MINNESOTA MENTAL HEALTH BILL OF RIGHTS

Compassionate Counseling Services, LLC
505 South State Street, Waseca, MN 56093 (507) 310-1321

THE STATE OF MINNESOTA HAS NOT ADOPTED UNIFORM EDUCATIONAL AND TRAINING STANDARDS FOR ALL MENTAL HEALTH PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATION PURPOSES ONLY.

The Mental Health Bill of Rights provides that:

- You have the right to file a complaint in writing or through a phone call with the practitioner's supervisor if there is a supervisor.
- You may file a complaint with the Office of Mental Health Practice, 2829 University Avenue SE, Suite 340, Minneapolis, MN 55414-3239. Their phone numbers are (612) 617-2105; TTY: (800) 627-3529; and fax: (612) 617-2103.
- You, the client, are billed directly for services, or your insurance coverage may be billed with your permission.
- You have a right to reasonable notice of changes in services or charges.
- You have the right to receive a summary, in plain language, of the theoretical approach used by us in working with clients.
- You have the right to complete and current information concerning our assessment and recommended course of treatment, including the expected duration of treatment.
- You have the right to expect courteous treatment and to be free from verbal, physical, or sexual abuse by the practitioner working with you;
- Your records and transactions with us are confidential, unless release of these records is authorized in writing by the client, or otherwise provided by law.
- You have the right to be allowed access to records and written information from records in accordance with Minnesota statutes.
- You have the right to choose freely among available practitioners, and to change practitioners after services have begun, within the limits of health insurance, medical assistance, or other health programs.
- You have a right to coordinated transfer when there is a change in the provider of services.
- You may refuse services or treatment, unless otherwise provided by law.
- You may assert these and other rights without retaliation.

CONFIDENTIALITY STATEMENT
Compassionate Counseling Services, LLC
505 South State Street, Waseca, MN 56093
(507) 310-1321

Under the rules governing Marriage and Family Therapists in the state of Minnesota, a therapist, and employees and professional associates of the therapist, must not disclose any private information that the therapist, employee, or associate may have acquired in rendering services except as follows.

- When the Board of Marriage and Family Therapy is reviewing a therapist. The Board shall be allowed access to records of a client treated by a therapist under review if the client signs a written consent permitting access. If no consent form has been signed, the hospital, clinic, or licensee shall first delete data in the record that identifies the client before providing it to the board.

- When disclosure is required by state law.

- When failure to disclose the information presents a clear and present danger to the health or safety of an individual.

- When the person, employee, or associate is a defendant in a civil, criminal, or disciplinary action arising from the therapy.

- When the patient is a defendant in a criminal proceeding and the use of the privilege would violate the defendant's right to a compulsory process or the right to present testimony and witnesses in that person's behalf.

- When a patient agrees to a waiver of the privilege accorded by this section, and in circumstances where more than one person in a family is receiving therapy, each such family member agrees to the waiver. Absent a waiver from each family member, a marital and family therapist cannot disclose information received by a family member.

All other private information must be disclosed only with the informed consent of the client.

NOTICE OF PRIVACY PRACTICES

Compassionate Counseling Services, LLC
505 South State Street, Waseca, MN 56093
(507) 310-1321

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

We are committed to protecting health information about you by complying with all applicable federal and state privacy and confidentiality laws and regulations. These laws require that health information that identifies you is kept private and confidential. These laws also require that we give you this notice of our legal duties and privacy practices with respect to health information about you, and that we follow the terms of the notice that is currently in effect.

I. Uses and Disclosures WITH Your Authorization

Generally, we will use or disclose your health information only when you give your authorization in writing for us to do so. You may revoke your authorization except to the extent that we have already taken action upon the authorization. There are some exceptions and special rules that allow for uses and disclosures without your authorization or consent, which are set forth below.

II. Uses and Disclosures WITHOUT Your Authorization: All Protected Health Information

Even when you have not given your written authorization, we may use and disclose information under the circumstances listed below.

A. Treatment.

We may use or disclose health information about you for treatment purposes. Treatment includes diagnosis, treatment and other services, including discharge planning. For example, if your counselor decides to consult with another health care provider about your condition, your counselor would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist your counselor in the diagnosis or treatment of your mental health condition. In addition, counselors may disclose your health information to each other to coordinate individual and group therapy sessions for your treatment or to discuss information about treatment alternatives or other health-related benefits and services that are necessary or may be of interest to you.

B. Payment.

Compassionate Counseling Services (CCS) does not work directly with your insurance. However, if you request that CCS submit information to your insurance we may use and disclose

health information about you so that the services you receive may be billed to and payment may be collected from you, an insurance company, or another third party. For example, if you have asked Compassionate Counseling Services to submit information to your health care provider and your health care provider requests a copy of your health records, or a portion thereof, in order to determine whether or not payment is warranted under the terms of your policy or contract, we are permitted to use and disclose your personal health information. We may also tell your health plan about a services you are going to receive, to obtain prior approval or to determine whether your plan will cover the rest of the services.

C. Health Care Operations.

We may use or disclose health information about you for the purposes of health care operations that include internal administration and planning and various activities that improve the quality and effectiveness of care. For example, if you have requested that we submit information to your health care provider and if that provider decides to audit Compassionate Counseling Services in order to review our competence and our performance, or to detect possible fraud or abuse, your health information may be used or disclosed for those purposes. Sometimes we my hire outside parties to help us carry out certain health care operations, such as computer maintenance performed by outside companies. If such outside parties will have any access to you health information when they are performing their jobs, we will require that they appropriately safeguard your information. This list of examples is for illustration only and is not an exclusive list of all of the potential uses and disclosures that may be made for health care operations.

D. Appointment Reminders, Treatment Alternatives, and Additional Services

We may use or disclose health information about you to provide appointment reminders or to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. Be sure to let us know if there are means (e.g., telephone, letter, email, fax) by which you prefer not to be contacted.

E. When Required By Law

We may use or disclose health information about you as required by state or federal law. For example, we may disclose such information in the following circumstances:

1. If disclosure is compelled by a court pursuant to an order of that court

2. If disclosure is compelled by a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority

3. If disclosure is compelled by a party to a proceeding before a court or administrative agency pursuant to a subpoena, subpoena duces tecum (e.g., a subpoena for mental health records), notice to appear, or any provision authorizing discovery in a proceeding before a court or administrative agency.

4. If disclosure is compelled by a board, commission, or administrative agency pursuant to an investigative subpoena issued pursuant to its lawful authority.

5. If disclosure is compelled by an arbitrator or arbitration panel, when arbitration is lawfully requested by either party, pursuant to a subpoena duces tecum (e.g., a subpoena for mental health records), or any other provision authorizing discovery in a proceeding before an arbitrator or arbitration panel.

6. If disclosure is compelled by a search warrant lawfully issued to a governmental law enforcement agency.

7. If disclosure is compelled by the patient or the patient's representative pursuant to Minnesota Statute 144.335 "Access to Health Records" or by corresponding federal statutes or regulations (e.g., the federal "Privacy Rule," which requires this Notice).

F. When Compelled or Permitted By Law in Certain Circumstances

We may use or disclose health information about you when compelled or permitted by state or federal law in the following circumstances:

1. For Health or Safety of You or Others. We may disclose your health information to avert or lessen a serious threat of harm to you, to others, or to the public. We may be compelled to disclose your health information where you have made a specific threat of serious physical harm to another specific person or the public, and disclosure is otherwise required under statute and/or common law.

2. Child Abuse or Maltreatment of Vulnerable Adults. We may disclose your health information for the purpose of reporting child abuse and neglect, or the maltreatment of vulnerable adults, to public health authorities or other government authorities authorized by law to receive such reports.

3. Commission of a Crime. We may disclose your health information to the police or other law enforcement officials if you commit a crime on the premises or against an employee or agent of Rekindle Counseling, or threaten to commit such a crime.

4. Death. We may disclose your health information to a coroner, medical examiner or other authorized person in the event of your death in order to determine the cause of your death.

5. Authorized Representatives. We may disclose your health information to a person appointed by a court to represent or administer your interests.

6. Oversight Agencies. We may disclose your health information when disclosure is compelled or permitted to a health oversight agency for oversight activities authorized by law, including but not limited to, audits, criminal or civil investigations, or licensure or disciplinary actions. The Minnesota Board of Marriage and Family Therapy, who license marriage and family therapists, is an example of a health oversight agency.

7. Department of Health and Human Services. We may disclose your health information to the United States Department of Health and Human Services when disclosure is compelled or permitted to investigate or determine my compliance with privacy requirements under the federal regulations (the "Privacy Rule").

G. In the event of Death, Disability, or Absence of Healthcare Professionals

In the event we are unable to access your health information or provide healthcare services to you due to the death, disability, or other absence of our healthcare professional(s), it is important that another healthcare provider is able to access your health information in order for your records to be accessible to you and for you to continue treatment. In these circumstances, an outside healthcare professional designated by us will have the ability to access your healthcare information for the purposes of notifying you of the absence, providing you access to your information, and ensuring that your healthcare treatment is not unduly interrupted.

III. Your Individual Rights

A. Right to Receive Confidential Communications.

Normally we will communicate with you through the phone number and address that you provide to us. If you desire us to use alternative methods of communication, you may provide us with a written request, and we will attempt to accommodate any reasonable request, for alternative means of communications or for alternative locations where you wish to receive our communications.

B. Right to Request Restrictions.

You have the right to request restrictions on certain uses and disclosures of health information about you, such as those necessary to carry out treatment, payment, or health care operations. We are not required to agree to your requested restriction. If we do agree, we will maintain a written record of the agreed upon restriction.

C. Right to Inspect and Copy Your Health Information.

You have the right to inspect and copy health information about you by making a specific request to do so in writing. This right to inspect and copy is not absolute – in other words, we are permitted to deny access for specified reasons. For instance, you do not have this right of access with respect to "psychotherapy notes." The term "psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical (includes mental health) record. The term excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. We will make every effort to accommodate your request within a week of receiving it in writing. If you have entered into couple or family therapy a release of information must be signed by all other parties who have participated in therapy before the records can be released. Unless the purpose of you request is to review current care you will be charged $.25/page for copies requested plus a fee of $10 for time spent retrieving and copying the records.

D. Right to Amend Your Records.

You have the right to amend your health information in our records by making a request to do so in a writing that provides a reason to support the requested amendment. This right to amend is not absolute – in other words, we are permitted to deny the requested amendment for specified reasons. You also have the right, subject to limitations, to provide us with a written addendum with respect to any item or statement in your records that you believe to be incorrect or

incomplete and to have the addendum become a part of your record. If your requested amendment to your records is accepted, a copy of your amendment will become a permanent part of our records. When we "amend," a record, we may append information to the original record, as opposed to physically removing or changing the original record.

E. Right to Receive an Accounting of Disclosures.

You have the right to receive an accounting from me of the disclosures of protected health information made by Compassionate Counseling Services in the six years prior to the date on which the accounting is requested. As with other rights, this right is not absolute. In other words, we are permitted to deny the request for specified reasons. For instance, we do not have to account for disclosures made in order to carry out our own treatment, payment or health care operations. We also do not have to account for disclosures of protected health information that are made with your written authorization. If you request an accounting more than once during a twelve (12) month period, there will be a charge. You will be told the cost prior to the request being filled.

F. Right to Receive a Paper Copy of This Notice.

Upon request, you may obtain a paper copy of this notice.

IV. Effective Date and Right to Change this Notice

A. Effective Date. This notice is effective on March 23, 2011.

B. Right to Change Terms of This Notice. We reserve the right to change the terms of this notice and/or my privacy practices and to make the changes effective for all protected health information that we maintain, even if it was created or received prior to the effective date of the notice revision. If we make a revision to this notice, we will make the notice available at my office upon request on or after the effective date of the revision and I will post the revised notice in a clear and prominent location.

V. Privacy Officer and Right to Complain

The Privacy Officer for Compassionate Counseling is Michelle Muff, whose telephone number is (507) 310-1321. The following notice is from the Privacy Officer:

As the Privacy Officer of this practice, I have a duty to develop, implement and adopt clear privacy policies and procedures for my practice and I have done so. I am the individual who is responsible for assuring that these privacy policies and procedures are followed not only by me, but by any employees that work for me or that may work for me in the future. I have trained or will train any employees that may work for me so that they understand my privacy policies and procedures. In general, patient records, and information about patients, are treated as confidential in my practice and are released to no one without the written authorization of the patient, except as indicated in this notice or except as may be otherwise permitted by law. Patient records are kept secured so that they are not readily available to those who do not need them.

Because I am the Contact Person of this practice, you may complain to me and to the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights may have been violated either by me or by those who are employed by me. You may file a complaint with me by simply providing me with a writing that specifies the manner in which you believe the violation occurred, the approximate date of such occurrence, and any details that you believe

will be helpful to me. My telephone number is (507) 310-1321 . I will not retaliate against you in any way for filing a complaint with me or with the Secretary. Complaints to the Secretary must be filed in writing. A complaint to the Secretary can be sent to U.S Department of Health and Human Services. For complaints involving covered entities located in Illinois, Indiana, Michigan, Minnesota, Ohio, or Wisconsin the address is: Region V, Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Ave., Suite 240, Chicago, Ill. 60601. Voice Phone (312) 886-2359. FAX (312) 886-1807. TDD (312) 353-5693.

If you need or desire further information related to this Notice or its contents, or if you have any questions about this Notice or its contents, please feel free to contact me.

Informed Consent For Treatment

- I give consent for evaluation and treatment to be provided for myself/my child by a Mental Health Professional at Compassionate Counseling Services, (CCS) LLC, 505 South State Street, Suite 4, Waseca MN 56093.
- I understand that I will be responsible to take an active part in counseling, treatment planning, participating in homework outside of session, reporting my progress or any changes, as well as regularly reviewing the progress toward attainment of treatment goals. I understand that assessment, treatment planning and implementation with Compassionate Counseling Services, LLC will be designed with the client's best interest in mind, and will be reviewed periodically.
- I understand there are benefits to therapy that have been shown by scientist in well-designed research studies. People who are depressed may find their mood lifting. Others many no longer feel afraid, angry or anxious. In therapy, people have a chance to talk things out fully until their feelings are relieved or the problems are solved. Clients' relationships and coping skills may improve greatly. They may get more satisfaction out of social and family relationships. Their personal goals and values may become clearer. They may grow in many directions-as persons, in their work or schooling, and in the ability to enjoy their lives.
- I understand there are also risks in participating in this treatment. It is possible that for a time uncomfortable levels of negative feelings may be felt and clients may recall some unpleasant and or bothersome memories. It is also possible that clients in therapy may have problems with people important to them. Clients may temporarily appear to worsen after the beginning of treatment. Most of these risks are to be expected when people are making important changes in their lives. Finally, even with our best efforts, there is a risk that therapy many not work for you.
- I understand that there are no guarantees made about the outcome of this therapy process. I understand and agree to the above stated limits of confidentiality, their meaning and ramifications. I understand that due to the laws of this state and the guidelines of the practitioners/professional's profession, ethical rules concerning privacy will be honored. I understand that no reports or information will be released to other entities without my written authorization to release that information, excepting those mandated by court order to probation or other court ordered entities.
- I understand that I may terminate treatment at any time.
- I understand that information concerning my/my child's in these services may be used for the purposes of evaluation and/or additional consultation with Gary Muchow, LMFT; Consultant for Compassionate Counseling Services.
- I understand that the first 2 sessions are an assessment period, and at the end of these 2 sessions, an integrated treatment plan will be developed.
- I have read and understand the information in this document, including the NOTICE OF PRIVACY practices and have had the opportunity to ask questions about and seek clarification of, anything that was unclear to me.

- I consent to treatment and agree to abide by the above stated policies and agreements with CCS.
- I have read and understand the Client Bill of Rights and have had all my questions answered.
- My signature below indicates that I understand and agree with all of the above statements. If my client is a minor or has a legal guardian appointed by the court, the client's parent or legal guardian must sign the consent.

_____ _____

Signature of Patient or Parent/Guardian Date

_____

Printed Name

_____

Relationship to Patient (if applicable)

_____

Printed Name of Therapist

_____ _____

Signature of Therapist Date

Restrictions On Disclosures For Health Care Operations

Clients Name_____Date of Birth_____

Help me protect your privacy by indicating below where you do and where you do not wish to be contacted in the event that we would need to reach you.

____Home Phone Number_____

How I should identify myself: _____

May I say the name of my private practice:____Yes ____No____

____Work Phone Number_____

How I should identify myself: _____

May I say the name of my private practice:____Yes ____No____

____Other Phone Number_____

How I should identify myself: _____

May I say the name of my private practice:____Yes ____No____

Other Restrictions:

_____

_____

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_____

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_____ _____

Signature of Client or Legal Guardian Date