Welcome to Gail Yost and Associates, LLC!

At Gail Yost and Associates, we customize therapy to address your concerns, build on your strengths and work with you in a direction that fits with your priorities. Our team shares a passion for the healing power of connections.

Here are the forms that I'll need filled out or signed before your first visit. Please bring all of the forms with you. I will keep them and provide you with copies upon your request. **Also, if you will be using insurance, please bring your insurance card to the first visit.** I will ask for the copayment (if there is one) at the time of the visit. We take checks, credit/debit cards, and cash.

If you have any questions or concerns about what's on the forms, please feel free to bring them up when we meet. I look forward to meeting with you!

- Nancy Prescott, MSEd, LPCC

Gail Yost and Associates

5000 W 36th Street, Suite 207, St. Louis Park, MN 55416
Office: 651.269.4937 • Secure email: nancy@gailyostandassociates.com

Insurance/Registration Form

Today's Date ________________________

Name (Print)____ **Date of Birth** _____________________
Last Name First Name Middle Initial

Street Address____ Home Phone (_______)________________

City_____________________++++_________State___________ZIP________________________ Work Phone (_______)________________

Gender__________________ Partnership: Sin Mar Wid Div Sep Other _____________ Cell Phone (_______)________________

E-mail address ____ May we send messages to you at this address? _____ _

Employer ____ Occupation ____

Emergency Contact ________________________________ Relationship ____________ Phone numbers ______________________________

How did you learn about us? ____

*Primary Insurance Please note: *I am not a Medicare provider**

Primary Insurance Company____ Phone (_____)________________

Ins. Claims Address____City______________________State________Zip_______________

Policy/ID #____Group/Plan #____________________________________
(This is sometimes the Policy Holder's social security number)

Policy Holder Information: (if the client is not the employee/policy holder)

Name____Relationship __________________________
Last name First Name Initial

Address____ City______________________ State______ Zip________________

Date of Birth_____________ Employer____

Diagnosis ____ Therapist______________________________
(for billing purposes — therapist will fill In) (therapist will fill In)

Secondary Insurance

Secondary Insurance Company____ Phone (_____)________________

Ins. Claims Address____City______________________State________Zip_______________

Policy/ID #____Group/Plan #____________________________________
(This is sometimes the Policy Holder's social security number.)

Policy Holder Information: (if the client is not the employee/policy holder)

Name____Relationship __________________________
Last name First Name Initial

Address____ City______________________ State______ Zip________________

Date of Birth_____________ Employer____

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Responsible Party (Where should the personal portion of the bill be sent, if not to the person named at the top of the page?)

Name____ Relationship ___________ Phone number ________________
Last name First Name Initial

Address____ City__________________ State_____ Zip_______________

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail billing statements. I authorize the use of my psychiatric and/or medical diagnoses on laboratory test order forms. I authorize the use of this signature on all insurance submissions.

____ ______________________________ __________________
Signature of Responsible Person Relationship (self, parent, etc.) Date

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Sharing of Information with Primary Care Provider

Some payers ask us to request your consent to communicate with your primary care provider.

____ There is no need to have my treatment plan mailed to my primary care provider or have you communicate with my primary care provider (No signature needed.)

____ I wish to have a copy of my treatment plan mailed to my primary care provider. I also give you consent to communicate with my primary care provider while I am a patient/client of Gail Yost and Associates.

PRIMARY CARE PROVIDER INFORMATION:

Name: ____

Clinic: ____

Fax Number:________________________________ Phone Number: __________________________________

Address:____

I am aware that Gail Yost and Associates, LLC and Gail Yost cannot ensure that this information will be kept confidential once it has been released to my primary care provider. I understand that my care at Gail Yost and Associates, LLC will not be affected in any way by whether or not I request to have this information sent out. I understand that I may revoke this authorization at any time by writing to Gail Yost. However, the revocation does not apply to actions that have already been undertaken.

Signature: ____ Relationship (self, parent, etc.):__________

Date signed: _________________________

Signature: ____ Relationship (self, parent, etc.):__________

Date signed: _________________________

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General Information

Contacting Me

In case of an emergency, call 911. The phone number for the Crisis Connection (a non-profit agency that provides crisis counseling via telephone) is 612-379-6363. I provide outpatient mental health services and I am not available for crisis care.

The best way to reach me is at my secure e-mail address, which is kate@gailyostandassociates.com. You can also reach me at (612) 817.47815. Please remember that I am NOT available for emergencies. In the case of an emergency, call 911.

Fee for Missed Appointments

I understand that I will be charged $150.00 for a missed appointment, unless the appointment is cancelled, by telephone voice message or e-mail, at least 48 hours in advance. The fee is intended to cover the lost time. I understand that insurance companies and other payers do not pay any part of this fee and it will not be billed to them.

I agree to pay this fee to Gail Yost within one week of the missed appointment:

Signature: ____ Relationship (self, parent, etc.): _________________

Date signed: __________________

Signature: ____ Relationship (self, parent, etc.): _________________

Date signed: __________________

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Legal Matters

I do not perform custody evaluations or disability determination nor do I appear in court on behalf of adults, children, individuals, or families. I do not perform court evaluations. I am not trained for court involvement. I do not write client data for the purpose of court involvement.

If I receive a court order signed by a judge to appear in court or my records are subpoenaed, I will charge a $17.21 processing fee and $1.30 per page for copying. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, and any legal fees that I might incur, even if I am called to testify by another party. I charge $150 per hour for preparation and attendance at any legal proceeding as well as travel time to and from any location. I require a $2,000 retainer fee two weeks prior to the appearance, presentation of records, or testimony requested.

Your signature below indicates that you understand my policies regarding legal matters. Your signature below also indicates that you will NOT call on me (or have an attorney or anyone else call on me) to testify in court or any other proceedings or have your psychotherapy records requested.

Signature: ____ Relationship (self, parent, etc.): ______________

Date signed: ______________

Signature: ____ Relationship (self, parent, etc.): ______________

Date signed: ______________

Possible Risks

Therapy can be a challenging process. Oftentimes, it involves talking about unpleasant aspects of your history or your present situation. This may elicit difficult feelings, such as sadness or anger. At times, symptoms may worsen before they get better. People tend to move through the therapeutic process at different rates.

Your signature below indicates that you understand these risks:

Signature: ____ Relationship (self, parent, etc.): ______________

Date signed: ______________

Signature: ____ Relationship (self, parent, etc.): ______________

Date signed: _______________

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Fee Schedule

For each service there is a 5-digit Current Procedural Terminology code. This system went through a major change as of January 1, 2013. Charges now depend on the complexity of the service that's provided.

In most cases, my fees are determined by my contract with your health plan. These fees will generally be lower than the amounts specified here.

90791: Evaluation/Intake Session (45-50 minutes): $250.00
90832: Individual Therapy Session (16-37 minutes): $125.00
90834: Individual Therapy Session (38-52 minutes): $125.00
90837: Individual Therapy Session (53-90 minutes): $225.00
90847: Family Therapy with the patient present (45-50 minutes): $175.00
90846: Family Therapy without the patient present (45-50 minutes): $175.00
90839: Crisis Session (60 minutes): $200.00
90840: Crisis Session (30 minutes): $125.00
90785: Complexity Add-On: $25.00
90853: Group Therapy (90 minutes): $150.00

Most insurance plans specify a copayment for each visit; it's usually indicated on your insurance card. This copayment is due at the beginning of each visit. We accept cash, checks (made out to "Gail Yost and Associates, LLC"), and credit & debit cards.

Fees are subject to change without notice.

Please inform me immediately if there is a change in your insurance.

Additional Professional Fees

In addition to appointments, I may charge $150 per 45 minutes for other professional services, though I will break down the hourly cost if I work for periods of less than 45 minutes. These services include written reports, telephone conversations lasting longer than 10 minutes, consultations with other professionals (with your permission), preparation of records or treatment summaries, and other services you may request of me. These services may not be covered by insurance. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, and **any** legal fees that I might incur, even if I am called to testify by another party. I charge $150 per hour for preparation and attendance at any legal proceeding as well as travel time to and from any location. I require a $2,000 retainer fee two weeks prior to the appearance, presentation of records, or testimony requested.

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Billing & Payments

You will be expected to pay your portion of the fee for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In a collection situation, the only information I would generally release regarding the treatment is the name, date(s)of service, and the amount due. The cost of collections or legal action will be added to the claim. All balances are subject to a monthly finance charge of $10, which, will accrue monthly.

You should be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above (unless prohibited by contract). I will provide you with a copy of any report I submit, if you request it. By signing this agreement, you agree that I can provide requested information to your carrier.

<u>Please be aware that when you apply for health or life insurance in the future, it's very possible that you will be required to agree to the disclosure of information about any past mental health treatment, if it's been paid for by a third party (a health plan).</u>

Please do not submit our bill to your health care provider unless we instruct you to do so, as this might cause your health care provider to reject our claim. We process all insurance claims on your behalf.

Your signature below indicates that you have read, understood and will adhere to the above information/policies on fees, billing, insurance and payments:

Signature: ____ Relationship (self, parent, etc.): _________________

Date signed: __________________

Signature: ____ Relationship (self, parent, etc.): _________________

Date signed: __________________

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Consent for Sharing of Information within Gail Yost and Associates, LLC

This will authorize Nancy Prescott, MSEd LPCC and any and all members of Gail Yost and Associates, L.L.C., to share with each other any information contained in any records kept by Gail Yost or any other member of the Gail Yost and Associates, LLC about me and any members of my family. I understand that the purpose of this release is to make it possible for members of Gail Yost and Associates, LLC members to work together and to provide mutual consultation.

I understand that I may revoke this authorization at any time by writing to Gail Yost. However, the revocation does not apply to actions already undertaken.

Signature: ___________________________ Relationship (self, parent, etc.): _________________

Date signed: ___________________

Signature: ___________________________ Relationship (self, parent, etc.): _________________

Date signed: ___________________

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Confidentiality

Information about clients and their families is confidential with exception to the following:

-Authorization by the client and/or family (using a valid authorization form).

-Therapist's duty to warn another in the case of potential suicide, homicide or threat of imminent, serious harm to another individual.

-Therapist's duty to report suspicion of abuse or neglect of children or vulnerable adults.

-Therapist's duty to report prenatal exposure to cocaine, heroin, phencyclidine, methamphetamine, and amphetamine or their derivatives.

-Therapist's duty to report the misconduct of mental health or health care professionals.

-Therapist's duty to provide parents of minor children access to their child's records. Minor clients can request, in writing, that particular information not be disclosed to parents. Such a request should be discussed with the therapist.

-Therapist's duty to release records if subpoenaed by the courts.

-Therapist's obligations to contracts (e.g. to an insurance carrier or health plan, or, in some cases, to the client's employer, if the employer is managing the health benefits).

My signature indicates I understand the above limits of confidentiality.

____ ________________
Signature Date

____ ________________
Signature of Parent/Guardian for person under 18 Date

____ ________________
Signature of Parent/Guardian for person under 18 Date

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Client Bill of Rights

Consumers of behavioral health and therapy services offered by professional clinical counselors licensed by the State of Minnesota have the right:

1. to expect that a therapist has met the minimal qualifications of training and experience required by state law;
2. to examine public records maintained by the Minnesota Board of Behavioral Health & Therapy which contain the credentials of a therapist;
3. to obtain a copy of the code of ethics from the Minnesota Board of Behavioral Health & Therapy, 2829 University Avenue SE, Suite 210, Minneapolis, Minnesota 55414-3222;
4. to report complaints to the Minnesota Board of Behavioral Health & Therapy by calling (612) 548-2177;
5. to be informed of the cost of professional services before receiving services;
6. to privacy as defined by rule and law;
7. to be free from being the subject of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services;
8. to have access to their records as provided in Minnesota Statutes, section 144.335, subdivision 2;
9. to be free from exploitation for the benefit or advantage of a therapist.

I consent to treatment, have read and understand my rights listed above.

____ ____________________
Signature Date

____ ____________________
Signature of Parent/Guardian for person under 18 Date

____ ____________________
Signature of Parent/Guardian for person under 18 Date

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MINNESOTA NOTICE FORM

Notice of Gail Yost and Associates, LLC

Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:
"*PHI"* refers to information in your health record that could identify you.
"Treatment, Payment, and Health Care Operations"
– *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or a psychologist.
- *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.
"*Use*" applies only to activities within my [office, clinic, practice group, etc.], such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
"*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If I know or have reason to believe a child is being neglected or physically or sexually abused, or has been neglected or physically or sexually abused within the preceding three years, I must immediately report the information to the local welfare agency, police or sheriff's department.

Adult and Domestic Abuse: If I have reason to believe that a vulnerable adult is being or has been maltreated, or if I have knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, I must immediately report the information to the appropriate agency in this county. I may also report the information to a law enforcement agency.

"*Vulnerable adult*" means a person who, regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:

that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and

because of the dysfunction or infirmity and the need for assistance, the individual has an impaired ability to protect the individual from maltreatment.

Health Oversight Activities: The Minnesota Medical Board may subpoena records from me if they are relevant to an investigation it is conducting.

Judicial and Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law and I must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case.

Serious Threat to Health or Safety: If you communicate a specific, serious threat of physical violence against a specific, clearly identified or identifiable potential victim, I must make reasonable efforts to communicate this threat to the potential victim or to a law enforcement agency. I must also do so if a member of your family or someone who knows you well has reason to believe you are capable of and will carry out the threat. I also may disclose information about you necessary to protect you from a threat to commit suicide.

Worker's Compensation: If you file a worker's compensation claim, a release of information from me to your employer, insurer, the Department of Labor and Industry or you will not need your prior approval.

IV. Patient's Rights and Clinician's Duties

Patient's Rights:

Right to Request Restrictions –You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)

Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI (and psychotherapy notes) in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Clinician's Duties:
I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

If I revise my policies and procedures, I will send you a copy by mail or give you a copy in session.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Gail Yost (owner of Gail M. Yost and Associates, LLC) at 651.269.4937.

If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to:

Gail Yost, MA, LMFT
Gail Yost and Associates, LLC
5000 West 36th Street, Suite 207
St. Louis Park MN 55416

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice went into effect on 9/1/07.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail or in session.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

____ ______________
Signature Date

____ ______________
Signature of Parent/Guardian for person under 18 Date

____ ______________
Signature of Parent/Guardian for person under 18 Date