NYSTROM & ASSOCIATES

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 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 inform 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.

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.

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

_____ _____

PRINTED NAME OF LEGAL GUARDIAN PHONE NUMBER OF LEGAL GUARDIAN

_____

ADDRESS OF LEGAL GUARDIAN

_____ _____

EMERGENCY CONTACT PHONE NUMBER OF EMERGENCY CONTACT

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____

EMAIL ADDRESS OF PATIENT OR LEGAL GUARDIAN

SUD Telehealth Consent Form

By signing this form, I understand the following:

1. I understand that the information and patient rights outlined in the Notice of Privacy Practices (NPP) continue to apply to me during tele-therapy.

2. I understand that in some cases the information transmitted may not be sufficient due to deficiencies or failures of the equipment or internet connection.

3. I understand that the laws to protect privacy and the confidential of medical information also apply to telehealth and that no information obtained in the use of telehealth will be disclosed without my consent. NAL has security and safeguards in place to protect such information; however, NAL cannot be responsible for any information that is disclosed on my end for lack of privacy at the location I am receiving services.

4. I understand that disclosure of the location I chose to conduct therapy online is required and if the location changes, it is the patient's responsibility to notify the provider to ensure compliance with State regulations. This is in place to ensure that appropriate emergency contacts/providers are accessible in the event of an emergency.

5. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that results cannot be guaranteed or assured. Additionally, I understand that telehealth may not be as effective as face-to-face services and if my provider believes another form of services would better serve me; my provider may refer me to seek a provider who can provide such services in my area.

Attestation for Consent: I have read and agree to the terms of NAL telehealth services. I hereby give my consent for the use of telehealth in my treatment.

Counselor's Clinic Location: _____

Client's Location: _____

Printed Name: _____ Date of Birth: _____

Signature of Patient: _____ Date: _____

NYSTROM & ASSOCIATES AUTHORIZATION TO RELEASE INFORMATION

Form can also be completed electronically at nystromcounseling.com/medical-records

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.

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

INITIAL ACTION

☐ Keep on File for Future Use
☐ Send Nystrom records to Agency/Name Listed Below
☐ 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)):

Only release Mental Health records checked below:

☐ 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) _____

Only release Substance Use Disorder (SUD) records checked below:

☐ Comprehensive Assessment/Update
☐ Letter of Recommendation
☐ Verification of Attendance Letter
☐ SUD Diagnostic Assessment
☐ Progress Notes/Treatment Plan
☐ Transition/Discharge Summary
☐ Information Exchange for Family Involvement, Collateral, or Emergency Contact

☐ **Or Any and All Mental Health 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
☐ Verbal Exchange

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 records may not be re-disclosed to investigate or prosecute a patient. c. My Substance Use Disorder (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.

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

NYSTROM & ASSOCIATES AUTHORIZATION TO RELEASE INFORMATION

Form can also be completed electronically at nystromcounseling.com/medical-records

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☐ Progress Notes/Treatment Plan
☐ Transition/Discharge Summary
☐ Information Exchange for Family Involvement, Collateral, or Emergency Contact

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

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

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Patient/Legal Guardian Signature: _____ Date: _____

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NOTE: If signed by someone other than the patient, we need written proof of authority.

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

NYSTROM & ASSOCIATES

Substance Use Evaluation

Client Privacy Rights - Tennessen Notice

Information about your rights under the Minnesota Data Practices Act: The Minnesota Government Data Practices Act, Minn. Statute Chapter 13, (hereinafter "Data Practices Act") seeks to protect the privacy of the individuals about whom government agencies, their subdivisions, and agencies under contract with them collect data. The Minnesota Government Data Practices Act also facilitates the release of information that is public. The information on this sheet applies to your current and future contacts with this agency, whether the contact is in person, by mail or by phone.

The Data Practices Act requires that whenever we ask you to provide us with private or confidential information about yourself that you be told:

- The purpose and intended use of the data within this agency;
- The legal requirements, if any, of providing the information;
- The legal consequences of providing or refusing to provide the information requested; and
- The identity of other persons or agencies authorized by statute to receive the information.

Purposes: The purposes of the information we collect from you are listed below. Because this list of purposes covers a variety of programs, some of the purposes listed may not apply to you. Details about the purposes of the information we collect from you are often listed on the forms you are asked to complete. Depending upon the program you are in, the data we collect from you may be used for the following purposes:

- To comply with any court ordered with any court ordered treatment
- Determine your eligibility for assistance or services provided by this agency
- Provide effective care and treatment of medical/social/psychological problems
- Establish the amount of financial aid for which you are eligible
- Enable us to collect federal, state or county funds for assistance and services for you and your family
- Determine your ability to pay for medical treatment or other assistance and services provided to you or to another person for whom you are responsible
- Collect reimbursement from other agencies or individuals for services or assistance we give you
- Obtain school assistance authorized by law
- Investigate complaints or reports of abuse, maltreatment, neglect, fraud or misconduct
- Investigate facility complaints
- Ascertain applicant's eligibility for adoption services
- Conduct program and financial audits
- Determine whether you or your children need protective services

During the time we will be involved with you, we will be asking you for information about your physical health, your mental and emotional health, your chemical use, your living situation and employment, your finances, and/or your relationships. We only ask for information that we are authorized by law to have that will help us provide you with appropriate services.

Minors: If you are a minor, you have the right to request that private data about you be kept from your parents. You must make this request in writing. You must explain why you wish this data be withheld and what you expect the consequences of sharing the data with your parents would be. If the agency agrees withholding the information from your parents is in your best interests, the data will not be shown to your parents.

Substance Use Evaluation

Client Privacy Rights - Tennessen Notice

Sharing Information: There are other agencies that we are allowed by law to share information with if they need it for investigations, for background studies, for licensing actions, or to help you or help us to help you. Information will only be shared with those entities or organizations and anyone under contact with these entities or organizations once it is determined they need the information to perform their jobs. These may include:

- Service providers under contact with Nystrom to provide Substance Use Disorder Assessment services
- Service providers under contact with Nystrom to provide 245G Substance Use Disorder Treatment services
- US Department of Health and Human Services
- Social Security Administration
- Minnesota Department of Human Services
- Minnesota Department of Health
- Local and State Law Enforcement
- Coroner or Medical Examiner
- County Attorney or Attorney General
- Internal Revenue Service
- Multidisciplinary Case Consultation Teams
- Minnesota Department of Revenue
- Other County Welfare or Human Services Agencies
- Court Officials
- Ombudsman for Mental Health & Mental Retardation
- Local Early Childhood Intervention Contacts
- Applicable school districts and service providers
- The Immigration and Naturalization Service
- Managed care organizations about your health care or benefits
- Insurance companies to check health care benefits for you or your family members
- Employees or volunteers of welfare agency who need the information to do their jobs
- Community Mental Health boards, state hospitals, state nursing homes, and or/entities under contract to one of these facilities, to the extent f the contract.
- Any other government agency that is authorized to have the information under state or federal law and has a need to know about the information

Other Rights

- You have the right to know what information is maintained about you.
- You have the right to view all public and private information about you maintained by this agency. This includes the right for you to authorize other persons or agencies to view it.
- You have the right to have data which you have access explained to you
- You have the right to request copies of the information which you have access. You may, however, be required to pay for the cost of those copies.
- You have the right to challenge the accuracy or completeness of any private information in your records. If you want to challenge any information, write to the responsible authority of the agency that has your records. You may also talk to person at this agency who works with you.
- You have the right to insert your own explanation of anything you object to in your records.

I acknowledge that I have received this notice that explains my privacy rights. If I have any questions or concerns, I can contact Nystrom, Substance Use Disorder Program at 651-628-9566.

Patient Signature:_____Date: _ ____

DEPARTMENT OF HUMAN SERVICES
DHS-6745-ENG 2-24

Options for Opioid Treatment in Minnesota and Overdose Prevention

People who have an opioid use disorder should know about treatment options that are available. Here is a brief description of some of the options.

Counseling

Individual and group counseling often focus on getting a person to stop using drugs. Treatment then shifts to helping the person stay free of drugs. The counselor tries to help the person:

- See the problem and make changes
- Repair damaged relationships
- Build new community with people who do not use drugs.

Members of counseling groups support each other and help find ways to live without using drugs. Group members also share their experiences and talk about their feelings and problems, and many find that others have similar problems. Counseling groups may also explore spirituality and its role in recovery.

Education groups help people learn about their illness and how to manage it. People learn about the effects of drug abuse on their brains and bodies. Training can include learning and practicing employment skills, leisure activities, communication skills, social skills, anger management, stress management, goal setting, and money and time management.

Medication-assisted therapy

Medications, in combination with counseling and other behavioral therapies, are an important element of treatment for many patients. Medications that can help individuals addicted to heroin or other opioids stabilize their lives and reduce illicit drug use include:

- Buprenorphine
- Methadone
- Naltrexone.

Because methadone and buprenorphine are themselves opioids, some people view these treatments for opioid dependence as substitutions of one addictive drug for another. However, taking these medications as prescribed allows people to hold jobs, avoid street crime and violence, and reduce their exposure to HIV by stopping or decreasing injection drug use and drug-related high-risk sexual behavior. Patients stabilized on these medications can also engage more readily in counseling and other behavioral interventions essential to recovery.

Mental health groups

Emotional problems are common among those with substance use disorders, such as depression, anxiety or post-traumatic stress disorder. By treating both the substance use and mental disorders at the same time, the odds of recovery increase. Programs may provide mental health care within the program or may refer people to other sites for this care. Mental health care may include the use of medications, such as anti-depressants.

Programs provide mental health education through lectures, discussions, activities and group meetings. Some programs provide counseling for families or couples, which can be especially helpful. Parents need to be involved in treatment planning and follow-up care decisions for adolescents.

Self-help groups

Self-help groups have been shown to help people maintain recovery. Participants in self-help groups encourage one another to live without drugs. Twelve-step programs may be the best known of these groups. Alcoholics Anonymous is widely known and available, and some individuals with opioid addiction have found help there. Other self-help groups include:

- Narcotics Anonymous (NA)
- SMART (Self-Management and Recovery Training) Recovery
- Women for Sobriety
- Secular Organizations for Sobriety (SOS).

Self-help group members themselves run these groups, not trained counselors.

Self-help groups are not the same as treatment. However, many treatment programs recommend or require attendance at self-help groups. Some treatment programs encourage people to find a "sponsor," who has been in the group for a while and can offer personal support and advice. Self-help groups for family members also exist and there are self-help groups for people with particular needs.

Opioid overdose

Opioid overdoses interfere with a person's ability to distribute oxygen throughout the body. Signs and symptoms of an opioid overdose include:

- Unconsciousness
- Irregular or stopped breathing
- Turning blue.

Overdose risk factors and prevention techniques

There are several factors that increase a person's risk for overdosing and ways to prevent them.

- Be aware of changes in the quality or purity of opioids. Try to use the same dealer.
- Be aware of changes in tolerance, especially after a period of abstinence. Use less than you did before.
- Avoid mixing drugs. Never mix opioids with benzodiazepines, alcohol or other opioids.
- Do not use alone. Make sure somebody knows you are going to use.

Naloxone (Narcan)

Naloxone, brand name Narcan, is a non-addictive, harmless and effective medication that reverses an opioid overdose. Within minutes after Naloxone is administered, this life saving medication allows the affected person to breathe again. There are two ways that naloxone can be administered: a shot in the muscle with a needle or a nasal spray. Naloxone is not a controlled substance, has no abuse potential and can be administered by ordinary citizens with little or no formal training.

Immunity from prosecution

A person in need of medical assistance or an individual who calls 911 during a drug overdose is generally immune from prosecution per [Minnesota Statutes 604A.05, Subd. 2].

Obtaining naloxone

To obtain naloxone, you can visit your primary care provider or contact the following agencies:

City of Minneapolis- Public Health: 612-673-2301

Indigenous Peoples Task Force (IPTF): 612-870-1723

Ka Joog: 612-255-3524

Lutheran Social Services (LSS), Street Works: 612-354-3345

Northwest Indian Community Development Center (NWICDC): 218-759-2022

Red Door Clinic: 612-543-5555

Rural AIDS Action Network (RAAN)

St. Cloud: 800-966-9735

Duluth: 218-481-7225

Mankato: 507-345-1011

St. Louis County- Public Health: 218-725-5260

Steve Rummler Hope Foundation: 952-943-3937

Twin Cities Recovery Project (TCRP): 612-886-2045

More information is available at:

- Principles of Drug Addiction Treatment
- What is Substance Abuse Treatment Booklet for Families
- Naloxone for Overdose Prevention
- Opioid Overdose Prevention Toolkit

You can also contact the Minnesota Department of Human Services Behavioral Health Division by email at dhs.adad@state.mn.us, or by calling 651-431-2460.

Naloxone portal

In the 2023 legislative session, the Minnesota Legislature mandated the carrying of naloxone by select groups in the state. The naloxone portal aims to increase access through these groups as an intervention to prevent opioid overdose deaths in Minnesota.

Mandated groups:

- Schools
- Corrections
- Law enforcement
- Substance use disorder treatment programs
- Sober homes.

The groups listed above are encouraged to sign up for the naloxone portal if they have not already at health.mn.gov/communities/opioids/mnresponse/nalstandorder.html

Other eligible groups include:

- Tribal Nations
- Tribal entities that serve tribal communities/ populations
- Syringe services programs.

This program currently has funding through March 2024. We anticipate this program to continue and be ongoing.

For more information, training resources and frequently asked questions, please visit the program website at health.mn.gov/communities/opioids/mnresponse/nalstandorder.html

651-431-2460

Attention. If you need free help interpreting this document, call the above number.

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ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

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LB2 (10-20)

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