PATIENT INFORMATION: **Is Treatment Court-Ordered? YES/ NO**

Last name: ________________ First:_____________________ M.I. ____ Nickname:________________

SSN: ______-____-_____ Birth date: __/__/____ Allergies: ___________________________ Sex:_____

Race:_______________Patient's marital status: ______ Patient's Spouse:__________________________

Address: _____________________________ City: ________________ State: _____Zip: _____________

Phone: H:______________ W:____________C:_____________ Email: __________________________

Permission to leave voicemails? YES/ NO   Permission to email? YES/ NO

Choose One Option for Appointment Reminder(s): _____ Email _____Text Message_____ Voicemail

Referral Source: __________Primary Doctor: __________ Reason for Referral:_____________________

RESPONSIBLE PARTY (if other than patient)

(Shared Custody? Please provide name and phone number of other party)

Last name: __________________________First Name:__________________________ M.I. ______

Address: _____________________________ City: _________________ State: _____ Zip: _______

Phone: home ____________________ work ____________________ cell ___________________

Employer's Name: _____________________________ City: _________________ State: _________

Other Party: Last name: ______________First Name:___________________ Phone Number:_______

EMERGENCY CONTACT ____**Same as Responsible Party**

Last name: __________________________First Name:__________________________ M.I. ______

Address: _____________________________ City: _________________ State: _____ Zip: _______

Phone: home ____________________ work ____________________ cell ___________________

Employer's Name: _____________________________ City: _________________ State: _________

INSURANCE INFORMATION: (Present Insurance Card to Office Staff Please)

Primary Insurance Company: ______________ *Secondary Insurance Company:*________________

Card Holder _____________________________ Card Holder ________________________________

Birth Date _______________________________ Birth Date _________________________________

SSN ____________________________________ SSN _______________________________________

Address _________________________________ Address ____________________________________

Phone # _________________________________ Phone # ____________________________________

Employer ________________________________ Employer ___________________________________

Policy ID #_______________________________ Policy ID # _________________________________

Group # ______-______ Group # ______-______

Please complete all information correctly and legibly.

266 Henrietta Ave. N., Park Rapids, MN, 56470
Phone: (218) 252-2785 Fax: (218) 732-4695

BILLING INFORMATION – Read and sign:

1. I authorize A Better Connection, Inc. to release medical and other information concerning this or related claims to government agencies including Social Security Administration and its intermediaries, agency accountant(s), agency legal representatives, RPT-S Supervisor, and insurance companies and carriers who may be responsible for payment of benefits.
2. I authorize A Better Connection, Inc. to release my medical records and billing information to my Primary Care and/or Referring Physician.
3. I authorize my insurance benefits to be paid to A Better Connection, Inc..
4. If a requested insurance claim is filed, I will receive a bill each month if my account has a balance due. I am responsible for any charges not paid by insurance.
5. I understand that if I do not provide the above insurance information, I will be responsible for my bill, regardless of whether or not I have insurance.
6. I understand that I am responsible for providing a referral to my insurance company if they require it.

Name of person completing this form (please print) ____
Signature of person completing this form_________________________________ Date: __________
Relationship to Patient: ____

PERMISSION TO TREAT A MINOR

I, __________________________________, hereby authorize A Better Connection, Inc. to provide psychotherapy to ____, a minor. I attest to the fact that I have the legal authority to grant this permission.

Signature: ____ Date: ________________

Is there currently a Restraining Order or Order of Protection on anyone? YES / NO

If so, what is the name of the individual(s)? ____

266 Henrietta Ave. N., Park Rapids, MN, 56470
Phone: (218) 252-2785 Fax: (218) 732-4695

TO BE FILLED OUT BY PARENT OR GUARDIAN

Child/Adolescent Diagnostic Assessment

(TO BE COMPLETED BY PARENT/CAREGIVER)

CHILD NAME (FIRST, MI, LAST)

DATE

Living situation

Parent's Home	Residential Care/Treatment Facility**		Other**	
RENT	HOSPITAL	TEMPORARY HOUSING	FRIEND'S HOME	RELATIVE/GUARDIAN'S HOME
OWN	RESIDENTIAL CARE	NURSING HOME	HOMELESS	

**IDENTIFY PERSON'S NAME OR FACILITY

Primary Household

STREET ADDRESS

Household member name	Relationship to child	Age	Occupation/School	Highest level of education	Quality of relationship

Does the client live in more than one household?

NO If no, skip to "Additional Family Members" **YES** If yes, complete the secondary household information below.

Secondary Household

STREET ADDRESS

Household member name	Relationship to child	Age	Occupation/School	Highest level of education	Quality of relationship

Family members who live in both households

ONLY CHILD **CHILD and (list):**

Additional family members living outside of the home

NO, parents or sibling other than those listed in primary or secondary households	YES, list family members:

Custody and parenting plan

LIVES WITH BOTH PARENTS (biological or adoptive) in same household	**SHARED CUSTODY** – parents in different households
SINGLE PARENT	**OTHER** (describe):

****Please bring documented proof if one/both biological parents should be excluded from participating in treatment due to loss of custodial rights.**

Developmental issues

Have you ever had concerns about the following issues with this child?

Pregnancy	Yes	No	Unknown
Had bleeding during first three (3) months			
Had bleeding during second three (3) months			
Had bleeding during last three (3) months			
Had toxemia			
Had to take medications Specify any medication:			
Got injured or hurt			
Gained less than 15 lbs. (7 kgs.) Specify:			
Took narcotic drugs			
Drank alcohol			
Had an infection			
Smoked during pregnancy			
Length of pregnancy: months			
Other pregnancy problems/illnesses Specify:			
Birth/Early Infancy	Yes	No	Unknown
Born prematurely			
Born with cord around neck			
Injured during birth			
Had trouble breathing			
Turned blue (cyanosis)			

Was a twin or triplet			
Had an infection			
Had seizures (fits, convulsions)			
Needed oxygen			
Was very jittery			

Childhood Health Issues	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Seizures (convulsions) or spells					
High fevers (over 103° F. or 39° C.)					
Head injury					
Asthma					
Trouble with hearing					
Trouble with vision					
Lead poisoning					
Other poisoning or overdose					
Other serious illness					
Other hospitalizations					

Functioning	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Poor appetite					
Constipation					
Stomach aches					
Trouble falling asleep					
Trouble staying asleep					
Overactivity					
Head banging					
Rocking in bed					
Temper tantrums					
Self-destructive behavior					
Difficulty in being comforted or consoled					
Stiffness or rigidity					
Looseness or floppiness					
Crying often and easily					

Shyness with strangers					
Irritability					
Extreme reaction to noise or sudden movement					
Attention problems	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Can concentrate for only a short time unless things are very interesting					
Understand the main ideas of things but misses important details					
Does work or performs many tasks carelessly without thinking					
Learns a new skill well one day and then can't seem to do it a few days later					
Receives very unpredictable (inconsistent) grades or test scores in school					
Can work well only on things he/she really enjoys doing or thinking about					
Often doesn't notice when he/she makes mistakes					
Seems not to realize when he/she is disturbing someone					
Doesn't do much better after punishment or correction					
Makes comments about or is distracted by background noises or unimportant things					
Seems to want things right away and/or is hard to satisfy					
Annoys or bothers other children					
Behavior is variable and hard to predict					
Is a troublemaker; bullies others					
Behaviors	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Has bad dreams					
Is often very quiet or withdrawn					
Is often "down" on himself/herself					
Is often tired					
Speaks unclearly, stutters, or stammers					
Wets bed or pants often					
Soils underwear or has accidents with bowel movements					

Is often too neat or orderly					
Is often too concerned about cleanliness					
Often plays with matches					
Destroys objects at home					
Destroys objects away from home					
Is fearless					
Is cruel to animals					
Is not liked by other children					
Feels ill on school mornings					
Has eating problems (either overeats or undereats)					
Is preoccupied with food or diet					
Is part of a clique or gang that causes trouble					
Other behaviors not noted above					
Have you ever had concerns about your child's early development (i.e. walking, talking, learning)?					
Have you ever had concerns about your child's sexual development or behaviors?					

IF THERE ARE INDICATIONS OF ISSUES, PLEASE EXPLAIN

Child's school functioning

Education classification Current School Current Grade Current Teacher

Level of learning: Gifted Above Average Average Below Average Borderline Developmentally Delayed

COMMENTS ON CLASSROOM LEARNING:

Is homework a problem? Yes No

IF YES, PLEASE EXPLAIN:

Does your child receive special education services? L YES L NO

If no, has your child ever been tested and determined not to need services? ☐ YES ☐ NO

Regular education classroom, no special services ☐ YES ☐ NO

If no, check all that apply below.

☐ Early Childhood Spec. Ed./Developmental Delay ☐ Special learning disability ☐ Physically Impaired

☐ Special Learning Disability ☐ Autism Spectrum Disorder ☐ Emotional/Behavioral Disorder

☐ Hearing Impaired ☐ Traumatic brain injury ☐ Developmental/Cognitive Disability

☐ Visually Impaired ☐ Other health impaired ☐ Other:

☐ Speech or Language Impaired ☐ Unsure ☐ Current 504 plan

COMMENTS ON EDUCATIONAL CLASSIFICATION

Has your child: Repeated a Grade Advanced a Grade Received In School Suspension Been Suspended Been Expelled

Child's legal history

Does your child have a history of legal charges? ☐ NO ☐ YES IF YES, DESCRIBE CHARGES

Is the child currently on probation? ☐ NO ☐ YES

Has the child ever been on probation? ☐ NO ☐ YES

Has the child ever been court-ordered into chemical health or mental health treatment? ☐ NO ☐ YES

Child's trauma history

Children's Protective Services (CPS) involvement with family ☐ NO ☐ YES IF YES, DESCRIBE

NAME OF CPS CASEWORKER(S) ASSIGNED TO FAMILY (IF APPLICABLE)

NAME OF GUARDIAN AD LITEM (GAL) OR COURT APPOINTED SPECIAL ADVOCATE (CASA) ASSIGNED TO FAMILY

Has your child ever experienced any of the following? ☐ REPORTED TO AUTHORITIES? WHEN? TO WHOM? ☐ NONE REPORTED

☐ NO TRAUMA HISTORY ☐ CAR ACCIDENT ☐ OTHER ACCIDENT ☐ COMMUNITY VIOLENCE ☐ SEXUAL ABUSE/MOLESTATION ☐ COMMUNITY VIOLENCE

☐ PHYSICAL ILLNESS ☐ PHYSICAL ABUSE ☐ DOMESTIC VIOLENCE/ABUSE ☐ EMOTIONAL ABUSE/NEGLECT ☐ PHYSICAL NEGLECT ☐ FIRE ☐ OTHER:

Child's mental health treatment history

Previous mental health treatment L NO L YES If yes, please list reason for treatment, and dates:

Reason Dates

What did you find helpful in your treatment?

What was not helpful in your treatment?

Currently on any medication(s)? L NO L YES Please List All Medications and Dosages:

PRIMARY CARE PHYSICIAN	CLINIC
OTHER PRESCRIBING PHYSICIAN(S)	CLINIC

Child's alcohol and drug history

Do you have any concerns about your child's use of alcohol or drugs? L NO L YES

Do you have any other issues or concerns about your child you would like to have addressed? L NO L YES COMMENTS

Child/Adolescent CageAid

Have you felt you ought to cut down on drinking or drug use? L NO L YES

Have you felt bad or guilty about your drinking or drug use? L NO L YES

Have people annoyed you by criticizing your drinking or drug use? L NO L YES

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)? L NO L YES

Family Environment/Relationships

Please indicate below the best descriptions of parent-child relationships.

Parent-Child (Client) Relationship(s)	**P** = Primary household	**S** = Secondary household	**B** = Both		
Parent-child conflict	_____ NONE – MILD	_____ MODERATE	_____ SEVERE		

Issues with supervision and monitoring of child	______ ALWAYS	______ USUALLY	______ INCONSISTENTLY	______ RARELY	
Cooperation between parents regarding child-rearing	______ ALWAYS	______ USUALLY	______ INCONSISTENTLY	______ RARELY	______ NOT PERTINENT
Parent positive activities with child	______ FREQUENT	______ OCCASIONALLY	______ INFREQUENT		
Parent satisfaction with relationship	______ SATISFIED	______ NEUTRAL	______ DISSATISFIED		
Child satisfaction with relationship	______ SATISFIED	______ NEUTRAL	______ DISSATISFIED		

COMMENT ON PARENT-CHILD RELATIONSHIPS (describe further if needed)

MATERNAL (MOM'S) SIDE OF THE FAMILY'S MEDICAL AND MENTAL HEALTH HISTORY

PATERNAL (DAD'S) SIDE OF THE FAMILY'S MEDICAL AND MENTAL HEALTH HISTORY

SIBLING MEDICAL AND MENTAL HEALTH HISTORY

Please indicate below the best descriptions of sibling-child relationships.

Sibling-Child (Client) Relationship(s) L NO SIBLINGS **P** = Primary household **S** = Secondary household **B** = Both

Child-sibling conflict	______ NONE – MILD	______ MODERATE	______ SEVERE
Sibling(s) positive activities with child	______ FREQUENT	______ OCCASIONAL	______ INFREQUENT
Sibling(s) satisfaction with relationship	______ SATISFIED	______ NEUTRAL	______ DISSATISFIED
Child satisfaction with relationship	______ SATISFIED	______ NEUTRAL	______ DISSATISFIED

COMMENT ON SIBLING-CHILD RELATIONSHIPS (describe further if needed)

Please indicate below the best descriptions of parent marital or couple relationships.

Parent Marital or Couple Relationship(s) L NOT APPLICABLE **P** = Primary household **S** = Secondary household **B** = Both

Marital or couples conflict	______ NONE – MILD	______ MODERATE	______ SEVERE
Marital or couples satisfaction	______ SATISFIED	______ NEUTRAL	______ DISSATISFIED

COMMENT ON PARENT MARITAL OR COUPLES RELATIONSHIPS (describe further if needed)

Other Family Concerns			If yes, indicate:		
	No	Yes	Parent	Sibling	Other
Family member health problems					
Family member disability					
Family member legal issues					
Family financial concerns					
Family member alcohol abuse					
Family member substance abuse					
Family member anxiety					
Family member depression					
Family member ADHD					
Family member mania					
Family member schizophrenia/other psychosis					
Significant family stressors (moves, deaths, divorce, loss of employment)					

OTHER FAMILY CONCERNS AND CHANGES IN CLIENT'S LIFE MAKING ADJUSTMENT DIFFICULT (Specify problems that impact child's needs.)

PLEASE INDICATE STRENGTHS (Including characteristics, activities, achievements, talents, etc.)

____

PARENT OR LEGAL GUARDIAN SIGNATURE:____ **DATE**:________________

Adolescent History Questionnaire

(To be completed by the adolescent)

Name:__________________________________Birth Date:__________________Age:_____

Has someone referred you to ABC?_____No _____Yes (If Yes, Who?)___________________

Reason for seeking services?____

On the chart below, please check what symptoms you have recently experienced. Check all that apply. Please feel free to ask ABC Staff questions if you do not understand.

☐		☐		☐		☐	
☐	Withdrawing from family/friends	☐	Emotional highs	☐	Excessive worry	☐	Murderous thoughts or wishes
☐	Decrease in energy or fatigue	☐	Restlessness	☐	Anxiety	☐	Problems at work/school
☐	Irritability	☐	Hyperactivity	☐	Panic Attacks	☐	Breaking rules
☐	Reduced interest or enjoyment with life	☐	Impulsiveness	☐	Fear of abandonment	☐	Trouble with authority
☐	Depressed mood or lingering sadness	☐	Anger or hostility	☐	Nightmares	☐	Stealing or dishonesty
☐	Trouble with sleep (too much, too little, insomnia)	☐	Noticeable mood swings	☐	Phobias or excessive fears(of___________)	☐	Destructiveness
☐	Crying spells/easy to tears	☐	Difficulty making decisions	☐	Nervousness	☐	Over-aggressiveness
☐	Difficulty thinking or concentrating	☐	Disorganization	☐	Obsessions, having trouble getting thoughts out of mind	☐	Physical health concerns
☐	Easily distracted	☐	Impaired memory	☐	Flashbacks to distressing events	☐	Eat when not hungry or beyond fullness
☐	Feelings of rejection	☐	Racing thoughts or speech	☐	Feel like you are outside your body watching self	☐	Dissatisfied with body shape or weight
☐	Low self-esteem	☐	Difficulty speaking	☐	Unsure of what is real	☐	Muscle twitches
☐	Feelings of guilt or shame	☐	Persistent desire for alcohol or drugs	☐	Feel others are spying or trying to poison you	☐	Emotional eating
☐	Helplessness	☐	Concern over your use of tobacco	☐	Sometimes think you are hallucinating	☐	Eating behaviors of starving, binging, or purging
☐	Hopelessness	☐	Concern over your use of alcohol and/or drugs	☐	Suicidal thoughts or wishes	☐	Sexual problems or concerns
☐	Don't care about anything	☐	History of relapse	☐	Injuring self (cutting, burning, pulling hair)	☐	Chronic pain

How often do symptoms affect you? ___1-2 days per week ___ 3-4 days per week ___ 5-6 days per week ___Everyday

How long have you been dealing with these symptoms?____

What makes the symptoms worse?____

How much do symptoms interfere with work, housework, getting along with others?

On a scale of 1 (not at all) to 10 (all the time):_______

What improves symptoms?____

When do you notice difficulty lessen or go away?____

Have you had previous treatment for these symptoms? NO/YES, if yes when and where? ______________

____

What did you find helpful in treatment?____

What did you find not helpful in treatment?____

PLEASE COMPLETE THE FOLLOWING

Patient Health Questionnaire – 9	**(Circle one)**			
Over the *last 2 weeks,* how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly everyday
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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
Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Have you thought of suicide recently or in the past?______________________________________

Have you attempted suicide recently or in the past?______________________________________

Were you hospitalized? **NO/YES**, if yes when and where? ____

Have you made use of Crisis Services if feeling suicidal? ____

Do you harm yourself in a manner (for example: cutting, burning, drinking, smoking, etc.)?

NO/YES, if yes please explain:____

Do you have any access to guns or weapons? YES/NO

Generalized Anxiety Disorder (GAD-7) Scale:

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several Days	More than half of the days	Nearly every day
Feeling nervous, anxious, or on edge	**0**	**1**	**2**	**3**
Not being able to stop or control worrying	**0**	**1**	**2**	**3**
Worrying too much about different things	**0**	**1**	**2**	**3**
Trouble relaxing	**0**	**1**	**2**	**3**
Being so restless that it's hard to sit still	**0**	**1**	**2**	**3**
Becoming easily annoyed or irritable	**0**	**1**	**2**	**3**
Feeling afraid as if something awful might happen	**0**	**1**	**2**	**3**

How difficult have the above problems made it for you to do work, complete housework, or get along with other people? (Circle One) Not difficult at all - Somewhat difficult - Very difficult - Extremely difficult

<u>In the following chart, please identify what experiences you have had in your life?</u>

(Circle HX if you have a History and/or P if it is a Present event)

Life Experiences					
Abusive relationship	Hx P	Miscarriage	Hx P	Unhappy childhood	Hx P
Experienced physical abuse	Hx P	Abortion	Hx P	Poor academic progress	Hx P
Experienced emotional abuse	Hx P	Crime Victim	Hx P	Few Friends	Hx P
Experienced sexual abuse	Hx P	War	Hx P	Family Problems	Hx P
Witnessed physical abuse	Hx P	Poverty	Hx P	Rape	Hx P
Witnessed emotional abuse	Hx P	Natural Disaster	Hx P	Death of someone close	Hx P
Witnessed sexual abuse	Hx P	Death of a parent	Hx P	Traumatic Brain Injury	Hx P

Please explain any details you wish to share about your life experiences:________________________

____

____

Below, please indicate if your functioning has been impacted in any of the following areas:

(Please circle and describe) Ratings: 1 (none) 2 (slight) 3 (moderate) 4 (severe) 5 (extreme)

		How has the problem made things worse?
Hobbies/Interests/Play Activities [Mental Health]	1 2 3 4 5	______________
Sleep Problems	1 2 3 4 5	______________
Abuse Issues	1 2 3 4 5	______________
Alcohol or Drug Use [Use of alcohol or drugs]	1 2 3 4 5	______________
Job Performance [Vocational Functioning]	1 2 3 4 5	______________
School Performance [Educational Functioning]	1 2 3 4 5	______________
Ability to Control Temper [Social Functioning]	1 2 3 4 5	______________
Friendship/Peer Relationships	1 2 3 4 5	______________
Marriage/Relationship Problems [Interpersonal Functioning]	1 2 3 4 5	______________
Family/Children Problems	1 2 3 4 5	______________
Activities of Daily Living[Self Care, Independent Living]	1 2 3 4 5	______________
Physical/Dental Health or Handicap [Medical/ Dental Health]	1 2 3 4 5	______________
Sexual Functioning	1 2 3 4 5	______________
Obtaining/maintaining Financial Assistance	1 2 3 4 5	______________
Obtaining/maintaining Housing	1 2 3 4 5	______________
Using Transportation	1 2 3 4 5	______________

What mental health services do you currently ***RECEIVE***? (examples: county assistance, case management, medication management)

What mental health services do you currently ***NEED***? (examples: county assistance, case management medication management)

Substance Use:

Past uses: ___alcohol____tobacco____caffeine____marijuana____meth____narcotics_____prescription drugs

Current uses:___alcohol____tobacco____caffeine____marijuana____meth____narcotics_____prescription drugs

Substance	When did you **start**	When/if you **stopped**	How you used; **amount, how often**	**Negative effects** or **consequences** of use

CageAid For Adolescents:

-Have you used more than one **chemical** at a time in order to get high? Yes No
-Do you **avoid** family activities so you can use? Yes No
-Do you have a **group** of friends who also use? Yes No
-Do you use to improve your **emotions,** such as when you feel sad or depressed? Yes No

Legal issues as a result of substance use: ___No___Yes Describe:______________________
____
____

Have you participated in a chemical dependency treatment program? ___No ___Yes (if yes, where and when?)____

Do you feel you have a problem with substances or alcohol? ___No ___Yes (if yes, do you want help with this problem?)____

Do you have family history of substance or alcohol abuse/dependence? ___No ___Yes (if yes, please describe) ____

NOTICE OF PRIVACY PRACTICES

Please read this notice and **sign and date** the attached acknowledgement.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act has given you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for you visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment activities and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified by removing all references to individually identifiable information.

We may contact you to provide appointment reminders and information about treatment alternative or other health-related benefits and services that may be of interest to you.
Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relaying on your authorization.

You have the following rights with respect to your protected health information which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosers of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we much abide by it unless you agree in writing to remove it.
- The right to reasonable requests to review confidential communications of protected health information from us at alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to receive an accounting of disclosers of protected health information.
- The right to obtain and we have to obligation to provide to you a paper copy of this notice from us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of out legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy has been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint: The U.S. Department of Health & Human Services Office of Civil Rights, 200 Independence Avenue, S. W., Washington, D.C. 20201 Phone: (2202) 619-0257 Toll Free: 1-877-696-6775

A Better Connection, Inc.

Acknowledgement of Notice of Privacy Practices

I acknowledge that I have received a written copy of the **A Better Connection, Inc. Privacy Practices.** I also acknowledge that I have been allowed to ask questions concerning this notice and my rights under this notice. I understand that this form will be a part of my record until such a time as I may choose to revoke this acknowledgment. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf.

______________________ ____

Date Signature of Client or Legal Guardian

Cancellation Policy/Agreement

Due to high demand for mental health services at A Better Connection Inc., clients and families are being asked to sign, and agree to, the cancellation policy terms and conditions. Text Message reminders 24 hours prior containing the appointment date and time are a courtesy provided by A Better Connection Inc. to ensure attendance. Please request this service if you do not currently receive text message reminders.

Late Cancel/No Shows: If patients arrive 15 or more minutes late to an appointment without calling to inform A Better Connection Inc. of the late arrival, they may be asked to reschedule as their appointment will be considered a Late Cancel/ No Show. Patients unable to attend a scheduled appointment or group session must cancel the appointment more than 24 hours prior to the appointment time. Reminder text messages are sent at this time. To cancel an appointment, please text or call 218-252-2785. In cases of extraordinary circumstances that arise less than 24 hours prior to the appointment time (e.g. physical illness), the clinic still appreciates to be informed about the missed appointment. There is a daily cancellation list of patients hoping to attend an open appointment time. It is appreciated by other clients and their families if you call with enough time to allow their attendance at that time. This also ensures the possibility of an appointment opening to reschedule your appointment at a later date. Failure to cancel an appointment less than 24 hours prior to an appointment will require:

- One late cancel/no show in a six month period= Client must call to confirm an appointment the following week. If no call is made, no appointment will be made for the following week.
- Two late cancels/no shows in a six month period= Client will lose their weekly/ biweekly session time and must schedule an appointment each week.
- Three late cancels/no shows in a six month period= Client will be required to call the morning of the day the client prefers to attend an appointment. A session will be scheduled if an appointment time is available. If no time is available, the client will need to call back at a later date.

I understand and agree to the above cancellation policy.

Signature:____ Date: _________

Printed Name: ____

TO BE FILLED OUT BY PARENT OR GUARDIAN

Strengths and Difficulties Questionnaire

P 11-17

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behavior over the last six months.

Your child's name .... Male/Female

Date of birth...

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other youth, for example CD's, games, food	☐	☐	☐
Often loses temper	☐	☐	☐
Would rather be alone than with other youth	☐	☐	☐
Generally well behaved, usually does what adults request	☐	☐	☐
Many worries or often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other youth or bullies them	☐	☐	☐
Often unhappy, depressed or tearful	☐	☐	☐
Generally liked by other youth	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other youth	☐	☐	☐
Often offers to help others (parents, teachers, children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets along better with adults than with other youth	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Good attention span, sees chores or homework through to the end	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behavior or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

• How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

• Do the difficulties upset or distress your child?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

• Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	A medium amount	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

• Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

Signature .... Date ....

Mother/Father/Other (please specify:)

Thank you very much for your help

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TO BE FILLED OUT BY ADOLESCENT

Strengths and Difficulties Questionnaire

S 11-17

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain . Please give your answers on the basis of how things have been for you over the last six months.

Your name.. Male/Female

Date of birth..

	Not True	**Somewhat True**	**Certainly True**
I try to be nice to other people. I care about their feelings	☐	☐	☐
I am restless, I cannot stay still for long	☐	☐	☐
I get a lot of headaches, stomach-aches or sickness	☐	☐	☐
I usually share with others, for example CD's, games, food	☐	☐	☐
I get very angry and often lose my temper	☐	☐	☐
I would rather be alone than with people of my age	☐	☐	☐
I usually do as I am told	☐	☐	☐
I worry a lot	☐	☐	☐
I am helpful if someone is hurt, upset or feeling ill	☐	☐	☐
I am constantly fidgeting or squirming	☐	☐	☐
I have one good friend or more	☐	☐	☐
I fight a lot. I can make other people do what I want	☐	☐	☐
I am often unhappy, depressed or tearful	☐	☐	☐
Other people my age generally like me	☐	☐	☐
I am easily distracted, I find it difficult to concentrate	☐	☐	☐
I am nervous in new situations. I easily lose confidence	☐	☐	☐
I am kind to younger children	☐	☐	☐
I am often accused of lying or cheating	☐	☐	☐
Other children or young people pick on me or bully me	☐	☐	☐
I often offer to help others (parents, teachers, children)	☐	☐	☐
I think before I do things	☐	☐	☐
I take things that are not mine from home, school or elsewhere	☐	☐	☐
I get along better with adults than with people my own age	☐	☐	☐
I have many fears, I am easily scared	☐	☐	☐
I finish the work I'm doing. My attention is good	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that you have difficulties in any of the following areas: emotions, concentration, behavior or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

• How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

• Do the difficulties upset or distress you?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

• Do the difficulties interfere with your everyday life in the following areas?

	Not at all	Only a little	A medium amount	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

• Do the difficulties make it harder for those around you (family, friends, teachers, etc.)?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

Your Signature .... Today's Date ....

Thank you very much for your help

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