Elaine Johnson, MA, LP, LADC
2055 White Bear Ave.
Maplewood, MN 55109

Intake Information

Client Name: ______________________________ DX Code: __________________

Client Address: ____
City/State Zip Code

Phone Numbers - Please circle preferred # to call.

Home: ________________Work: __________________Cell: __________________

Please circle if we can leave a message there? Yes No

Social Security Number: ____________________ D.O.B.__________________

Insurance Company: ____

Subscriber Name & Their DOB: ____

Group #: _____________________ID# : ____________________________________

Relationship to subscriber: ______________ Employer: ________________________

I hereby verify that all information supplied above is current and accurate.

____
Signature Date

Elaine K. Johnson, MA, LP, LADC
2055 White Bear Avenue, Suite A
Maplewood, MN 55109
651-209-0560 Ext. 3 * Fax 651-770-8018

Informed Consent for Confidentiality

If anyone requests information about me, Elaine K. Johnson will not give it unless and until I have signed a separate written authorization for her to do so. Ms. Johnson will not discuss anything about me with anyone without my written permission, except as noted below:

A. If I use insurance benefits, Elaine K. Johnson cannot guarantee confidentiality from the insurance company.
B. If Elaine K. Johnson learns that I have abused a child, a spouse, or a vulnerable adult (or if I am a child, spouse, or vulnerable adult and report having been recently abused), she must report it to the proper authority.
C. If Elaine K. Johnson has good reason to believe that I intend to physically harm myself or someone else, she will discuss it with me and may be required to warn that person or persons (the Tarasoff duty), or to take steps to prevent such harm.
D. If Elaine K. Johnson has good reason to believe that I may be a danger to myself, she will contact at least one concerned person and/or take steps to prevent such harm.
E. If I give permission to release my records to a legal representative of my choice, these records could become discoverable by other legal representatives. If subpoenaed by the courts to release your records, we may have to do so.
F. Elaine K. Johnson may discuss my case with outside professional case consultation groups. Identifying information (such as full name) will not be shared without written permission.

All non-emancipating minor clients under the age of 18 years of age must have the consent of their parents following an initial intake session to receive further treatment services. All minors have the right to request that their records be withheld from their parents. No information will be provided to parents of minors without the knowledge of the client.

My signature indicates that I have read, discussed, and understand this information.

____

Client's Signature Date

____

Parent/Guardian Signature Date

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, ______________________, understand that as part of my health care, Elaine Johnson, MA, LP, LADC, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Elaine Johnson, MA, LP, LADC, is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Elaine Johnson, MA, LP, LADC, reserves the right to change her notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Elaine Johnson, MA, LP, LADC, change her notice, she will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

____
____
____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

______________________________ ______________________________
Patient's Signature Date

FOR OFFICE USE ONLY

[ ] Consent received by ______________________________ on ____________________.
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on ____________________.

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Release Form

Ins. Comp.: ______________________ (please attach copy of card)

Please list any additional insurance coverage: ______________________

____

Payment of Account and Insurance Release

Name of Responsible Party: ______________________________

Contact Telephone Number: ______________________________

Can we leave a message at this number? Yes No

I hereby authorize Elaine Johnson, MA, LP, LADC, to furnish the above named Insurance Company all information that said insurance company, may request concerning my present condition/illness.

I hereby assign to Elaine Johnson, MA, LP, LADC, insurance proceeds to be credited against total fee for service due on my account and will pay my portion of charges incurred as indicated by my insurance company.

____

Signature Date

Elaine K. Johnson, MA, LP, LADC
2055 White Bear Avenue, Suite A
Maplewood, MN 55109
651-209-0560 Ext. 3
Fax: 651-770-8018

Payment Agreement

I understand that I am responsible to pay the co-pay for services received each time that I attend a session at the clinic.

I further understand that canceled appointments require at least 24 hours notice. In the case of a cancellation without 24 hour notice, a missed appointment or a late arrival, I may be charged for a full session. Insurance companies or public assistance funds will not pay for appointments that are canceled or missed.

The agreed upon fee for clinical services is as follows:

50 Minute Sessions: $150.00

75 Minute Sessions: $225.00

Group Sessions: $75.00

I understand and agree to the above conditions:

____

Client/Parent/Guardian Signature Date