Liz Pollnow, LCSW
Mindfully Reconnect at Fleming Associates
1001 West 31st Street
Cheyenne, WY 82001

For office use only:
DX: ________________

PATIENT INFORMATION SHEET

*Patient Name: ____________________ *Date of Birth: ____________________
*Street: ____________________
*City: ____________________ *State: ____________________ *Zip: ____________________
*Home Phone: ____________________ *Work Phone: ____________________ *Cell phone: ____________________
*Sex: Male [ ] Female [ ] *Social Security No. (Last Four): ____________________
*Patient Relationship to the Responsible Party (Circle one): Self Spouse Child Other
*E-mail address: ____________________
*Primary Care Physician: ____________________
*Emergency Contact: ____________________ *Phone: ____________________

RESPONSIBLE (OR INSURED) PARTY INFORMATION

*Responsible Party Name: ____________________ *Date of Birth: ____________________
*Street: ____________________
*City: ____________________ *State: ____________________ *Zip: ____________________
*Home Phone: ____________________ *Social Security No. (Last Four): ____________________

INSURANCE INFORMATION *attach copy of card(s) for commercial payers

***Primary Insurance**: ____________________ *Phone: ____________________
*Claims Mailing Address: ____________________
*Name of Subscriber: ____________________ *Subscriber's Date of Birth: ____________________
*Policy ID: ____________________ *Group No.: ____________________
*Patient Relationship to Subscriber (Circle one): Self Spouse Child Other

***Secondary Insurance**: ____________________ *Phone: ____________________
*Claims Mailing Address: ____________________
*Name of Subscriber: ____________________ *Subscriber's Date of Birth: ____________________
*Policy ID: ____________________ *Group No.: ____________________
*Patient Relationship to Subscriber (Circle one): Self Spouse Child Other

I authorize Liz Pollnow, LCSW to furnish my insurance carrier with all information to process my claim for services rendered. I understand that if my insurance should deny payment, I am responsible for the full charges. If my plan requires pre-authorization or referrals, I understand that it is my responsibility to request referrals from my primary care provider in advance and to be aware of the terms of my plan benefits. *Also, there will be a $25.00 fee add if you fail to call and cancel your appointment the day of or before your scheduled appointment*. I have read and agree to the above information:

Signature: ____________________ **Date:** ____________________

Elizabeth Pollnow, LCSW
Mindfully Reconnect, LLC at Fleming Associates
1001 W 31st Street
Cheyenne, WY 82001
307-634-6883

Consent and Disclosure Statement

Welcome to Mindfully Reconnect, LLC. My name is Elizabeth Pollnow and I am a Licensed Clinical Social Worker through the Wyoming Mental Health Professions Licensing Board. My license number is WY-731. I received a Bachelor of Arts in Psychology from the University of Wyoming, in 2006 and a Master of Social Work from the University of Denver, in 2009. I specialize in high risk youth, early childhood mental health, play therapy and childhood trauma.

This disclosure statement is required by the Wyoming Mental Health Professions Licensing Act. The Wyoming Mental Health Professions Licensing Board regulates the practice of licensed persons in the field of social work and other mental health professions in the State of Wyoming. Concerns or complaints regarding the practice of social work may be directed to the licensing board. Their contact information is provided below:

Wyoming Mental Health Professions Licensing Board
2001 Capitol Avenue, Room 104
Cheyenne, WY 82002
Phone: (307) 777-3628
Fax: (307) 777-3508

I will adhere to the Code of Ethics of the National Association of Social Workers. Responsibilities and ethics are established and published by the Wyoming Mental Health Professions Practice Act of 1997.

Fees and Cancellations

We do bill primary insurance companies . You may be responsible for co-payments and /or co-insurance. I accept cash, credit cards and checks.

Please give at least 24 hours' notice when cancelling an appointment or you may be charged $25.00 for the session. Exceptions for late cancellations may be made in emergency situations. If you are late to your session, your time may be shortened or you may be rescheduled.

Confidentiality

Counselors must keep information related to counseling services confidential unless disclosure is in the best interests of clients, is required for the welfare of others, or is required by law. When disclosure is required, only information that is essential is revealed and the client is informed of such disclosure. Wyoming has a privileged communication statue. This law states, when involved in legal proceedings (civil, criminal or juvenile), clients retain the right of privacy, unless these specific circumstances exist:

1) Suspected abuse or neglect of children, the elderly, disabled or incompetent.
2) Information related to treatment is necessary to defend against a malpractice action brought by a client.
3) An immediate threat of physical violence against a readily identifiable victim is disclosed to the clinician.
4) In the context of civil commitment proceedings, where and immediate threat of self-inflicted harm is disclosed to the clinician.
5) The client alleges mental or emotional damages in civil litigation or his/her mental or emotional state becomes an issue in any court proceeding concerning child custody or visitation. In this circumstance, a judge may order my testimony if he/she determines that the issues demand it.
6) In the context of investigations and hearings brought by the client and conducted by the board, where violations of this act are at issue.

Court Testimony

At times, clients will request I testify in court proceedings. My court fees are $200.00 per hour and $100.00 per hour for court preparation. Please be aware that having me testify in court puts any testimony regarding confidential therapeutic content into the public record. It also produces a risk of the entire therapeutic file being ordered in the public record. If you or your attorney subpoena me for testimony, you are responsible for assuming these risks.

Client's Rights and Grievance Procedure

As a client in therapy, you have the following rights:

1) You have the right to be treated with dignity and respect.
2) You are entitled to information about any procedures, methods of therapy, techniques, fees and the possible duration of treatment.
3) You have the right to terminate therapy at any time without any moral, legal or financial obligations other than those you have already accrued.
4) You have the right to receive a second opinion from another therapist or change therapists at any time.
5) You have the right to review and/or receive a summary of your records at any time.
6) In a professional relationship, sexual intimacy between a therapist and client is never appropriate. If sexual intimacy of any kind occurs, it should immediately be reported to the State Grievance Board.

7) You have a right to expect confidentiality within the limits described above. If you request it, any part of your records can be released to any person or agency you designate.
8) You have the right not to be discriminated against due to race or ethnicity, sex or gender, age, religion, education, ability, sexual orientation or socioeconomic status.
9) You have a right to be informed of your rights in a way that you understand.
10) You have a right to make a complaint or grievance at any time without retaliation. If you have complaints or concerns about the way that you have been treated, you may speak directly with me and/or file a grievance with the State Grievance Board.

Consents for Treatment

Health and Medical Care Consent: I give my consent to all mental health care services performed by Mindfully Reconnect LLC and Elizabeth Pollnow, LCSW to provide such medical care (including assessment and diagnostic) as may be deemed necessary and appropriate.

Release of Information and Insurance: I authorize Mindfully Reconnect, LLC and Elizabeth Pollnow, LCSW to release my medical and/or financial records to individuals and entities as specified in the notice of privacy practices and/or by federal and state law. I understand that any withdrawal of consent will not be effective for disclosers necessary to effectuate any payments for health care that has been provided.

I have read and understand these disclosures and consents. I agree to the above stated policies and procedures.

______________________________________ ___________________________________
Client Name (Please Print) Client Signature (if needed)

______________________________________ ____________________________________
Parent or Guardian Signature

____
Therapist

GUARANTEE OF PAYMENT

Many insurance companies, including managed care organizations, require prior written authorization for treatment and follow-up visits. It is your responsibility as a patient to obtain all necessary authorizations from your insurance company prior to receiving medical services. If you have not received prior approval for the service or authorization has been denied, you are fully responsible for all charges if your insurance company does not agree to pay. In addition, you will be responsible for all deductibles, co-insurance, co-payments, and service that are not covered by your insurance plan, and any service that your insurance company has determined not to be “medically necessary.”

* *

I have read and understand this information. I understand that my insurance company may deny coverage and request that **Elizabeth Pollnow, LCSW.** perform this medical service anyway. I agree to be personally and fully responsible for all charges.

I understand that if necessary any outstanding balances will be submitted to:
American Collection Systems
407 S 21st Street
Laramie, WY 82070

______________________________ ______________________________ ___________________

Patient or Legal Representative **Print Name** **Date**

Fleming Associates

PRIVACY NOTICE – Effective Date: April 14, 2003
THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

1. PURPOSE: Fleming Associates and its professional staff and employees follow the privacy practices described in this Notice. Fleming Associates keeps your information in records that will be maintained and protected in a confidential manner, as required by law. Please note that in order to provide you with the best possible care and treatment, all professional staff involved in your treatment and employees involved in the health care operations of the agency may have access to your records.

2. HOW YOUR INFORMATION IS USED FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO):
   We will always limit the use(s), disclosure(s) and request(s) of your protected health information to that which is determined to be the minimum necessary to accomplish the intended purpose. Your treatment may include sharing information among mental health care professionals who are involved in your treatment. For example, if you are seeing both a physician (psychiatrist) and a psychologist, they may share information in the process of coordinating your care. Your insurance company or third party payer may request information that we are required to submit in order to provide and bill for your services. Anyone reviewing records must follow the same confidentiality laws and rules required of all health care providers. Treatment records may be reviewed as part of an on-going process directed toward assuring the quality of Agency operations. Staff members designed by Fleming Associates may access clinical records periodically to verify that Agency standards are met. Records are sometimes used for reasons other than client care. For example, records are periodically reviewed to evaluate the quality of care, or to be sure that Fleming Associates follows the rules of regulatory agencies for the efficient and effective utilization of care.

3. HOW YOUR PROTECTED HEALTH INFORMATION IS USED AND STORED:
   Your clinical record will be stored in locked file cabinets when not in use and retained by Fleming Associates for a minimum of six years after your last clinical contact with the agency. After that time has elapsed, the record will be shredded or otherwise destroyed in a way that protects your privacy, except where law requires it to be kept for a longer period of time.

In addition to those listed above in #2 (TPO), and until the records are destroyed, they may be used for the following purposes unless you ask for restrictions on a specific use or disclosure (instructions listed in #5 below):

- Appointment reminders;
- Notification when an appointment is cancelled or rescheduled;
- As may be required by law;
- For public health purposes such as reporting of child or elder abuse or neglect; reporting reactions to medications; infectious disease control; notifying authorities of suspected abuse, neglect, or domestic violence (if you agree or as required by law);
- Mental health oversight activities, e.g., audits, inspections or investigations of administration and management of Fleming Associates;
- Lawsuits and disputes (We will attempt to provide you advance notice of subpoena before disclosing information from your record.);
- Law enforcement (e.g., in response to a court order or other legal process) to identify or locate an individual being sought by authorities; about victim of a crime under restricted circumstances; about a death that may be the result of criminal conduct; about criminal conduct that occurred on Fleming Associates property when emergency circumstances occur relating to a crime;
- To prevent a serious threat to health or safety;
- To carry out treatment and health care operations functions through medical transcription services;
- To military command authorities if you are a member of the armed forces or a member of a foreign military authority;
- National security and intelligence activities;

- Protection of the President or other authorized persons for foreign heads of state, or to conduct special investigations.

4. YOUR AUTHORIZATION IS REQUIRED FOR OTHER DISCLOSURES. Except as described previously, we will not use or disclose information from your record unless you authorize (permit) Fleming Associates to do so. You may revoke your permission in writing, which will be effective only after the date of your written revocation.

5. YOU HAVE RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION.
   You have the following rights regarding your health insurance.
   - Right to request restriction. You may request limitations on your mental health information we may disclose, but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
   - Right to confidential communications. You may request communications in a certain way or at certain location, but you must specify how or where you wish to be contacted.
   - Right to inspect and copy. You have the right to inspect and copy your information regarding decisions about your care; however, psychotherapy notes may not be inspected and copied. We may charge a fee for copying, mailing, and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed mental health professional chosen by Fleming Associates.
   - Right to request to clarify record. If you believe that the information we have about you is incorrect or incomplete you may ask to add clarifying information. Fleming Associates is not required to accept the information that you propose.
   - Right to accounting of disclosures. You may request a list of the disclosures of your mental health information that have been made to persons or entities other than for treatment, payment or health care operations in the last six (6) years, but not prior to April 14, 2003.
   - Right to a copy of this Notice. You may request a paper or electronic copy of this Notice at any time.

6. REQUIREMENTS REGARDING THIS NOTICE.
   Fleming Associates is required to provide you with this Notice that governs our privacy practices. Fleming Associates may change its policies or procedures in regard to privacy practices. If and when changes occur, the changes will be effective for information we have about you as well as any information we receive in the future. Any time you come in to Fleming Associates for an appointment, you may ask for and receive a copy of the Privacy Notice that is in effect at the time. Fleming Associates will have the Notice posted.

7. COMPLAINTS.
   If you believe your privacy rights have been violated, you may file a complaint with Fleming Associates. You will not be penalized or retaliated against in any way for making a complaint.

   If you have a complaint, if you have any questions about this notice, if you wish to request an additional copy of this notice, or if you wish to request restrictions on uses and disclosure for health care treatment or operations, Contact:

   Fleming Associates
   1001 West 31st Street
   Cheyenne, WY 82001
   Phone: (307) 634-6883
   FAX: (307) 634-9462
   mail@flemingassociates.net

   Please acknowledge receipt of Fleming Associates Privacy Notice by signing below:

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Signature