ALLISON HOLT & ASSOCIATES
CHILD, ADOLESCENT & ADULT PSYCHIATRY AND THERAPY
Change is within reach.

Allison Holt, MD
Angie O'Shea, MA, LMFT
NURSE Becky Orpen, RN

allisonholtmd.com
Tel **952-467-6214** FAX **952-467-6215**
261 School Avenue, Suite 220, Excelsior, MN 55331

Client Information Packet: Psychiatry Visit

Name: _____ Date: _____

Here is some information about our practice. Please let us know if you have any questions about these policies or any other issues not addressed in this packet.

Appointments for Psychiatry: Dr. Holt allots 60 minutes for an initial evaluation. Follow up visits are between 30-45 minutes long, which includes time for record keeping, setting up the next appointment and payment of services. In addition to scheduled appointment fees, I may charge for other professional services which may include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries and time spent performing other services you may request. These services may not be covered by insurance. Please initial that you have read, understand and agree with the appointment and service fees policy.

Initials: _____

Cancellations: To avoid being charged for a pre-arranged appointment, please give **7 days notice**. If you give us less notice but we can fill your time slot, you will not be charged for the time. Please initial that you have read, understand and agree with the cancellation policy.

Initials: _____

Billing: Please pay for your initial appointment or medication visit at the time that you are seen. Our office is not set up for filing insurance claims, so you will need to submit the claim we give you to your insurance company for reimbursement. Any questions concerning your coverage need to be addressed directly with your insurer. If you need to obtain pre-approval from your insurer for additional sessions, it is your responsibility to let us know when and how to contact them. As we do not contract directly with any insurance plans, including Medicare, payment for sessions that are not approved will be your responsibility. There is a $15 charge for checks returned for insufficient funds. Fees and other costs are set yearly and are increased yearly due to the increased costs of doing business. Please initial that you have read, understand and agree with the billing policy.

Initials: _____

Prescriptions: If you need a prescription, Dr. Holt will give you enough medication to last until your next appointment. If you miss your appointment and need a refill, please call your pharmacy and have your pharmacy send over the request for refill. You will need to give us 4 days notice if you need a medication called into your pharmacy. If the medication requires a hand written prescription please allow 7 days for refills. Also, please call our clinic if you are having problems with side-effects in between appointment times. Please initial that you have read, understand and agree with the prescription policy.

Initials: _____

Telephone Calls: We have a nurse available Monday through Friday from 730am to 3:30pm. Calls left after 3pm may not be returned until the following business day. We ask that non-urgent calls after 3:30pm be made the following business day. Urgent calls and voicemails left after business hours or on the weekends go directly to Dr. Holt's cell phone and will be returned within 24 hours. If you feel you will need to be in closer touch with Dr. Holt, please let us know so we can make other arrangements. In case of an emergency, please call 911 or go to the nearest emergency room for evaluation. Please initial that you have read, understand and agree with the telephone call policy.

Initials: _____

Print Form

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Correspondence: We prefer that all correspondences be made by phone call. **Please note that emails may not be checked daily and should not be sent when you need a response within 24-48 hours**. Please call 952-467-6214 if you have any concerns or questions. Please initial below allowing staff members to leave a detailed voice mail on the answering machine.

Initials: _____

Vacations: We will try to give you several weeks notice of any upcoming vacations. Another psychiatrist will provide coverage for emergencies during that time. Please initial that you have read, understand and agree to the vacation policy.

Initials: _____

Statement of Services: Upon patient request, a statement of service will be provided to you in order for you to collect reimbursement of services from your insurance company. Please initial that you agree to have a statement of services sent by email.

Initials: _____

I have read, understand and agree to these policies.

Print Name: _____ Date: _____

Signature: _____ Date: _____

If applicable please have guarantor sign below. I have read, understand and agree to these policies

Guarantor's Name: _____ Date: _____

Signature: _____ Date: _____

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Contact List

Client name (and parent's name if client is a minor):

Home Phone: Work Phone: Cell Phone:

OK to leave a message at home? ☐ Yes ☐ No

OK to leave a message at work? ☐ Yes ☐ No

OK to leave a message on cell? ☐ Yes ☐ No

Anti-Problem Team

In our experiences, we have found that isolation can be one of the tactics some problems utilize to cause difficulties in people's lives. For this reason, we are strong believers in developing an anti-problem team. By organizing this team, people are not forced to deal with the problem(s) on their own. When you think about who may be a resource or a support, who might you want to include? Examples include family, friends, physicians, social workers, teachers, coaches, people from your past who provided positive influence, authors, hobbies, pets, books, movies, celebrities, etc. Feel free to include as many as you prefer. If you need more space, please print this sheet and continue on the back side.

Name: Relation to You: Name: Relation to You:

Name: Relation to You: Name: Relation to You:

Name: Relation to You: Name: Relation to You:

Emergency Contacts

Our first priority is to maintain the safety of each of our clients/patients. Due to this priority, if there comes a time when we are concerned with your safety, we ask that you provide two names of people we could call to verify your safety. If you are a parent of a client/patient, there may be times when we are unable to contact you immediately and need someone else to verify your child's safety. Please list the individuals below.

First Emergency Contact: Relation to You:

Contact Number(s):

Second Emergency Contact: Relation to You:

Contact Number(s):

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Confidentiality Agreement

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

1) Written authorization by the client and/or family (valid authorization form).
2) Provider's duty to warn another in the case of potential suicide, homicide or threat of imminent, serious harm to another individual.
3) Provider's duty to report prenatal (during pregnancy) exposure to cocaine, heroin, phencyclidine, methamphetamine, and amphetamine or their derivatives, THC, or excessive & habitual alcohol use. (253b.02;2007).
4) Provider's duty to report the misconduct of mental health or health care professionals.
5) Provider's duty to report suspicion of abuse or neglect of children or vulnerable adults.
6) Provider's duty to provide a spouse or parent of a deceased client access to their child or spouse's records.
7) Provider'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 request should be discussed with the therapist.
8) Provider's duty to release records if subpoenaed by the courts.
9) Provider's obligations to contracts (e.g. to employer of client, to an insurance carrier or health plan).

Consent for sharing information within Allison Holt and Associates:

Allison Holt and Associates, consists of a consulting team including: Allison Holt, M.D., Angela O'Shea, MA, LMFT, and Rebekah Orpen, RN.

The purpose of consulting with colleagues is to obtain additional insight, further therapeutic skills, and ensure the highest possible service to the people we serve. During collegial consultation we will make every effort to provide only those details necessary to gain adequate feedback.

As a client you have the right to know and inquire about the following:

1) The cost of appointments, time frame for payment, access to billing statements, billing procedure for missed appointments, and any issues related to insurance coverage.
2) When the provider is available and where to call during off hours in case of an emergency
3) The manner in which the therapist or psychiatrist conducts sessions concerning intake, treatment, and termination. Clients may take an active role in the process by asking questions about relevant medication or therapy issues, specifying goals and renegotiating goals when necessary

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4) The nature and perspective of the provider's work, including techniques used, and alternative methods of treatment.

5) The purpose and potential negative outcomes of treatment. Clients may refuse any treatment intervention or strategy.

6) The anticipated length and frequency of treatment and limitations that that may arise due to difficulties in financing.

7) The liberty of clients to discuss any aspect of their care with others outside Allison Holt & Associates, including consultation with another provider.

8) The status of the provider including the provider's training, credentials, and years of experience.

9) The maintenance of records, including security and length of time they are kept, client's rights to access personal records, and release policies.

10) The right to request a referral and the right to require the current provider to send a written report regarding services to the qualified referred therapist or organization upon the client's written authorization.

11) The procedure followed in the event of the provider's death/illness.

I consent to treatment, have read and understand the Confidentiality Agreement form, my rights listed above, and have reviewed the Client Bill of Rights posted in the office.

Client Signature: _____ Date: _____

Parent/Guardian Signature for Minor: _____ Date: _____

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Name: _____ Date: _____

Notice of Privacy Practices (HIPAA)

EFFECTIVE DATE: APRIL 15, 2003

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
NOTE: INDIVIDUALS WITH COMMUNICATIONS BARRIERS OR WHO SPEAK A LANGUAGE OTHER THAN ENGLISH WILL BE PROVIDED WITH REASONABLE ACCOMODATION TO RECEIVE THIS NOTICE IN A FORM THEY CAN UNDERSTAND.

1. Allison Holt and Associates is permitted to make uses and disclosures of protected health information for treatment, payment and health care operations, as described in the following examples:

a. For treatment - We may use information about you in order to provide treatment or services. We may disclose or share information about you to any of the staff at Allison Holt and Associates involved with your care. For instance, a psychiatrist may share information about medications you are taking with your therapist.
b. For payment - We may use information about you to help obtain payment for services rendered to you. This information may be shared internally between staff such as the office manager telling your therapist that your insurance plan provides for ten visits or your therapist telling the billing staff your diagnosis in order to include this on the billing form. We also will share information with insurance companies if you authorize your insurance company to be billed such as; providing a diagnosis or a list of the specific services you have received in order to obtain payment.
c. For health care operations - We may use information about you with our staff in order to help coordinate your care or to direct our staff and make sure supplies and other resources are available. For instance, we may review your records to monitor our quality of care and our documentation of your care; we may involve support staff in your care to type clinical records or to schedule your services; we may use your case as a discussion point in clinical meetings where cases are reviewed and discussed.

2. Besides the uses described for treatment, payment and operations, Allison Holt and Associates is permitted or required, under specific circumstances, to use or disclose an individual's protected health information at other times without the individual's written authorization. Some examples of these circumstances are:

a. Health Oversight Activities: We may disclose information to a government group to allow them to monitor the health care system. Examples would be licensure surveys, audits, investigations, inspections and compliance with civil rights.
b. Lawsuits and Law Enforcement Requests: If you are involved in a lawsuit, we may disclose information about you in response to a court order. If we are presented with a court order we will provide information to law enforcement about you.
c. Protection of Vulnerable Persons: We may reveal information about you if there is a necessity to report abuse of a child or a vulnerable adult.
d. National Security: If required by law we may reveal information about you to federal officials involved in national security or federal protective services.
e. Other Legal Disclosures: If state or federal law compels Allison Holt and Associates to release information, we will release it.

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Name: Date:

3. Other uses and disclosures will be made only with the Individual's written authorization, and the individual may revoke such authorization. Written authorizations will be valid for one year, after which time they will need to be renewed if they are to continue. This is true even for individuals who die, their written authorizations continue only to end of the year they were in effect.

4. Allison Holt and Associates may contact individual clients to provide appointment reminders or information about treatment or alternative treatments or other health related benefits and services that may be of interest to the individual.

5. The Individual has the following rights regarding protected health information:

a. The right to request restrictions on certain uses and disclosures of protected health information. Allison Holt and Associates is not required to agree to a requested restriction, however.
b. The right to receive confidential communications of protected health information, as applicable.
c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.
d. The right to amend protected health information, as provided in the Privacy Regulation.
e. The right to receive an accounting of disclosures of protected health information.
f. The right to obtain a paper copy of this Notice from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically.

6. Allison Holt and Associates is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information. This Notice of Privacy Practices fulfills this purpose.

7. Allison Holt and Associates will provide all new clients with a copy of this Notice of Privacy Practices.

8. Allison Holt and Associates is required to abide by the terms of the Notice currently in effect.

9. Allison Holt and Associates reserves the right to change the terms of this Notice. Allison Holt and Associates reserves the right to make new Notice provisions effective for all protected health information that it maintains or to apply it only to new information obtained or created after the date of the change in the Notice.

10. Allison Holt and Associates will provide individuals or clients with a revised Notice by posting the new Notice in the lobby of its offices. Any person may ask for a copy of the new Notice.

11. Allison Holt and Associates will provide written copies of this notice and will have electronic versions available on pdf for email.

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12. Individuals may complain to Allison Holt and Associates and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated. A brief description of how the individual may file a complaint follows:

a. Make your complaint known to clinic staff involved with your care and ask for a remedy.
b. If you are unsatisfied with the resolution of your complaint, ask to have a form to put your complaint into writing (staff may assist you if you are unable to do this yourself).
c. Your complaint will be logged and then directed to Allison Holt, MD.
d. If you are afraid to address your complaint to persons involved in your care then do not do so; instead ask any staff member for a complaint form. You are not required to address the persons involved with your care regarding your complaint unless you are comfortable doing so.

13. Allison Holt and Associates contact person for matters relating to complaints is:

Allison Holt, MD: 261 School Avenue, Suite 220, Excelsior, MN 55331, T: 952-467-6214

14. This Notice is first in effect on April 14, 2003.

15. Allison Holt and Associates elects to limit the uses or disclosures that it is permitted to make, as follows:

Other uses and disclosures of information not covered in this Notice or the laws that apply to its use will be made only with your written permission. If you provide us permission to use or disclose information you may revoke that permission, in writing, at any time. If you revoke your permission, we may not use the information in the way that way previously covered in the authorization.

I. Receipt of Required Notices:

I hereby acknowledge that I have received a copy of Allison Holt and Associates Notice of Privacy Practices.

II. Consent for Treatment and Use of Personal Health Information (PHI):

I acknowledge that I have consented to receive mental health and related services from staff of Allison Holt and Associates which will be described in full through the treatment planning process. I understand that I must consent to receive services or I will not be served. I further acknowledge that I consent that my PHI may be used for treatment, payment or operations, subject to the uses and limitations set forth in state and federal law. Any additional uses of my PHI beyond those which are provided for in state and federal law shall require my authorization.

Client Signature or Parent/Guardian of a Minor: _____ Date: _____

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Name: Date:

Confidential Individual Questionnaire

1) How did you hear about Allison Holt & Associates or who referred you to Allison Holt & Associates?

2) What is the main concern(s) or problem(s) that brought you to consult with a provider at Allison Holt & Associates at this time?

3) Have you or are you being treated/diagnosed for any mental/physical illness?

4) Who or what is the person/issue you are most concerned about and why?

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Problem List

Listed below are possible challenges you might be experiencing. Please rate each according to the degree you might be experiencing any of these. Circle the scaling number to indicate the current intensity and explain briefly, what specifically makes any of these a concern at this time.

1) Depression (Low) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (High)

2) Thoughts/actions of self-injury/self-harm (Low) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (High)

3) Worry/anxiety (Low) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (High)

4) Family/relational conflict (Low) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (High)

5) Verbal harm/behavior/threat (Low) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (High)

6) Sexual harm/behavior/threat (Low) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (High)

6) Sexual harm/behavior/threat (Low) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (High)

7) Physical harm/behavior/threat (Low) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (High)

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8) Legal challenge(s) (Low) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (High)

9) Internet usage challenges (Low) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (High)

10) Alcohol/chemical health challenges (Low) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (High)

11) Gambling challenges (Low) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (High)

12) Spiritual/faith concerns (Low) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (High)

13) Other concerns (Low) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (High)

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Assessment

Why do you think these challenges are present for you? How long have the challenges been present?

What is the main goal or need you have for today's appointment?

What are your ideas on how that goal might be accomplished?

What attempts have you made in the past to challenge these concerns?

If the work that we did together were helpful or successful, what would the outcome(s) be? What would be different in your life?