For the first appointment it will be helpful if you download, print and complete the following forms before your appointment:

- *Demographic Information* form.
- *Assignment of Benefits* form - authorizes Dr. Sethre to bill your insurance company.
- *Record of Disclosures* form- required by the very strict Federal Law the governs the confidentiality of medical information, HIPPA. Dr. Sethre uses it to keep track of information about you that he provides (with your authorization) to others, such as a report to a surgeon.
- *Release of Information* forms - also required by HIPPA. It is important for your health care providers to exchange information about your health care. There are 3 versions of the form. Please complete one form for each provider (typically a primary medical provider or clinic, and mental health specialist, if you are seeing a psychiatrist or therapist). The 3rd version is for other coordination of care such as medical specialists (other than a primary provider or psychiatrist), family, a lawyer, school, etc. The date range, required by HIPPA, should start on the date of your first appointment and go through the end of the year. Dr. Sethre will review the forms to ensure that they are compliant with HIPPA guidelines, and will sign as the "witness."
- If you have any other medical providers that you would like to receive information from Dr. Sethre, you may complete as many of these release forms as needed- just print as many as needed.
- *Patient Information and Rights* form- you keep this form.
- *Bariatric Intake Form.* You may have completed a similar form for your bariatric program, but Dr. Sethre's form covers less medical information and more psychological and "behavioral" information.

Please fill the forms out as best you can. Dr. Sethre will review them with you to make sure that they are complete, and will be glad to answer any questions that you have at the first appointment.

New Patient Demographic Information
Richard F. Sethre, Psy.D., L.P.

Name_____ **Date** _____

Birth date _____ **Relationship status**_____

Address_____
Street City State Zip Code

Emergency Contact (Name/telephone)

Who referred you to Dr. Sethre? _____

***If a professional referral*, may Dr. Sethre notify that professional that you had an initial appointment? ___ Yes ___No**

By law, information provided to mental health professionals is strictly confidential, and may not be disclosed without your written permission, with the specific exceptions listed below. If Dr. Sethre becomes aware of any of these rare situations, he is required by law to file a report, and the recipient of the report may or may not act on this information. *Please review them and initial each one to indicate that you are aware of these exceptions.* If you have any questions or concerns, please discuss them with Dr. Sethre (please initial each line).

- **Abuse of a child or vulnerable adult ____** (initial)
- **Suicidal risk ____** (initial)
- **Risk of physically harming someone else ____** (initial)
- **Information about ethical misconduct by another medical professional ____** (initial)

***I understand that I am responsible to pay copayment, coinsurance and annual deductible fees required by my medical insurance contract.* _____** (initial)

Signature _____
Date ___/_____/_____

Authorization of Benefits Form

Richard F. Sethre, Psy.D.

This form authorizes Dr. Sethre to send a bill to your insurance company and to otherwise communicate with your insurance company, as required by the company. If you have more than once medical insurance policy, please fill out one copy of this form for each policy. Some policies do not have group numbers or a name of the policy, so please just fill it out as best you can and Dr. Sethre will check to make sure it is complete.

PATIENT NAME

Guardian or Parent name (if applicable)

I hereby authorize the release of any medical information necessary to process this claim to the insurance company and/or the responsible party for this account *(please print and sign).*

➡ _____ _____

Signature **Date**

I hereby authorize payment of medical benefits for services rendered to me and/or my dependents to **Richard F. Sethre, PsyD , LP**

Insurance Company
ID Number _____ Group Number _____
Name of Policy (if applicable)
Policyholder's Name
Policyholder's Birth Date (if not the patient)

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL

PRIVACY POLICY

The privacy of your medical information is important to Dr. Sethre. A record of your care will be created for the services received while a patient at Dr. Sethre's office. This record is necessary to provide you with quality care and to comply with State and Federal laws. Dr. Sethre's "Patient Information and Rights" handout provides more detailed information about your privacy rights.

PATIENT RECORD OF DISCLOSURES FORM
Richard Sethre, Psy.D., L.P.

The Federal law governing medical records, HIPAA, gives patients the right to request a restriction on uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications or that a communication of medical information be made by alternative means, such as sending correspondence to the location of their choice (such as to their office instead of their home). There are exceptions to this, which are listed in Dr. Sethre's "Patient's Rights and Responsibilities" handout. You are welcome to discuss any concerns about confidentiality with Dr. Sethre.

PATIENT NAME:

I wish to be contacted in the following manner

Phone communication

□ *Home telephone number*_____

□ *Work telephone* _____

□ *Mobile* _____

□ OK to leave message with detailed information

□ Leave message with call-back number only

□ OK to leave message with detailed information

Written Communication

□ Send mail to my home address

□ Send mail to other address: _____

_____ _____

Patient signature (OR GUARDIAN) **Date**

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for medical information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made in response to an authorization to release information by the patient. Healthcare entities must keep records of disclosures of medical information. Information provided below, if completed properly, will constitute an adequate record.
Note: Uses and disclosures for this information may be permitted without prior consent in an emergency.

FOR OFFICE USE

RECORD OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

Date	Recipient	Description of Disclosure/Purpose	By Whom Disclosed	Mail or Fax

Richard Sethre, Psy.D.
Licensed Psychologist.
1405 Lilac Drive N., #160F
Golden Valley, MN 55422
612-460-0692 fax 612-234-4586
drsethre@mhconcierge.com

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
(OTHER MENTAL HEALTH PROFESSIONAL/PROGRAM)

PATENT NAME:_____ BIRTHDATE:_____

This will authorize Dr. Sethre to: _____ obtain from _____ provide to:

(**therapist, psychiatrist, program**):_____

Location (Name of clinic, city):_____

The information to be disclosed includes but is not limited to: (Cross out any NOT to be released)

Intake Summary Psychological Assessment Report

Interim Treatment Summaries Discharge Summary Phone consultation

Other:_____

FOR THE FOLLOWING TREATMENT DATES: ___/___/___ to ___/___/____
(Specify dates)

I am requesting this information be released for the following purposes:
___ Coordinating care with other professional/program ___Treatment planning
___ Other: _____

I understand I may revoke this authorization at any time to the address listed at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will automatically expire one year from the date of my signature. I understand that once information is released pursuant to this authorization we can not prevent the re-disclosure of this information to another third party.

A COPY OF THIS AUTHORIZATION WILL BE CONSIDERED AS VALID AS THE ORIGINAL

_____ _____
Signature of Patient/Authorized Person Date

If signed by someone other than patient, authorized person's authority to sign: ____ Parent _____ Legal Guardian Other:_____

_____ _____
Witness (may be signed by Dr.Sethre) Date

For office use only: This form was sent by ___ Mail ____ Fax on _____ by _____
Date Staff initials

Richard Sethre, Psy.D.
Licensed Psychologist.
1405 Lilac Drive N., #160F
Golden Valley, MN 55422
612-460-0692 fax 612-234-4586
drsethre@mhconcierge.com

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
(PRIMARY MEDICAL PROVIDER)

PATENT NAME:_____ BIRTHDATE:_____

This will authorize Dr. Sethre to: _____ obtain from _____ provide to:

(**name of primary medical provider, or clinic**):_____

Office Location (Name of clinic, city):_____

The information to be disclosed includes but is not limited to: (Cross out any NOT to be released)

Intake Summary Psychological Assessment Report

Interim Treatment Summaries Discharge Summary Phone consultation

Other:_____

FOR THE FOLLOWING TREATMENT DATES: ___/___/___ to ___/___/____
(Specify dates)

I am requesting this information be released for the following purposes:
___ Coordinating care with PCP ___Treatment planning
___ Other: _____

I understand I may revoke this authorization at any time to the address listed at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will automatically expire one year from the date of my signature. I understand that once information is released pursuant to this authorization we can not prevent the re-disclosure of this information to another third party.

A COPY OF THIS AUTHORIZATION WILL BE CONSIDERED AS VALID AS THE ORIGINAL

_____ _____
Signature of Patient/Authorized Person Date

If signed by someone other than patient, authorized person's authority to sign: ____ Parent _____ Legal Guardian Other:_____

_____ _____
Witness (may be signed by Dr.Sethre) Date

For office use only: This form was sent by ___ Mail ____ Fax on _____ by _____
Date Staff initials

Richard Sethre, Psy.D.
Licensed Psychologist.
1405 Lilac Drive N., #160F
Golden Valley, MN 55422
612-460-0692 fax 612-234-4586
drsethre@mhconcierge.com

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATENT NAME: _____ BIRTHDATE: _____

This will authorize Dr. Sethre to: _____ obtain from _____ provide to

Name: _____

Address: _____

The information to be disclosed includes but is not limited to: (Cross out any NOT to be released)

Intake Summary	Psychological Assessment Report	Court/Probation Reports
Progress Notes	Psychological Assessment Raw Data	History & Physical
Interim Treatment Summaries	Insurance Treatment Plan	Academic assessments
Discharge Summary	Social Service Reports	Phone consultation

Other: _____

FOR THE FOLLOWING TREATMENT DATES: ___/___/___ to ____/___/____
(Specify dates)

I am requesting this information be released for the following purposes:
_____ Coordinating care with another provider ___Treatment planning
___ Other: _____

I understand I may revoke this authorization at any time to the address listed at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will automatically expire one year from the date of my signature. I understand that once information is released pursuant to this authorization we can not prevent the re-disclosure of this information to another third party.

A COPY OF THIS AUTHORIZATION WILL BE CONSIDERED AS VALID AS THE ORIGINAL

_____ _____
Signature of Patient/Authorized Person Date

If not signed by patient, authorized person's authority to sign: ____ Parent _____ Legal Guardian
Other:_____

_____ _____
Witness (may be signed by Dr.Sethre) Date

For office use only: This form was sent by ____ Mail ____ Fax on _____ by _____
Date Staff initials

Richard Sethre, Psy.D.
Licensed Psychologist
1405 Lilac Drive N., #150-F
Golden Valley, MN 55422
612-201-0566 Fax: 612-234-4586
drsethre@mhconcierge.com

PATIENT INFORMATION AND RIGHTS

Most people use their *medical insurance benefits* for mental health services. *Dr. Sethre recommends that if you have any questions about your coverage that you contact your insurance company, using the phone number provided on your insurance card.* If you are using insurance benefits and have an annual deductible, or copayment for each appointment, Dr. Sethre will work with you to arrange a workable payment plan, if needed.

Appointments start and end as scheduled to best serve all patients. If you arrive late, please expect the session to still end at the scheduled time. If Dr. Sethre is late, your appointment will go later to ensure that your entire time is provided.

Dr. Sethre's hourly *fee* is $130 for all professional services, except the initial Intake visit, which is $250. No charge is made for telephone contacts less than ten minutes long. Dr. Sethre is usually readily available by *phone* during his normal business hours, 8:00 am to 5:00 pm. If he is not immediately able to answer your call, you will be able to leave a message. Please speak slowly and clearly, and be sure to state specifically why you are calling. He will receive your message immediately, and will use the information that you provide in your message to help him know when and how to respond.

Insurance company regulations require that charges for therapy sessions be based on your actual time with Dr. Sethre, which usually will be a 25 minute or 50 minute appointment.

Dr. Sethre also may ask you to complete assessment aids, such has psychology or health inventories. There is a charge for this part of the assessment that is separate from the therapy appointment. This charge is usually covered by insurance, although you may have a copayment, co-insurance or annual deductible fee. The fee for this service includes the expense of the materials and computer processing service, and Dr. Sethre's time required to explain the materials, process the results, dictate a report and send the report to any other medical professionals that you authorize. The bill for all of this is usually submitted on the day that the report is completed, which often will not be the day that you completed the assessment materials.

If you have any questions or concerns about Dr. Sethre's bill, please feel free to contact him.

Dr. Sethre is available by phone for a brief *urgent or emergency* consultation during non-business hours, but there are times when he is not immediately available. He will respond as quickly as possible. In an extreme emergency please call the Crisis Connection service at 612-379-6363, or your county crisis line. Or, you may dial 911 or go to hospital emergency room for a life-threatening emergency.

You are welcome to communicate with Dr. Sethre by *email* at drsethre@mhconcierge.com. You are welcome to use this for routine, non-confidential messages. If you contact Dr. Sethre by this email, please keep in mind that non-encrypted email may potentially not be safe from hacking. Dr. Sethre may check his email less often on busy days. *When in doubt, please call. Sending him an email message indicates that it is acceptable for him to respond, and that you are taking responsibility for controlling access to your email account. Please do not include medical or other sensitive information in email messages.*

You are also able to send Dr. Sethre text messages at 612-460-0692. *Text messages should be limited to scheduling information or notifying him that you are running late, but should not include medical or other sensitive information.*

Dr. Sethre understands that receiving a response to all message is important, and his goal is to respond to all messages as soon possible. He does, however, have some days that are busier, and at times it may be necessary for him to respond in the evening, or early the next day.

By law, any information provided to Dr. Sethre may not be conveyed to anyone else without your expressed written consent. *You have the right to refuse to give any information you do not feel comfortable disclosing. You also have the right to have copies of anything in your file.*

There are, however, specific circumstances in which State Law and professional ethical standards place *specific limitations on your confidentiality*. These exceptions are:
1. When there is a clear and present danger of harm to self or another identifiable person.
2. In the case of apparent child abuse or the abuse of a vulnerable adult.
3. In the event of a court order for information.

You have the right to examine public data on Dr. Sethre maintained by the Minnesota Board of Psychology. You have the right to report any complaints about Dr. Sethre to the Minnesota Board of Psychology, 2829 University Ave. SE, Suite 320, Mpls. MN 55414-3239. 612-617-2230 , fax 612-617-2240.

(updated 1-18)