Nystrom Billing Policies and Consent for the Release of Records

If you plan to submit your own claims to your insurance company, it is our policy that payment of the entire fee is due at the time of service. As a service to our patients, Nystrom & Associates (Nystrom) staff will submit your insurance claims. If you fail to provide active insurance information in a timely manner you will be held liable for this. Co-payments are due at the time of service. Deductibles and coinsurances will be billed to your account. In the event the undersigned is entitled to health insurance benefits of any type, insuring patient or any other party liable to the patient, their benefits are hereby assigned to this health care facility for application to the patient's account.

Billing & Payments

By signing, you authorize Nystrom to release information, including medical records, to your insurance company or the designee of your third party payer (authorized agent) as may be necessary to determine benefits, process and pay health care claims, and perform quality of care reviews at Nystrom. Nystrom will submit charges to your insurance company whenever possible for services rendered. Payments will be applied to the oldest charge on your account. Charges are based on what occurs during your treatment with Nystrom. Charges associated with your appointment depend on your individual medical necessity and level of care, as determined by your treating provider.

Time billed for court appearances, court case review, report writing, letters, telephone consultation, and other charges excluded by insurance coverage are your responsibility. Charges vary based on time spent and type of service.

A service charge of 1.5% (18% annual rate), or the highest statutory amount allowed, whichever is higher, will be charged monthly on accounts past due 28 days. If payment from insurance is not received within 90 days the account may be due and payable in full by the patient. An account 90 days past due will be subject to collection procedures and/or small claims court, and the patient agrees to be held responsible for the cost disbursement, including reasonable attorneys, collection, and court fees. Nystrom may use the information listed below to contact you regarding your account. There is a fee of $30 for checks returned for insufficient funds. **Patients seen in Minnesota only:** Minnesota Care Tax will be added where applicable, and you agree to be held responsible for these fees.

Insurance Coverage

Nystrom can make no guarantee that your insurance company will provide payment for services rendered. It is your responsibility to know what is and is not covered under your policy. You are responsible for the full amount of the charge, whether or not your insurance will cover any portion. If your insurance company requires preauthorization of services you are responsible to info rm us. Be aware that some insurance companies have an annual maximum benefit for outpatient mental health coverage.

Cancellations

Nystrom requires a 24-hour notice when cancelling an appointment. This will allow us to schedule the time for someone else. Please note: **IF YOU DO NOT ATTEND A SCHEDULED APPOINTMENT OR CANCEL WITH LESS THAN 24-HOUR NOTICE, YOU WILL BE CHARGED A FEE THAT CORRESPONDS TO THE SCHEDULED LENGTH OF YOUR SESSION**. Your insurance cannot be billed for missed appointments. At the discretion of Nystrom your services may be discontinued due to excessive failed appointments or late cancels.

Financially Responsible Party

The parent or guardian who signs this agreement will be considered the responsible party and will receive all billing statements and letters. Any alternative financial arrangements, including court-ordered financial arrangements, must be worked out between the parents or guardian of the children outside of this agreement.

Unclaimed Refunds

Please remember to read your invoices carefully and call us if you have any questions, especially if you believe there is a credit on your account. If Nystrom confirms that it owes you or your payer a credit refund, it will resolve that promptly. After 120 days, if a credit of less than $25 remains on the account, and no credit refund has been requested it will be removed from the account. If Nystrom determines that it owes you a credit refund but cannot locate you, then Nystrom will file an Unclaimed Property Report with the State. The State publishes those Reports to alert the public that Nystrom owes you money that you have not yet claimed. The State typically publishes your name, your address, the amount unclaimed, and the identity of who owes you the money, which would be Nystrom and Associates.

Involuntary Discharge

There are certain circumstances in which Nystrom can involuntarily discharge a patient from services. These circumstances include but are not limited to: abusing or selling prescription medications, obtaining similar medications from alternate providers, non-disclosure of regularly prescribed controlled medications, refusal to sign requested releases or attestation forms, threatening behavior towards staff or other patients, threatening litigation toward Nystrom or a Nystrom provider, and inability to pay for services (entering into collections process).

Attestation for Consent

Release of Information for Coordination of Care/Treatment, Operations, and/or Payment of Service

By signing, you authorize Nystrom to disclose your behavioral health records to your primary care provider for the purpose of coordinating care for best treatment outcomes. This consent will remain in effect until you cancel it in writing to Nystrom. In addition, you authorize Nystrom to disclose your behavioral health records and substance use disorder (SUD) records to other Nystrom providers, including providers at Nystrom Residential Treatment LLC, Life Works, Psychiatric Associates and Sandhill for purposes of treatment coordination and care.

By signing, I understand my mental health and/or substance use disorder records may be disclosed for treatment, payment, or operations. I understand my records may be re-disclosed as provided by regulations. I understand my substance use disorder records may not be re-disclosed for use in civil or criminal proceedings without expressed written consent or a valid court order.

Case Management Only:
By signing, I understand that my mental health and/or substance use disorder records may be shared through the Collective Network for care coordination. I understand that I am authorizing Nystrom & Associates to receive and/or disclose protected health information for treatment and care coordination. I understand I can opt out of the Collective Network at any time by contacting my case management team.

Electronic Signature

By signing, you understand that this becomes your electronic signature for the following forms: Initial Treatment Plan, Updated Treatment Plans, and the DBT Agreement Form. The provider will ask for your verbal consent after reviewing the forms with you.

Do you have a legal guardian for healthcare decision making? If yes, your legal guardian must sign this document and provide guardianship paperwork prior to your appointment.

Communication from Nystrom about Your Care

By signing, you authorize Nystrom to contact you via mailed correspondence, phone, text message, or email regarding your payment, treatment, and healthcare operations. Nystrom is not financially liable for any charges you incur from your service provider. By supplying your home phone number, mobile number, email address, and any other personal contact information, you authorize Nystrom and your healthcare provider, or a business associate of theirs, to contact you at any numbers or email addresses using an automatic telephone dialing system, using a pre-recorded voice or other third-party automated outreach and messaging system as well as to use your protected health information, or other personal or identifying information, during such contact for any administrative or health matter. You consent to the practice, your provider, or their business associate contacting you via unencrypted email and text messages. You also agree that they may leave detailed messages on your voice mail, answering system, or with another individual, if you are unavailable at the number provided.

Notice of Privacy Practices

By signing, you acknowledge that Nystrom's HIPAA Notice of Privacy Practices and Patient or Consumer Rights Handout, procedures for reporting alleged violations of patient's rights and grievance procedures have been made available to you.
This agreement may not be altered in any way. I have read and agree to the above and hereby guarantee payment of all charges for services with the financial arrangements of Nystrom.

______________________________	____________________
PRINTED FULL LEGAL NAME OF PATIENT	PATIENT DATE OF BIRTH
______________________________	____________________
SIGNATURE OF PATIENT OR LEGAL GUARDIAN (If you have a legal guardian, they must sign here)	DATE
______________________________	____________________
PRINTED NAME OF LEGAL GUARDIAN	PHONE NUMBER OF LEGAL GUARDIAN
______________________________	____________________
ADDRESS OF LEGAL GUARDIAN	EMAIL ADDRESS OF PATIENT OR LEGAL GUARDIAN
______________________________	____________________
EMERGENCY CONTACT	PHONE NUMBER OF EMERGENCY CONTACT

NYSTROM & ASSOCIATES AUTHORIZATION TO RELEASE INFORMATION

Please note that adult patients have the option to register for a FollowMyHealth account and can view their records there immediately, rather than going through the records request process.

Nystrom has partnered with Sharecare to fulfill your requests for records. If you would like Nystrom to send records, please utilize our online submission portal by visiting www.nystromcounseling.com/medical-records.

PATIENT INFORMATION		
Patient Name		Date of Birth
Address		Phone Number
City	State	Zip Code

INITIAL ACTION
☐ Keep on File for Future Use ☐ Request records from Agency/Name Listed Below

I AUTHORIZE NYSTROM & ASSOCIATES TO	☐ **RELEASE INFORMATION TO:** ☐ **RECEIVE INFORMATION FROM:**
Agency/Name	Relationship to Patient
Phone Number	Fax Number
Address	City, State, Zip Code
Email	☐ **This is my primary care provider.**

INFORMATION TO BE RELEASED (CHECK APPROPRIATE BOX(ES)):	
<u>Only release Mental Health/Medical records checked below:</u> ☐ Standard Release (Recent Intake Assessment, Last 3 Progress Notes, and Most Recent Treatment Plan) ☐ Most Recent Intake Assessment ☐ Last 3 Progress Notes ☐ Most Recent Treatment Plan ☐ Psychological Testing Interpretive Report ☐ Other (Specify Type) ____________________________	**<u>Only release Substance Use Disorder (SUD) records checked below:</u>** ☐ Comprehensive Assessment/Update ☐ Letter of Recommendation ☐ Verification of Attendance Letter ☐ Progress Notes/Treatment Plan ☐ Transition/Discharge Summary ☐ Information Exchange for Family Involvement, Collateral, or Emergency Contact ☐ Other (Specify Type) ____________________________
☐ **Or Any and All Mental Health/Medical Records Dated From:** __________ **to** __________	☐ **Or Any and All SUD Records Dated From:** __________ **to** __________

PURPOSE OF RELEASE (CHECK APPROPRIATE BOX(ES)):

The purpose of this release is for coordination of care or:

☐ Personal Use/Review*
☐ Social Security Appeal/Disability*
☐ Insurance Payment/Claim*
☐ Family Involvement
☐ Collateral
☐ Emergency Contact Only
☐ Litigation/Legal*
☐ Continuation of Care
☐ Other* ______________

**Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 CFR § 164.542.*

METHOD OF COMMUNICATION (CHECK APPROPRIATE BOX(ES)):

Electronic Methods:

☐ Non-Secure Email (PDF)
☐ Secure Email (PDF)
☐ CD (Password-Protected PDF)

NOTE: Transmission of records via standard email is not a secure method of transmission. By choosing email, I understand that I risk my information being intercepted by an unauthorized individual.

Standard Methods:

☐ Phone/Email Conversation
☐ Pick Up
☐ Fax
☐ Mail

I understand the following: a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released according to this authorization. b. The information released in response to this authorization may be re-disclosed to other parties. Substance Use Disorder (SUD) records may not be re-disclosed to investigate or prosecute a patient. c. My SUD records are protected under the federal regulations governing confidentiality and SUD patient records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160, 164. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. e. Disclosure is only allowed with my authorization, except in limited circumstance as described in Nystrom Privacy Policy. f. I have the right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws. This authorization shall be in force and effect until 1 year from the date of execution at which time this authorization expires. Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 CFR § 164.524.

Patient/Legal Guardian Signature: ____ Date: ________________

Representative's Relationship to Patient (Parent, Guardian, etc.): ______________________________________
NOTE: If signed by someone other than the patient, we need written proof of authority.

If you are completing this release for a minor patient involved in Substance Use Disorder (SUD) treatment, the minor patient must also consent to the release of their protected health information by signing below.

Minor Patient Signature: ____ Date: ________________

DO NOT FORWARD TO ANOTHER PERSON OR AGENCY WITHOUT PATIENT CONSENT.

ADULT Health Screening Questionnaire
Ages 18 and older

Date: ______________________ Clinician: ______________________

Name: ______________________ Birth date: ______________________

Please answer the following questions to help our providers learn more about your nutrition and physical health.

Question	Answer
Do you skip breakfast, lunch or dinner?	Yes / No
Do you ever eat to the point where you feel uncomfortable or out of control?	Yes / No
(CIRCLE THOSE THAT APPLY) Do you have a history of, or are currently struggling with, an eating disorder, binge eating or emotional eating?	Yes / No
Do you have trouble sleeping?	Yes / No
Do you drink more than two servings of caffeine daily?	Yes / No
Do you have pre-diabetes or diabetes?	Yes / No
Do you have high cholesterol, high triglycerides or take medication for lowering cholesterol?	Yes / No
Do you have high blood pressure or take medication to lower blood pressure?	Yes / No
Have you lost or gained more than 10 pounds in the last 6 months? **(IF YES, CIRCLE ONE)**	Yes / No
Have you experienced unintentional weight loss or weight gain? **(IF YES, CIRCLE ONE)**	Yes / No
During a normal week, how often are you physically active? ______ minutes per day ______ days per week	
On a scale of 1-10, how ready are you to be more physically active? _______ *(10=extremely motivated; 1= no motivation at all)*	
(CIRCLE THOSE THAT APPLY) Do you have any problems with swallowing, chewing, diarrhea, or constipation?	Yes / No
Do you follow any special diet? If yes, what type of diet? ______________________	Yes / No
Do you have any food allergies/intolerances/sensitivities? If yes, what foods? ______________________	Yes / No
Do you experience significant pain on a regular basis? *Examples: migraines, Fibromyalgia, Irritable Bowel Syndrome, etc.*	Yes / No
Do you have enough food to eat?	Yes / No
During a normal meal, is half the food on your plate fruits and vegetables?	Yes / No
On a scale of 1-10, how ready are you to eat more fruits and vegetables? ________ *(10=extremely motivated; 1=no motivation at all)*	
Do you eat protein with every meal?	Yes / No
Do you drink 8 or more glasses of water a day?	Yes / No
What concerns, if any, do you have with your eating habits? ______________________ ______________________	
Do you smoke cigarettes?	Yes / No
On a scale of 1-10, how ready are you to quit smoking cigarettes? ________ *(10=extremely motivated; 1=no motivation at all)*	
Would you like to schedule an appointment with the Dietitian? *If you answer YES to this question, a Registration staff member will contact you to schedule for nutrition services.*	Yes / No

An initial nutrition assessment is recommended to compliment the care you are already receiving here at Nystrom and Associates. Please discuss this with the Front Office Associate after your initial appointment or call (651) 529-8671 to speak with our Registration team.