150 10th St NW, Suite 2, Milaca, MN 56353
P: 320-983-2335 | F: 651-342-8029
www.lighthousecfs.com

CHILD INTAKE PACKET

Complete and return the following documents to Lighthouse Child & Family Services (LCFS):

- Client Information and Consent Form
- Child Client Information Form

The policies and procedures within this packet (listed below) are for your records and do not need to be Returned to LCFS. It is your responsibility to review the documents and contact LCFS with any questions you may have.

- Client Bill of Rights and Grievance Policy
- Office and Financial Policy Agreement
- Notice of Privacy Practices

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CLIENT INFORMATION AND CONSENT

Client Legal Name: _____ DOB: _____

Preferred Name: _____

Legal Guardian Name*: _____ DOB: _____

Street Address: _____ City/State: _____ ZIP: _____

Phone: _____ Email: _____

Emergency Contact Name: _____ 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 whoever 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, Notice of Privacy Practices, Bill of Rights and Grievance Procedures. 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 LCFS.
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 I understand it is my responsibility to notify LCFS if my insurance changes or is no longer active.
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.
7. I give my informed consent to participate in the use of telehealth services for treatment. With my signature, I consent to engaging in telehealth mental health services, when needed and appropriate.

Day Treatment Program Only: I confirm I have received and reviewed the Day Treatment Program Manual and understand and agree with the policies, procedures and conduct of behavior expected of me as a parent/guardian and of my child in the Day Treatment Program. *Initial here* _____

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 (PCP). Please indicate an option:

___ I have no current PCP OR I do NOT currently authorize the release of information to/with my PCP.
___ I authorize the release/exchange of clinical and/or medical information with my PCP. ROI(s) will be completed at my appointment(s).

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, COVID etc.)? Yes____ No____ If yes, please list: _____

Please complete (for reporting purposes only):

Race: ☐ White ☐ Black/African Amer. ☐ Amer. Indian/Alaska Native ☐ Asian ☐ Other
Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Both Hispanic and Non-Hispanic
Spoken Language: ☐ English ☐ Other: _____

X_____ X_____
SIGNATURE OF CLIENT/LEGAL GUARDIAN **DATE**

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CHILD INFORMATION FORM

GENERAL INFORMATION

Child's Full Legal Name: _____ Preferred Name: _____

DOB: _____/_____/_____ Age: _____ Sex: _____

Referred to LCFS by: _____

Mother's Name: _____ Phone Number: _____

Father's Name: _____ Phone Number: _____

Parental Relationship Status: ☐ Married ☐ Separated ☐ Divorced ☐ Never Married

Parental/Child Relationship:
☐ Biological
☐ Step
☐ Adoptive – Child adopted at age: _____
☐ Foster – Child in Foster Care since: _____

Additional Parents Names and Phone Numbers (include stepparents, foster parents, etc.):

_____

_____

Primary reason(s) you are concerned about your child:

_____

_____

What are your child's strong points? _____

What are your child's hobbies? _____

Please provide the following family information regarding your child's brothers and sisters (include all pregnancies, adoptions, and foster siblings and use a separate sheet of paper if necessary):

First/Last Name	Sex	Age	Relationship to child (full, step, half, foster)	Child-Sibling Relationship (positive, neutral, negative)
1.				
2.				
3.				
4.				

Custody and/or visitation concerns (if applicable):

_____

_____

Describe your family dynamics (i.e., the family is loud and interactive, quiet and more reserved, enjoys outdoor activities, etc.):

_____

_____

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

_____

MENTAL HEALTH HISTORY

Does the child have immediate or extended family with a history of mental illness or substance use?

☐ Yes ☐ No If yes, please explain: _____

Is there a history of suicide in your family?

☐ Yes ☐ No If yes, what family member in relation to your child? _____

Any previous psychological or psychiatric treatment?

☐ Yes ☐ No If yes, with whom, where and when: _____

Any previous testing (school/psychological)?

☐ Yes ☐ No If yes, with whom, where and when: _____

List any medications previously used for emotional problems and if they seemed helpful or not: _____

_____

TRAUMA HISTORY

Has your child experienced any of the following? If checked, please give dates and more details on the lines below.

☐ Abuse – Emotional/Verbal
☐ Abuse – Physical
☐ Abuse – Sexual
☐ Accident/Serious Injury
☐ Death or Loss of a Parent
☐ Death or Loss of Someone Very Close
☐ Death or Loss of a Pet
☐ Frightening Experience
☐ Legal Difficulties
☐ Parental Separation/Divorce
☐ Prolonged Separation from a Parent
☐ Witness to Domestic Violence

If checked, please provide details/dates:

_____

_____

MEDICAL HISTORY

Name and city of child's physician/medical group: _____

Last appointment with physician: _____/_____/_____

Date of last physical: _____/_____/_____

Does your child have a history of serious illness, injuries, handicaps, or hospitalizations?

☐ Yes ☐ No If yes, please explain: _____

Does your child have any infectious diseases?

☐ Yes ☐ No If yes, list disease and medical precautions taken: _____

Are there any major medical conditions in the child's immediate family?

☐ Yes ☐ No If yes, list the condition and the relationship of the family member to the child: _____

_____

Please list all prescribed medications your child is currently taking including vitamins, minerals, herbal remedies, and its purpose:

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

Please list any known allergies: _____

Has your child ever had or been diagnosed with any of the following?

☐ Arthritis	☐ Chronic Pain	☐ Infection Disease	☐ Premenstrual Syndrome
☐ Asthma	☐ Diabetes	☐ Low Blood Pressure	☐ Seizures
☐ Attention Deficit Disorder	☐ Eating Disorder	☐ Lyme Disease	☐ Stomach Aches
☐ Autism	☐ Fibromyalgia	☐ Menopause	☐ Thyroid Problems
☐ Brain Injury	☐ Gastrointestinal Problems	☐ Muscle Tension	☐ Ulcers
☐ Breathing Problems	☐ Headaches/Migraines	☐ Neurological Problems	☐ Other: _____
☐ Cancer, type: _____	☐ Heart Problems	☐ Numbness	
☐ Chronic Fatigue Syndrome	☐ High Blood Pressure	☐ Pain in Chest	
	☐ High Cholesterol	☐ Postpartum Depression	

If checked, please provide details/dates: _____
_____
_____

DEVELOPMENTAL ISSUES *(during pregnancy, the child's birth and early infancy)*

1. During Pregnancy

Length of Pregnancy:	_____ Months	
Was the pregnancy planned?	☐ Yes ☐ No	
Was there bleeding?	☐ Yes ☐ No	
Did you have Pre-eclampsia?	☐ Yes ☐ No	
Were you on any medications?	☐ Yes ☐ No	If yes, please list: _____
Were you injured/hurt?	☐ Yes ☐ No	If yes, please explain: _____
Did you gain less than 15 pounds?	☐ Yes ☐ No	
Did you take any narcotic/street drugs?	☐ Yes ☐ No	
Did you drink alcohol?	☐ Yes ☐ No	If yes, how much: _____
Did you smoke?	☐ Yes ☐ No	If yes, how much: _____
Did you have any infection(s)?	☐ Yes ☐ No	If yes, please explain: _____
Did you experience any Trauma?	☐ Yes ☐ No	If yes, please explain (loss of housing, domestic violence, etc.): _____

2. During the Child's Birth/Early Infancy

Was the baby born prematurely?	☐ Yes ☐ No	If yes, at how many weeks: _____
Was the ambilocal cord wrapped around the baby's neck?	☐ Yes ☐ No	
Did an injury occur during birth?	☐ Yes ☐ No	If yes, please explain: _____
Did the baby turn blue (Cyanosis)?	☐ Yes ☐ No	
Was the baby a twin/triplet/etc.?	☐ Yes ☐ No	
Did the baby have any infection(s)?	☐ Yes ☐ No	If yes, please explain: _____
Did the baby have seizures?	☐ Yes ☐ No	
Did the baby need oxygen?	☐ Yes ☐ No	
Was the baby very jittery?	☐ Yes ☐ No	

SUBSTANCE USE HISTORY

Does the client currently use or have a history of chemical use (including tobacco)? ☐ Yes ☐ No

Is there a history of drug/alcohol use on either side of the family? ☐ Yes ☐ No

SCHOOL HISTORY

Current School: _____

Grade: _____

Has your child ever repeated a grade? ☐ Yes ☐ No If yes, which grade(s): _____

Do you have attendance concerns? ☐ Yes ☐ No

Do you have concerns about your child's grades? ☐ Yes ☐ No

What grades to they generally receive? (circle) A B C D F

Does your child receive Special Education services? ☐ Yes, they qualify by: _____

☐ No, they have not been tested/determined to need services

☐ No, they have been tested and determined not to need services

Last tested (month/year): _____

Do you have concerns about any other academic or general problems your child has in school? ☐ Yes ☐ No If yes, please list: _____

CHILD CARE HISTORY

Is your child currently in a childcare setting? ☐ Yes ☐ No

Have they been involved in multiple settings? ☐ Yes ☐ No If yes, how many total? _____

Have there been any issues at any of the settings? ☐ Yes ☐ No If yes, please explain: _____

_____

FAITH/SPIRITUALITY HISTORY

If applicable, please briefly describe your spiritual/faith background and its importance in your life: _____

_____

SYMPTOM/PROBLEM CHECKLIST

Check all symptoms your child is experiencing that are a concern to you.

1. Behavioral Issues

☐ Aggression
☐ Agitation
☐ Animal Abuse
☐ Avoidance
☐ Belligerence
☐ Binge Eating
☐ Bullying
☐ Compulsiveness
☐ Defiance
☐ Disinhibition
☐ Exaggerated Startle Response
☐ Fire Setting
☐ Hyperactivity
☐ Hypervigilance
☐ Impulsiveness
☐ Isolative Activities
☐ Night Walking
☐ Over-extending
☐ Pleasure Seeking
☐ Purging
☐ Refusing to Eat
☐ Task Initiation
☐ Thrill Seeking
☐ Withdrawing

2. Cognitive Issues

☐ Amnesia
☐ Aphasia
☐ Difficulty Making Decisions
☐ Difficulty Focusing
☐ Difficulty Organizing
☐ Difficulty Problem-solving
☐ Easily Distracted
☐ Irrational Thinking
☐ Loss of Cognitive Skills
☐ Memory Problems
☐ Nightmares/terrors
☐ Obsessive Thinking
☐ Poor Judgement
☐ Racing Thoughts
☐ Rigidity
☐ Sequencing Problems
☐ Tangential Thinking
☐ Tracking/Attention Problems

3. Emotional Issues

☐ Anger Issues
☐ Anxious/Nervous
☐ Apathy
☐ Boredom
☐ Confusion
☐ Depression
☐ Difficulty Coping
☐ Easily Annoyed
☐ Embarrassment
☐ Feeling Guilty
☐ Feeling Shame
☐ Helplessness
☐ Hopelessness
☐ Humiliation
☐ Insecurities
☐ Irritability Loneliness
☐ Jealousy Problems
☐ Panicky Feelings
☐ Powerlessness
☐ Sadness
☐ Scared/Fearful
☐ Shy
☐ Stressed
☐ Worried

4. Family/Couple Issues

☐ Abusing Others
☐ Adoption Difficulties
☐ Arguing/Fighting
☐ Being Abused
☐ Divorce
☐ Having an affair
☐ Intimacy Problems
☐ Parenting Problems
☐ Partner Infidelity
☐ Separation or Estrangement

5. Interpersonal Issues

☐ Being Misunderstood
☐ Difficulty Communicating
☐ 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

6. Physical Issues

☐ Ambulation Difficulties
☐ Balance Problems
☐ Being Overweight
☐ Being Underweight
☐ Bumping Into Things
☐ Dizziness
☐ Excessive Fatigue
☐ Excessive Sweating
☐ Fine Motor Control Difficulties
☐ Gastrointestinal Problems
☐ Headaches/Migraines
☐ Heart Problems
☐ Muscle Weakness
☐ Nausea/Vomiting
☐ Psychomotor Retardation
☐ Rapid Breathing
☐ Repetitive Movements
☐ Rocking
☐ Sensory Avoidance
☐ Sensory Sensitivity
☐ Shortness of Breath
☐ Sleeping too little
☐ Sleeping too much
☐ Stomach Aches
☐ Tremors
☐ Weight Gain
☐ Weight Loss
☐ Visual Disturbances

7. Safety/Security Issues

☐ Agoraphobia
☐ Being Bullied
☐ Being Stalked
☐ Being Threatened
☐ Homicidal Ideation
☐ Previous Suicide Attempts
☐ Self-harm: Burning
☐ Self-harm: Cutting
☐ Self-harm: Head Banging
☐ Self-Harm: Scratching
☐ Suicidal Ideation
☐ Trauma Experience

8. Substance Use Issues

☐ Active Use
☐ Cravings/Urges
☐ Recently Quite
☐ Tolerance
☐ Withdrawal Symptoms

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CLIENT BILL OF RIGHTS

1. Patients have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.
2. Patients shall have or be given, in writing, the name, business address, telephone number, and specialty, of any provider responsible for coordination of their care. In cases where it is medically inadvisable, as documented by the provider in a patient's care record, the information shall be given to the patient's guardian or other person designated by the patient as his or her representative.
3. Patients shall be given, by their provider, complete and current information concerning their diagnosis, treatment, alternatives, risks and prognosis as required by the provider's legal duty to disclose. This information shall be in terms and language the patients can reasonably be expected to understand. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the provider, the information shall be given to the patient's guardian or other person designated by the patient as his or her representative. Individuals have the right to refuse this information.
4. Patients shall have the right to be cared for with reasonable regularity and continuity of staff assignment as far as facility policy allows.
5. Patients have the right to be informed and active participants in all decisions and treatment planning concerning their mental health needs.
6. Patients have the right to refuse treatments or participation in research and/or training procedures.
7. Patients shall be free from maltreatment, nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a patients' physician for a specified and limited period of time, and only when necessary to protect the patient from self-injury or injury to others.
8. Patients have the right 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.
9. Patients shall have the right to a prompt and reasonable response to their questions and requests.
10. No patient shall be required to perform services for the facility that are not included for therapeutic services in their plan of care.
11. Every patient may associate and communicate privately with the person of their choice as it relates to rights protection or advocacy services.
12. Patients have the right 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.
13. Patients have the right to examine public records maintained by MN professional boards which contain the credentials of a mental health professional.
14. Patients have the right to obtain a copy of the code of ethics which guides your provider's professional conduct from the State Register and Public Documents Division, Department of Administration, 117 University Avenue, Saint Paul, MN 55155.
15. Patients have the right to be informed of the cost of professional services before receiving the services.
16. Patients have the right to be free from being the object of discrimination based on age, race, color, creed, religion, national origin, sex, gender identity, marital status, disability, sexual orientation, ability to pay for health care services, status regarding public assistance, or because payment for services would be made under Medicare, Medicaid or the Children's Health Insurance Program (CHIP).
17. Patients have the right to have access to their records as provided in Minnesota Statutes, section 144.292.
18. Patients have the right to be free from exploitation for the benefit or advantage of a provider.
19. Patients have the right to be informed prior to a photograph or audio or video recording being made of them. The patient has the right to refuse to allow any recording or photograph that is not for the purposes of identification or supervision by the agency.
20. Every patient has the right to present a grievance to appropriate clinic staff in writing, orally, or by any alternative method by which the patient communicates. The staff shall attempt to resolve the grievance at the time it is presented according to the grievance procedure.

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GRIEVANCE AND COMPLAINT PROCEDURE

1. Clients, former clients, and their authorized representatives are allowed to submit a grievance to Lighthouse Child & Family Services (LCFS).
2. Grievances may be filed by completing the grievance form or reporting the grievance orally or in an email.
3. Within three business days, LCFS will acknowledge in writing that the agency received the grievance.
4. The Grievance will be forwarded to the involved staff member and their direct supervisor.
5. If the issue cannot be resolved, the grievance will be forwarded to the Clinical Director.
6. If the issue cannot be resolved with the Clinical Director, the grievance will be forwarded to the Executive Director.
7. LCFS will provide a written response within 15 business days of receiving the client's grievance and provide a written final response to the client's grievance containing an official response to the grievance.
8. Clients are allowed to bring a grievance to the person with the highest level of authority in the program.
    a. Executive Director: Julie Hanenburg, MSW, LICSW (320)983-8009.
9. At any time, clients are allowed to contact any of the entities listed below to file a complaint.

<u>Current Public Contact Information</u>

MN Department of Human Services; Licensing Division
651-431-6500

Office of Ombundsman for Mental Health and Developmental Disabilities
651-757-1800 or 1-800-657-3506 or ombudsman.mhdd@state.mn.us

Department of Health, Office of Health Facility Complaints
651-201-4200 or health.ohfc-complaints@state.mn.us.

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; (612)617-2220
b. Minnesota Board of Social Work, University Park Plaza Building, 2829 University Ave SE, Suite 340, Minneapolis, MN 55414; (612) 617-2100
c. Minnesota Board of Behavioral Health & Therapy, University Park Plaza Building, 2829 University Ave SE, Suite 210, Minneapolis, MN 55414; (612) 617-2178

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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 from our Office and Financial policy. You will acknowledge your agreement to these policies on a separate signature page. That 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 (Health Insurance Portability & Accountability Act) 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 may sometimes lead to uncomfortable feelings such as sadness, anger, guilt, or 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 service.

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 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 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 the program you are involved in is partially funded by the MN Department of Human Services (SLBH, Early Childhood) your demographic information may be shared with the MN Department of Human Services.
- When your mental health service provider 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 service provider will *not* reveal personal details which could identify you during consultation with other professionals.

LCFS does not allow video and/or audio recording of in person or telehealth sessions, without the written consent of the provider and the client.

Mental Health Services with Minors: Parents have the right to access their minor child's records unless the minor legally consents to their own services, as outlined below. If a mental health provider feels harm may come to a client with a record being released, said provider may withhold the information in question. All minor clients under the age of sixteen (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.

Minor Consent to Treatment: In addition to the above circumstances, a minor 16 or older may consent to outpatient (nonresidential) mental health services without parental consent. If a minor represents to a health professional that the minor can give effective consent for mental health treatment but is in fact not able to do so, the minor's consent is effective if relied upon in good faith by the agency. A minor who consents to their own mental health services is financially responsible for the cost of the services. A minor consenting to services billed under their parent's insurance coverage must give LCFS consent to communicate with parents regarding billing. When a minor legally consents to their own services, parents or guardians do not have access to the minor's health records without the minor's authorization. However, a health professional may inform a minor's parent or guardian of treatment if, in the professional's judgment, failure to inform the parent or guardian would seriously jeopardize the minor's health.

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 or others, you have the right to access these records. All requests for records should be in writing to our Medical Records Specialist. 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 have the right to request your record be amended to add information to make it more accurate or complete. LCFS will 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 benefiting from the therapeutic relationship.
- You are a safety risk to agency staff or other clients.
- You have not followed through on the financial requirements 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. Your services may be discontinued, or you may be restricted from scheduling further services at LCFS, 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, VISA and Discover). 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 Business Manager 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 monthly by the Business Manager. 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 unable to pay for services 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: LCFS reserves the right to employ a collections agency for overdue balances. In the event this occurs, services will be suspended. Sliding Fee Scale clients are not subject to collections.

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 or 988, the East Central MN Crisis Help Line at 1-800-523-3333 or text MN to 741741.

Communication: Face-to-face communication is the most effective and 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 choose to communicate with 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 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 $250 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.

Telehealth Services: LCFS offers mental health services via telehealth. LCFS's telehealth services use HIPAA compliant software, which allows direct audio and visual communication over individual computers. LCFS recognizes that telehealth can be an effective model of service provision for many situations; however, there are some circumstances where telehealth is not an appropriate way to receive services. LCFS reserves the right to decide not to offer and/or to discontinue services via video conferencing. When engaging in telehealth services, you agree to the following:

- I agree to download the HIPAA compliant video conferencing software onto my computer or phone when necessary.
- I agree to provide names of emergency contacts, with whom my provider has my permission to communicate in the event my provider has concerns for my immediate safety.
- I understand that internet connectivity is beyond the control of the provider, and that in the event of connectivity failure, the provider will respond with the established protocol.
- I understand that the provider will be in a private location and will be the only person accessing the information on the computer. If necessary, a language interpreter may also be present.
- I understand and agree that I (we) will be in a private location and only the identified clients will be in the room accessing the information on the computer. (When necessary, a language interpreter may also be present.)
- I understand and agree that my insurance provider will be billed by LCFS for the services provided using telehealth.
- I understand and agree that my provider may make the decision to discontinue telehealth services if they determine that mental health services via telehealth are no longer an effective model.

Symptoms/Sickness: LCFS is committed to maintaining the health and safety of our clients, staff, and communities. LCFS reserves the right to refuse services to any person who presents to an appointment with symptoms that may indicate a transmittable LCFS clients are expected to notify their provider if they have any communicable disease which may be transmitted to other LCFS clients or staff.

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P: 320-983-2335 | F: 651-342-8029
www.lighthousecfs.com

NOTICE OF PRIVACY PRACTICES

As required by the Health Insurance Portability and Accountability Act (HIPAA) and the Minnesota Data Privacy Act

Lighthouse Child & Family Services, Inc. (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 its clients with 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* will refer to this Notice of Privacy Practices.

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 receive in the future. We will provide you with an updated Notice when you request one. We will also post the most current Notice on our website.

Data Privacy

Why we ask for information – We ask you for information to assist us in determining which 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 choose not to give us information, it may limit our ability to serve you. If you are seeking services because of a court order, and you refuse to provide us with information, that refusal may be communicated to the court.

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 any time. If you have received an electronic copy of this notice, you are still entitled to a paper copy. This notice may be picked up from our office, printed from our website or you may 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 the restriction(s) you want and to whom you want them to apply. 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 receive copies of your PHI if we maintain the information. You must make your request in writing. LCFS has the right to deny your request. If your request is denied, you may ask LCFS to review the denial.

Request amendment – If you feel that your PHI is incorrect or incomplete, you may ask us to amend it. You must make this request in writing, and it must contain which specific information you would like amended and your 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 may ask that we only call you on your cell phone or send your mail to a specific address. These requests must be made in writing. We will accommodate all reasonable requests.

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 notify 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.

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 may 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 may file a complaint with:

Compliance Officer
Lighthouse Child & Family Services
150 10th St NW, Suite 2
Milaca, MN 56353

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