Apollo Counseling Inc. Informed Consent and Disclosure Authorization Form

Version 03/24/2023

Name		Phone #		ID #	
Address		Legal Sex		Date of Birth	
City/State/Zip		Gender		SS# or PMI#	
Legal Guardian		Relationship		Phone #	
Emergency Contact		Relationship		Phone #	

1st Insurance		Member #		Group #	
2nd Insurance		Member #		Group #	
Service Start Date		Client Status		Reservation	
		County		Tribe	

The following information is provided to familiarize you with Apollo Counseling Inc.'s (The Company) policies and help you to best understand your rights as a client. If you have any questions about any aspect of your professional relationship with your provider or about the specifics of these policies, please review them with your provider. If you find no adequate resolution with your provider, please contact The Company at 651-434-2166.

Client Bill of Rights

Minnesota law establish a variety of legal rights for individuals undergoing a course of treatment with The Company. They are described in the accompanying Minnesota Patients' Bill of Rights. In addition to those rights, you also have the right:

1. To expect that a therapist has met the minimal qualifications of training and experience required by state law.
2. To examine public records which contain the credentials of a therapist.
3. To report complaints to the professional's relevant board:

MN Board of Marriage and Family Therapy	MN Board of Social Work	MN Board of Behavioral Health & Therapy
335 Randolph Ave. #260	335 Randolph Ave. #245	335 Randolph Ave. #290
St. Paul, MN 55102	Saint Paul MN 55102	St. Paul, MN 55102
612-617-2220	612-617-2100	651-201-2756
mft.board@state.mn.us	social.work@state.mn.us	bbht.board@state.mn.us
https://mn.gov/boards/marriage-and-family/	https://mn.gov/boards/social-work/	https://mn.gov/boards/behavioral-health/

4. To privacy as defined by rule and law (further described under HIPAA Notice and Privacy Practices & Consent to Disclose).
5. To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.
6. To have access to your records as provided in Minnesota Statutes, section 144.292.
7. To be free from exploitation for the benefit or advantage of a therapist.

Other Client Rights and Responsibilities:

1. You have the right to refuse to provide information. (If you do not provide needed information, you may not be eligible for the services for which you are applying/receiving).
2. You have the right to refuse treatment or terminate services at any time (unless prohibited by law or court order).
3. You have the right to ask for a referral to a different provider or to seek services through another company for any reason.
4. You have the right to information about the cost of services, your diagnosis, treatment alternatives, recommended treatments, and estimated length/outcome of services.
5. You have the right to a non-technical description and explanation of assessment results.
6. You have the right to know the intended recipients of your Protected Health information (PHI) and to withdraw consent to the release of your PHI (If you do not give consent to release needed information, you may not be eligible for the services for which you are applying/receiving).
7. You have the right to assert these rights without retaliation.
8. You are responsible to participate in determining your own treatment plan and to make sure that you understand it to your satisfaction.

You acknowledge that any service provided by The Company may be terminated at any time if it is determined that the provider's objectivity and/or effectiveness is impaired, or if you are unlikely to benefit from continued professional services with The Company. If services are terminated, The Company will offer to make a recommendation to you for other appropriate mental health services.

Acknowledgement of Receipt of Notice of HIPAA Privacy Practices & Consent to Disclosure of 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

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains patient rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office at 651-434-2166.

You have the right to request that we restrict how protected information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You also consent to our use and disclosure of protected health information for other purposes authorized under Health Insurance Portability and Accountability Act of 1996 and the corresponding regulations ("HIPPA"), including but not limited to:

- information about victims-of abuse, neglect or domestic violence;
- for judicial and administrative proceedings;
- for law enforcement purposes;
- for public health activities;
- for health oversight activities;
- information about decedents;
- for cadaver organ, eye or tissue donation purposes;
- for certain limited research purposes;
- to avert a serious threat to health or safety;
- for specialized government functions; and
- that relate to workers' compensation programs.

You have the right to revoke the Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Company provides this form to comply with HIPAA and the Minnesota Health Records Act.

You understand that:

- Protected health information may be disclosed or used for treatment, payment or health care operations and other purposes as provided under HIPAA, including to the Clinic's Business Associates as defined under HIPAA. .
- The Company has a Notice of Privacy Practices and that you have the opportunity to review this notice.
- The Company reserves the right to change the Notice of Privacy Practices.
- You have the right to request restrictions to the uses of their information, but The Company does not have to agree to those restrictions.
- You may revoke this Consent in writing at any time and full disclosures will then cease.
- The Company may condition receipt of treatment upon the execution of this consent.
- This Consent lasts for one year or until: ____________________________

I have received a copy of the Notice of Privacy Practices and, by signing at the bottom of this form, hereby consent to the use and disclosure of my protected health information as provided therein.

Complaint and Emergency Procedures

To file a complaint there are two main procedures available to every client.

1. Provide a written complaint to The Company
    a. Clients are to submit a signed written report citing all relevant information about their complaint, and any potential outcomes they would request to address the complaint. They may also report the complaint and requested outcomes to staff who then would create this written document to be signed by the client.
    b. Once received all written complaints are immediately given to the owner and clinical supervisor Sam Major LMFT who is responsible for addressing all complaints given to The Company.
    c. Within 10 business days The Company will provide to the client a written acknowledgement stating:
        i. The name and contact information of the person responsible for handling the complaint
        ii. The expected timeline for investigating and determining an outcome for the complaint, generally within 30 days from receipt of the complaint unless otherwise noted.
2. Provide a complaint to the MN Office of Ombudsman for Mental Health and Developmental Disabilities
    a. Clients may file online - https://mn.gov/omhdd/client-services/how-to-file-a-complaint.jsp
    b. Clients may contact a Regional Ombudsman for the county where the client is located. This can be found by using the regional map or the Regional Ombudsman via the county list.
        i. Call the OMHDD: 651-757-1800 or 1-800-657-3506.
        ii. Email the OMHDD: ombudsman.mhdd@state.mn.us
        iii. Fax the OMHDD: 651-797-1950
    c. Clients may send a letter by US postal mail:
        i. The MN Office of Ombudsman for Mental Health and Developmental Disabilities
        ii. 121 7th Place East
        iii. Suite 420 Metro Square Building
        iv. St. Paul, Minnesota 55101-2117

Emergency Procedures:

1. The Company provides outpatient/in-home therapy and ARMHS by appointment only.
2. The Company and its staff DO NOT provide crisis intervention services.
3. In case of emergency The Company recommends calling one of the following numbers for crisis intervention services:
    a. National Resources
        i. Police and Emergency Services: 911
        ii. Suicide and Crisis Emergencies: 988
        iii. Crisis Text Line: Text “home” to 741741
        iv. MN Domestic Abuse and Violence Hotline: 1-866-223-1111, or Text 612-399-9995
    b. County Specific Resources:
        i. Anoka County Crisis Line: 763-755-3801
        ii. Benton County Crisis Line: 320-253-5555
        iii. Carver County Crisis Line: 952-442-7601
        iv. Dakota County Crisis Line: 952-891-7171
        v. Hennepin County Adult Crisis Line: 612-596-1223
        vi. Hennepin County Child Crisis Line: 612-348-2233
        vii. McLeod County Crisis Program: 320-864-2713
        viii. Meeker County Crisis Line: 1-800-432-8781
        ix. Ramsey County Crisis Line: 651-266-7900
        x. Rice County Crisis Line: 1-877-399-3040
        xi. Scott County Crisis Line: 952-818-3702
        xii. Sherburne County Crisis Line: 1-800-635-8008
        xiii. Sibley County Crisis Line: 1-877-399-3040
        xiv. Stearns County Crisis Line: 1-800-635-8008
        xv. Washington County Crisis Line: 651-275-7400
        xvi. Wright County Crisis Line: 1-800-635-8008

COVID-19 Assumption of Risks
While the COVID-19 pandemic continues, you can choose between in person and tele-medicine services, with the awareness that there are pluses and minuses to both types of services, including that your preferred provider may not be available for in-person therapy and that the quality of remote services may not be the same as in-person services. If you decide that your situation is better serviced by in-person services, you assume the risk of receiving services in person during the COVID-19 pandemic, which includes potential exposure to COVID-19 and any damages from the illness, even when staff are using reasonable precautions to guard against infection.

Telemedicine Consent
For your convenience, health, and safety, The Company offers telemedicine. Telemedicine includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of Protected Health Information (PHI), and education using synchronous or asynchronous audio, video, or data communications. However it is important to understand that telemedicine is different than traditional in person services, and comes with unique risks regarding your PHI.

Prior to utilizing Telemedicine with The Company you have read, understand, and acknowledge that:
1. Telemedicine is not the same as a face-to-face visit since you will not be in the same room as your healthcare practitioner, and that telemedicine services and care may not be as effective as face-to-face services.
2. The Company will assess the appropriateness of telemedicine for the services you have requested it for, and if it is determined that you would be better served by receiving different services, such as face-to-face services, recommendations for treatment and treatment providers or facilities will be provided to you.
3. At any time in place of telemedicine you may seek face-to-face consultation with a health care provider.
4. It may be required that you provide identifying information or copies of identifying documents such as a State ID at the request of your healthcare practitioner before any health services are provided via telemedicine.
5. There are risks of incomplete or ineffective consultation because of the technology utilized, and that if any of these risks occur, the consultation may terminate. The risks may include but are not limited to:

a. Failure, interruption, or disconnection of the audio/video connection
b. Audio or video that is not clear enough to meet the needs of the consultation
c. Access to the consultation through the interactive connection by electronic tampering.

6. If you are unable to connect with the telemedicine or phone call platform or are disconnected during a session due to a technological breakdown, try to reconnect within 5 minutes. If reconnection is not possible, contact your practitioner at the number they have provided. If that is not possible, then The Company can be reached at the following phone number: 651-431-1731.
7. The Company may use and respond to e-mail and text messages only to arrange or modify appointments with if you have provided consent for them below.
8. Email and text messaging are not secure forms of communication. You agree not to send PHI or other information related to your treatment through e-mail or text messages and acknowledge that any health-related questions or issues will not be addressed by The Company in any other electronic communication, but will be dealt with during your next health session.

Privacy and risk with Telemedicine:
1. The Company utilizes several policies and procedures to protect your privacy and security, and all electronic communications between yourself and your healthcare practitioner will be transmitted using reasonable measures to ensure confidentiality, but limitations exist whenever conducting services over electronic communications.
2. The risks and consequences of telemedicine include, but are not limited to

a. Interrupted or distorted transmission of data or information due to technical failures
b. Access or interception of protected health information by unauthorized persons.
c. Any electronic transmissions of information are retained in the logs of service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the service providers. I acknowledge that any electronic communication, e-mails, or any communications sent via social media, online, or The Company's website are not secure, and I assume the risks of the insecure transmission.

3. In the event that other professionals are called in by your healthcare practitioner either for health consult or technical support (e.g. to operate or fix audio/video equipment) during your session, are bound to maintain confidentiality of any PHI disclosed.

4. Any individuals invited at your discretion are not bound by any confidentiality agreements, and your confidentiality may be waived.

Other Electronic Communication:

For your convenience, The Company utilizes several methods of communication, including voice mail, text messaging, e-mail, and fax. These methods are specifically for the purposes of scheduling and communicating other non-PHI. Any health-related questions or issues will not be addressed by The Company in these forms of electronic communication but will be dealt with during your next health session. For a better understanding of how to safely utilize these other forms of electronic communication, please see the non-exhaustive list of their risks below:

1. Voice Mail, Text Messages, E-mail, and Faxes are not secure forms of communication, and any information in them may be obtained and/or reviewed by people other than the intended recipient due to user error, or by a 3rd party by error or for malicious purposes.
2. PHI information contained in Voice Mail, Text Messages, E-mail, Faxes may also be forwarded/broadcast to 3rd parties due to user error, or by a 3rd party by error or for malicious purposes.
3. Voice Mail, Text Messages, E-mail, and Faxes may leave backup copies on servers and user terminals that are not accessible to be deleted by the sender, recipient/client, or any one party.
4. Voice Mail, Text Messages, E-mail, and Faxes may no longer be considered part of a client's medical record, and therefore be open to discovery during legal inquiries.
5. Voice Mail, Text Messages, E-mail, and Faxes can be an A-synchronous form of communication and should not be relied on for urgent messages that need to be acted on immediately.
6. Digital information is easily altered or falsified and may be subject to technological failures.

After reviewing the provided information and risks for both telemedicine and other electronic communications, and acknowledging that there may be other risks not listed when using telemedicine or other electronic communication, by signing this document, I acknowledge that:

- I authorize The Company to provide telemedicine and communicate with me via the means indicated above.
- I have a right to revoke this authorization at any time by sending written notification to The Company. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.
- I release The Company, its employees, agents, and assigns from any and all liability which may arise from this telemedicine consultation, the use of interactive video or audio connections, or from the taking or authorized use of any images or audio obtained.
- I understand the limitations inherent in ensuring client confidentiality of information transmitted in telemedicine and agree to waive my privilege of confidentiality with respect to any confidential information that may be accessed by an unauthorized third party despite the reasonable efforts of The Company to arrange a secure line of communication
- I understand that The Company cannot prevent the re-disclosure of information transmitted as a result of this authorization and that it may not be subject to privacy rule protections; therefore, The Company is released from any and all liability resulting from user error and/or re-disclosure by 3rd party sources.
- I agree that neither I nor my healthcare practitioner will record any part of my sessions unless The Company and I mutually agree in writing that the health session may be recorded.
- I further acknowledge that The Company objects to my recording any portion of my sessions without The Company's written consent.
- I expressly agree that audio and video recordings used for security or legal and documentation purposes are not part of my health records and are therefore not protected by confidentiality or any other provisions under this agreement.
- The Company has provided you a satisfactory explanation of all technology that will be used, how to use it, and risks associated with its use.
- I have read this form and/or have had it read to me and explained in a language that I can understand.

Payments and Health Insurance:

1. The Company's Fees for Service (unless otherwise negotiated):
   a. Fees for services are usually covered by insurance, county contract, private pay, or a combination of these options. Private pay and Co-pay/co-insurance is due at the time of service. Cash, credit cards and personal checks are accepted. If the therapeutic service is provided under an agreement with a government or other agency, there may be no cost directly to you from The Company. Please be advised that in certain circumstances the government or other agency may charge you for the services provided by The Company.
   b. Many insurance plans cover outpatient mental health services. It is your responsibility to check with your insurance carrier for specific information regarding your coverage. Please be aware that authorization for treatment by your insurance carrier does not ensure payment to a provider. If your insurance carrier refuses payment for any reason, you are responsible for your bill.
2. All payments should be made to The Company at the time of services.
3. When you make an appointment, The Company holds that time for you. You are responsible to keep your appointment or to notify your provider with at least 24 hours advance notice of any cancelation.
4. For individuals covered by commercial insurance (and other individuals as permitted by law), missed appointments or late cancels (cancellations with less than 24 hours of notice) will result in a charge for the session. These charges are not covered by your insurance company.
5. Please leave all messages for business concerns, including cancellations with your provider. If you are unable to get a hold of your provider, you can call 651-434-2166 to leave a message. If you leave a voice message, staff will return your call within 48 business hours.
6. The Company is a provider for several major insurance companies. Because health insurance policies vary, please verify your benefits with your insurance company.
7. The Company will submit claims to your insurance company and receive payment directly from them.
8. You are agreeing to pay copays and/or deductibles at the time of service and understand that you are financially responsible for payment of any services provided that are not covered by your insurance, including but not limited to: deductibles, co-payments, and co-insurance. Payments can be made out to The Company.

ARMHS Specific Transportation Waiver

ARMHS is a service that is provided in the community, and therefore you may decide to utilize various means of transportation including public and private transport. Transportation is NOT an ARMHS service, and you assume all of the risk of any transportation you arrange while in an ARMHS session with an The Company staff member, including getting to your destination safely. Under no circumstances shall The Company be liable for damages from any transportation you utilize during the provision of ARMHS by The Company Counseling Inc while out in the community. If you receive transportation from a staff member of The Company, the staff member is doing so on their own will and not at The Company's direction.

By signing this document, you are acknowledging that you understand, agree too, and have received a copy of The Company's policies for Client Rights, Notice of HIPAA of Privacy Practices, Telemedicine Consent, Electronic Communication Consent, Emergency Procedures, Payments and Health Insurance, Transportation Waiver, and COVID-19 Assumption of Risks.

Credit/Debit Card Options:

1. As an added convenience, you may authorize The Company to charge your card automatically for Private Pay and Co-Payments for your appointments, late cancelations, no-shows, and any other outstanding balances on your account. Please allow up to 5 business days to process your charge.
2. The undersigned cardmember consents and permits The Company to charge their credit card account specified above, with the amounts due for services provided by The Company.
3. I release The Company from any and all claims arising from the use of this service. I understand and agree that The Company may continue to charge such amounts to my debit/credit card account until receiving notification from myself I have withdrawn this consent and permission, at which time The Company shall cease charging any such amounts to my Credit Card Account.

Name on Card	
Card #	
Expiration Date	
Security CCV#	
Billing Address	

By signing at the bottom of this form, I hereby acknowledge, agree, and consent to the policies contained herein as identified by my initials below.

Please initial for all permissions given:

	Client Rights
	Notice of HIPAA Privacy Practices
	Telemedicine Consent
	Electronic Communication Consent
	Emergency Procedures
	COVID-19 Assumption of Risk
	Payments and Health Insurance
	ARMHS Specific Transportation Waiver
	Consent to Keep and Charge Credit Cards Information

This authorization expires one year from the date of the client/legal guardian's signature, unless explicitly documented here:

Alternate Expiration Date	

Client/Legal Guardian		Signature		Date	
☐ Client/LG provided verbal authorization to the witness					
☐ Client/LG refused/unable to sign – Explain:					
Witness		Signature		Date	