Volunteers of America
MINNESOTA AND WISCONSIN

VONA
CENTER FOR MENTAL HEALTH™
Volunteers of America MINNESOTA

CLIENT INFORMATION

Client Legal Name:		**Date of Birth:**	**Age:**
Preferred name:	**Ethnicity:** ☐ Hispanic ☐ Non-Hispanic	**Race:**	

Client Information

Address:		Primary Language:
City:	State/Zip:	County:
Home phone:	Work phone:	Can we call you at work? ☐ Yes ☐ No
Email Address:		Can we email you? ☐ Yes ☐ No
Social Security #:		Gender:
Occupation:	Employer:	
How did you hear about this clinic?		

Responsible Party

Parent/Guardian:		Primary Language:
Address:		
City:	State/Zip:	County:
Home phone:	Work phone:	Can we call you at work? ☐ Yes ☐ No
Email Address:		Can we email you? ☐ Yes ☐ No
Emergency Contact:	Phone:	
Relationship to Client:		

Insurance Information

Name of Policy Holder:		
Insurance company:		
Address:		
City:	State/Zip:	Phone:
Policy holder Social Security#:	Policy holder DOB:	
Group #:	Policy #:	Effective date:

In consideration of the services rendered to me. I agree to pay the expenses and charges for these services to Vona Center for Mental Health in accordance with its regular rates and terms. The undersigned certifies that s/he has read the foregoing and is competent to execute it, or is authorized to execute it on another's behalf.

Signature of Responsible Party **Date**

Anoka Clinic 22426 St. Francis Blvd NW
Anoka, MN 55303
Phone: 763.753.7310
Fax: 888.965.5130

New Hope Clinic 9220 Bass Lake Road, Suite 255
New Hope, MN 55428
Phone: 763.225.4052
Fax: 888.965.5130

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CLIENT CONSENT AGREEMENT

I. TREATMENT CONSENT

I, _____, consent to Vona Center for Mental Health's routine services which may include but are not limited to; assessment, evaluation, diagnosis, treatment planning, education, therapy, discharge planning, referral and follow-up care. I acknowledge that these program elements have been explained to me and I understand what Vona Center for Mental Health routine services are. I have been informed of treatment alternatives, costs of treatment and the procedures for reporting grievances or any violations of my rights.

II. CIVIL RIGHTS

I understand and acknowledge that Vona Center for Mental Health has explained that each client has rights. These rights include non-discrimination on the basis of race, religion, sexual orientation, ethnic origin, psychological well being, handicap, financial support, social support or number of prior intakes at Vona Center for Mental Health.

III. CLIENT RIGHTS

It has been further explained to me and I understand that:

- Every client has the right to receive treatment.
- Every client has the right to refuse treatment.
- Every client has the right to considerate and respectful care.
- Every client can reasonably expect to obtain from his/her mental health staff complete and current information concerning his/her diagnosis, treatment, prognosis in terms and language the client can reasonably be expected to understand. In such cases that it is not therapeutically advisable to give such information to the client, the information may be made available to the appropriate person on his/her behalf
- Every client has the right to know by name and specialty, if any, of the staff person responsible for coordination of his/her care.
- Every client has the right to every consideration of his/her privacy and individuality as it relates to his/her age, sex, race, sexual orientation, social, ethnic, religious and psychological well being
- Every client has the right to expect Vona Center for Mental Health to make a reasonable response to the requests of the client.
- Every client has a right to respectfulness and privacy as it relates to his/her treatment program. Case discussion, consultation, examination and treatment are confidential and should be conducted discretely.
- Every client has the right to obtain information as to any relationship of Vona Center for Mental Health to other health care related agencies insofar as his/her care is concerned.
- Every client has the right to expect reasonable continuity of care, which shall include, but not be limited to, what appointment times and other agencies are available.
- Every client has the right to refuse to participate in research projects.
- Every client has the right to examine and receive an explanation of his/her bill, regardless of source of payment, i.e.: insurance, medical assistance, or third party payers.
- Every client has the right to know what Vona Center for Mental Health rules and regulations apply to his/her conduct as a client.
- Every client has the right to be actively involved in the development of his/her treatment plan. Being involved in the development of the treatment plan is vital to each client's successful therapeutic experience. Every client also has the right to be informed of all updates to the treatment plan.

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IV. RELEASE OF TREATMENT RECORDS AND CONFIDENTIALITY

I understand that my mental health records and history will be handled within the confidentiality guidelines set down by the State of Minnesota. These guidelines specify that all records will remain confidential unless the client signs a release of information form. The release of information needs to identify the person, purpose of disclosure, the type of information to be disclosed and the time period during which disclosure to the person is permitted. I understand that I shall have access to treatment records and have those records copied at my own expense during regular business hours. Appointments for inspection of treatment records are made by contacting the Director of Vona Center for Mental Health.

I understand that my records will remain confidential unless any of the following situations present themselves; 1) a release of information is signed by the client, 2) in the case of audit for the purpose of third party payment, 3) in response to a subpoena by a court, 4) in an emergency situation where information is necessary to prevent harm to oneself or another, and 5) for research purposes.

In addition, I have been informed that it is the responsibility of the mental health clinician under law to report all cases of sexual abuse of a minor and all situations threatening to the welfare of a vulnerable adult. The law specifies that threats of harm to self or others requires assessment to determine the least restrictive means of intervention and may include the filing of a petition to involuntarily hospitalize individuals deemed in danger. Further, threats of harm made against another party may require the mental health clinician to notify legal authority regarding the potential for or actual threat of harm.

I further acknowledge that it has been explained to me and I understand that all state and federal regulations concerning confidentiality in treatment apply at Vona Center for Mental Health.

V. SLIDING FEE SCALE:

I understand that Vona Center for Mental Health has a sliding fee scale, which is accessible to those who are uninsured and underinsured. Eligibility is determined using the Vona Center for Mental Health sliding fee scale policy and I can pursue a sliding fee by contacting the Business Operations Manager.

VI. NO GUARANTEE OF CURE

I acknowledge that no guarantees have been made to me as to the result of treatment provided to me at Vona Center for Mental Health.

Client Signature	Date	Parent/Guardian Signature	Date
Print Client Name		Print Parent / Guardian Name	

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PRIVACY RIGHTS

(MINNESOTA DATA PRIVACY ACT)

By the way of introduction, we want to provide you with a very brief summary of the laws and rules that determine use of information gained in your Vona Center for Mental Health records.

1. The information we obtain from you will be used to establish diagnosis, determine your treatment plans and goals, and provide the services you request. The information will also be used to establish your ability to pay for these services from third party payers such as; insurance companies, social services, medical assistance, etc..
2. You are not required to provide information about yourself, however, without some information we may not be able to provide the most appropriate services. If you are here because of a court order and you refuse to provide information, that refusal may be communicated to the court.
3. The data we collect about you will be classified as either Private or Confidential by Minnesota or Federal law. You may review private data if you make a request in writing.
4. The information we maintain about you may be shared with other agencies or individuals only under the following circumstances:
    a. if you sign a consent form of release of this information.
    b. if it is court ordered.
    c. if we have reason to believe there has been abuse of a child or vulnerable adult. State and Federal law require us to report this to appropriate agencies.
    d. If a non- custodial parent requests information, they may receive information of our services to their child, but not about services to other parents.
    e. if a client states an intention to seriously harm another person we may have a legal obligation to warn the intended victim and/or call the police
    f. if there is an emergency, we may communicate your condition to a family member or other appropriate persons.
    g. if other Vona Center for Mental Health personnel require access to your record in order to do their work.
    h. if your account is delinquent we may attempt to obtain reimbursement through small claims court or a collection agency.
    i. examination of records for an audit, accreditation, or administration of a county contract.
    j. summary or non-identifying statistical data.
    k. if a new statue, Federal law or State Commissioner of Administration authorizes a new use of the information after you have been given this notice.
5. Minnesota State law authorize that a minor has the right to request that private data about them be kept from their parents. This request will be honored if we believe it will protect a child from physical or psychological harm.
6. If you feel that any information about you is inaccurate or incomplete, you may file a grievance and/or discuss the matter with your Mental Health Professional.

PLEASE SIGN TO INDICATE YOU HAVE READ THIS FORM OR HAVE HAD IT READ TO YOU.

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

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RELEASE OF INFORMATION FOR INSURANCE PURPOSES

I, _____, authorize Vona Center for Mental Health to release any and all information regarding my diagnosis, treatment and prognosis with respect to the treatment of mental health issues to _____(Insurance company name).

Any such disclosure will be limited to information that is necessary for the discharge of the legal or contractual obligations of the insurance company.

I understand that the information obtained by the use of this authorization will be used by the above insurance company to determine benefits under my existing policy. Any information obtained will not be released to any other person, employers or organizations, unless I authorize it by my original signature. I know that I can request a copy of this authorization.

I know that I can revoke this authorization at any time except to the extent that the program which is to make the disclosure has acted in reliance upon it; acting in reliance includes the provision of treatment services in reliance on my consent to disclose the above referenced information to the above insurance company. I agree that this authorization shall remain valid until the closure of this claim.

Client Signature Date Parent/Guardian Signature Date

To the extent that my treatment is subject to concurrent review, I hereby authorize Vona Center for Mental Health staff to communicate to _____(Insurance company) such information as is necessary for the review from the above agency to make a determination relative to the appropriate level of care and length of stay.

Client Signature Date Parent/Guardian Signature Date

I hereby authorize payment directly to Vona Center for Mental Health of the policy benefits otherwise payable to me, but not to exceed the provider's regular charges for the period of treatment. I understand that I am financially responsible to Vona Center for Mental Health for all charges not covered by this authorization.

Client/Policyholder/Parent/Guardian Signature Date

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ACKNOWLEDGMENTS

_____ Initial

I hereby acknowledge that I have received a copy of Vona Center for Mental Health Notice of Privacy Practices.

_____ Initial

I hereby acknowledge that I have received a copy of Vona Center for Mental Health Grievance Policy.

_____ _____

Client's Name Date

_____ _____

Parent or Guardian Name Date

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CANCELLATION POLICY

In order for Vona Center for Mental Health to serve you to the best of our ability, we need to manage our time and scheduling carefully.

- If you are unable to keep your scheduled appointments(s), we ask that you cancel **24 hours prior** to the appointment. Please try to reschedule at the time of cancellation.
- If this is not possible due to illness or an emergency, please contact us as soon as possible.
- If you cancel with **less than 24 hour notice or do not show** for the appointment, **you will be considered as a no show.**
- If you accumulate 3 no shows or cancellations with less than 24 hour notice, or have repetitive cancellations, we reserve the right to cancel our services with you.

I have read and understand Vona Center for Mental Health cancellation policy and agree to follow it as stated.

_____ _____

Client Date

_____ _____

Parent/Guardian Date

DATE OF APPOINTMENT	CANCELLED	DID NOT SHOW	SIGNATURE OF CLIENT

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