Phone ____________
City ________________________ State ________ Zip ________ Mobile Phone ____________
Social Security # ________________ Emergency Contact/Number: ______________________
Sex ☐ Male ☐ Female Age ________ Marital Status: ____________ Employer: ______________
Primary Care Physician ______________________ Referred by ______________________

Primary Insurance

Primary Insurance Company ______________________________ Phone ________________
Ins Claims Address ____________________ City______________ State ________ Zip ________
Policy/ID # ______________________________ Group Plan # ______________________

Policy Holder Information (If the patient is not the policy holder)

Name: ____________________________ Relationship ______________ Date of Birth _______
Address ____________________________ City ______________ State ________ Zip ________
Social Security # ________________ Employer ______________________________

Secondary Insurance

Secondary Insurance Company ____________________________ Phone ________________
Ins Claims Address ____________________ City______________ State ________ Zip ________
Policy/ID # ______________________________ Group Plan # ______________________

Policy Holder Information (If the patient is not the policy holder)

Name: ____________________________ Relationship ______________ Date of Birth _______
Address ____________________________ City ______________ State ________ Zip ________
Social Security # ________________ Employer ____________________________________

Responsible Party (Where should the patient's bill be sent, if not to the patient)

Name ____ Relationship ______________
Address ____ Phone ________________

____________________ ____________________ ____________
Responsible Party Signature Relationship to Patient Date

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above ad assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature	Relationship to Patient	Date

Behavioral Health & Wellness

Terms of Billing and Consent

- Clients are responsible for knowing their insurance benefits and plan requirements. Therefore, if your insurance company does not pay (unless it was our error in billing or getting prior authorization) you are responsible for all charges incurred.
- Charges for psychological evaluations and therapy vary by provider. Please speak with our office manager for more information.
- We reserve the right to charge $50 for non-emergency, no-shows and/or cancellations made less than 24 hours in advance. This cannot be submitted to your insurance company. This must be paid prior to your next scheduled session.
- If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for all of their professional time, including transportations costs, even if they are called to testify by another party. The fee for preparation and attendance at any legal proceeding is $225 per hour.
- If you are the parent who is authorizing medical care for your minor child, but the other parent is legally responsible for medical payment, we will bill as requested. However, if we cannot secure payment with reasonable effort, we will expect payment from you as the parent who authorized treatment. Therefore, if at all possible, it is recommended that both parents authorize treatment.
- I will pay my co-payment of each visit and/or the total amount due.
- I will notify you immediately of any change in insurance company. Without such notification, any refusal on the part of my insurance carrier to pay for services because of needed preauthorization will be my responsibility.
- I consent to release of protected health information to my insurance company or EAP group for processing of claims, care coordination, and treatment determination needed to respond to the inquiry. I understand Sonder will give only the minimal necessary information needed to respond to the inquiry.

- If my account becomes past due (60 days) and I have not arranged for/or made regular payments, I understand Sonder may turn my account over to a collection agency and/or small claims court to obtain payment. My failure to make payments or arrange payments to settle my account is tactic authorization to Sonder to release the minimal protected health information necessary to the collection agency and/or small claims court.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Sonder. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. In signing this, I am consenting to: 1) terms of billing 2) release of health information as needed for collection purposes, and 3) medical benefit assignment.

______________________________ ____________

Signature Date

Behavioral Health & Wellness

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care.

Therefore, effective January 1, 2016, Sonder reserves the right to charge a fee of **$50.00** for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice.

- "No Show" fees will be billed to the patient.
  This fee is not covered by insurance, and must be paid prior to your next appointment.
- Multiple "no shows" in any 12-month period may result in termination from our practice. We will provide a referral for another provider.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients!

Behavioral Health & Wellness

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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!

Our Duty to Safeguard Your Protected Health Information

Protected Health Information (PHI) refers to information in your health record that could identify you. It is individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care. Examples of PHI include your name, address, birth date, age, phone number, diagnosis, medical records, and billing records.
-We are required by applicable federal and state law to maintain the privacy of your protected health information, and to give you this Notice of Privacy Practices that describes our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notification takes effect August 11, 2014 and will remain in effect until replaced.
-We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.
-You may request a copy of our Notice of Privacy Practices at any time. For more information about our privacy practices or additional copies of this Notice, contact our office.

How We May Use and Disclose Your Protected Health Information

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its HIPAA Privacy Rule (Rule), we are permitted to use and/or disclose your PHI for a variety of reasons. Except in specified circumstances, we are required to use and/or disclose only that minimum amount of your PHI necessary to accomplish the purpose for the use and/or disclosure. Generally, we are permitted to use and/or disclose your PHI for the purposes of treatment, the payment for services you receive, and for my normal health care operations. For most other uses and/or disclosures of your PHI, you will be asked to grant your permission via a signed Authorization. However, the Rule provides that we are permitted to make certain other specified uses and/or disclosures of your PHI without your Authorization. The following information offers more descriptive examples of our potential use and/or disclosure of your PHI:

1. Uses and/or Disclosures of PHI for Treatment, Payment, and Health Care Operations That Do Not Require Authorization

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you or for the management of healthcare and related services. This also includes, but is not limited to, consultations and referrals between one or more providers. For example, an insurance company may contact a provider on your behalf to facilitate your access to mental health treatment.
Appointment Scheduling/Reminders: Unless you request that we contact you by other means, the Privacy Rule permits us to contact you by phone/ voice mail to schedule appointments and to leave appointment reminders.
Payment: We may use or disclose your health information to obtain reimbursement for your healthcare. For example we may disclose your PHI to your health insurer to determine eligibility or coverage for psychotherapy. Or, we may disclose PHI when we obtain reimbursement from your health insurer for your health care.
Healthcare Operations: We may use or disclose your health information in healthcare operations. For example, we may disclose your PHI to your health insurer for care coordination or case management.

2. Uses and/or Disclosures of PHI Requiring Authorization

You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocations will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
Psychotherapy Notes: We will also need to obtain an authorization before releasing your psychotherapy notes. Psychotherapy notes are notes we have made about our conversation during an individual, group, conjoint, 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.

3. Uses and/or Disclosures Not Requiring Your Authorization or Consent
The HIPAA Privacy Rule provides that we may use and/or disclose your PHI without your Authorization in the following circumstances:
When required by law: We may use and/or disclose your PHI when existing law requires that we report information including each of the following areas:

- **Reporting abuse, neglect or domestic violence:** We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of domestic violence or the possible victim of other crimes.

- **Child abuse:** Whenever we, in our professional capacity, have knowledge of or observe a child we know or reasonably suspect, has been the victim of child abuse or neglect, we must immediately report such to a police department or sheriff's department, county probation department, or county welfare department. Also, if we have knowledge of, or reasonably suspect that, mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other way, we may report such to the above agencies.

- **Adult and domestic abuse:** If we, in our professional capacity, have observed or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if we are told by an elder or dependent adult that he or she has experienced these, or if we reasonably suspect such, we must report the known or suspected abuse immediately to the local ombudsman or the local law enforcement agency. We do not have to report such an incident told to us by an elder or dependent adult if (a) we are not aware of any independent evidence that corroborates the statement that the abuse has occurred; (b) the elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia; and (c) in the exercise of clinical judgment, we reasonably believe that the abuse did not occur.

- **To avert a serious threat to health or safety:** We may use and/or disclose your PHI in order to avert a serious threat to health or safety. If you communicate to us a serious threat of physical violence against an identifiable victim, we must make reasonable efforts to communicate that information to the potential victim and the police. If we have reasonable cause to believe that you are in such a condition as to be dangerous to yourself or others, we may release relevant information as necessary to prevent the threatened danger.

- **Public health activities:** We may use and/or disclose your PHI to prevent or control the spread of disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food, dietary supplements, product defects and other related problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether or not you have a work-related illness or injury, in order to comply with Federal or state law.

- **Health oversight activities:** We may use and/or disclose your PHI to designated activities and functions including audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs.

- **Judicial and administrative proceedings:** We may use and/or disclose your PHI in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process.

- **Law enforcement activities:** We may use and/or disclose your PHI for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death.

- **Relating to decedents:** We may use and/or disclose the PHI of an individual's death to coroners, medical examiners and funeral directors.

- **For specific government functions:** We may use and/or disclose the PHI of military personnel and veterans in certain situations. Similarly, we may disclose the PHI of inmates to correctional facilities in certain situations. We may also disclose your PHI to governmental programs responsible for providing public health benefits, and for workers' compensation. Additionally, we may disclose your PHI, if required, for national security reasons.

4. **Uses and/or Disclosures Requiring You to Have an Opportunity to Object**

We may disclose your PHI in the following circumstances if we inform you about the disclosure in advance and you do not object. We may use or disclose health information to notify or assist the notification of (including identifying or locating) a family member, your personal representative or another person responsible for our care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such use or disclosure. However, in the event of your incapacity or emergency circumstances and you cannot be given an opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests. We

will disclose only health information that is directly relevant to the person's involvement in your healthcare. You must be informed and given an opportunity to object to further disclosure as soon as you are able to do so.

Your Rights Regarding Your Protected Health Information (PHI)

The HIPAA Privacy Rule grants you each of the following individual rights:

Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of your PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record.
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 Request an Amendment: If you believe that your PHI is incorrect or incomplete, you may ask us to amend the information. This request must be made in writing, and it must explain why the information should be amended. 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 Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. A request for a restriction must be put in writing. However, we are not required to agree to a restriction you request. You do not have the right to limit the uses and disclosures that we are legally required or permitted to make. If we do agree to your request, we will put these limits in writing and abide by them except in emergency situations.
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 me. Upon your request, we will send your bills to another address.) You must make your request in writing. It must specify how and/or where you wish to be contacted. We will accommodate all reasonable requests.
Right to an Accounting: You generally have the right to receive a list of disclosures of PHI for which you have neither authorization nor consent (see above for this section). This accounting will begin on 8/11/2014 and disclosure records will be held for six years. On your request, we will discuss with you the details of the accounting process.

Limits of privacy when treating persons under the age of 18

All references to parents include legal guardian in the absence of parent.

- The provider maintains a record that contains dates of evaluation, goals of evaluation, diagnostic impressions, and recommendations.
- The parents of a client who is younger than the age of 18 have the right to read their child's/adolescent's record, which includes all information generated from Sonder.
- The provider will inform parents if he/she assessed the child/adolescent to be in immediate danger or to be a danger to someone else.
- The provider will also communicate to the parent a summary of the evaluation as needed or as requested.
- The provider requests that parents otherwise respect their child's/adolescent's privacy regarding the content of the evaluation and treatment. A provider's evaluation may be more beneficial when parents do not ask to read the evaluation or ask the provider to reveal the content of the evaluation.
- The provider can refuse to give information to the parents about their child/adolescent if the provider predicts that disclosing such information may be harmful to the child/adolescent.

Questions and Complaints

-If you want more information about our privacy practices or have questions or concerns, please contact us at 952-999-6097.
-If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about your access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the Secretary of the U.S. Department of Health and Human Services. Upon request we will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. Any complaint you file must be received by us, or filed with the Secretary, within 180 days of when you know, or should have known, the act or omission occurred.
-We support your right to the privacy of your health information. We will not retaliate in any way if you make a complaint.

Effective Date: This Notice of Privacy Practices is effective August 11, 2014.

Behavioral Health & Wellness

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of August 11, 2014.

______________________________________ ______________________

Signature of Patient/Patient Representative Date

____

Relationship to Patient

For Office Use Only

Sonder attempted to obtain written acknowledgment of receipt of his/her Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign
_____ An emergency situation prevented him/her from obtaining the acknowledgment
_____ Other (specify)

____
____
____

Behavioral Health & Wellness

Clinical Intake Form

Name:____ Today's Date:__________________

DOB:_____________________

Referral Source:____

What would you like therapy to help you change?____

____

____

Family History ***Please circle as indicated:*** ***Y=Yes N=No DK=Don't know***

Were you raised by both biological parents? Y N *If no, by whom?__________________________

Were your biological/adoptive parents divorced/separated? Y N *If yes, how old were you?________

What # child were you in your family of origin?___________ Of how many children?________________

Were you raised with half siblings or step siblings? Y N

Did you ***OBSERVE ABUSE OF*** any family member in your family of origin? Y N DK

Were you abused/neglected in your family or origin? Y N DK

Have your father, mother, or siblings experienced any of the following problems?

Alcohol or drug abuse?	Y	N	DK	If yes, whom?________________________________
Significant depression?	Y	N	DK	If yes, whom?________________________________
Suicidal attempts?	Y	N	DK	If yes, whom?________________________________
Mental illness?	Y	N	DK	If yes, whom?________________________________
Hospitalization for emotional problems?	Y	N	DK	If yes, whom?________________________________
Chronic physical illness?	Y	N	DK	If yes, whom?________________________________
Incarceration (jail/prison)?	Y	N	DK	If yes, whom?________________________________
Anger problems?	Y	N	DK	If yes, whom?________________________________

Have you experienced the loss by death of a:

Parent?	Y	N	DK	If yes, whom?________________________________
Other close family member?	Y	N	DK	If yes, whom?________________________________
Close friend?	Y	N	DK	If yes, whom?________________________________

Outside of your family of origin, have you experienced abuse? Yes No Don't Know

Circle type of abuse: Sexual abuse Physical abuse Emotional abuse/harassment

Primary Relationships (Current or past)

Currently married? Yes No How long?__________ Living with spouse? Yes No

Average weekly alcohol intake: None 1-3 drinks 4-8 drinks More than 8
Recreational/mood enhancing non-prescription drug use? None Daily Weekly Monthly
Drug Used? Cannabis Cocaine Painkillers Speed Methamphetamine
Other:______________________________

In the last year have you experienced any of the following:

Picked up or charged with a drug-related driving offense?	Y	N	DK
Lost time from school or work because of use?	Y	N	DK
Experienced a medical problem because of use?	Y	N	DK
Been fired from a job because of use and its effects?	Y	N	DK
Felt you ought to cut down on drinking or drug use?	Y	N	DK
Had people annoy you by criticizing your drinking or drug use?	Y	N	DK
Felt bad or guilty about your drinking or drug use?	Y	N	DK
Had a drink or used drugs as an eye opener first thing in the morning to steady your nerves or get rid of a hangover or to get the day started?	Y	N	DK

My average daily nicotine use is:______________________________
My average daily caffeine use is:______________________________

Current Medical Care

Physician:______________________________
Medical Diagnosis:______________________________
Medications/Dosage:______________________________
____

What type of exercise do you get?______________________ Frequency?__________

Past Mental Health/Chemical Dependency Treatment

(Include outpatient treatment and hospitalizations):

Dates (Month/Year)	Where?	Primary Therapist?

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + ______ + ______ + ______

=Total Score: ______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all __________
Somewhat difficult __________
Very difficult ______________
Extremely difficult __________

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.