Dear CLIENT NAME,

We are so pleased to welcome you to Hamm Clinic. We look forward to the opportunity to provide you with high quality mental health care and are glad that you reached out for support.

Your initial appointment is scheduled for: ______at: ____ with:__________________________.

You will receive an invitation and link to the appointment directly from your therapist. Please plan to check-in/log-in for your appointment 30 minutes ahead of time to complete and sign some paperwork.

Attached, please find copies of that paperwork for your review. In order to best serve you, some of the following forms are required for service; some others are optional. Please know, you may choose whether or not to complete all of these forms ahead of time. You are welcome to review and complete these forms with your therapist. However, we cannot open your file without these forms being completed: Client Rights and Responsibilities; Client Information Sheet (Face Sheet); Insurance Questionnaire; Insurance Release of Information; Fee Agreement; Collections Policy; Consent for E-Mail and Text Message (SMS) Communication; Informed Consent for TeleMental Health Services.

Additional forms that will need eventual completion are: TeleMental Health Client and Provider Agreement; Appointment Attendance Policy; Health and Personal History; CAGE AID; Somatic Symptom Scale – 8 (SSS-8); PHQ-9; OQ-45.

For Your First Visit:

- Please log-on to SecureVideo/Zoom to complete the forms that have been left for you in the virtual “waiting area” ahead of time.
- The billing department will reach out to you in advance to answer any questions regarding billing/payment/insurance coverage. Billing will also provide you with the required insurance/payment forms. These will need to be completed prior to your session.
Please call us with any questions or concerns prior to your appointment. If you need to cancel your appointment for any reason, we kindly ask that you give us at least 24 hours’ notice. We look forward to meeting you and providing you high-quality, culturally responsive, multidisciplinary mental health care. We hope your experience here is helpful and meaningful.

Thank you,

Hamm Clinic Staff

- Detailed List of Enclosures (New Telemental Health Intake Packet):
  - Client Rights, Responsibilities, and Informed Consent
  - Client Information Sheet (Face Sheet)
  - Insurance Questionnaire
  - Insurance ROI
  - Fee Agreement
  - Collections Policy
  - Consent for E-Mail and Text Message (SMS) Communication
  - Informed Consent for TeleMental Health Services
  - TeleMental Health Client and Provider Agreement
  - Authorization and Consent to Receive Text Messages for Appointment Reminders
  - Appointment Attendance Policy
  - Health And Personal History Form (needed for psychiatry)
  - CAGE-AID
  - Somatic Symptom Scale – 8 (SSS-8)
  - PHQ-9
  - OQ-45
  - ROI (general)
  - ROI for Primary Care
  - Hamm Clinic Prescribing and Medication Refill Policies (needed for psychiatry)
Client Rights, Responsibilities, and Informed Consent

About Hamm Clinic
Hamm Clinic is a nonprofit mental health clinic. We have served the community since 1954. Our primary mission is to provide quality, culturally responsive services to adults and their families, particularly the underserved and those unable to afford the full cost of care. It is our goal to provide each client a safe and welcoming place to address their issues of concern. We believe quality mental health care is crucial to the well-being of the individual, families, and our communities. Hamm Clinic is accredited by the State of Minnesota through Rule 29.

Our services are tailored to meet the specific needs of each client. We offer individual, group, couple, and family therapy, psychiatric assessment, and specialized psychological assessment as appropriate. We offer medication management for clients active in psychotherapy. Our clinical staff is multi-disciplinary including psychologists, clinical social workers, licensed marriage and family therapists, psychiatrists, and a nurse. As a training facility, some of our services are offered by clinical social work interns, doctoral psychology interns, and psychiatry residents from accredited graduate training institutions.

Scope of Services
Hamm Clinic services are provided in short- and long-term formats within the training, experience, and availability of clinical staff. If at any time it is determined that the presenting issues of clients fall outside of the scope of practice for Hamm Clinic, appropriate referrals will be made. Hamm Clinic referral services either after the initial session or as these factors become more apparent during services. Hamm Clinic providers can suggest referral options that we believe will best meet a client’s needs, but the decision for ongoing treatment ultimately is the responsibility of the client.

General Information about Therapy
The purpose of therapy (individual, group, couple, and family) is to assist you in meeting your goals and supporting your personal development. A wide variety of concerns may be discussed including depression, anxiety, trauma, stress, relationship difficulties, and more. Your initial sessions will involve an assessment of your needs and you will create a treatment plan with your provider to help you address your goals for therapy. Therapists have a variety of ways of working with clients and supporting healing, change, and growth. Therapy is an opportunity to discuss your problems or issues you may be experiencing. Therapists rarely give advice or suggest how to solve a problem. Rather, your therapist will provide a warm and empathic environment as well as assist you in processing issues and reaching better understanding.

Appointments
In order to provide the best service possible, Hamm Clinic schedules appointments for a specific day and time. Therapy sessions are usually scheduled on a weekly or biweekly basis. Individual, couple, and family therapy appointments are generally 50-55 minutes. Therapy groups usually meet for about 90 minutes, and psychiatry appointments are usually 20-25 minutes after an initial 60 minute appointment. We expect you to make every effort to keep your appointments. In order to assist you, we offer an option of signing up for text reminders of appointment times.
**Client Rights**
- To be treated with dignity, respect, and courtesy by qualified, competent professionals
- To be given the same consideration as anyone else regardless of your race, ethnicity, beliefs, gender, national origin, source of payment, age, religion, disability or sexual or affectional preference
- To be informed of the options, benefits, and risks related to treatment and provide consent for treatment at Hamm Clinic
- To participate with the provider in defining needs and determining a treatment or goal plan
- To have respect given for the uniqueness of each person’s religious faith, social philosophy, and cultural background
- To disagree with the provider and to express concern openly about any part of the treatment plan, either verbally or in writing
- To be given specific reasons for referral, transfer, or termination of services
- To be free from exploitation for the benefit or advantage of the provider
- To refuse recommended treatment or services and be advised by your provider of the consequences for refusal

**Client Responsibilities**
- To be an active participant in the treatment or goal plan
- To give 24-hour notice if an appointment cannot be kept; 48 hours for psychiatry appointments
- To respect the privacy rights of other persons served by Hamm Clinic

**Updated Contact Information**
It is important that Hamm Clinic have current and accurate phone, address, and email on file in order to contact you about appointment changes or other important information. Please inform the staff as soon as possible about any change in your address, email, home or cell phone number.

**Record Retention Policy**
Client files will be securely stored in accordance with HIPAA and other applicable state and federal law. These files will remain at Hamm Clinic until ten years, at which point they will be destroyed in a secure manner. Records are released under limited circumstances as ordered by a court, as otherwise required by law or as authorized by the client. Contact your provider for more information on access to your records.

**Data Privacy and Access to Records**
Hamm Clinic maintains information about clients who receive services. Most of this information or data is protected by federal and/or state law. Policies are as of April 1, 2020.

**You have a right to:**
- Be told the purpose of collecting data from you and its intended use by Hamm Clinic.
- Be told that you may refuse to give Hamm Clinic information and whether or not it is legally required for you to do so.
- Be informed of what, if any, consequences might arise from your refusal to supply information sought by Hamm Clinic. The information may be important for Hamm Clinic to assist you, so refusal to provide the information may limit or prevent Hamm Clinic from providing assistance.
- Be informed of the identity of other persons or entities authorized by state or federal law to receive the data, if any. You have a right to have your records kept private, accessible only to appropriate Hamm Clinic staff and (possibly) appropriate employees of governmental units if you are participating in a program which receives city, county, state, or federal funding, unless disclosure is required by law.
- Have access to review, with your provider, information pertaining to you in your file and to be told what it means.

**The information will be used in the following ways:**
- to explore the usefulness of Hamm Clinic services to you
- to provide results of any testing or assessment in language you can understand
- to determine treatment plans and goals
- to understand possible outcomes and side effects of services
- to anticipate expected length and cost of services
Exceptions to Confidentiality

Information cannot and/or will not be kept confidential in the following circumstances:

1. MN Statutes, Section 626.556, requires that any and all social service agencies and their personnel report:
   a. any incident or knowledge of suspected neglect, physical or sexual abuse or mental injury of children to Child Protection Services. (We respect your privilege to report any incidents personally prior to our report.)
   b. any maltreatment of vulnerable adults as specified in the Vulnerable Adults Act (MN Statutes, Section 626.557).
2. If federal law requires that we disclose the information.
3. If you sign a consent to the release of the information.
4. If a court order requires information to be released or the release is otherwise required by law.
5. If personnel within this agency, because of their work assignments, require access to the information.
6. We send grouped data (without identifying clients by name or contact info and pursuant to the HIPAA “de-identification” standards) to community agencies, funding sources, and for research and training purposes.
7. If you are required to be in treatment by the courts (i.e., court-ordered, probation, child protection services or parole), then Hamm Clinic will send progress reports to the assigned contact.
8. In an effort to save your life or someone else’s life, Hamm Clinic will do whatever possible to prevent a suicide or homicide. Hamm Clinic will also contact the police and/or the suspected victim in any case where we have reason to fear for someone’s safety or well-being.
9. All other agencies or individuals must have a court order to review client information.

Any revisions to the Notice will be provided to current and new clients at the individual’s next session, via the agency website, or by having copies available at the agency site.

Complaints may be made to Hamm Clinic and/or the Department of Health and Human Services Office of Civil Rights, without fear of retaliation by the organizations if the individual believes their privacy rights have been violated. For questions or complaints about data privacy or client privacy rights, you may contact the Director of Clinical Services. A complaint to the Office of Civil Rights may be filed in writing through fax, email, or the OCR Complaint Portal or by mail at:

Office for Civil Rights
U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601

Grievance Procedure

It is our goal and hope that your experience at Hamm Clinic will be helpful and satisfying. In the event you have a concern or question about the services you receive at Hamm Clinic please discuss it with your provider. If you prefer, you may ask to speak with the Director of Clinical Services or the Executive Director. If you are not satisfied with the response you receive, you may make a written request for administrative review. Your complaint or concern will be investigated, and you will receive a written response from Hamm Clinic within 30 days. A written description of the complaint procedure is available upon request at the front desk. You may also file a complaint with the Minnesota Department of Human Services, 444 Lafayette Road N., St. Paul, MN 55155.

Access

Clients have the right to view their protected health information (PHI), with a few exceptions: If a doctor or licensed provider believes that it will be harmful to the client or others or information compiled in anticipation of, or for use in, a civil, criminal or administrative action or proceeding.
Clients may read the information in their file and may also have copies of the information in their file. For any questions about who has access to information, please see your provider. Clients may have the information explained to them by a Hamm Clinic provider and may request corrections, additions, or amendments to any information in their client chart. Hamm Clinic is not required to agree to make the changes requested. In these cases, the client’s request will accompany relevant documents that are released with proper authorization.

Benefits and Risks
Research has shown that mental health care can be beneficial and effective in helping people deal with emotional, relational, and developmental issues. However, benefits and specific outcomes cannot be guaranteed, and there are some risks involved. Therapy and psychiatry offer an environment to process unpleasant issues, present and past, and may cause negative feelings to arise, which may include loneliness, sadness, anger, and others. Your provider will support you through the process.

Staff Consultation
In order to provide you with the best care, Hamm Clinic providers, including staff, fellows, interns, and psychiatric residents, may occasionally find it helpful to consult other professionals about a case. These consultations occur between your provider and their supervisor, as well in professional consultation meetings. Your provider may consult with another member of our professional staff concerning the service we provide you to ensure you are receiving the highest quality care. Hamm Clinic providers may also consult outside professionals about client cases; when consultation outside Hamm Clinic is sought, our providers do not reveal the identity of the client. If you don’t object, our providers will not tell you about these outside consultations unless we feel that it is important for you to know.

Audio or Video Recording
No audio or video recording of a treatment session will be made without client written permission. No one except Hamm Clinic staff or a clinical consultant contracted by Hamm Clinic will view or listen to a treatment session or recording of a session, or read a verbatim transcript of a session, unless the client gives permission.

Research and Evaluation
Hamm Clinic conducts ongoing research designed to evaluate and improve our work. You may view information about our published research on our website www.hammclinic.org. Currently, we routinely use a research instrument called the Outcome Questionnaire (OQ). You will receive the OQ at Intake and then on a regular basis after that. We may also offer you the opportunity to use a client feedback instrument called the PCOMS. This brief instrument is completed in session to give immediate feedback. Participation in completing either instrument is not a condition of therapy. It is voluntary, but important. When you complete these instruments, you consent to having your numerical ratings and not your personal information used to determine the effectiveness of Hamm Clinic services. We strive to provide the highest quality services possible, and your feedback is crucial in meeting this goal. We welcome any questions or feedback you have about our research.

Client’s signature___________________________________________________ Date____________

Hamm Clinic Staff signature__________________________________________ Date____________
<table>
<thead>
<tr>
<th>Contact Information</th>
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<tbody>
<tr>
<td>Last Name:</td>
</tr>
<tr>
<td>Preferred Name:</td>
</tr>
<tr>
<td>Street Address:</td>
</tr>
<tr>
<td>Billing Street Address (if different):</td>
</tr>
<tr>
<td>Home Phone:</td>
</tr>
<tr>
<td>Safe to Call? Y N</td>
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<tr>
<td>Safe to Call? Y N</td>
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<tr>
<td>Person to Contact in an Emergency:</td>
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<tr>
<th>Demographics (optional):</th>
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<tbody>
<tr>
<td>Race:</td>
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<tr>
<td>☐ African American or Black</td>
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<tr>
<td>☐ American Indian or Alaska Native</td>
</tr>
<tr>
<td>☐ Asian</td>
</tr>
<tr>
<td>☐ Caucasian White or Non-Latinx</td>
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<tr>
<td>☐ Latinx or Hispanic</td>
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<tr>
<td>☐ Native Hawaiian or Other Pacific Islander</td>
</tr>
<tr>
<td>☐ Other Race</td>
</tr>
<tr>
<td>Please check if you have:</td>
</tr>
<tr>
<td>☐ Visual impairment</td>
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<tr>
<td>☐ Hearing impairment</td>
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<tr>
<td>☐ Mobility impairment</td>
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<tr>
<td>☐ Learning disability</td>
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<td>☐ Other:</td>
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<tr>
<td>Individual annual income:</td>
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<tr>
<td>☐ Less than $10,000</td>
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<tr>
<td>☐ $10,000 - $19,999</td>
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<tr>
<td>☐ $20,000 - $29,999</td>
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<tr>
<td>☐ $30,000 - $39,999</td>
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<tr>
<td>☐ $40,000 - $49,999</td>
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<tr>
<td>☐ $50,000 +</td>
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<tr>
<td>Gender:</td>
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<tr>
<td>☐ Male</td>
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<tr>
<td>☐ Female</td>
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<tr>
<td>☐ Other:</td>
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<tr>
<td>Pronouns:</td>
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<td>☐ He</td>
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<td>☐ She</td>
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<td>☐ They</td>
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<tr>
<td>☐ Other:</td>
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<tr>
<td>Sexual Orientation:</td>
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<tr>
<td>☐ Heterosexual</td>
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<tr>
<td>☐ Gay/LGBTQ</td>
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<tr>
<td>☐ Lesbian</td>
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<tr>
<td>☐ Bisexual</td>
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<tr>
<td>☐ Other:</td>
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<tr>
<td>Relationship Status:</td>
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<tr>
<td>☐ Single</td>
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<tr>
<td>☐ Married</td>
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<td>☐ Engaged</td>
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<tr>
<td>☐ Widowed</td>
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<tr>
<td>☐ Divorced</td>
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<tr>
<td>☐ Separated</td>
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<tr>
<td>☐ Other:</td>
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<tr>
<th>Ethnic/Cultural Identity:</th>
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<tbody>
<tr>
<td>We recognize that the Federal racial categories listed above are limiting. Please write below whatever terms or phrases you find most descriptive of your ethnic or cultural identity or identities.</td>
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<tr>
<th>What is the highest level of education you've completed? (please circle one):</th>
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<tbody>
<tr>
<td>High School/GED</td>
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<tr>
<td>Technical/Trade School</td>
</tr>
<tr>
<td>Some College</td>
</tr>
<tr>
<td>Associates Degree</td>
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<tr>
<td>Bachelor's Degree</td>
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<tr>
<td>Master's Degree</td>
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<tr>
<td>Doctoral Degree</td>
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<tr>
<th>Current Occupation:</th>
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<tbody>
<tr>
<td>Military Status:</td>
</tr>
<tr>
<td>☐ Active Duty</td>
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<tr>
<td>☐ Veteran</td>
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<tr>
<td>☐ None</td>
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<tr>
<th>Referral Information</th>
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<tbody>
<tr>
<td>How did you learn about Hamm Clinic?</td>
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### Primary Insurance Information

<table>
<thead>
<tr>
<th>Insurance Company Name:</th>
<th>ID #:</th>
<th>Group #:</th>
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<table>
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<tr>
<th>Policy Holder Name:</th>
<th>Relationship to you:</th>
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### Secondary Insurance Information

<table>
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<tr>
<th>Insurance Company Name:</th>
<th>ID #:</th>
<th>Group #:</th>
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<tr>
<th>Policy Holder Name:</th>
<th>Relationship to you:</th>
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</table>

### Prescription Insurance Information

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<tr>
<th>Insurance Company Name:</th>
<th>ID #:</th>
<th>Group #:</th>
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<table>
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<tr>
<th>Policy Holder Name:</th>
<th>Relationship to you:</th>
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### Preferred Pharmacy

<table>
<thead>
<tr>
<th>Pharmacy Name:</th>
<th>Pharmacy Address:</th>
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<tbody>
<tr>
<td>Pharmacy Phone #:</td>
<td></td>
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### Primary Care Provider

<table>
<thead>
<tr>
<th>Primary Provider Name:</th>
<th>Clinic Name:</th>
</tr>
</thead>
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<table>
<thead>
<tr>
<th>Primary Provider Address:</th>
<th>Primary Provider Phone #:</th>
</tr>
</thead>
</table>

### Acknowledgement of Receipt of HIPPA Privacy Practices

I have received the notice of privacy practices which outline the Health Insurance Portability and Accountability Act (HIPAA) Standards.

___________________________________________________________                       __________________________
Signature                                                                                             Date
Current Insurance Coverage Questionnaire

Client Name:                                      Date:

I presently have health insurance that I elect to use for services at Hamm Clinic:

  o  Yes
  o  No

If yes, please complete the fields below:

  Insurance Name:

  Insured's Name (if not self):

  Insurance ID:                       Group Number:

  Insurance Phone Number (from the back of the card):

If no, do you plan to pay full fee or elect to apply for the reduced, sliding fee scale?:

  o  Full Fee
  o  Sliding Fee Scale

Client’s signature______________________________________ Date__________

Hamm Clinic Staff signature_______________________________ Date__________
AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE AND/OR MEDICAL ASSISTANCE CARRIERS AND
AUTHORIZATION FOR ASSIGNMENT OF BENEFITS TO HAMM CLINIC

I, __________________________________________ (name)

__________________________________________ (address)

Authorize Hamm Memorial Psychiatric Clinic to release to the following insurance company:

__________________________________________ (name)  __________________________________________ (address)

The information they require, including but not limited to: my name and the name of the person who is insured, my
diagnosis, services I receive, persons providing and supervising these services, other information required on the
health insurance claim form, treatment plan information, therapy goals, nature of therapy, anticipated number of
sessions, statements of progress including summaries of therapy, psychological testing information and results, and
any other information necessary to satisfy the requirements of the insurance or medical assistance carrier.

I understand that the information is to be reviewed by the insurance or medical assistance carrier personnel who
will determine eligibility for coverage of services and/or authorize services to be received at Hamm Clinic.

I understand the information released is subject to protection as private data to the extent permitted by law and will
not be released to others without my consent.

I recognize that Hamm Clinic cannot guarantee the confidentiality of information released by it under this
authorization, but it is my intent that the insurance/medical assistance carrier use it only for purposes of
determining eligibility, authorizing services, and authorizing payment of services.

I also authorize the payment of all benefits for which I am entitled from the above-named insurance company be
made directly to Hamm Clinic.

Furthermore, I understand that I may rescind this authorization at any time by giving written notification to Hamm
Clinic, and that otherwise it will expire on _____________________________. If no date is
specified, this authorization will automatically expire one year from the date of my signature.

I fully understand all the above and my consent on this form is freely given.

__________________________________________  __________________________________________
Signature of Client                                Date of Signature

__________________________________________
Legal Guardian (if applicable)

04/2020
Fee Agreement

Client Name: ____________________________________________________________

Client Date of Birth: _________________________________     Client ID: _______________________

THIS IS NOT A GUARANTEE OF PAYMENT FROM YOUR INSURANCE COMPANY.
CLIENTS ARE ENCOURAGED TO CONTACT THEIR INSURANCE COMPANIES REGARDING THEIR BENEFITS.

Client Payment Responsibilities
• If my health insurance has a copay, I understand this copay is due at the time of service and I agree to pay at each visit until the out of pocket maximum for my insurance plan has been met.
• If my health insurance has co-insurance or a deductible, I agree to pay the balance due at each visit.

Assignment of Insurance Benefits
• I certify that the financial and insurance information provided is true and accurate to the best of my knowledge.
• I authorize Hamm Clinic to verify insurance information from my clinical records to my insurance company, Medical Assistance, MN Care or other 3rd party sources for payment of therapy-psychological services.
• I authorize payments directly to Hamm Clinic.
• I agree this authorization shall be valid for the duration of my treatment unless I revoke consent, either in writing or in person.

Client Rights and Responsibilities
• This is to certify that I have received a copy of the Client’s Rights and Responsibilities Statement and the Privacy Rights Statement.
• If I have health insurance and choose not to access for reimbursement of services, I agree I am responsible for payment of the full fee, unless I meet the qualifications for a Sliding Fee Agreement outlined on the Hamm Clinic Sliding Fee Application.
• I understand that I am requested to call to cancel any appointments at least 24 hours in advance. Failure to notify Hamm Clinic more than 24 hours in advance may result in prevention of scheduling future appointments.

I understand that this is not a guarantee of payment from my insurance company and that
I am responsible for all balances not covered by my insurance.

________________________________________________________ ______ / ______ / 20_____
Signature        Date
Thank You for Choosing Hamm Clinic

It is our hope and intent that attention and compliance to our policies will facilitate improved access to both present and future clients of Hamm.

Copayments & Co-Insurance

Please remember that all co-payments are due and payable at the time of each office visit. Ignoring fee payment responsibility may result in suspension or termination of services.

Clients with No Insurance or High Deductibles

Clients with no insurance or high insurance deductibles may qualify for our sliding fee based on documentable household income and number of dependents. All clients approved for sliding fee services will need to complete a Reduced Fee application and routinely provide updated documentation of household income. The delay of providing documentation will result in services billed at full fee. The ability to offer reduced fee services is a result of the establishment of the Hamm Foundation allowing clients to access services in an affordable manner. These resources are limited and intended to be used for those clients with the greatest financial need. **Failure to pay your agreed upon sliding fee may result in suspension or termination of services.**

Client Past Due Accounts

If you have an account that is currently past due, please discuss this with the Billing Specialist. It will be necessary to set up a payment plan and adhere to your agreed upon plan so that we can continue to serve you. Past due accounts with no agreed upon payment plan may result in suspension or termination of services. **Failure to pay the agreed upon payment plan amount may also result in suspension or termination of services.**

*Please sign and date below to acknowledge you have received our Financial Policies Communication.

_________________________   _____ / _____ / 20 _____
Signature                  Date

_________________________
Client ID
Consent for E-Mail and Text Message (SMS) Communication

Name: __________________________________________________________

EMAIL COMMUNICATION
By signing, I allow Hamm Clinic staff to communicate with me about my health using electronic mail (e-mail) and/or text message (SMS) communication (see reverse).

Important Points:
- E-mail is not private or “secure”.
- E-mail can be altered or “forged”.
- E-mail can be forwarded without your permission (either on purpose or by mistake). If forwarded, the information may no longer be protected by HIPAA privacy rules.
- Backup copies of e-mail may exist even after it has been deleted.
- E-mail may not be seen or answered right away. Please call for urgent issues.
- A copy of all e-mail communication is added as a part of the medical record. E-mail can be used in court cases whether or not the information relates to your diagnosis and treatment.

Additional Legal Information:
- You may withdraw or cancel this authorization at any time by sending written notification to the Hamm Clinic business address listed below. Your withdrawal will not apply e-mails or text messages sent before the written notice is received.
- A personal representative (for example: a legal guardian or parent) may sign this authorization after the clinic receives documentation of the personal representative’s authority to act for the client.

I (we) understand the information stated above and understand that e-mail is not a secure means of communication. I understand that the provider may decline to communicate via e-mail depending on the nature of the medical information. I give permission for Hamm Clinic to use electronic mail (e-mail) as a means of communication regarding my care. I understand that I may withdraw this authorization at any time by notifying Hamm Clinic in writing.

Client Signature: ____________________________________________ Date: ______________

Client Email Address(es): ____________________________________________

Hamm Clinic
408 St. Peter Street Suite 429
Saint Paul, MN 55102–1109
Informed Consent for TeleMental Health Services

Client Name:________________________________  DOB:____________

Telemental health services do not change your rights to privacy or your protected health information. Hamm Clinic TeleMental Health Services involve the use of HIPAA compliant, live, two-way interaction between the client and provider using audio-visual technology for the delivery of mental health services to and from remote locations. These interactive systems are compliant with current privacy regulation.

By signing this consent form:

• I consent to receive outpatient mental health services by means of telemental health technology.
• I understand that I will not physically be in the same room as my telemental health provider.
• I understand that while the session is conducted via HIPAA compliant software, factors in my own environment (others present, privacy of the location) may impact the confidentiality of my sessions.
• I understand that all documentation and storage of my protected health information will take place in the electronic health record utilized by Hamm Clinic.
• I understand that either my telemental health provider or I can discontinue the visit if the telemental health services are not adequate for my situation.
• I understand that I will be informed if individuals other than my telemental health provider are present in the room at the time of service, and I have the right to request non-medical personnel to leave the room and/or terminate the service.
• I allow Hamm Clinic to submit insurance claims on my behalf and I agree to pay in full any balance due for services not covered by my health insurance.
• I understand that my provider can terminate telemental health therapy services if they determine that I would receive a greater benefit from in-clinic services. My provider will assist me in locating the appropriate resources and will complete the referral.

This authorization expires one year from the date indicated below.

_________________________________________________________  ____________________________
Signature of Client/Parent/Legal Guardian                    Date

_________________________________________________________  ____________________________
Signature of Hamm Provider                                   Date
TeleMental Health
Client and Provider Agreement

Client Agrees to:

- Attend scheduled therapy appointments:
  - [ ] in my home  [ ] at another approved secure location: __________________
- Attend all scheduled therapy sessions and will call Hamm at 651-224-0614 if unable to attend. I understand that cancellations within 24 hours for therapy and 48 hours for psychiatry will be seen as a missed appointment.
- Arrive to sessions on time, if I am 15 or more minutes late, I understand I will not been seen by my therapist or psychiatrist that day and it will be considered a missed appointment.
- Attend sessions in a secure location and understand that if it appears to my therapist that I am not at my home or previously approved secure location the session will be ended immediately.
- Follow Hamm Clinic’s missed appointment policy and understand that if I choose not to, I may be switched from telemental health to in-clinic services. I understand that if I am terminated from the telemental health program, I will receive services in clinic for six months prior to being considered for telehealth again.
- Attend sessions free of the influence of alcohol or other illegal drugs.
- Complete a client emergency plan as part of my first telemental health session and to follow that plan if a crisis arises.
- Contact my local emergency room or county crisis mental health support if I am experiencing a mental health crisis between sessions.
- Provide up to date insurance information. Copays are due at the time of service. I will be responsible for making deductible and co-insurance payments in a timely manner. Hamm Clinic accepts credit, debit and HSA cards.
- Complete all necessary consents, screeners, releases and additional paperwork in a timely manner and return to the clinic.

Therapist Agrees to:

- Conduct therapy effectively and in accordance with standard practices.
- Conduct therapy in an ethical, professional manner.
- Maintain a set schedule and will let clients know as soon as possible about a planned absence. I will also make every effort to reschedule if I am out sick.
- Maintain confidentiality, with the understanding that there are situations that I cannot legally keep confidential, for example, high risk of suicide, child abuse or harm to others.

Hamm Clinic reserves the right to terminate telemental health services at any time for any reason.

Client Signature_____________________________________________ Date_____________________

Provider

Signature____________________________________________________ Date_____________________


AUTHORIZATION AND CONSENT TO RECEIVE TEXT MESSAGES FOR APPOINTMENT REMINDERS

I request that Hamm Clinic send text messages to a mobile device of my choosing to remind me of the date and time of my scheduled appointments. I understand my wireless carrier may charge me for such messages.

➢ I understand that communicating outside of the office setting is less secure than in-office communication, and that text communications may be unintentionally viewed by others.
➢ I understand Hamm Clinic does not receive text messages of any kind and I will not receive a reply from Hamm Clinic if I try to respond to a reminder text. Hamm Clinic provides this text reminder service as a convenience to its clients.
➢ I may withdraw this consent at any time by notifying the Front Office staff.
➢ I understand I will need to complete a new Authorization and Consent to Receive Text Messages for Appointment Reminders form if I would like to be contact at a different number.

I would like my text message to be sent: (please check one)

☐ TWO DAYS IN ADVANCE
☐ ONE DAY IN ADVANCE
☐ SAME DAY (You will receive the text message approximately 4 hours prior to your appointment)

I understand that Hamm Clinic still requires at least 24 hours’ notice for cancelation of therapy appointments and 48 hours’ notice for cancelation of Psychiatry appointments.

_________________________________________________________  ____________________________________________
Name of Client Phone Number for Receiving

_________________________________________________________  ____________________________________________
Signature of Client Date
Thank you for choosing Hamm Clinic as your mental health care provider. The following is a statement of our Attendance Policy.

**Late Cancelled or Missed Appointments:**

As with all healthcare services, it is important to keep the appointments you schedule. If appointments must be cancelled, Hamm Clinic requires 48 hours’ notice to cancel a psychiatry appointment or psychological assessment appointment and 24 hours’ notice to cancel a therapy appointment.

1. **For Therapy:** If you miss or late cancel (less than 24 hours’ notice) 3 appointments in a row, your chart will be closed from all services at Hamm. You are welcome to contact the clinic to request to be added to the waitlist for services.

2. **For Psychiatry:** If you miss or late cancel (less than 48 hours’ notice) 3 appointments in a row, your chart will be closed from psychiatry services at Hamm. You are welcome to discuss re-starting psychiatry services with your therapist.

3. If you miss or late cancel 3 out of every 8 scheduled appointments, your chart will be closed from all services at Hamm. As above, you are welcome to contact the clinic to request to be added to the waitlist for services.

*Please Note: If your chart is closed from therapy services at Hamm Clinic, you will be unable to continue your care with your psychiatric prescriber. The prescriber will make a plan for transferring your care with you.*

**Late Arrivals:**

In order to provide the best service possible, Hamm Clinic schedules appointments for a specific day and time. We hope you will make every effort to keep your appointments and to attend at the scheduled time. Please note:

4. If you are 15 minutes late, there is no guarantee you will be seen by your psychiatry or therapy provider. You will not be seen by your provider if you are 25 minutes late.

5. For group therapy participants, you will not be admitted to a group appointment if you are 20 minutes late.

**ACKNOWLEDGEMENT OF RECEIPT OF ATTENDANCE POLICY**

I have received and reviewed the Hamm Clinic Attendance Policy.

_________________________________________  _____________

**Client Signature**  **Date**

_________________________________________  _____________

**Provider Signature**  **Date**
HEALTH AND PERSONAL HISTORY FORM

Client Name: ___________________________ Client Account Number: ___________________________

Date of Birth: ___________________________ Today's Date: ___________________________

*Please fill in such information as you know, or have readily at hand

Healthcare Information

Who is your primary physician/clinic? ____________________________________________
When was your last checkup/visit? _______________________________________________

List all current Medications
*Please list medications:
  vitamins, and supplements: ____________________________________________________
  Psychiatry Medications, if any _______________________________________________

_________________________________________________

Any drug or other allergies?  Y  N
  List if known
    ________________________________________________

Any serious childhood illness?  Y  N
  _________________________________________________

Any adult illnesses or infections?  Y  N
  _________________________________________________

Any Surgeries?  Y  N
  _________________________________________________

Any illness in Family/relatives?  Y  N
  _________________________________________________
### Current Physical Concerns (review by "systems")

1) Weight change/fevers: Y  
   Overall Health/Nutrition?

2) Problems with eyes/vision? Y

3) Problems with ears/hearing? Y

4) Nose/throat/sinus trouble? Y

5) Chest, asthma, lung concern? Y
   Smoking, if any? Y
   Hearth Rhythm disorder? Y

6) Heart, high blood pressure? Y

7) Stomach, bowel, digestion? Y

8) Kidney or bladder concerns? Y

9) [Women] Pregnancy, delivery? Y
   Pelvic/breast exam? Y

10) Any sexual concerns? Y
11) Diabetes, thyroid, endocrine trouble? Y N
*Cholesterol or lipid concerns? Y N

12) Bone, joint pain, arthritis? Y N

13) Headaches, dizziness, stroke? Y N
*Head Injury or trauma? Y N

14) Bleeding, anemia, or cancer? Y N

15) Skin rash, cuts or bruises? Y N

16) Any other health concerns? Y N
CAGE-AID Questionnaire

Name________________ Date __________

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

In the last six months:

1. Have you ever felt that you ought to cut down on your drinking or drug use? 
   Yes  No

2. Have people annoyed you by criticizing your drinking or drug use?
   Yes  No

3. Have you ever felt bad or guilty about your drinking or drug use?
   Yes  No

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?
   Yes  No

Permission for use granted by Richard Brown, MD
Somatic Symptom Scale – 8 (SSS-8)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Somewhat</th>
<th>Quite a bit</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stomach or bowel problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Back pain</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Pain in your arms, legs, or joints</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Headaches</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Chest pain or shortness of breath</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Dizziness</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Feeling tired or having low energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Trouble sleeping</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

During the past 7 days, how much have you been bothered by any of the following problems?

# PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the **last 2 weeks**, how often have you been bothered by any of the following problems? *(Use “✔️” to indicate your answer)*

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**FOR OFFICE CODING**

1. Not at all
2. Somewhat difficult
3. Very difficult
4. Extremely difficult

= **Total Score:**

---

If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all □
- Somewhat difficult □
- Very difficult □
- Extremely difficult □

---

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.
Outcome Questionnaire (OQ®-45.2)

Name: ___________________________
Date: ___________________________

1. I get along well with others.  
2. I tire quickly.  
3. I feel no interest in things.  
4. I feel stressed at work/school.  
5. I blame myself for things.  
6. I feel irritated.  
7. I feel unhappy in my marriage/significant relationship.  
8. I have thoughts of ending my life.  
9. I feel weak.  
10. I feel fearful.  
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark “never”)  
12. I find my work/school satisfying.  
13. I am a happy person.  
14. I work/study too much.  
15. I feel worthless.  
16. I am concerned about family troubles.  
17. I have an unfulfilling sex life.  
18. I feel lonely.  
19. I have frequent arguments.  
20. I feel loved and wanted.  
21. I enjoy my spare time.  
22. I have difficulty concentrating.  
23. I feel hopeless about the future.  
24. I like myself.  
25. Disturbing thoughts come into my mind that I cannot get rid of.  
26. I feel annoyed by people who criticize my drinking (or drug use). (If not applicable, mark “never”)  
27. I have an upset stomach.  
28. I am not working/studying as well as I used to.  
29. My heart pounds too much.  
30. I have trouble getting along with friends and close acquaintances.  
31. I am satisfied with my life.  
32. I have trouble at work/school because of drinking or drug use. (If not applicable, mark “never”)  
33. I feel that something bad is going to happen.  
34. I have sore muscles.  
35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.  
36. I feel nervous.  
37. I feel my love relationships are full and complete.  
38. I feel that I am not doing well at work/school.  
39. I have too many disagreements at work/school.  
40. I feel something is wrong with my mind.  
41. I have trouble falling asleep or staying asleep.  
42. I feel blue.  
43. I am satisfied with my relationships with others.  
44. I feel angry enough at work/school to do something I might regret.  
45. I have headaches.  

Almost Never Rarely Sometimes Frequently Always
Authorization to Release Protected Health Information

Name___________________________________

First Middle Last

Birth Date__________________

Month/Day/Year

Release Information: TO or FROM (choose one): Hamm Clinic

408 Saint Peter Street, Suite 429
St. Paul, MN 55102
Phone: 651-224-0614
Fax: 651-224-5754

Release Information: TO or FROM (choose one):

Agency or Person: ________________________

Address: ______________________________________________________________

City/State/Zip: __________________________________________________________

Phone: ______________________________________________________________

Fax: ______________________________________________________________

*I authorize both parties indicated above to continue an on-going exchange of information, including verbal consultation for the duration of my treatment: YES or NO (choose one)

Purpose of Release:

☐ Treatment/Continued Care ☐ Personal ☐ Legal

☐ Other (specify) ________________________________

Information to be Released:

☐ Diagnostic Assessment ☐ Psychiatric Evaluation

☐ Psychological Evaluation ☐ Progress Notes

☐ Medication Information ☐ Summary of Treatment (Closing)

☐ Other (specify) ________________________________

I authorize Release of Information indicated above. This authorization may be revoked at any time, except to the extent that action has been taken in reliance on it. Revocation must be made in writing to the provider/facility releasing the information. Hamm Clinic will not condition the treatment on whether I sign the authorization. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the law. I understand the information to be released may include records related to behavioral and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS and genetics. I may be charged for copies in accordance with state law.

I want to receive a copy of this authorization form: YES or NO (choose one)

This authorization will expire one year from this date of signing except as noted above or unless I indicate an earlier date or event here: __________________________________________

Signature: ________________________________ Date Signed: ____________

Printed name of person signing (if not patient): ___________________________________

Indicate your legal authority to sign and provide documentation of authority.
Authorization to Release Protected Health Information

Name_________________________________________ Birth Date________________________

First         Middle         Last      Month/Day/Year

Release Information: TO or FROM (choose one): Hamm Clinic
408 Saint Peter Street, Suite 429
St. Paul, MN 55102
Phone: 651-224-0614
Fax: 651-224-5754

Release Information: TO or FROM (choose one):
Primary Care Doctor/Clinic: ________________________________

Address: ____________________________________________

City/State/Zip: _______________________________________

Phone: ______________________________________________
Fax: ________________________________________________

*I authorize both parties indicated above to continue an ongoing exchange of information, including verbal consultation for the duration of my treatment: YES or NO (choose one)

Purpose of Release:

☐ Treatment/Continued Care       ☐ Personal       ☐ Legal
☐ Other (specify) ______________________________

Information to be Released:

☐ Diagnostic Assessment       ☐ Psychiatric Evaluation
☐ Psychological Evaluation    ☐ Progress Notes
☐ Medication Information      ☐ Summary of Treatment (Closing)
☐ Other (specify) ______________________________

I authorize Release of Information indicated above. This authorization may be revoked at any time, except to the extent that action has been taken in reliance on it. Revocation must be made in writing to the provider/facility releasing the information. Hamm Clinic will not condition the treatment on whether I sign the authorization. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the law. I understand the information to be released may include records related to behavioral and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS and genetics. I may be charged for copies in accordance with state law.

I want to receive a copy of this authorization form: YES or NO (choose one)

This authorization will expire one year from this date of signing except as noted above or unless I indicate an earlier date or event here: ________________________________

Signature: __________________________Date Signed: ______________

Printed name of person signing (if not patient): ________________________________

*Indicate your legal authority to sign and provide documentation of authority.
Hamm Clinic Prescribing and Medication Refill Policies

Our goal is to work collaboratively with you to provide the most appropriate and effective psychotherapy and psychiatric treatments available at the clinic. If you are referred to psychiatry services here for evaluation and/or medications, your treatment plan may include prescriptions. Hamm Clinic authorizes prescriptions through our electronic health record systems; most prescriptions can be sent electronically to a pharmacy of your choice. An adequate supply of medication will be authorized to last until your next regularly scheduled psychiatry appointment.

1. If you experience difficulties with medications, if symptoms are worsening or if you have concerns about your treatment with medication, please call the Hamm Clinic for assistance. Ask for your treating psychiatric provider or the staff nurse/medical assistant.

2. For treatment to be adequately monitored, timely face-to-face appointments with your psychiatrist are essential. The best time to arrange for all medication refills is during your appointment with your doctor.

3. For other refills, please call your pharmacy with the information printed on the bottles; they will contact us for further refills. Please allow 3 business days for these requests. More time may be needed for medications which require printed scripts, such as controlled stimulants. The clinic does not provide refills after business hours or on holidays. Please allow adequate time for staff to respond if refills are requested between appointments.

4. Please let us know which pharmacy you use, especially any changes in locations.

5. If follow-up appointments are missed or cancelled, the clinic will provide only a limited quantity of medications to last until you are again seen in office. These interim refills require that a follow up appointment be made. If you are out of medication for any other reason, your pharmacy may be able to provide an emergency several day supply until you can be seen.

6. By state and federal laws, prescriptions for certain “controlled” classes of medication must be printed out at the clinic, on special paper and for one month only. If these are lost or misplaced, they will not be re-written for that month.

7. If concerns arise that medications are being misused, refills may be withheld or a written contract regarding medication adherence may be requested.

8. Your therapist is part of your care team, but medication issues – especially access and refills – are best directed to your psychiatry staff and our nurse.

I have read and understand the above and agree to Hamm Clinic’s prescribing and refill policies. I have been given a copy of this policy.

_____________________________________________________________________________________
Name of Client

_____________________________________________________________________________________
Signature of Client          Date

FOR OFFICE USE ONLY

Client Account Number: ______________________
Date of Renewal: ______________________