Lighthouse Child & Family Services

CLIENT BILL OF RIGHTS

Your rights and responsibilities as a client of Lighthouse Child & Family Services, Inc. We hope we can give you the kind of support and help you are looking for. As a client, you have the right:

1. to expect that a provider (mental health professional and/or mental health practitioner) has met, or continues to meet, the minimal qualifications of training, experience, and supervision required by state law;

2. to examine public records maintained by MN professional boards which contain the credentials of a mental health professional;

3. to obtain a copy of the code of ethics that guide your provider's professional conduct from the State Register and Public Documents Division, Department of Administration, 117 University Avenue, Saint Paul, MN 55155;

4. to report complaints to our Privacy Officer at 320-983-2335;

5. to report complaints directly to a provider's licensing board:
    a. Board of Marriage and Family Therapy, University Park Plaza Building, 2829 University Ave SE, Suite 330, Minneapolis, MN 55414-3222;
    b. Minnesota Board of Social Work, University Park Plaza Building, 2829 University Ave SE, Suite 340, Minneapolis, MN 55414
    c. Minnesota Board of Behavioral Health & Therapy, University Park Plaza Building, 2829 University Ave SE, Suite 210, Minneapolis, MN 55414

6. to be informed of the cost of professional services before receiving the services;

7. to have their information kept private and confidential, except as described in Lighthouse Child & Family Services, Inc. Office and Financial Policies Agreement and as defined by rule and law;

8. to be free from being the object of discrimination based on race, religion, gender, sexual orientation, national origin, source of payment, ethical or political beliefs or other unlawful category while receiving services;

9. to be informed and active participants in all decisions and treatment planning concerning your mental health needs;

10. to refuse treatments or participation in research and/or training procedures;

11. to have access to their records as provided in Minnesota Statutes, section 144.292; and

12. to be free from exploitation for the benefit or advantage of a provider.

PLEASE SEE NEXT PAGE FOR PRIVACY PRACTICES NOTICE

Notice of Privacy Practices

As required by the Health Insurance Portability and Accountability Act (HIPAA)
and the Minnesota Data Privacy Act
Effective May 1, 2008, updated August 3, 2016 and March 1, 2018

Lighthouse Child and Family Services (LCFS) is required to protect the privacy of our client's Personal Health Information (PHI). LCFS is required by the Health Insurance Portability and Accountability Act (HIPAA) to provide it's clients with a notice of our legal duties and privacy practices with respect to PHI. For the remainder of this document, the terms *we, our* and *us* refer to LCFS and the terms *you* and *your* refer to our clients.

Notice Information

This Notice of Privacy Practices describes how LCFS may use and disclose your PHI to carry out treatment, payment, and health care operations, as well as any other purpose specified by law.

We reserve the right to change this Notice. The changes will apply to PHI we already have about you and any PHI that we might get about you in the future. We will provide you with and updated Notice when you request one. We will also post the most current notice in all of our offices, as well as on our website.

Data Privacy

Why we ask for information. We ask you for information from you to assist us in determining what service may be appropriate for you and the development of a treatment or service plan that will help you accomplish your goals.

You are not required to give us any information. If you chose to not give us some information, it may limit our ability to serve you well. If you are seeking services because of a court order, and you refuse to provide us information, that refusal may be communicated to the court.

Minors. If you are under the age of 18, you may request that information about you be kept from your parents. This request must be made in writing. You will need to tell us what information you don't want shared and why you don't want your parents to see it. The treating professional will review your request and determine if it is in your best interest to not disclose the information or if can be safely shared with your parents.

If you are at least 16 years old, you may seek services without the consent of your parents. You may need to pay for those services yourself, if you do not want your parents to know.

Protected Health Information

Protected Health Information (PHI) is:

- Information about your mental or physical health, related health care services or payment for health care services.
- Information that is provided by you, created by us or shared with us by outside agencies.
- Information that identifies you or could be used to identify you, such as demographic information (age, year of birth, race, ethnicity, blood type), contact information, Social Security Number, dependents and health history

How LCFS Protects Your PHI

Except as described in this Notice or otherwise specified by law, LCFS will not use or disclose your PHI. LCFS will use reasonable efforts to request, use and disclose the minimum amount of PHI necessary for treatment, continuity of care or billing purposes.

Whenever possible, we will de-identify or encrypt your personal information so that you cannot be identified. We have put physical, electronic and procedural safeguards in place to protect your PHI and comply with state and federal laws.

Your Rights

You have the following rights with respect to your PHI:

Obtain a copy of this notice. You may obtain a copy of this notice at anytime. If you have received an electronic copy of this notice, you are still entitled to a paper copy. This notice can be picked up from our office, printed from our website or you can call and one will be sent to you.

Request restrictions. You may ask us to not use or disclose any part of your PHI. This request must be made in writing and include what restriction(s) you want and to whom you want them to apply. This includes the right to restrict discloses of PHI to health insurance companies, when services are paid for in full out of pocket. LCFS will review and grant reasonable requests, with respect to and within all state and federal laws

Inspect and copy. You have the right to inspect and copy your PHI as long as we maintain the information. You must make your request in writing. LCFS may charge you for the cost of copying, mailing or for any supplies that are necessary to grant your request.

LCFS has the right to deny your request to inspect and copy. If your request is denied, you may ask LCFS to review the denial.

Request amendment. If you feel that your PHI in incorrect or incomplete, you may ask us to amend it. You must make this request in writing and it needs to contain which specific information you would like amended and the reason for the amendment. LCFS may deny your request for amendment if it includes information that was not created by us or if we believe that the information on file is complete and accurate.

If we deny your request for amendment, you have the right to submit a statement of disagreement that will be placed on file with your records.

Receive a list (an accounting) of disclosures. You have the right to receive a list of disclosures (called an accounting) that LCFS has made of your PHI for a period of three years, prior to the date of the request. This list will not include disclosures that we are not required to track, such as disclosures for the purposes of treatment, payment, or health care operations; disclosures which you have authorized us to make, or disclosures made directly to you.

Request alternative ways to communicate. You have the right to request that we communicate with you in specific ways. For instance, you can ask that we only call you on your cell phone or we send your mail to a specific address. These requests must be made in writing. We will accommodate all reasonable requests.

Special rules for Psychotherapy notes. *Psychotherapy Notes* are notes recorded by a mental health professional that document or analyze the contents of conversations during a counseling session. The Minnesota Health Records Act ensures you have access to your complete medical record, including psychotherapy notes, except when the treating mental health professional deems that the information is detrimental to your physical or mental health, or is likely to cause you to inflict self-harm, or to harm another.

It is not the practice of LCFS to keep psychotherapy notes as defined by HIPAA or the Minnesota Health Records Act.

Notification. You have the right to be notified if any of your PHI is impermissibly released or disclosed, due to a breach, including theft, loss or other form of disclosure. We will all affected individuals in the event of a breach. We will use the most recent contact information on file.

When LCFS May Use and Disclose PHI

Treatment. To provide, coordinate or manage health care and related services to ensure that you are receiving appropriate and effective care. This includes contacting other health care providers or a third party, to consult with them about the services we are providing for you.

Payment. To obtain payment or reimbursement for services provided to you. For example, we may need to disclose some PHI to determine eligibility for treatment or claims payment.

Health care operations. To assist in carrying out administrative, financial, legal and quality improvement activities necessary to run our business and support the core functions of treatment and payment.

Business Associates. Our business associates perform some health care related administrative tasks for us. Our primary business associates are billing services and claims administrators. We require our business associates to sign agreements limiting how they might use or disclose PHI. By law, business associates are required to comply with all HIPAA regulations and requirements regarding the use and protection of PHI.

Individuals involved in your care or payment for your care. We may disclose your PHI to a family member, friend or any other person that **you** identify as being involved in your care or payment for your care.

As required by law. We must disclose PHI about you when required to do so by law. This includes the reporting of suspected abuse, neglect or domestic violence to an agency authorized to receive such information, such as law enforcement or county social services. Additionally we are required to disclose pertinent PHI when the treating professional believes that it is necessary to prevent a serious threat to their health and safety or the health and safety of any other individual or the public.

Less common reasons. Occasionally, we are legally required to disclose PHI for very specific reasons. These include being an inmate in a correctional facility, in response to a court order for a judicial or administrative proceeding, to comply with worker's compensation laws, to authorized public health officials, to a coroner or medical examiner to assist them in identifying a deceased person or determining their cause of death and to oversight officials in the investigation of a complaint or for a compliance review.

We may release PHI to authorized federal officials for the purposes of national security, intelligence, counterintelligence and for the protective services of the President or other heads of state.

Your Written Permission

We are required to get your written permission before using or disclosing your PHI for any purpose other than those listed in this Notice. If you do not want to authorize a specific request for disclosure, you may refuse to do so. If you change your mind, this permission can be withdrawn at any time. This request must be made in writing.

You May File a Complaint

If you believe that your privacy rights have been violated, you can file a complaint with:

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Lighthouse Child and Family Services
160 3rd Avenue NW
Milaca, MN 56353

Medical Privacy Complaint Division
Office for Civil Rights
200 Independence Avenue SW
Room 509 F, HHH Building
Washington, DC 20201

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Medical Privacy Complaint Division
Office for Civil Rights
200 Independence Avenue SW
Room 509 F, HHH Building
Washington, DC 20201

Lighthouse Child & Family Services

Adult Client Information Form **Today's Date ___/___/___**

I. General Information

Name _____ Sex ___ Age ___ Date of Birth ____ / ____ / ____
(Please include previous names/maiden)

Status (check one): ___ Single ___ Married ___ Divorced ___ Partnered ___ Remarried ___ Separated ___ Widowed

Referred by _____

How long have you lived in this area? ____ yrs. County of Residence _____

Are finances currently a stressor for you? Yes/No If yes, why? _____

Have you ever had any legal problems? Yes/No If yes, give date(s)/outcome(s) _____

1. Briefly state what brings you into counseling? _____

_____

2. How long have you been experiencing these problems? _____

_____

3. What are your goals for counseling? _____

_____

4. How will you know when you have achieved your goals? _____

_____

5. Describe how your symptoms affect your daily living:

Work _____

Home/Family _____

School _____

Socially/Relationships _____

Self-Care _____

Legally _____

6. What are your strengths? _____

_____

7. What are your hobbies? _____

_____

8. Have you ever had fears of doing harm to self, others, or of losing control? Yes ____ No _____

If yes, when? _____

9. In the past year, have there been any changes in your life (moved, changed school/jobs, medical issues, loss of a loved one, end of relationships, etc.)? _____

_____

II. Current Family Data (Spouse/Children/Etc.)

Please provide the following family information (include all pregnancies, adoptions, and foster siblings):

First Name-Last Name	Sex	Age	Relationship	Quality of Relationship (positive, neutral, negative, etc.)
1.				
2.				
3.				
4.				
5.				

Do you have any history of suicide in your family? Yes/No

If yes, please list member(s)/relationship: _____

III. Counseling history (past and present) and/or hospitalizations:

Agency, Counselor, Hospital	Date of Service	Problem/Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

IV. Medical History

Name and address of physician/medical group _____

Last appointment with physician? ___ / ___ / ___ Reason for visit _____

Please list all prescription medication you are currently taking including vitamins, minerals, herbal remedies, and their purpose:

Name	Dosage	Prescribing Physician	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any known allergies: _____

_____

Do you have any medical concerns or chronic health problems (diabetes, heart conditions, seizures, asthma, cancer, head injuries, etc.)? _____

_____

Do you have any infectious diseases? ___ Yes ___ No

If Yes, please indicate the disease and medical precautions taken: _____

_____

_____

List any major medical conditions in your immediate family (e.g., diabetes, cancer): _____

_____

V. Substance Use

Do you drink any caffeine? Yes/No If yes, how much per day/week? _____

Do you drink alcohol? Yes/No If yes, how much per day/week? _____

Do you smoke/use tobacco? Yes/No If yes, how much per day/week? _____

Have you ever used recreational drugs – other than alcohol? Yes/No If yes, please list drug and duration:_____

Have you ever had a problem with drugs/alcohol? Yes/No

CAGE-AID:

1. Have you ever felt you should cut down on your drinking or drug use? Yes/No
2. Have people annoyed you by criticizing your drinking or drug use? Yes/No
3. Have you ever felt bad or guilty about your drinking or drug use? Yes/No
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves, or get rid of a hangover? Yes/No

Do you have immediate or extended family with a history of mental illness or chemical dependency? If so, please list below:

_____

_____

_____

IV. Employment History

Are you currently employed? ___ Yes ___ No If yes, please list current employer and length of current employment:

	Occupation	Name of Employer	Date Employed
Present	_____	_____	_____
	_____	_____	_____
Previous	_____	_____	_____
	_____	_____	_____

VI. Faith/Spirituality History

Please briefly describe your spiritual/faith background and its importance in your life: _____

_____

Are there any other cultural concerns you have or would like us to be aware of? _____

_____

Is there anything else you think would be important for us to know in helping you?

_____

_____

_____

Please complete the symptom checklist on the next page

VII. Symptoms Checklists

Please check all the problems/symptoms which you have experienced:

Behavioral Issues
___ Aggression
___ Agitation
___ Animal abuse
___ Avoidance
___ Belligerence
___ Binge eating
___ Bullying
___ Compulsive
___ Defiant
___ Disinhibition
___ Exaggerated startle response
___ Fire setting
___ Hyperactivity
___ Hypervigilance
___ Impulsiveness
___ Isolative activities
___ Night walking
___ Overeating
___ Over-extending
___ Pleasure seeking
___ Purging
___ Refusing to eat
___ Risk taking
___ Task initiation
___ Thrill seeking
___ Withdrawing

Interpersonal Issues
___ Being misunderstood
___ Communication difficulties
___ Difficulty following directions
___ Fighting
___ Grandiosity
___ Lack of social resources
___ Low self-esteem
___ Sexual difficulties
___ Sexual disinterest
___ Social awareness difficulties
___ Social communication challenges
___ Social motivation issues

Physical Issues
___ Ambulation difficulties
___ Balance problems
___ Being overweight
___ Being underweight
___ Bumping into things
___ Dizziness
___ Excessive fatigue
___ Fine motor control difficulties
___ GI problems
___ Headaches
___ Increased heart rate/palpitations
___ Muscle weakness
___ Nausea/vomiting
___ Pain problems
___ Psychomotor retardation
___ Rapid breathing
___ Repetitive movements
___ Rocking
___ Sensory avoidance
___ Sensory sensitivity
___ Shortness of breath
___ Sleep too little
___ Sleep too much
___ Stomach aches
___ Sweating
___ Tics
___ Tremors
___ Weight gain
___ Weight loss
___ Visual disturbances

Chem. Dependency
___ Active Use
___ Cravings/Urges
___ Recently quit
___ Tolerance
___ Withdrawal symptoms

Consequences:
___ Academic
___ Health
___ Interpersonal
___ Legal

Emotional Issues
___ Anger issues
___ Anxious/Nervous
___ Apathy
___ Being easily annoyed
___ Boredom
___ Confused
___ Depression
___ Embarrassment
___ Feeling guilty
___ Feeling shame
___ Hard time coping
___ Helplessness
___ Hopelessness
___ Humiliation
___ Insecurity
___ Irritability
___ Loneliness
___ Panicky feelings
___ Powerlessness
___ Problems with jealousy
___ Sadness
___ Scared/fearful
___ Shy
___ Stressed
___ Worried

Safety/security
___ Agoraphobia
___ Being bullied
___ Being stalked
___ Being threatened
___ Having experienced trauma
___ Homicidal ideation
___ Previous suicide attempts
___ Self-harm: burning
___ Self-harm: cutting
___ Self-harm: head banging
___ Self-harm: scratching
___ Suicidal ideation

Cognitive Issues
___ Amnesia
___ Aphasia
___ Decision-making difficulties
___ Difficulty sustaining focus
___ Easily distracted
___ Irrational thinking
___ Loss of cognitive skills
___ Memory problems
___ Nightmares/night terrors
___ Obsessive thinking
___ Organizing difficulties
___ Poor judgement
___ Problem-solving difficulties
___ Racing thoughts
___ Rigidity
___ Sequencing problems
___ Tangential thinking
___ Tracking/attention problems

Family/Couples
___ Abusing others
___ Adoption difficulties
___ Arguing/fighting
___ Being abused
___ Divorce
___ Having an affair
___ Intimacy problems
___ Parenting problems
___ Partner infidelity
___ Separation or estrangement

Lighthouse Child & Family Services

Client Information and Consent Form

Client Name: _____ **DOB:** _____

Legal Guardian Name*: _____ **DOB:** _____

Address: _____

Home Phone: _____ **Cell Phone:** _____

Emergency Contact: _____ **Phone:** _____

***A copy of a divorce decree or other legal documents (i.e., custody agreements, restraining orders) may be requested by your provider or administrate staff as it may pertain to your child's mental health care. Please notify your provider or administrative staff of any court orders or legal documentation which may affect who has the right to consent for services for your minor child.**

Consent:

By signing this form, you are acknowledging the following agreements with Lighthouse Child and Family Services, Inc. (LCFS):

1. I have been offered and/or have received a copy of LCFS's office and financial policies as well as the Notice of Privacy Practices. I understand my rights, including those related to confidentiality and its limitations.
2. I agree to all LCFS office and billing policies and consent for treatment of myself or my minor child by Lighthouse Child & Family Services, Inc.
3. I authorize the release of any information, including medical and billing information, by LCFS to my referring doctor, insurance company, contracted billing company with LCFS, the responsible party named above, and immediate family on behalf of myself and/or dependents.
4. I authorize payment of medical benefits by my insurance company to LCFS for services rendered to myself and/or dependents. I understand it is my responsibility to notify LCFS if my insurance is no longer active, or changes.
5. (If applicable): I give consent for my minor child to receive therapeutic services in my presence or in my absence, at school or any other mutually agreed upon location.
6. If I am receiving services from a program that is partially funded by MN DHS, I consent for LCFS to share necessary data with DHS for reporting purposes.

Appointment Reminder by Text: I request to be notified of my upcoming appointments by text message. I agree to pay the standard text messaging rates for this service, if applicable. *Initial here* _____

Physician Release: Mental Health Professionals are required to attempt to coordinate services with primary care physicians. Please indicate which option:

___ I have no physician currently OR I do NOT authorize the release of information to/with a physician currently.

___ I authorize the release and exchange of clinical and/or medical information with my physician.

Health Care and Advance Psychiatric Directives (18 years and older): Do you have a Health Care Directive or an Advance Psychiatric Directive? Yes____ No____ If no, are you interested in receiving information regarding either? Yes____ No____

Medical Concerns: Do you have any medical concerns (including chronic or infectious diseases) of which we should be aware (influenza, seizure disorder, MRSA, tuberculosis, etc.)? Yes____ No____ If yes, please list: _____

X_____ X_____

Signature of Client/Legal Guardian Date

Please complete - for reporting purposes only:

1. Race: ☐White ☐Black/African Amer. ☐Amer. Indian ☐Alaskan Native ☐Asian ☐Other
2. Ethnicity: ☐Latino/Hispanic ☐Somali ☐Hmong/Loation ☐African ☐Other
3. Spoken Language: ☐ English ☐ Other _____

Lighthouse Child & Family Services

Office and Financial Policy Agreement

Thank you for choosing Lighthouse Child and Family Services, Inc. (LCFS) as your mental health care provider. The following is a statement of our Office and Financial policy. You will acknowledge your agreement to these policies on a separate signature page. This signature page will become a part of your health record. We are happy to discuss further questions or remaining concerns you may have now, or at any time in the future.

Mental Health Services: As a client of mental health services, you have certain rights and responsibilities which are important for you to understand. There are also legal limitations to those rights of which you should be aware. LCFS has corresponding responsibilities to you. These rights and responsibilities will be explained further in this document, as well as in our Client Bill of Rights and HIPAA Notice of Privacy Policy documents.

Benefits and Risks: Receiving mental health services may involve discussing unpleasant and difficult aspects of your life and/or challenge you or your minor child in new ways. This can sometimes lead to uncomfortable feelings such as sadness, anger, guilt and frustration. However, mental health services have been shown to have benefits such as better relationships, solutions to problems and decreased stress. There is no guarantee as to what will happen or what the outcome of your mental health services will be. Mental health services require a very active effort on your part. If you feel the services you are receiving are not benefiting you, you may address these concerns with your provider who will help you find alternative or additional services.

Confidentiality: Federal and state law, as well as ethical codes, protect the privacy of both your identity as a client of LCFS, and the information you share with us. LCFS providers may only disclose protected health information about you and/or your treatment to others when you sign a Release of Information form. You may revoke, in writing, such authorizations at any time. However, there are exceptions to confidentiality and times when your authorization is *not* required for us to disclose information. Below is a summary of those exceptions (for further information and detail, please refer to the HIPAA Notice of Privacy Practices document):

- When state law mandates the report of suspected abuse or neglect of a child or vulnerable adult, or prenatal exposure to drugs and alcohol.
- When failure to disclose the information presents a clear, present, and imminent danger to the health or safety of any individual (including, but not limited to, the threat of suicide or homicide).
- When the courts or other regulatory agencies subpoena records, or when disclosure is required by federal, state, or local law (i.e., lawsuits, legal action, workers compensation claims).

- When LCFS is operating within their daily organization needs; billing for service, insurance claims, quality assurance, determining eligibility, improvement activities, business related activities, appointment reminders, etc.
- When your mental health services psychotherapist presents the case in consultation with other professionals, supervisors, or consultants, who are also bound by the legal framework of confidentiality, for professional development and guidance purposes. Your mental health services psychotherapist will *not* reveal personal details which could identify you during consultation with other professionals.

Mental Health Services with Minors: Parents have the right to access their minor child's records. If a mental health provider feels harm may come from records being released, your provider may withhold the information which could cause harm. All minor clients under the age of eighteen (except when the minor is married, living apart from their parents and providing for their own financial needs, or has given birth to a child) must have consent of their parent(s)/guardian(s) to receive on-going mental health services.

Records: LCFS maintains all records related to your treatment by electronic means on a secure server maintained by Procentive, Inc. Each treatment record for a client must minimally contain: intake forms, history, evaluations and assessments, diagnosis and case formulation, treatment plans, progress notes, discharge summaries, record of non-trivial phone calls with you or about you, legal forms, and financial records.

Except in unusual circumstances which involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, LCFS recommends you initially review them with your mental health provider. You may be charged an appropriate fee for requests of personal records. You have the right to request your record be amended to add information to make it more accurate or complete. LCFS may not release records obtained from another agency.

Termination: You have the right to end services at any time, for any reason. We encourage you to call and schedule a final session with your provider. There are times when LCFS may discharge you from services. These situations include:

- If you have excessive no-show appointments or cancelled appointments without 24-hour notice.
- If you have not scheduled or attended appointments for 90 or more days.
- If your provider believes there to be a conflict of interest, it becomes medically necessary for you to be referred to a higher level of care, or you are no longer benefitting from the therapeutic relationship.
- You are a safety risk to agency staff or other clients.
- You have not followed through on the financial agreements described below.

Upon termination, LCFS will provide you with viable alternatives to seek treatment from another qualified mental health service provider when required by professional standards or requested by you.

Appointments: LCFS requires 24-hour notice to cancel an appointment. At the discretion of LCFS, your services may be discontinued due to excessive failed appointments or late cancels. LCFS considers three 'no show' or 'late cancel' appointments excessive. Any exceptions to this policy may be discussed directly with your provider.

Insurance: As a service to our clients, LCFS will submit claims to your insurance provider on your behalf. It is your responsibility to inform LCFS of all insurance policies in effect and of any changes to your insurance coverage, after you start services.

Payments: All copays are due at the time of service. Co-insurance and deductibles are due upon receipt of statement. We accept cash, check debit or credit cards (Mastercard and VISA, only).

Arrangements may be made, when necessary, for clients to carry a balance on their account. Clients with questions regarding their balance, or who state they are unable to pay their current per session fee, will be referred to the Billing Specialist for a payment plan to be agreed upon. Failure to make agreed upon payments may result in the suspension or termination of services.

Active client accounts with a balance over $200 will be reviewed on a monthly basis by the Billing Department. Any client with a balance over $200 will be asked to make a payment or may have services suspended or terminated. Discussions regarding these accounts may be held with client and/or clinical staff as appropriate.

In divorce and/or custodial situations the parent who brings the minor child in for services will be responsible for all payments. Court ordered financial arrangements must be worked out between the parents of the children.

Sliding Fee Scale: Clients without health insurance may apply for the Sliding Fee Scale program. Those who wish to apply for the Sliding Fee Scale program will be required to provide specific documentation as requested to establish eligibility for qualifying prior to their first appointment. Appointments may be delayed until documentation requirements are met.

Clients using a sliding fee will be required to re-establish their eligibility bi-annually or whenever they have a significant change in their financial circumstances.

Collections: Lighthouse reserves the right to employ a collections agency for overdue balances. In the event this occurs, services will be suspended.

Emergency Services/Crisis: Apart from certain programs, LCFS providers are not available outside their normal working hours. In the event of a mental health crisis or emergency, please call 911, the East Central MN Crisis Help Line at 1-800-523-3333 or text MN to 741741.

Communication: Face -to-face communication is always most effective and the most confidential way to communicate with your LCFS provider. It provides opportunity for less confusion, misunderstandings, and clarity in the moment, rather than waiting for a response via other forms of communication. It also is the most HIPAA compliant way for providers and clients to communicate. However, we recognize not all things can wait until the next face-to-face opportunity, to be communicated. Phone calls are the next best thing to face-to-face conversation. Emails and texts are convenient, however, LCFS cannot assure the confidentiality of that message. If you chose to communicate to your LCFS team via email or text, we want you to be aware of the risks involved and we encourage you to limit the content of those conversations.

Risks include, but are not limited to:

- Unencrypted email is not secure and may be breached by a third party
- Senders may easily misaddress emails/texts and send information to the wrong recipient
- Backup copies of emails/texts may exist, even after they have been deleted
- Emails/texts may be intercepted, altered, forwarded, or used without authorization or detection
- Emails/texts may be used as evidence in court
- Emails/texts may become part of the client's clinical record
- Emails/texts are not always reliable and sent or received accurately or in a timely manner
- If emails/texts are on a mobile device, others may have access if stolen, lost, or inappropriately discarded

Please let your provider know if you chose to NOT communicate via text or email.

Court Proceedings: It is generally not the expertise of LCFS staff to participate in legal proceedings, particularly in making recommendations regarding custody of children. However, if legal action occurs when you or someone else requires your provider's participation in court proceedings, LCFS charges $150 per hour, for all time spent to meet obligations, including but not limited to personal preparation, professional consultation, preparation of documentation, attendance at any legal proceeding, etc. For more information regarding LCFS's policy on staff testifying in court proceedings, please ask your provider.

Consultation: The mental health providers at LCFS meet regularly for clinical consultation and supervision. Information about clients may be disclosed in consultation and/or supervision with other LCFS mental health providers to provide you with the best possible treatment.

PATIENT HEALTH QUESTIONNAIRE-9
(PHQ-9)

Patient Name: _____ **Date:** _____

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**
⑤	⑤	⑤	⑤

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than 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 is 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

(*For office coding: Total Score T*____ = ____ + ____ + ____)