THANK YOU FOR CHOOSING OUR OFFICE

The following are the forms you will need to review and complete prior to your first appointment with Kim Minter, LCSW. All these forms are fillable via the computer. We will need these forms returned at least 24-hours prior to your appointment so once you fill them out, please either print and mail them to our office at 413 N Allumbaugh Street, STE 101 Boise ID 83704, or fax them to us at 208-323-9604 or save them on your computer and email them to us at newpatients@sage-healthcare.com

1. **Initial Intake Form**
2. **Financial Agreement Form**
3. **Policy and Practices**
4. **Notice of Privacy Practices**
5. **Acknowledgment/Message Permission Form**
6. **Release of Information Form**

If you have insurance you wish us to bill, please call us with your insurance information. If you have any questions about your first appointment or in general, the answer may possibly be found on our website under "*Frequently Asked Questions*" or please call our office at 208-323-1125.

Kimberlee Minter, LCSW
413 N Allumbaugh Street, Suite 101
Boise ID 83704

ADULT SELF-REPORT FORM

Name: _____ DOB: _____

What is the primary reason you are here today?

In What ways is this problem affecting your life, family, social interactions, marriage, work and school?

Have you participated in past counseling?

Yes ☐ No ☐

Have you ever been hospitalized for mental health reasons?

Yes ☐ No ☐

When and Where?

Please describe briefly the reason(s) for your hospitalizations(s).

*Please list all medications you are currently taking; include dosage, frequency, and prescriber.

What issues would you like to focus on in counseling?

What changes would you like to see in your life as a result of counseling?

FINANCIAL AGREEMENT

Provider**: Kimberlee Minter, LCSW**

CLIENT INFORMATION Preferred Pronouns: ☐ she/her/hers ☐ He/him/his ☐ They/them/theirs ☐ Other: Please specify:_____

Legal Patient Name_____DOB_____SS#_____

Address_____City_____State_____ Zip_____

Phone #_____Can we leave messages at this number: Yes____☐__No____☐

Gender Assigned at Birth: F____☐__M____☐ Other_____Decline to Answer____☐____Marital Status: S____☐ D____☐ W____☐ Other_____

Current Gender: F____☐__M____☐ Other_____Decline to Answer____☐____Preferred Name: _____

Employer:_____Work Phone#_____

Address_____City_____State_____ Zip_____

SPOUSE/PARTNER INFORMATION: Name**:** _____DOB_____SS#_____

Employer:_____Work Phone#_____

FINANCIAL RESPONSIBLE (If other than Client)

Name_____DOB_____SS#_____

Address_____City_____State_____ Zip_____

Ph#_____Employer: _____Work#_____

EMERGENCY CONTACT: Name_____DOB_____SS#_____

Address_____City_____State_____ Zip_____Ph#_____

INSURANCE INFORMATION

Primary Insurance_____ Policyholder Name_____

Policyholder ID#_____ Group #_____ Employer_____

Secondary Insurance_____ Policyholder Name_____

Policyholder ID#_____ Group #_____ Employer_____

OFFICE POLICY: Payment is due at the time of service. You are responsible for all fees regardless of insurance coverage. We charge $25.00 for all returned checks. As a courtesy, we will submit claims to the above-named insurance company. Benefits quoted by your insurance company are not a guarantee of payment. If your insurance company has not paid your claim within 60 days, the payment of the claim will be your responsibility. We do not bill for the following: student insurance, retroactive Medicaid, victims and workers' compensation, or third parties listed in divorce decrees. All minors must be accompanied by a parent or legal guardian. If your insurance company requires an authorization or referral for your visit, you are responsible to obtain and maintain the authorization or referral. Our providers do not do disability paperwork or FMLA until you have been an established patient for at least 6 months.

ASSIGNMENT OF BENEFITS: I request that payment of authorized insurance benefits be made on my behalf to Sage Health Care or the provider of my choice for any services furnished to me by that provider. I authorize the holder of medical information about me or any information needed to determine these benefits to be released to the insurance company(s) listed above.

Policyholder Signature or Responsible Party_____Date_____

Kim Minter, LCSW POLICY AND PROCEDURE

Welcome to Kim Minter's private practice located within Sage Health Care, PLLC. Kim Minter sees private practice patients at this location; however, her practice is a separate company from Sage. Our office is committed to giving you excellent service and treatment. The following are our policies and practices in which we require you to read and sign prior to any treatment. Please let us know if you have any questions or concerns.

Please note that Kim Minter requires a patient to be

REGARDING PAYMENT/INSURANCE:

Full payment or co-payment is required at the time of service. We accept cash, check or credit card.

Your insurance policy is a contract between you and your insurance company. We are not a part to that contract but will bill your primary insurance as a service to you. If your insurance has not paid your claim in full within sixty days of billing, we will require the balance to be paid by you.

Our providers do not accept all insurances so please make sure to check with the office prior to coming in if the provider you are scheduling with accepts the insurance you have. If you have applied for workers' compensation benefits, we will assist you in any way we can but require that you keep your account current at all times. If you are receiving assistance from your church or a charity organization, please talk with the billing office before scheduling your appointment.

OFFICE HOURS: our office is open Monday – Thursday 8:00 am to 5:00pm and Friday 8:00am to 3:00 pm

EMERGENCY SITUATIONS: For after hour emergencies, please call 911 or go to your local emergency room.

DISABILITY and FMLA PAPERWORK: Kim does not see patients for disability or FMLA paperwork unless she has been treating the patient for at least 6 months.

UNATTENDED CHILDREN:
Please note that our office does not allow and are not responsible for unattended children in the lobby.

CANCELLATION AND NO SHOW POLICY: If you need to cancel or change your appointment, please do so as soon as possible. If cancellation does not occur at least 24-hours in advance or you no show for the appointment, you may be charged for that appointment.

REASONS FOR TERMINATION OF CLINICIAN-PATIENT RELATIONSHIP:

1. If you feel you are not compatible with your clinician, arrangement can be made to be seen by another provider
2. If you are not complying with your clinician orders, he/she may request to discontinue treatment
3. If you are not meeting financial obligations, your clinician may discontinue treatment
4. If you are disruptive or inappropriate towards the staff, care may be terminated
5. Dishonesty and/or deceitfulness may require termination of treatment

I have read the above policies and practices. I understand and agree to comply with the above.

_____ _____

Patient/Guardian 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 REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your health information, to notify you of our legal duties and privacy practices with respect to your health information and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your protected health information. Our duties and your rights are set forth more fully in 45 C.F.R. part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. USES AND DISCLOSURES OF INFORMATION THAT WE MAY MAKE WITHOUT WRITTEN AUTHORIZATION

We may use or disclose protected health information for the following purposes without your written authorization. These examples are not meant to be exhaustive.

TREATMENT: We may use or disclose your protected health information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

PAYMENT: We may use or disclose protected health information so that we, or other health care providers, may obtain payment for treatment provided to you. For example, we may disclose information from your medical records to your health insurance company to obtain pre-authorization for treatment or submit a claim for payment.

HEALTHCARE OPERATIONS: We may use or disclose protected health information for certain health care operations that are necessary to run our practice and ensure that our patients receive quality care. For example, we may use information from your medical records to review the performance or qualifications of physicians and staff; train staff; or make business decisions affecting our practice.

Other Uses or Disclosures: We may use or disclose your health information for certain other allowed by 45 CFR part 164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- To our third party business associates who perform activities involving protected health information for us, e.g., billing or transcription services. Our contracts with the business associates require them to protect your health information.

2. USES AND DISCLOSURES OR INFORMATION THAT WE MAY MAKE UNLESS YOU OBJECT

Unless you instruct us otherwise, we may use and disclose protected health information in the following instances without your written authorization:

FACILITY DIRECTORIES: Unless you object, we will include your name, your location in our facility, your general condition, and your religious affiliation in our facility directory. We may disclose the foregoing information to clergy and, except religious affiliation, to people who ask for you by name.

PERSONS INVOLVED IN YOUR HEALTH CARE: Unless you object, we may disclose protected health information to a member of your family, or other person identified by you who is involved in your health care or the payment for your health care. We will limit the disclosure to the protected health information relevant to that person's involvement in your health care or payment.

NOTIFICATION: Unless you object, we may use or disclose protected health information to notify a family member or other person responsible for your care of your location and condition. Among other things, we may disclose protected health information to a disaster relief agency to help notify family members.

3. USES AND DISCLOSURES OF INFORMATION THAT WE MAY MAKE WITH YOUR WRITTEN AUTHORIZATION

Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes; or if we seek to sell your information. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. YOUR RIGHTS CONCERNING YOUR PROTECTED HEALTH INFORMATION

You have the following rights concerning your protected health information. To exercise any of these rights, you must submit a written request to the Privacy Contact identified below.

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.
- We normally contact you by telephone or mail at your home address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.
- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.
- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete.
- You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.
- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice at any time, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

6. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. Contact Information.

If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:

Privacy Officer: Brenda Schwartz
Phone: 208-954-5579
Address: 413 N Allumbaugh Street, suite 101 Boise, ID 83704
Email: brenda.schwartz@sage-healthcare.com

8. Effective Date. This Notice is effective Sept 13, 2021

(#5)**Acknowledgement Message Permission Form**: Please fill out and bring to first appointment

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices

_____ _____

Signature Date

Relationship to Patient if signed by someone other than patient:

Parent ☐ Guardian ☐ Other:_____

Permission to Leave Messages

By signing below, I give the staff at Sage Health Care, PLLC permission to leave detailed appointment information on my answering machine at the phone number(s) that I have provided to their office. I understand that I have the right to revoke this authorization at any time.

_____ _____

Patient Signature or legal Guardian Date

_____ _____

Printed Name Date

Release of Information Form: Please fill out and return to our office if you wish us to obtain or disclose information about your care

R070616

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name:_____**DOB**_____

I hereby authorize Kimberlee Minter, LCSW and her office staff to use and or disclose my individually identifiable Protected Health Information ("PHI") in the manner described below. I understand that the person or entity receiving my PHI, may re-disclose my PHI, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such redisclosure by the person or entity receiving my PHI. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.

☐ Obtain information from: AND/OR ☐ Disclose information to:

Name and Address:_____

_____Phone #:_____

Category and Time Period of PHI

Please initial the Category of PHI you wish to release

☐ Initial Evaluation ☐ Claims/Billing Information ☐ Lab Results

☐ Progress Notes ☐ Therapy notes ☐ Entire Medical Record

☐ other_____

Time period of healthcare treatment records you wish to be included:

☐ Anytime ☐ Healthcare provided between (date)_____ and (date) _____

Limit of PHI

I understand that this authorization extends to all of any part of the records/information designated above which may include treatment for physical and mental illness, alcohol/drug abuse; HIV/AIDS test results or diagnosis. I understand that if I wish to limit the use and disclosure of my PHI, I would have indicated below by initialing the appropriate category of PHI I *DO NOT* wish to be released.

_____ HIV/AIDS test results or diagnosis _____Alcohol/drug abuse _____ Other_____

Please limit the use and disclosure of my PHI to only include the following dates:_____

[Example: laboratory results from July 1998; mental health records from January 2001 to present"]

Purpose of PHI

☐ Continuity of Care ☐ Aftercare Planning

☐ Contact with Referring Supervisor ☐ Referral

☐ Family Involvement ☐ Other_____

I understand that this authorization will expire on the following date or event:_____
If no specific date or event is stated, this authorization will expire one (1) year from the date of this authorization. I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying the above provider in writing. I understand that my revocation or modification of this authorization will not effect any actions taken by the provider mentioned above in reliance on this authorization before the provider mentioned receives my request for revocation or modification. I must sign my written request and send it to: 413 N Allumbaugh Street, Suite 101, Boise, ID 83704

Signed:_____Date:_____

If not signed by the patient, please indicate authority or relationship:_____

Note to Agency/Person receiving information: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42CFR Part 2.1) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.