Client Rights Brochure

Welcome to Headway Emotional Health Services. We are pleased you have chosen us for your care. Our staff is committed to working with you in a sensitive, private, and professional manner.

Headway Emotional Health Services is a private, nonprofit organization that is licensed to provide both mental health and chemical health care to adults, children, and families. In addition we provide community support services.

Privacy and Confidentiality

Headway Emotional Health is committed to providing high quality, professional care. As such we value the privacy of our clients.

The information you provide to us, or that we obtain per your written permission will be used by Headway Emotional Health's employees and contractors to assist in providing your care. The information will help determine your eligibility to participate in our programs, to provide you therapy or other services, to coordinate services with other professionals, or for related administrative purposes. The information you share will likely be documented in our client records. Our use of this information may include sharing it with Headway's Board of Directors or with business associates who we retain to provide services such as supervision, consultation, legal review, or quality assurance activities.

Unless ordered by a court to do so, you are not required to provide the information that we ask of you or on our forms. If you choose not to provide this information, however, we may not be able to provide appropriate services to you. Also, you may become ineligible for financial assistance or to receive services.

Any disclosure of information about you is limited to those disclosures that are permitted or required under state and federal law, as described in our Notice of Privacy Practices. In addition, we often need to share information with third party payers, including insurance companies or county agencies, in order to maintain your eligibility for services. We believe it is important that you are aware that there are exceptions to when we are required by law to provide information without your written permission. These include, but are not limited to:

- Risk of harm to self or others
- Suspected child abuse or neglect that has occurred within the last three years
- Suspected abuse or neglect of vulnerable adults
- Court orders or Minnesota state laws
- Collection agencies—limited to demographics and treatment time frame

Your Rights

You have the right to courteous and respectful treatment, as well as appropriate care based on your needs. All professionals from whom you will receive care are licensed by a professional board. Licensed staff includes psychiatrists, therapists, counselors, and nurses.

You have the right to:

- Obtain the rules of professional conduct governing the professional practice of a licensed staff member
- Review the public records that the professional board maintains
- File a complaint with the Professional Board

To pursue your rights concerning the practice of a professional, contact the respective board of the licensed provider from whom you receive care. A listing of the Professional Boards and their telephone numbers can be found at the end of this document.

For copies of official documents governing the various programs of Headway Emotional Health, you may contact: Public Documents Division, Minnesota Department of Administration, 666 Olive Street St. Paul, MN 55155 or (651) 297-3000.

You have the right to expect that the professional working with you has met the minimal qualifications of training and experience required by state law. Also you have the right, upon request, to be informed of the professional's education, training, and experience.

You have the right to receive complete and current information about your treatment, including information concerning diagnosis, treatment, and progress, in plain language, so that you can consider your options and make informed decisions. This includes being informed of the most common risks and treatment options, including prescribed medications and their purpose, possible side effects, and an alternative to medication.

You also have the right to participate in the design of your treatment plan. If your care involves testing, you have the right to a brief summary of the results. Reasonable accommodations will be made for those clients who cannot read, or who have communication impairments, and for those who do not read or speak English. Headway Emotional Health will also respect your right to privacy and individuality around your social, religious, and psychological well being.

You have a right to information about the costs and anticipated length of your care, before beginning treatment. You have a right to reasonable notice of changes in services or charges. You have a right to information on fees, the method of billing, insurance coverage, and information about adjusted fees.

You have the right to refuse or terminate care for treatment. Clients who are court-ordered may face consequences imposed by the court for failure to complete treatment. You also have the right to request a different professional within the limits of our agencies, clinical practices, health insurance, medical assistance, or other payment programs or agreement. You have the right to a coordinated transfer of care.

You have the right to a referral if you need mental health services that we cannot provide. We will also make a referral when you ask us to do so. Upon request we will provide you information on or about available health and social services within the community.

You have the right to review your medical record. HIPAA laws (see Notice of Privacy Practices) provide that a therapist may restrict your access to the records (believing it is in your best interest). You may receive copies of your medical records unless restricted by your therapist. MN Statutes Section 144.335.

You have the right to treatment free of discrimination. We will not discriminate against you based on age, sex, creed, marital status, national origin, disability, sexual preference, or public assistance status.

You have the right to a timely response to requests. You have the right to obtain information as to any relationship Headway or its employees have with other health care or related institutions, as it relates to your care. You have the right to expect reasonable access to care, which includes staff availability to schedule appointments and as need arises. You may assert your rights without retaliation.

If you have questions about your rights, please ask your therapist.

Rights of Minors

In providing services to minors (under age 18), Headway Emotional Health encourages and supports the involvement of the minor's parent(s) or guardians in their care.

A minor's right to make decisions and to confidentiality of her/his health information will be different depending on whether the minor is emancipated. You will be considered emancipated if you are:

- Financially independent of your parent or guardian as well as living separately from a parent or guardian; or
- You are married; or
- If you have borne a child

Emancipated Minors

- You have the right to authorize who does or does not have access to your medical records, except in the circumstances noted in the previous section on Privacy and Confidentiality. You will be responsible for the payment for your services.
- We will notify your parents and share information when we determine that the failure to notify your parents would seriously jeopardize your health.

Non-Emancipated Minors may receive care without the knowledge or consent of a parent or guardian:
• If the nature of your request for services involves sexually transmitted disease, alcohol or drug abuse;
• Referrals for information on birth control options as relevant to treatment; or
• In an emergency situation, Headway Emotional Health Services can provide mental health or chemical dependency services absent of parental notification or consent. Once the crisis is stabilized, we will notify your parent or guardian.

If services are provided without the knowledge or consent of your parent(s), you may be responsible for paying your bill.

Parents of Non-Emancipated Minors have a right to the medical records of their children. However, we ask that parents respect the confidential relationship between their child and the child's therapist. Parents can expect that they will be given information regarding the treatment plan and progress of their child without the specific details of the sessions.

The staff of Headway Emotional Health will use discretion as to what information is shared.

Your Responsibilities

As a client of Headway Emotional Health, you have responsibilities as well as rights.
• You are responsible for being clear and direct about the problems you are experiencing. It is important that you provide complete and accurate information about past illnesses, hospitalizations, treatment programs, medications, and other matters related to your background.
• You are responsible for understanding your treatment plan. Your willingness to help design your treatment plan and follow it bears directly on the success of your treatment.
• You are responsible for arranging payment for the cost of services you receive if you are on a fee-based program.
• You are responsible for respecting the right of privacy and confidentiality of other clients you see in our treatment programs.
• The State of Minnesota asks its licensed programs to conduct satisfaction surveys or other evaluations of the services provided. We ask you to please participate in this process and know that privacy will be respected in such matters.
• You share the responsibility with us in assuring that the helping relationship remains respectful and that our staff, other clients, and visitors feel safe and protected. We reserve the right to terminate contact with clients who engage in abusive language or behavior, any form of harassment, or who are perceived to be under the influence of mood-altering chemicals.

For services operated by scheduled appointments:
• You are responsible for keeping scheduled appointments. If you cannot keep an appointment please call and cancel at least 24 hours in advance.
• If you miss three appointments or more, your services may be terminated. A no-show fee may be charged for appointments not kept. If you miss several appointments and have not made payments to your account, your treatment may be interrupted until payment is made.
• If your appointment needs to be rescheduled due to inclement weather or some other type of emergency, you will be called as soon as possible. Weather closings are also announced through each individual location's telephone recorded message.

Payment Policy

At the time of intake we will assist you in determining who is responsible for the cost of services. A subsidized fee is available to Hennepin county residents. In order to qualify for the subsidized fee, you must provide proof of income and financial inability to pay. Your ability to pay will be evaluated periodically and with any change in your financial situation. Payment must be received at the time of service.

Please let us know if you change jobs, insurance companies, your home address, or telephone number.

We will attempt to collect from your insurance company; however, you are responsible for paying your co-pay and deductible at the time of service. We accept reimbursement from most insurance companies, including Medicare and Medical Assistance. Benefits vary from one plan to another. Some diagnoses do not qualify for payment from insurance companies or other payers. Insurance companies often request copies of client records to determine payment for claims made.

Please discuss questions about your coverage with your employer, or customer service of your insurance plan. We will help to resolve questions about your account. You, however, are ultimately responsible for the charges you incur.

If it becomes necessary to place your account with a collection agency because of non-payment, any legal and/or collection fees will be added to your account balance.

Grievance Procedure:
If you are dissatisfied with your care we encourage the following:
Talk with your therapist
Talk with the Program Director
Talk with the Director of Client Services (612) 798-8189

Response time will be within three business days of the receipt of the complaint. If you wish to file a formal grievance in writing, staff members are available to assist you.

If you wish to file a grievance with a reporting board external to Headway Emotional Health, you can contact:
Office of Health Facilities and Complaints
P.O. Box 64970, St. Paul, MN 55164-0970
Phone: (651) 201-4201
National, Toll Free 1-800-369-7994
Office of the Ombudsman for Mental Health and Developmental Disabilities 651-757-1800 or 1-800-657-3506 or MN Relay Service 711

Minnesota State Board with whom your provider is licensed
MD ________________________________ (612) 617-2130
Psychology __________________________ (612) 617-2230
Social Work __________________________ (612) 617-2100
Nursing _____________________________ (612) 617-2270
Chemical Dependency __________________ (612) 617-2178
Marriage and Family Therapy ______________ (612) 617-2220
Behavioral Health and Therapy ____________ (612) 548-2177

Licensing Division of DHS Licensing:
Twin Cities metro: (651) 296-3971
Outstate: 1-800-627-3529
TTY: (651) 282-6832

Staff Rights
The staff at Headway Emotional Health are committed to respecting your rights. The staff also have rights that guide them as professionals.

Staff have the right to keep their private lives separate from their professional lives and will not give out their home address, telephone number, family information, or other personal information.

Staff have the right to consult with other staff as needed.

Staff have the right to transfer clients to other professionals or terminate therapy if they believe:
- Their objectivity has become impaired
- The problems presented are outside of their area of competence
- Therapy is not indicated
- The client is not benefiting from service provided or following the treatment plan
- A client is being abusive

Staff have the right to expect respectful treatment, not to be intimidated, threatened, or harmed by clients.

Emergency Services
Headway Emotional Health has contracted with After Hours Service to respond to emergency situations outside of regular business hours (typically 8:00 AM to 5:00 PM Monday through Friday). If medication management services are part of the care

that you receive through Headway Emotional Health, the After Hours Service will contact the psychiatrist with whom a client is working for any urgent matter that cannot wait until the next business day. Calls are answered by Masters Level clinicians. We ask that clients show discretion in the frequency with which this service is utilized.

The After Hours number is: 612-852-2209. Please tell the service from which program of Headway Emotional Health you receive care, or the name of your Headway Emotional Health Services therapist or psychiatrist.

Please note, "you may be treated or referred without your consent if immediate action is required to protect the health and safety of yourself or others."

Headway Emotional Health Locations

Richfield 6425 Nicollet Avenue South
Richfield, MN 55423
(612) 861-1675

Golden Valley 701 Decatur Avenue North #109
Golden Valley, MN 55427
(763) 746-2400

Hopkins 1001 Highway 7 Suite 309
Hopkins, MN 55305
(952) 426-6600

Brooklyn Center 5910 Shingle Creek Parkway
Brooklyn Center, MN 55430
763-569-5200

Services are also provided in the community and at various local schools.

Headway Emotional Health Services BANS GUNS on all of its premises.

Business hours for all locations are 8:00 AM to 5:00 PM.
Evening or weekend appointments vary with each program.

Client ID# ____________

Date: ____________

CLIENT REGISTRATION & INSURANCE INFORMATION

Please Print

CLIENT INFORMATION

Name ______________________________
Last Name First Name Middle Initial

Address: ______________________________
Street Apt. # City State Zip County

Sex: ☐ M ☐ F Age: ________ Birth Date: ____________ Soc. Sec. # ____________

Home Phone Number ____________ Work Phone Number ____________

Email Address: ______________________________

RESPONSIBLE PARTY

Responsible Party if **Other Than Client**: ______________________________

Address (if different than above): ______________________________

Home Phone Number ____________ Work Phone Number ____________

Birthdate: ____________ Soc. Sec. # ____________ Relationship to Client: ____________

Email Address: ______________________________

PRIMARY INSURANCE

Policy Holder's Name: ______________________________
Last Name First Name Middle Initial

Birthdate: ____________ Soc. Sec. # ____________ Relationship to Client: ____________

Address (if different from above) ______________________________
Street City State Zip

Home Phone Number: ____________ Work Phone Number: ____________

Employer: ______________________________

Insurance Company Name: ____________ Effective Date: ____________

Insurance ID Number: ____________ Group Number: ____________

SECONDARY INSURANCE

Policy Holder's Name: ______________________________
Last Name First Name Middle Initial

Birthdate: ____________ Soc. Sec. # ____________ Relationship to Client: ____________

Address (if different from above) ______________________________
Street City State Zip

Home Phone Number: ____________ Work Phone Number: ____________

Employer: ______________________________

Insurance Company Name: ____________ Effective Date: ____________

Insurance ID Number: ____________ Group Number: ____________

Please Read The Following

As a Community Mental Health Center and a Rule 29 Clinic, Headway is required to report certain demographic information to the state and Hennepin County. All information is reported anonymously to protect your privacy. Your voluntary responses are greatly appreciated.

Gross (Yearly) Household Income: ( )$ 0-$10K ( ) $10K-20K ( ) $20K-$29K ( ) 30K-39K ( ) $40K-$49K ( ) $50K-$59K ( )$60K-$69K ( ) $70K-$79K ( ) $80K-$89K ( ) $90K-$99K ( ) $100K-$119K ( ) $120K and Up

Race: ( ) African American ( ) Asian American ( ) Caucasion ( ) Hispanic ( ) Hmong ( ) Multi-Racial ( ) Native American ( ) Pacific Islander ( ) Somali ( ) Sudanese ( ) Other

PLEASE SEE REVERSE SIDE FOR SIGNATURE AND OTHER INFORMATION

Headway
Emotional Health

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our financial policy. An important part of keeping our services accessible is having our clients follow through with their financial obligations. Please read this policy carefully prior to agreeing to treatment.

Full Payment for fees or co-pays is due at the time of service. Fees may be paid with cash, check, or credit card. All outstanding balances are the responsibility of the client, regardless of whether or not insurance covers the services.

Insurance Coverage - Insurance coverage is a contract between the insurance company and the covered person. Providers of health care are NOT a part of the contract. Instead, healthcare providers accept the assignment of benefits. **This assignment can only happen with a client's signed authorization.** Further, if the insurance company requires a referral, the client must obtain the referral prior to receipt of any care. Fees not covered by insurance after 120 days become the responsibility of the client. It is critical that clients keep us apprised of any insurance changes, ranging from policy number changes to new plans. Failure to do so can cause billing inaccuracies that result in full payment responsibility to the client.

Medicare and Medical Assistance - We are an authorized provider for Medicare and Medical Assistance and accept assignment of benefits. Eligibility for Medical Assistance is verified each month. Please have your Medical Assistance card available to assist us in verifying this coverage.

Reduced Fees - As a non-profit community mental health provider, we may be able to reduce fees in certain circumstances. Please speak with a billing representative to negotiate a payment plan or if a reduced fee is needed. Clients who qualify for reduced fees are still responsible for paying the agreed upon fee.

Missed Appointments – A 24-hour notice for cancellations is required. This enables us to arrange care for another client. Failure to cancel **24-hours ahead** of a scheduled appointment will **automatically** result in charges regardless of reason. Your treatment provider will not be able to prevent or reverse charges for missed appointments. If you feel you have been charged in error, please request to speak with a billing representative.

32% of the Full Fee for an appointment will be charged for a missed appointment due to a late cancellation.

PLEASE NOTE: Failure to attend a group is an automatic charge, regardless of notice. This is because another client cannot fill the vacancy of an absent group member.

If you have any questions regarding our fees and your financial obligations, please contact our billing department at 952-582-6691.

My signature below is authorization for the release of any medical information necessary to process the claim for benefits. Any release of medical information is understood to follow the standards set by HIPAA and the Data Privacy Act. I authorize payment of all benefits directly to Headway Emotional Health. I acknowledge that I have read, understand and agree to the above Financial Policy.

Client Signature: ______________________________ DATE: ____________

Responsible Party Signature: ______________________________ DATE: ____________

Headway Emotional Health Services
Child and Adolescent Intake Form

Today's Date:____________

Adolescent's Name: (First) (M.I.) (Last)			Birthdate:	Age:
Mother's Work Phone: Home Phone:	Father's Work Phone: Home Phone:			Sex: M F
Father's Name:	Age:	Occupation:		Education Level:
Mother's Name:	Age:	Occupation:		Education Level:
Legal Guardian:	Teen currently lives with:			
Step-Parent(s) (if applicable):				

Name of person completing form:________________________________

Please give a brief description of why you are seeking treatment:________________________________

____

Who referred you to our clinic?________________________________

1. FAMILY AND SOCIAL HISTORY

Adolescent's Siblings	Age	Sex	Grade	Adolescent's Siblings	Age	Sex	Grade

Is the teen or any siblings adopted?________________________________

List all members living in the household:________________________________

If applicable, give date(s) of adolescent's parents' marriage, separation(s) and/or divorce:______________

____

Comments about custody/visitation (if applicable)________________________________

____

Describe any family history of mental health or chemical dependency problems or treatment:______________

____

Is child presently in any childcare setting? Yes No

If yes, how much of the time (per week)?______________

List any involvement with social services, child protection, the court system or legal services:______________

____

Has your child ever been hurt? Yes No

If yes, please circle: Physically Emotionally Sexually By ways of neglect

FAMILY AND SOCIAL HISTORY (CONTINUED)

Has your child ever witnessed somebody else being hurt? ______________________________

What major stresses or changes have occurred in your child's life? ______________________________

____

Who does your child regard as the most supportive in their life (specific family members, teacher, coach, friends, pets, etc.): ______________________________

____

2. SCHOOL HISTORY

Name of current School: ____________________ Grade: ________ Teacher's Name: ____________

List any special services received through the school system and grade level child received services: ____________

____

Do you have a job outside of school? Yes No

3. DEVELOPMENTAL HISTORY

Were there any problems in pregnancy, labor, birth or delivery with this adolescent? Yes No
If yes, please give details:

____

____

Have there been any concerns or delays with your development in any of the following areas? If yes, please indicate who evaluated the problem if help was sought:

			Evaluated by:
1. Speech and language	Yes	No	____________
2. Hearing	Yes	No	____________
3. Vision	Yes	No	____________
4. Intelligence/ability to learn	Yes	No	____________
5. Bladder/Bowel Control	Yes	No	____________
6. Emotional/Maturity Level	Yes	No	____________
7. Social Skills	Yes	No	____________
8. Eating Habits	Yes	No	____________
9. Fine Motor Skills (writing, coloring, etc.)	Yes	No	____________
10. Gross Motor Skills (walking, running, etc.)	Yes	No	____________

4. MEDICAL HISTORY

Primary Care Clinic:______________________ Physician:__________________

Date of last medical examination:________________

List any current medical problems:____

List any hospitalizations or serious medical problems:__________________________________

List any medication currently taking:____

List any previous medications taken and their effectiveness:_____________________________

____

List any drug allergies:____

List any other allergies:____

Have there been any pregnancies, miscarriages, abortions?_____________________________

Do we have your permission to contact your primary care physician to assist with coordination of your care?
Yes No

Does your child use any over-the-counter medications regularly/frequently?_________________

Does your child have any communicable diseases. Yes No If yes, please list__________________
(examples: Tuberculosis)

5. CHEMICAL USE HISTORY

Please check any that apply:

Drug Name	Use currently	Within last 12 months	Have used in past	Never
Cannabis – Marijuana, Hash				
Alcohol				
Amphetamines – Speed, Cocaine, Crack, Crank, Dexedrine, White Crosses, Ritalin, Cylert, etc.				
Tranquilizers – Valium, Xanax, Ativan, Librium, Sleeping Pills, Seconal, Quaaludes, etc.				
Narcotics – Codeine, Percodan, Darvon, Demerol, Morphine, Heroin, Methadone, Talwin, etc.				
Other – Inhalants, PCP, LSD, Mushrooms, Paint Thinner, Nitrite "Poppers," etc.				

Have you used more than one chemical at the same time in order to get high? Yes No
Do you avoid family activities so you can use? Yes No

CHEMICAL USE HISTORY (CONTINUED)

Do you have a group of friends who also use? Yes No

Do you use to improve your emotions such as when you feel sad or depressed? Yes No

Do you use tobacco products? Yes No If yes, type?__________

Quantity per day__________

Do you use caffeine? Yes No If yes, type?__________

Quantity per day__________

6. PREVIOUS TREATMENT

List any counselors seen in the past and reason for visits:__________

List dates of any psychiatric hospitalizations:__________

7. OTHER

What are your child's strong points?__________

Is spirituality and/or faith system important in your family? In your child? __________

Additional comments:__________

Strengths and Difficulties Questionnaire

P 11-17

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behavior over the last six months.

Your child's name .... Male/Female

Date of birth...

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other youth, for example CD's, games, food	☐	☐	☐
Often loses temper	☐	☐	☐
Would rather be alone than with other youth	☐	☐	☐
Generally well behaved, usually does what adults request	☐	☐	☐
Many worries or often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other youth or bullies them	☐	☐	☐
Often unhappy, depressed or tearful	☐	☐	☐
Generally liked by other youth	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other youth	☐	☐	☐
Often offers to help others (parents, teachers, children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets along better with adults than with other youth	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Good attention span, sees chores or homework through to the end	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behavior or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress your child?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	A medium amount	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

Signature .... Date ....

Mother/Father/Other (please specify:)

Thank you very much for your help

© Robert Goodman, 2005

Strengths and Difficulties Questionnaire

S 11-17

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain . Please give your answers on the basis of how things have been for you over the last six months.

Your name.. Male/Female

Date of birth...

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings	☐	☐	☐
I am restless, I cannot stay still for long	☐	☐	☐
I get a lot of headaches, stomach-aches or sickness	☐	☐	☐
I usually share with others, for example CD's, games, food	☐	☐	☐
I get very angry and often lose my temper	☐	☐	☐
I would rather be alone than with people of my age	☐	☐	☐
I usually do as I am told	☐	☐	☐
I worry a lot	☐	☐	☐
I am helpful if someone is hurt, upset or feeling ill	☐	☐	☐
I am constantly fidgeting or squirming	☐	☐	☐
I have one good friend or more	☐	☐	☐
I fight a lot. I can make other people do what I want	☐	☐	☐
I am often unhappy, depressed or tearful	☐	☐	☐
Other people my age generally like me	☐	☐	☐
I am easily distracted, I find it difficult to concentrate	☐	☐	☐
I am nervous in new situations. I easily lose confidence	☐	☐	☐
I am kind to younger children	☐	☐	☐
I am often accused of lying or cheating	☐	☐	☐
Other children or young people pick on me or bully me	☐	☐	☐
I often offer to help others (parents, teachers, children)	☐	☐	☐
I think before I do things	☐	☐	☐
I take things that are not mine from home, school or elsewhere	☐	☐	☐
I get along better with adults than with people my own age	☐	☐	☐
I have many fears, I am easily scared	☐	☐	☐
I finish the work I'm doing. My attention is good	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that you have difficulties in any of the following areas: emotions, concentration, behavior or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress you?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your everyday life in the following areas?

	Not at all	Only a little	A medium amount	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties make it harder for those around you (family, friends, teachers, etc.)?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

Your Signature ....   Today's Date ....

Thank you very much for your help

© Robert Goodman, 2005

The CAGE and CAGE-AID Questionnaires

Item	Text
1.	Have you ever felt you ought to cut down on your drinking or drug use?
2.	Have people annoyed you by criticizing your drinking or drug use?
3.	Have you ever felt bad or guilty about your drinking or drug use?
4.	Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?

Note. The plain text shows the CAGE questions. The italicized text was added to producc the CAGEAID. For this study, the CAGE-AID was preceded by the following instruction: "When thinking about drug use, include illegal drug use and the use of prescription drugs other than as prescribed."

Table from "Thc prevalence and detection of substancc use disorder among inpatients ages 18 to 49: An opportunity for prevention" by Brown RL, Leonard T, Saunders LA, Papasouliotis O. Preventive Medicine, Volume 27, pages 101-110, copyright 1998, Elsevier Sciencc (USA), reproduced with permission from the publisher.

The CAGE and CAGE-AID Questions

The original CAGE questions appear in plain type. The CAGE questions Adapted to Include Drugs (CAGE-AID) are the original CAGE questions modified by the italicized text.

The CAGE or CAGE-AID should be preceded by these two questions:

1. Do you drink alcohol?
2. Have you ever experimented with drugs?

If the patient has experimented with drugs, ask the CAGE-AID questions. If the patient only drinks alcohol, ask the CAGE questions,

CAGE and CAGE-AID Questions

1. In the last three months, have you felt you should cut down or stop drinking or using drugs ? Yes
2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?

   Yes No
3. In the last three months, have you felt guilty or bad about how much you drink or use drugs?

   Yes
4. In the last three months, have you been waking up wanting to have an alcoholic drink or use drugs?

   Yes No

Each affirmative response earns one point. One point indicates a possible problem. Two points indicate a probable problem.

From: The Society of Teachers of Family Medicine. Project SAEFP Workshop Materials, Screening and Assessment Module, page
18. Funded by the Division of Health Professionals, HRSA, DHHS, Contract No. 240-89-0038. Reprinted by permission.

CONSENT FOR TREATMENT

I give my consent to participate in mental health treatment or related services through Headway Emotional Health. I understand that staff employed directly through Headway Emotional Health will provide this treatment. This consent may include services such as evaluations, therapy, medication management or testing (if indicated).

I understand that I may decline a specific treatment and may withdraw my consent to treatment at any time, for any reason. I understand that withdrawing consent would end my ability to continue to receive services.

All clients and/or their families will be involved in the design of a treatment plan with their service provider. I consent and agree to being involved in the treatment planning process.

______________________________ ______________

Printed name of client Date

______________________________ ______________

Signature of adult client or parent/guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF THE
PRIVACY PRACTICES & CLIENT'S RIGHTS BROCHURES

Consistent with the Health Insurance Portability and Accountability Act-HIPAA (1996), I have been provided with a copy of the Notice of Privacy Practices. I have also been provided with a copy of the Client's Rights and Responsibilities, which provides a description of my rights as a recipient of services.

I understand that I may receive another copy of either of these documents at any time and that I may direct any complaints or concerns about the services I received to the Program Director, Clinical Director, or the Executive Director.

I understand that Headway Emotional Health encourages me to fully read each of these documents and inform my provider if I have any questions or concerns.

____________________________________ ____________

Printed name of client Date

____________________________________ ____________

Signature of adult client or parent/guardian Date

Appointment Confirmation and Client Contact Consent Form

I give my consent for Headway Emotional Health to contact me via voicemail, text message, and/or email message to remind me of an upcoming appointment or to alert me to an appointment cancellation due to inclement weather or provider illness. This will also be used to provide me things like our client satisfaction surveys.

I understand that by accepting a voicemail, text message, and/or email message appointment confirmation that the message will not be encrypted. The confirmation will include the following information:

- Patient's first name, agency name and location, date and time of the appointment

Voicemail/Text Message Confirmation:

_____ **Yes,** Headway **may** confirm my appointments by voicemail or text message to my home or mobile phone number.

Please provide a home phone number for **voicemail** only confirmation: ______________________________
Please provide a cell phone number for voicemail or **text message** confirmation: ______________________________

OR

_____ **No,** Headway **may not** confirm my appointments by voicemail or text message to my home or mobile phone number.

Email Message Confirmation:

_____ **Yes,** Headway **may** confirm my appointments by email message.
If yes, may we also add you to our agency mailing list so you receive our agency e-mail newsletter and information on other agency sponsored events?
_____ Yes _____ No

Please provide the email address: ______________________________

OR

_____ **No,** Headway **may not** confirm my appointments or contact me in any way by email message.

**Headway does not share or sell text numbers or email addresses to third parties.

______________________________ ______________
Printed name of client Date

______________________________ ______________
Signature of adult client or parent/guardian Date

NOTICE TO CLIENTS
Supervision Notice

The Minnesota State Department of Human Services, BlueCross & BlueShield as well as United Behavioral Health/Medica all have a supervision requirement to which we must alert you.

Until a therapist has his or her own billing number, or until a therapist has an *independent* license to practice, he or she must be supervised by a therapist who is enrolled in the insurance plan for which you are covered.

If a therapist being supervised relevant to this rule provides your care, we must inform you and have you acknowledge with your signature that you have been so advised.

Headway Emotional Health believes in the importance of furthering the profession of Social Workers, Psychologists and/or Marriage and Family Therapists. We provide highly supervised internships that meet the requirements of the state, the professional licensing boards, as well as the standards set by your insurance company.

*Know that Headway Emotional Health hires **only** therapists who are licensed by the State of Minnesota to provide therapy. Having a State License means your therapist holds a Master's Degree. Further, he or she completed over 2,000 hours of supervised clinical experience just to be eligible to take the state licensing exam. Headway hires therapists who have many years of experience well after they have passed their state licensing exam. You can feel assured that the therapist to whom you are assigned is highly competent and is an approved provider for many other insurance companies. Both their licensure and experience make them eligible to participate in this new agreement.*

I have been advised of this supervisory arrangement and acknowledge being informed by my signature below.

______________________________ Signature of Client

______________________________ Signature of Parent/Guardian

______________________________ Printed Name of Client

______________________________ Date