1909 Cuba Ave. Ste. 5
Alamogordo, NM 88310
Phone: (575) 489-4616
Fax: (575) 489-4619

Client Intake Form

Name______________________________ Date______________________________

SSN______________________________ Marital Status______________________________

Physical Address______________________________ Date of Birth/Age______________________________

______________________________ Referral Source ______________________________

Mailing Address______________________________ Employer______________________________

______________________________ Employer Address______________________________

Home Phone ______________________________ ______________________________

Cell Phone______________________________ Employer Phone______________________________

Occupation______________________________

*Please present your current insurance card(s) so we may keep a copy on file.

Responsible Party: Self Spouse Parent
Name of Insurance 1:______________________________Copay:______________
Policy ID#:______________________Group ID#:______________________
Effective Date: ______________Subscriber's Name:______________________
SSN:______________________DOB:______________________
Employer (Insured):______________________________
Classification Level/Rank: ______________________________

Responsible Party: Self Spouse Parent
Name of Insurance 2:______________________________Copay:______________
Policy ID#:______________________Group ID#:______________________
Effective Date: ______________Subscriber's Name:______________________
SSN:______________________DOB:______________________
Employer (Insured):______________________________
Classification Level/Rank:______________________________

Whom may we contact or leave a message with in case of scheduling problems?

Name______________________________Phone______________________________

I do certify that the information given above is true and correct to the best of my knowledge. The primary use of this information is to provide, plan and coordinate health care. I understand that I am responsible for all charges incurred for services my dependents or I receive. Payment is due when services are rendered. After 90 days past due accounts may be turned over to a collection agency and the client will be responsible for collection fees in addition to the account balance. I have read, understand and agree to the attached disclosures and give my "Informed Consent." Unless approved for a lower rate, I understand that the hourly rate for counseling is $160.00 for the initial appointment and $125.00 for additional appointments. No-shows, cancellations or rescheduling less than a 24-hour in advance will be subject to a $40.00 no-show fee. No shows will be subject to removal from the schedule. No shows on Saturday and evening appointments (5pm appointments and later) will be charged a $60.00 fee.

Client/Guardian's Signature________________________________ Date___________

Witness Signature______________________________________ Date___________

Disclosure of Information/Consent for Treatment of a Minor (Reference 32A-6A)

A child fourteen years of age or older is presumed to have capacity to consent to treatment without consent of the child's legal custodian, including consent for individual psychotherapy, group psychotherapy, guidance counseling, case management, behavioral therapy, family therapy, counseling, substance abuse treatment or other forms of verbal treatment that do not include aversive interventions.

A child under fourteen years of age may initiate and consent to an initial assessment with a clinician and for medically necessary early intervention service limited to verbal therapy. The purpose of the initial assessment is to allow a clinician to interview the child and determine what, if any, action needs to be taken to ensure appropriate mental health or habilitation services are provided to the child. The clinician may conduct an initial assessment and provide medically necessary early intervention service limited to verbal therapy with or without the consent of the legal custodian if such service will not extend beyond two calendar weeks.

A clinician or other mental health and developmental disabilities professional shall promote the healthy involvement of a child's legal custodians and family members in developing and implementing the child's treatment plan, including appropriate participation in treatment for children fourteen years of age or older. However, nothing in this section shall limit the rights of a child fourteen years of age or older to consent to services and to consent to disclosure of mental health records.

Except as otherwise provided in the Children's Mental Health and Developmental Disabilities Act, a person shall not, without the authorization of the child, disclose or transmit any confidential information from which a person well-acquainted with the child might recognize the child as the described person or any code, number or other means that could be used to match the child with confidential information regarding the child. When the child is under fourteen years of age, the child's legal custodian is authorized to consent to disclosure on behalf of the child.

Common Exceptions to Confidentiality

You are entitled to confidentiality with your provider. This includes all information contained on your intake forms and any that you bring to subsequent counseling sessions. All communications regarding personal information will be held in strict confidence except as permitted by law (Refer to Notice of Privacy Practices for further information). In most other cases, an Authorization for Release of Information must be signed by you before any information is released. The following are some of the most frequent exceptions to confidentiality that you should be aware of:

1) Under New Mexico law, a release of information is not required "When such disclosure is necessary to protect against a clear and substantial risk of imminent serious physical injury or death inflicted by the client on himself or another." (NM Statute 43-1-19)

2) New Mexico law requires that child abuse and neglect be reported. "Every person, including but not limited to a licensed physician, a resident or an intern examining, attending or treating a child, a law enforcement officer, a judge presiding during any proceeding, a registered nurse, a visiting nurse, a schoolteacher or a school official or social worker acting in an official capacity that knows or has a reasonable suspicion that a child is an abused or neglected child shall report the matter immediately to: (1) a local law enforcement agency; or (2) the county Social Services Department or the Human services Department in the county where the child resides. (NM Statute 32A-4-3). In these situations, New Mexico statutes do not provide privileged communication between provider and client. Information from your file and/or your provider's testimony could be introduced in any legal action.

3) If you (the client) are receiving services from Open Minds, LLC, and initiate legal action against Open Minds, LLC, its therapist, staff or business associate, a release of information is not required for defense from the action.

4) If consistent with the protections provided by Health Insurance Portability and Accountability Act (HIPPA) and Part 2 of Title 42 of the Code of Federal Regulations, disclosure of confidential materials may be court ordered. Open Minds, LLC must comply with all legitimate court orders.

Group Therapy Confidentiality

Should client be involved with any group therapies, client agrees that he/she will keep all conversations/disclosures from other group members highly confidential. Any violation of confidentiality will result in immediate termination from all group therapy services with Open Minds and client may be denied group services in the future.

Client/Guardian Signature________________________________ Date___________________

Witness Signature_______________________________________Date__________________

Disclosure of Relationships

Client acknowledges that he/she has been advised that their provider may participate in case staffings and clinical supervision sessions with other licensed mental health professionals during which the client's confidential information may be disclosed. The client understands that other licensed professionals and clinical supervisors are obligated to maintain the client's confidentiality.

Disclosure of Licensure Level

Client acknowledges that Open Minds, LLC utilizes both independently (PhD., PsyD., LFMT, LPCC, LISW and CNP) and non-independent (LPC, LMHC, MSW, LDAC) licensed providers to serve its clients. Providers who are not independently licensed receive clinical supervision in accordance with legal and ethical requirements. You may request to work with an independently licensed provider but this may result in delays or higher costs of treatment.

Disclosure of Treatment Protocols

Client acknowledges that he/she that during the course of treatment, a number of different treatment approaches and strategies may be employed. The client understands that if at any time during the course of treatment he/she has any questions regarding the process, purpose, or procedure being used, that he/she is encouraged to request clarification immediately.

Client acknowledges that some clients will be offered a treatment approach known as Eye Movement Desensitization and Reprocessing (EMDR). The client understands this approach has been validated by research and is being successfully used for a variety of complaints as research continues. The client understands that they may obtain whatever additional information they need either from my provider or from other sources regarding EMDR. The client understands that they may choose whether or not to engage in or continue treatment using the EMDR or any other treatment approach.

Disclosure of Recorded Sessions

Open Minds, LLC strives to provide the high quality, accessible services that you deserve. Often services are provided during non-traditional hours and days. To aid with clinical supervision and to ensure everyone's safety, sessions may be recorded. Recordings will be held confidential, in accordance with state and federal law.

Alcohol/Drug/Infectious Disease/Psychiatric Records

Alcohol/Drug/Infectious Disease/Psychiatric Records are protected by Federal Regulation 42CFR, Part 2, and release of these records requires specific consent. This protection covers all records and information including verbal and facsimile communication and provides that specific consent is necessary for the release of the following: Drug or alcohol abuse, infectious diseases (including HIV), and psychological or psychiatric problems unless otherwise specified below.

Client/Guardian Signature________________________________ Date___________________

Witness Signature______________________________________Date__________________

Assignment of Insurance of Benefits

I request that payment of authorized benefits on my behalf be paid to Open Minds, LLC for any services furnished to me, my dependents or my family. I also authorize release of Protected Health Information (PHI) needed to determine eligibility or process claims for services rendered to me or my dependents to my insurance carrier(s) or other payment sources.

Client/Guardian Signature________________________________ Date___________________

Witness Signature______________________________________Date__________________

Client's Rights and Responsibilities

__________________________________hereby acknowledges that he/she has been informed that he/she is entering into a professional relationship with Open Minds, LLC and its providers.

I understand that I have the right to consideration and respect. I understand that I am expected to make my own decisions and to take responsibility for my actions. I understand that my provider will help facilitate change that I decide I want to make. My provider adheres to the ethical standards of the certification/licensing boards with whom he/she is associated. Any grievance should be discussed with my provider, their supervisor or sent to the appropriate licensing board.

I have read and/or had explained what it means to become a client of Open Minds, LLC, I agree to their terms and wish to become a client.

Client Signature________________________________ Date _____________________

Parent/Guardian Signature_______________________ Date _____________________

Witness Signature______________________________ Date _____________________

Crisis Contact Flowchart

1. For all life threatening emergencies, call 911 or go to the nearest emergency room.

2. Contact person support system. List names and numbers of family, friends and/or Pastor to contact during crisis.

   Name_____________________________ Number_____________________

   Name_____________________________ Number_____________________

   Name_____________________________ Number_____________________

3. Office hours are by **Appointment Only** and will vary. If you are unable to reach anyone at the office number please leave a message. Your call will be returned as quickly as possible.

No Harm Contract

I PROMISE NOT TO HARM MYSELF OR ANYONE ELSE. If I have thoughts of killing myself or anyone else I will call 911 or go to the nearest emergency room. I understand that not every therapist may accept "after hours" calls and those that do are not be available on a 24/7 basis. I understand that leaving a message is NOT sufficient to meet my obligation under this agreement.

My provider has spoken with me about the No Harm Contract and its requirements. My signature below represents my willingness to comply with its terms while I am an active client of Open Minds, LLC.

Signature____Date_________________

Witness Signature_____________________________________Date__________________

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice of Privacy Practices describes how Open Minds, LLC, including its therapists, staff and contractors, hereafter referred to as "OM" may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

OM is required to abide by the terms of this Notice of Privacy Practices. OM may change the terms of my notice at any time. The new notice will be effective for all protected health information that OM maintains at that time. You may request a revised copy by asking your therapist, by writing or by calling the office. OM will provide you with the revised Notice of Privacy Practice by mail, email, fax or at the time of your next appointment

1. **<u>Permitted Uses and Disclosures of Protected Health Information</u>**

Your PHI may be used and disclosed by OM and others that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support OM's operations. The following are examples of the types of uses and disclosures of you PHI that OM is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by this office.

Treatment: OM will use and disclose your PHI to provide, coordinate or manage your care and any related services. This includes the coordination and management of your health care with a third party that has already obtained your permission to have access to your PHI. For example, OM would disclose your PHI to physicians who may be treating you to ensure that the physician has the necessary information to diagnose or treat you. In addition, OM may disclose your PHI from time to time to another counselor or health care provider who, at OM's request, becomes involved in your care by providing assistance with your care by providing assistance with your health care, diagnosis or treatment.

Payment: Your PHI may be used to seek approval for or to pay for the health care services payment from your health plan, from other sources of coverage such as an automobile insurer, other third-party payers who are responsible for paying all or part of the cost of your care, the credit bureau, debt collection agencies, including Small Claims Court. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Healthcare Operations: OM may use or disclose, as needed, your PHI in order to support the business activities of the practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of counseling students, licensing, marketing and conducting or arranging for other business activities. For example, OM may disclose your PHI to practicum or intern students that see clients at the office. In addition, OM may call you by name in the waiting room when you are ready to be seen. OM may use or disclose your PHI, as necessary to contact you to remind you of or reschedule your appointment. OM will share your PHI with third party business associates that perform various activities (e.g. billing) for the practice. Whenever an arrangement between OM and an outside business involves the use of or disclosure of your PHI, OM will have an agreement that contains terms that will protect the privacy of your PHI.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization: Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization at any time, in writing, except to the extent that OM has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity To Object: OM may use and disclose your PHI in the following instances. You have the opportunity to agree or object to the use of disclosure of all or part of you PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then OM may, using our professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

Others Involved In Your Healthcare: Unless you object, OM may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your heath care. If you are unable to agree or object to such disclosure, OM may disclose such information as necessary if OM determines that it is in your best interest based on our professional judgment. OM may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, OM may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your care.

Other permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object: OM may use or disclose your PHI in the following situations without your authorization. These situations include: **Required By Law:** OM may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law of any such uses or disclosures. **Public Health:** OM may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. I may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority. **Communicable Diseases:** OM may disclose your PHI to a health oversight agency for activities authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition. **Health Oversight:** OM may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations and programs, other government regulatory programs and civil rights laws. **Abuse or Neglect:** OM may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect In addition, OM may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws. **Food and Drug Administration:** OM may disclose your PHI to a person or company required by the FDA to report adverse events, product defects or problems, biological product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required. **Legal proceedings:** OM may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) in certain conditions in response to a subpoena, discovery request or other lawful process. **Law Enforcement:** OM may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes required by law, (2) limited information request for identification and location purposes, (3) pertaining to victims of a crime (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the practice's premises) and it is likely that a crime has occurred. **Coroner, Funeral Directors, and Organ Donation:** OM may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. OM may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. OM may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaver, organ, eye or tissue donation purposes. **Research:** OM may disclose your PHI to researcher when their research has to be approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI. **Criminal Activity:** Consistent with applicable federal and state laws, OM may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. OM may also disclose PHI if its necessary for law enforcement authorities to identify or apprehend an individual. **Military Activity and National Security:** When the appropriate conditions apply, OM may use or disclose PHI of individuals who are Armed Forces personnel (1) for the activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military service. OM may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized. **Worker's Compensation:** Your PHI may be disclosed by OM as authorized to comply with worker's compensation laws and other similar legally established programs. **Required Uses and Disclosures:** Under the law, OM must make disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine my compliance with the requirements of Section 164.500 etseq.

2. Your Rights

The following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights. You have the right to inspect and copy your protected health information. You may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. A designated record set may contain counseling and billing records and other records that OM use for making decisions about you. Under federal law, however, you may not inspect or copy the following records, psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. Depending on the circumstances, a decision to deny may be able to be reviewed. Please contact us if you have any questions about access to your medical record. You have the right to request a restriction on the release of your protected health information. This means you may ask OM not to use or disclose any part of you PHI for the purpose of treatment or payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. OM is not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If we do agree to the requested restriction, OM may not use or disclose your PHI in violation of the restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with us. Request a restriction form from OM. You have the right to receive confidential communications from OM by alternative means or at an alternative location. OM will accommodate reasonable requests. OM may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. OM will not request an explanation from you as to the basis for the request. Please make this request in writing. You have the right to request amendments to your protected health information. You may request an amendment of PHI about you in a designated record set for as long as I maintain this information. In certain cases, OM may deny your request for an amendment. If OM denies your request for an amendment, you have the right to file a statement of disagreement with OM and OM may prepare a rebuttal to your statement. OM will provide you with a copy of any such rebuttal. Please contact OM if you have questions about amending your medical record. You have the right to receive an accounting of certain disclosures we have made of your protected health information. This right applies to disclosure for purposes other than treatment payment or healthcare operations as described in the Notice of Privacy Practices. It excludes disclosures OM may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. Disclosures made pursuant to a signed authorization by you are also excluded from the accounting. You have the right to receive specific, information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

3. Electronic Communications

OM attempts to provide you with the greatest flexibility when communicating with us. All forms of electronic communication are subject to interception by third parties. Some present greater risk than others. HIPPA approved forms of electronic communications changes as does the technology and safeguards. In general, only traditional mail, land based phones and facsimiles are considered secure. OM also uses email that includes a form of electronic security that is HIPPA compliant; however, you are responsible for security once the message is retrieved from our secure server. Many of our therapists will communicate with you by cell phone, text message, or another manner at your request. Initiating, participating or providing us with your cell phone number/user name/etc. is an acknowledgment of the risks and considered a waiver of HIPPA's electronic communications security requirements. You must notify OM in writing if you no longer wish to communicate with us in that manner.

4. Complaints

You may complain to OM or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with OM by notifying Tamara Dees. OM will not retaliate against you for filing a complaint. You may contact Tamara at (575) 489-4616 for further information about the complaint process.

This notice was published and becomes effective on June 1, 2013

I have received and understand the conditions and limitations contained in the Notice of Privacy Practices and wish to enter treatment with OM.

Client/Guardian Signature____ Date__________________

Witness Signature____Date__________________

Payment In Lieu Of Insurance

Open Minds, LLC makes an attempt to maintain relationships with third party payers (e.g. insurance companies) to make services available and to control costs to our clients. In the event that a relationship with your particular payer source does not exist or you prefer not to utilize a third party payer, OM, at its sole discretion, may agree to accept your prescribed co-payment amount as full payment for services. These payments may not count toward required deductibles or co-insurance costs mandated by your payer source.

Co-Pay, Sliding Scale and Special Services Fees

Open Minds, LLC, is committed to provide the same quality mental health services to all of its clients, regardless of income. Any person may elect to pay for services based on the sliding fee scale described below by simply informing your provider and providing current proof of income, such as a recent pay stub(s). As always, co-pay and sliding scale payments are expected at the time services are rendered.

Household Income	Initial Appointments		Subsequent Appointments			
	Counseling	Med. Mgt.	Individual Counseling	Family Counseling	Med. Mgt. (15 min.)	Med. Mgt. (30 min.)
$0 - $10,000	$65.00	$75.00	$50.00	$60.00	$55.00	$70.00
$10,001 - $70,000	$75.00	$85.00	$60.00	$70.00	$65.00	$80.00
$70,001 - $100,000	$85.00	$95.00	$70.00	$80.00	$75.00	$90.00
$100,001 - $150,000	$110.00	$110.00	$90.00	$100.00	$90.00	$100.00
$150,001 and above	$150.00	$160.00	$125.00	$150.00	$135.00	$160.00

Special Services (*Advance Payment Required*):

Clinical Evaluation & Report	$275.00
Substance Abuse Evaluation & Report	$175.00
Domestic Violence Evaluation & Report	$175.00
Court Appearance & Testimony (Minimum Charge: $80.00)	$50.00 per hour
Copies of File (A $25 additional fee may apply if file is archived)	$25.00 + .50/pg

I understand that I have an option on how I pay for services.

Client Initial
☐ I wish to pay for services based on this sliding scale fee. My annual household income is $_______________. I understand that I may be required to provide supporting documentation.

Client Initial
☐ I wish that services be billed through my insurance company. My insurance company is ________________________. I understand that I am personally responsible for co-payments or any amounts not paid by my insurance company.

Client Initial
☐ I wish to pay for services based on a co-payment amount prescribed by my insurance company as full payment for services. I understand that I may be required to provide supporting documentation and that this option requires approval by Open Minds, LLC.

____ ____

Client/Parent/Guardian Signature Date OM Representative Signature Date