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

Coordination with Primary Care Provider and other Nystrom Providers

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 any and all substance use disorder (SUD) records to other Nystrom providers, including providers at Nystrom Residential Treatment LLC, for purposes of treatment coordination and care.

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 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

Nystrom & Associates, LTD.

Psychiatry & Medication Management
Primary Care Provider Release of Information

Address: _____
City / State: _____ Zip: _____
Phone: _____ Fax: _____

Patient Full Name: _____ **Date of Birth:** _____

Nystrom Provider: _____

☐ **Send information about my initial evaluation and treatment plan to my Primary Care Provider. Coordinate with my Primary Care Provider as necessary for care.**

(Unless otherwise specified, the option above includes all Substance Use and/or mental health related information)

☐ **Do not coordinate care with my Primary Care Provider**

☐ **I do not have a Primary Care Provider.**

I authorize Nystrom & Associates, LTD. to RELEASE to and RECEIVE from:

Primary Care Provider/Clinic: _____

Street Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

I understand the following: See 45 CFR §164.508(c)(2)(i-iii) 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. c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. d. Communications resulting from this authorization will reveal I have received services from NAL/FSSI. e. My health information is protected by federal regulations and state laws. Disclosure is only allowed with my authorization, except in limited circumstance as described in NAL/FSSI 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. A photocopy of this authorization will be treated in the same manner as the original. This authorization will remain valid until care is terminated with NAL or this authorization is revoked by the patient. I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use disorder Patient Records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Patient Signature: _____ **DATE**: _____

Legally authorized representative signature: _____ DATE: _____

Representative's relationship to patient (parent, guardian, etc.) _____

Name (If not signed by patient): _____

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.

Psychiatric Consent and Agreement Form

Thank you for choosing us for your care, it is important for you to read each of the following statements carefully. If you have any questions about the items below, please discuss them with your new provider at your appointment.

General:

- You are consenting to be evaluated and undergo possible medication treatment for your mental illness. Medication options will be discussed with you by your provider during your appointments. You may also be recommended to participate in other forms of mental health care treatment.

- Nystrom ***does not offer*** after-hours services. If you have a concern, please contact us using FollowMyHealth or by calling your clinic. During business hours, your message will first be triaged through our Psychiatry Triage Nurse Team.

- If you have an emergency, such as severe suicidal thoughts, thoughts to hurt someone else, or a severe drug reaction, you should call 911, 988 (for suicidal thoughts), go to your local urgent care, or go to the emergency room.

- Minors must have a Legal Guardian present at all appointments for treatment. If a guardian fails to attend the appointment, it will be cancelled and rescheduled. It is strongly recommended that an adult who is not their own legal guardian have their legal guardian present for all appointments.

- Release of Information is required for our providers to establish and provide ongoing care. Please complete a Release of Information for your Case Manager, any Substance Use Treatment Services, previous Psychiatric care including psychiatric hospitalization records. Medical records are vital to maintaining continuity of care and allow us to verify past/current medical and medication history.

- If you are disrespectful to any staff (including but not limited to yelling, foul language, bullying or harassing) or if you disrupt the care of other patients, we may end care with you.

- You may be asked to only use one pharmacy and your provider may talk with the pharmacist about your medications.

- You will be asked to participate in having vitals taken at a Nystrom location for monitoring purposes. This includes Height, Weight, Blood Pressure, and Pulse.

- You will be considered an inactive patient and unable to receive medication refills through Nystrom & Associates if you have not attended an appointment with your medication provider in a 12-month period.

Medication Refill Requests:

- You should contact your pharmacy or use FollowMyHealth first for all medication refill requests.

- Refill authorizations can take up to 5 business days.

- Early Refills of Controlled medications will not be authorized.

- Refills of ADHD/Stimulant medication, controlled sleep medication, or benzodiazepine will not be issued outside of appointments.

- Your provider may not grant early refills for any reason (i.e. lost, stolen, damaged) for any controlled medication.

Appointment Scheduling and Cancelations:

- Patients are responsible for scheduling their next appointments to avoid running out of medications between office visits.

- Appointments canceled without a 24-hour notice may be assessed a fee.

- If you miss 3 appointments with your medication provider, we will end care with you. You will be ineligible to schedule ongoing care for 12 months following your discharge from care.

- Many of our providers work with medical or nursing students. You should inform your provider if you do not want a student participating in your appointments.

- Therapy appointments cannot be scheduled for the same day as psychiatric appointments.

Forms/Letters:

- Our providers require an appointment to complete any forms. Any forms needing completion should be dropped off at the front desk or uploaded to our website at **www.nystromcounseling.com**. Your provider will review the forms and notify staff how long to schedule your forms appointment for. Any forms completed outside of an office visit will be assessed a fee, requiring prepayment.

Laboratory & Psychological Testing:

- Your provider will request you complete certain laboratory tests before initiating or continuing certain medications. Laboratory tests may include but are not limited to; saliva, hair follicle, urine, blood serum, electrocardiograms, psychological testing, genomic testing, etc.
    - Drug Screens, laboratory tests, and counts of remaining pills may be requested if you are taking controlled medications and must be completed within a 48-hour period.

- Laboratory testing is not available at all Nystrom locations. Laboratory testing fees are your responsibility. If your insurance plan will not cover the cost of laboratory, psychological, or other testing, you will be responsible for all costs. incurred.

Billing and Insurance:

- A charge for psychotherapy in addition to a medication management billing code may appear on your billing statement. Psychotherapy is a standard psychotherapy add-on code that all Nystrom medication providers use to reflect psychotherapy services that occur in session. Psychotherapy is defined in Current Procedural Terminology (CPT) by the American Medical Association as “the attempt to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage personality growth and development” (2012).

Controlled Substance Medications:

- Patients are responsible for informing all other physicians of the controlled substance medication received through Nystrom & Associates. Likewise, patients will inform Nystrom & Associates medication provider of any other controlled substance medications received from another physician.

- Our providers may not prescribe standing doses of benzodiazepines with stimulant medications.
- Our providers must follow Nystrom & Associates prescribing and maximum dosing guidelines for controlled medications. If you are pregnant, have certain medical or psychiatric conditions, controlled medications may not be appropriate for you. If you are currently taking psychotropic medications, it is up to the clinical judgement of your new Nystrom & Associates Psychiatric Medication Management Provider whether they will continue them as they are currently prescribed.

- Our providers do not prescribe pain medication or medical cannabis. If you are taking narcotic pain medication, medical cannabis, have a history of substance abuse, or are not currently sober, our providers may not prescribe controlled medications to you. If you are taking medical cannabis, methadone, suboxone or other any other narcotic-based medications on an ongoing basis, controlled medications may be stopped while you are taking these other medications.

- If you sell, trade, share, fill early, or increase the dose of controlled medications on your own, these medications will be stopped and cannot be restarted during the duration of your care at Nystrom & Associates.

- Failure to notify your provider of any history of drug, alcohol, or prescription drug misuse may result in stopping any controlled medications.

- You can be found guilty of Driving Under the Influence (DUI) if taking these medications and driving.

_____	_____
Printed Name of Patient	Patients Date of Birth
_____	_____
Printed Name of Legal Guardian	Phone Number of Legal Guardian
_____	_____
Signature of Patient or Legal Guardian	Date

NYSTROM & ASSOCIATES
PSYCHIATRIC MEDICATION PEDIATRIC EVALUATION PACKET

Today's Date: _____

Identification:

Child's Name: _____ DOB: _____ Age: _____

Nickname/Preferred Name: _____ Preferred Pronouns: _____

Preferred Pharmacy: _____

Home Phone: _____ Cell Phone: _____ Other: _____

Emergency Contact/Relationship: _____ Phone: _____

Guardianship:

Please Note:

-The parent, guardian, court appointed guardian, adoptive parent, or a designated temporary custodian **must be present at the intake appointment.**

- We ask that any court documents pertaining to Joint legal custody, sole legal custody, court appointed guardian, designated temporary custodian, or adoption be provided **prior to the appointment.**

Legal Guardian #1/Relationship: _____ Phone: _____

Legal Guardian #2/Relationship: _____ Phone: _____

Legal Custody:
- ☐ Joint
- ☐ Mother
- ☐ Father
- ☐ County
- ☐ Foster Parent
- ☐ Other: _____

Physical Custody:
- ☐ Joint
- ☐ Mother
- ☐ Father
- ☐ County
- ☐ Foster Parent
- ☐ Other: _____

Additional Custody Considerations: _____

_____

_____

Current Providers:

If anything below applies to the patient, it is requested that a release of information be placed on file**.**

Medical/Primary Care Provider: _____

Clinic: _____

Phone:_____ Date of last physical: _____

Home Health Nurse or PCA: _____

Company:_____ Phone: _____

Psychologist/Therapist: _____

Clinic:_____ Phone: _____

County Social Worker/Case Manager: _____

Phone:_____ Cell/Pager: _____

Probation Officer: _____

Phone:_____ Cell/Pager: _____

Presenting Information:

1. How were you referred to this clinic for medication evaluation?

_____

_____

_____

2. What initial goals do the parent/guardian or patient want to accomplish the most?

_____

_____

_____

3. Does your child have a past psychiatric diagnosis (such as ADHD, depression, etc.)? If yes, please describe.

_____

_____

_____

4. Do you know of, or suspect, your child has used or is currently using tobacco, drugs, or alcohol?

_____

_____

_____

5. Has your child had legal problems related to drug or alcohol use, curfew, stealing, fighting, etc.? If yes, please describe.

_____

_____

_____

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6 – 17

Child's Name: _____ **Age:**____ **Sex:** ☐ **Male** ☐ **Female** **Date:**_____

Relationship with the child:_____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS**, how much (or how often) has your child…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS**, has your child…						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS**, has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

Current Medications:

Please list **ALL current medications**, including over-the-counter & vitamins:

Medication	Dose	Directions	Date/Time of Last Dose

Does patient have any known allergies to medications of any kind (circle)? YES NO

If yes, please list medication and reaction:

_____

_____

Previous Medications:

Please list all past trials of Psychiatric Medications, dose, length of use, and reason for discontinuing:

Medication	Dose	Length of Use	Reason for Discontinuing

Family History:

1. Has anyone in the child's biological family been diagnosed or treated for a mental health problem?
   If yes, please describe:

   _____

   _____

   _____

2. Has anyone in the child's family attempted or completed suicide? If yes, please describe:

   _____

   _____

   _____

Social History:

1. Has there been any divorce/separation/remarriage/adoption/foster placement in the family?
   If yes, please describe:

   _____

   _____

   _____

Family Members	Age	Sex	Occupation	Education (Highest Level)	Religion	Living in home?
Parent/Guardian						
Parent/Guardian						
Siblings 1.						
2.						
3.						
4.						
5.						
6.						
Step-Parent(s) 1.						
2.						
Other Family						

Please indicate below if you know of, or suspect, your child has been the victim of any kind of abuse or trauma.

☐ Physical Abuse ☐ Emotional Abuse ☐ Verbal Abuse

☐ Sexual Abuse ☐ Bullying ☐ Other Trauma

Developmental/Medical History

1. Describe any known or suspected prescription medication use, alcohol use, or drug use during pregnancy:

   _____

   _____

2. Were there any complications with labor/delivery or a significant period of bed rest?

   _____

   _____

3. Please complete the table below regarding developmental milestones:

Gross Motor Development (crawling, walking)	☐ Early	☐ Average	☐ Late
Fine Motor Development (fingers/hands)	☐ Early	☐ Average	☐ Late
Communication Development	☐ Early	☐ Average	☐ Late
Self-Care	☐ Early	☐ Average	☐ Late
Social Skills	☐ Early	☐ Average	☐ Late
Education (alphabet, numbers)	☐ Early	☐ Average	☐ Late
Toilet Training	☐ Early	☐ Average	☐ Late

4. Please indicate if the child has a history of any of the following:

   ☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy ☐ Sensory Issues

5. Please indicate below if the child has a chronic medical problem:

   ☐ Diabetes ☐ Cancer ☐ Seizure Disorder

   ☐ Heart Condition ☐ Asthma ☐ Kidney or Liver Problems

   ☐ Other: _____

6. Has the child ever had surgery? If yes, please describe:

   _____

   _____

7. Has the child ever been treated for a head injury, serious accident, or lead poisoning? If yes, please describe:

   _____

   _____

School Information:

Current School: _____ Grade: _____

Address/City: _____

Contact/Title: _____

Phone: _____ Fax: _____

Please describe past and present academic work:

_____

_____

_____

_____

Does your child have an IEP/504 Plan (circle)? YES NO

Has your child ever repeated a grade? If yes, please describe:

_____

_____

Does your child have a learning disability? If yes, please describe:

_____

_____

Does your child have a history of truancy, suspension, expulsion, or detention? If yes, please describe:

_____

_____

Comprehensive Release of Information

Address: _____

City / State: _____ Zip: _____

Phone: _____ Fax: _____

Patient Information	Name: _____ Date of Birth: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____
I Authorize	**Nystrom & Associates, Ltd. and Family Support Services, Inc.** to exchange information with:
Agency #1	Agency/Name: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____ Email: _____ Fax: _____
Agency #2	Agency/Name: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____ Email: _____ Fax: _____
Agency #3	Agency/Name: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____ Email: _____ Fax: _____
Agency #4	Agency/Name: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____ Email: _____ Fax: _____
Information to be Released	**Release records checked below:** ☐ Most Recent Diagnostic Assessment ☐ 3 Most Recent Progress Notes, and Treatment Plan ☐ Psychological Testing Interpretive Report ☐ Other: _____ **NOTE**: Unless otherwise indicated, all related records regarding Mental Health will be included. This does not include records legally defined as Psychotherapy notes. Or ☐ All Records Dated from: _____ to _____ ☐ Any/All Medical Records (Entire medical record may be sent)
Type of Communication	☐ Verbal & Email Conversation ☐ Standard Email ☐ Secure Email **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. ☐ Medical Records
Purpose of Release	Records exchanged per patient request or _____.

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. c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. d. Communications resulting from this authorization will reveal I have received services from NAL/FSSI. e. My health information is protected by federal regulations and state laws. Disclosure is only allowed with my authorization, except in limited circumstance as described in NAL/FSSI 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. A photocopy of this authorization will be treated in the same manner as the original. This authorization shall be in force and effect until 1 year from date of execution at which time this authorization expires. . *Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F. R. §164.524

Patient Signature: _____ **DATE**: _____

Or legally authorized representative

Name (If not signed by patient): _____

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

Representative's relationship to patient (parent, guardian, etc.) _____

DO NOT FORWARD TO ANOTHER PERSON OR AGENCY

For internal Use: Faxed Date: _____ Initials: _____

Guidelines for completing your Authorization for Releasing of Confidential Information

Nystrom & Associates, Ltd. (NAL), and Family Support Services, Inc. (FSSI), recognizes the importance of patient confidentiality as well as the importance of coordinating care and treatment with other professionals, family, friends, and others involved in your care. Please review all items on this form and contact NAL/FSSI with any questions concerning this form at the below listed offices or website.

Patient Information: Complete this entire section with clear and legible writing so the information easily identifies the patient whose information is being requested/released.

Information to be Released: The purpose of this section is to indicate what information you wish to be shared. Please select the appropriate box or write in date range. Selecting Any/All authorizes NAL/FSSI to share or send your entire medical record.

Type of Communication: Use this space to indicate what method you would like records transmitted. If you would only like NAL/FSSI to have verbal communicate with the identified person/agency, select the Verbal & Email option. If you wish records to be transmitted to the person or agency, select the Medical Records option

Purpose of Release: Identify the reason you need to release/request information. This helps NAL/FSSI appropriately provide care and track releasing confidential information. It informs us who may be responsible for the cost of medical records being released and is required on each release. * Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F. R. §164.524 (when applicable).

Authorization and Revocation: Signing this form (or having the legal guardian sign for a patient) will grant authorization to share/receive confidential information. Please sign and date this form to validate this authorization. If signed by someone other than the patient, you will be required to provide written proof of your authority. Unless otherwise noted this consent will automatically expire in one year from the date signed. The authorization can be revoked or can be edited at any time at your written direction to our organization.

Helpful Tips:

- ✓ If requesting records, please allow 7-10 business days for processing of the Release of Information. In some cases it can take up to 30 days (45 CFR §164.524(b)(2)(i).
- ✓ For questions or concerns regarding this form please contact your NAL facility listed below.

CHILD Health Screening Questionnaire *(to be completed by parent or guardian)*

Ages 12 and under

Date: _____ Clinician: _____

Name: _____ Birth date: _____

Please answer these questions to help our providers learn more about your child's nutrition and physical health.

Was your child premature?	Yes / No
Is your child less than the 10th percentile on the wt/ht growth chart?	Yes / No
Is your child greater than the 90th percentile on the wt/ht growth chart?	Yes / No
Does your child have trouble sleeping?	Yes / No
Is your child on a special diet? If yes, what kind of diet? _____	Yes / No
Is your child allergic or sensitive to any foods? If yes, what foods? _____	Yes / No
Is your child a "picky eater?" If yes, how so? _____	Yes / No
(CIRCLE THOSE THAT APPLY) Does your child have any problems with diarrhea, constipation, nausea, vomiting, chewing, or swallowing?	Yes / No
During a normal week, how often is your child physical active? _____ minutes per day _____ days per week	
On a scale of 1-10, how ready are you to help your child to be more physically active? _____ *(10=extremely motivated; 1=no motivation at all)*	
Does your child have any physical health issues? _____	Yes / No
Has your child experienced unintentional weight loss or weight gain? **(IF YES, CIRCLE ONE)**	Yes / No
Does your child have concerns about their body image?	Yes / No
Are you or your child currently on WIC or other food support programs? If yes, what programs? _____	Yes / No
Does your family have enough food to eat?	Yes / No
During a normal meal, is half the food on your child's plate fruits and vegetables?	Yes / No
On a scale of 1-10, how ready are you to help your child eat more fruits and vegetables? _____ *(10=extremely motivated; 1=no motivation at all)*	
Does your child eat protein with every meal?	Yes / No
Does your child drink at least 8 glasses of water a day?	Yes / No
What concerns, if any, do you have with your child's eating habits? _____ _____	
Does anyone in your child's household smoke cigarettes?	Yes / No
On a scale of 1-10, how ready are they to quit smoking cigarettes? _____ *(10=extremely motivated; 1=no motivation at all)*	
Would you like to schedule an appointment for your child 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.