



Moving Waters Counseling
Dustin Holden LMFT
8 N 2nd Ave E Suite 310
Duluth, MN 55802

CLIENT INFORMATION

Name _____

Address _____

Phone _____

Is it OK to call you at this number? Yes___No___

E-mail _____

Is it OK to inform you about available services?
Yes___No___

Date of Birth _____

Gender M___F___

Marital/Partner Status _____

SS# _____

GUARDIAN/PARTNER INFORMATION

Name _____

Address _____

Phone _____

Is it OK to call you at this number? Yes___No___

E-mail _____

Is it OK to inform you about available services?
Yes___No___

Date of Birth _____

Gender M___F___

Marital/Partner Status _____

SS# _____

Primary Physician

Name _____

Location _____

Phone _____

How did you find Moving Waters
Counseling? Who referred
you? _____

INSURANCE INFORMATION

Insurance Name _____

Phone _____

Policy Holder Name

Policy/ID # _____

Group # _____

INFORMED CONSENT



Consent for Treatment

I authorize Moving Waters Counseling to provide counseling and/or psychotherapy services for myself or for a person for whom I have the legal right to give such consent.

Treatment Policies

It is very important that all written or verbal communications with Moving Waters Counseling are confidential, but there are the following exceptions:

- When a current, written release is on file.
- If Child Abuse is suspected.
- If any threat of violence is made toward yourself, another person, or is reported about a third party.
- If you are involved in litigations, and court representatives request information.
- To your insurance company, if applicable, to allow for payment of services.
- During consultation with other professional therapists, in discussions about treatment approaches and community resources intended to ensure you are receiving the best treatment possible. During these discussions, names are not mentioned, and every effort is made to not identify clients in any way. If you have concerns about this, please mention your preference to not be discussed.

Please provide 24 hours of notice if you need to cancel a scheduled appointment. **You will be responsible for paying a cancellation fee of \$50 for a session if you miss or cancel within 24 hours.**

Risks and Benefits

Please know that there are both risks and benefits from these services, and that there is unfortunately no guarantee. Typical benefits include an improvement in functioning at home, school, work, or socially, improvement of symptoms, and a greater sense of control over one's life. Risks may include no change in functioning, increased symptoms in the short or long term, or changes in relationships with others.

Assignment of Benefits

I hereby assign payment directly to this office for professional services rendered and I shall be personally responsible for any unpaid balance to the therapist.

Consent for Disclosure of Protected Health Information

As explained in the Notice of Privacy Practices, I consent to the disclosure of my information within limits of the law for the purposes of Treatment, Payment, or Healthcare Operations. I understand that I may revoke this consent at any time.

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES that explains how my personal health information will be handled. I understand that questions regarding my health information can be directed to Dustin Holden at Moving Waters Counseling by calling 218-722-1920.

Fee Agreement

Session fees or insurance co-payments are due on the day of service unless other arrangements are made. You are welcome to pre-pay for any amount of sessions you desire.

I agree to pay a fee of _____ per session group Insurance Co-payment
Payment source: _____

Print Name _____ Signature _____ Date _____
Print Name _____ Signature _____ Date _____

Guardian Signature _____ Date _____ Relationship _____
_____ Date _____ Relationship _____



Moving Waters Counseling

Dustin Holden LMFT
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Duluth, MN 55802
218-722-1920

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Name: _____ Birth Date: _____
Address: _____ Phone: _____

I authorize Moving Waters Counseling-Dustin Holden to release information to or exchange information with:

Agency or Individual: _____
Address: _____

For the purpose of:

- | | |
|---|--|
| <input type="checkbox"/> Treatment Planning/Continuing Care | <input type="checkbox"/> Social Services Involvement |
| <input type="checkbox"/> Legal | <input type="checkbox"/> Personal Use |
| <input type="checkbox"/> School | <input type="checkbox"/> Other: _____ |

The information will contain:

- | | |
|--|--|
| <input type="checkbox"/> Diagnostic Assessment/Psych. Evaluation | <input type="checkbox"/> Counselor/Therapist Summary |
| <input type="checkbox"/> Summary of Medical History | <input type="checkbox"/> School Reports: grades, behaviors |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Other: _____ |

The disclosure will only include dates between: _____ and _____

- I understand that I may revoke this authorization at any time by providing written notification, and that it will automatically expire after one year.
- I understand that there will be no conditions placed on my treatment based on my willingness or refusal to sign this authorization.
- I understand that information released may be subject to re-disclosure and will not be protected by Federal privacy regulations.
- I understand that I have a right to inspect or copy information released by this disclosure, and that I will be responsible for reasonable costs related to this.
- I understand that I have a right to a photocopy of this signed authorization.

Signature of Client or Legal Representative

Relationship to Client

Date

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

INTRODUCTION

Each time you visit Moving Waters Counseling, a record of your visit is made. Typically, this record contains information regarding why you visited and what services were rendered. Information regarding assessment, diagnosis, treatment, and a plan for future treatment is often part of the record that is kept. This record will be created to provide you quality care and to comply with legal requirements. Moving Waters Counseling is committed to maintaining the privacy and security of your health information.

This notice is a summary of your rights, possible uses of your information, the responsibilities Moving Waters Counseling has regarding your health information, and how to report a problem. For more detailed information, please contact the office at 218-722-1920.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Although the treatment record is the physical property of Moving Waters Counseling, the information in it belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Privacy Practices on request.
- Review and obtain copies of your personal record, with the exception of psychotherapy notes.
- Request that your treatment record be amended if you feel that it is inaccurate or incomplete.
- Obtain an accounting of disclosures of your treatment record.
- Request a restriction on certain uses and disclosures of your information.
- Request that communications with you occur by alternative means or at alternative locations.
- Revoke your authorization to use or disclose your treatment record in the future.

HOW YOUR INFORMATION MAY BE USED OR DISCLOSED

Federal law allows for your information to be disclosed without your authorization in the following cases:

- Treatment-Your information may be exchanged with other agencies or service providers to ensure appropriate services or to gather information to determine the course of treatment that would work best for you.
- Payment-A bill may be sent to you or a third-part payer. This may include identifying information, your diagnosis or the treatment provided.
- Healthcare Operations-Your information may be used in office operations. Examples include reviewing treatment and assessing outcomes of services toward continued improvement of the quality and effectiveness of the services provided. Information may be used to determine additional services that may be offered, or how current services compare to other similar health care centers.
- As required by law-Sometimes reports including your health information must be made to legal authorities. For instance, we may have to report abuse, neglect, domestic violence, or respond to a court order.

Other disclosures will be made only with your written permission. If you give permission to disclose information, only the minimum amount necessary will be released. This permission may be revoked in writing at any time, after which no further disclosures will be made. Please understand that if any information has already been released, this cannot be undone.

OUR RESPONSIBILITIES

Moving Waters Counseling is required to:

- Provide this notice of our legal duties and privacy practices with respect to information about you.
- Maintain the privacy of information that identifies you.
- Follow the terms of this notice.
- Ensure that any business associates of Moving Waters Counseling that come in contact with your information follow this notice. (e.g. for billing purposes, or volunteers you allow to be involved while at the office)
- If these privacy practices change, an updated copy will be made available at the office.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information, please contact Dustin Holden at Moving Waters Counseling by calling 218-722-1920.

If you believe that your privacy rights have been violated, you may file a complaint in writing to Dustin Holden at Moving Waters Counseling, 8 N. 2nd Ave E. Suite 310 Duluth, MN 55802, or with the Secretary of the Department of Health and Human Services. **YOU WILL NOT BE PENALIZED FOR MAKING A COMPLAINT.**