



Diamond Lake Clinic

Patient Intake Information

5939 Portland Ave S, Minneapolis, MN 55417
Office: (612) 869-4444 Fax: (612) 254-8244

Patient Demographics: DOB: ____/____/____ Race: _____

Patient Name: _____
(First Name) (Middle Name) (Last Name)

Address: _____
(Street) (City) (State) (Zip Code)

Social Security #: ____ - ____ - ____ Preferred Name: _____

Sex assigned at birth: Female Male Gender Identity: _____

Phone #: (____) _____ Email Address: _____

Preferred Method of Contact: Phone Call Text Email

Emergency Contact Information

1) Name: _____

Phone #: (____) _____ Relationship: _____

Insurance Information:

Primary Insurance Company: _____

Insurance ID#: _____ Insurance Group #: _____

Name of Policy Holder: _____

Policy Holder's DOB: _____

Secondary Insurance Company: _____

Insurance ID#: _____ Insurance Group #: _____

Name of Policy Holder: _____

Policy Holder's DOB: _____

Visit Information: (What is the reason for you want to be seen?)



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Authorization to Release Health Information

<i>First Name, Middle Name, Last Name</i>	/	/	<i>Date of Birth</i>
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<i>Address</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>
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I allow: Diamond Lake Clinic - 5939 Portland Ave S Minneapolis, MN 55417
Phone: (612) 869-4444 Fax: (612) 254-8244

To give information to and receive information from:

Name (Organization)

Address

<i>Phone Number</i>	<i>Fax Number</i>	<i>Email</i>
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I give my permission to disclose/receive the following information regarding mental health:

- | | | |
|-----------------------------|-------------------------|----------------------------|
| Admission/Intake Summary | Conversations Regarding | EKG Reports |
| Diagnosis/ Treatment Plan | Care | Urine Drug Screens Results |
| Progress/Clinic Notes | Discharge Summary | Emergency Room Report |
| Assessments/Evaluations | Lab Results | Medications |
| Other (Must Specify): _____ | | |

Purpose of Release:

- | | | |
|---------------------|---------------------|----------------------------|
| Personal | Insurance Attorney/ | Disability/Social Security |
| Attorney/Litigation | Litigation | |
| Continued Care | | |

Other (Must Specify): _____

By signing below, I give my permission for agents of Diamond Lake Clinic to verbally communicate about me in order to arrange for the coordination of care, payment, or services. I understand that may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. I also understand that this authorization automatically expires in one year from the date of my signature unless I revoke it earlier. Diamond Lake Clinic will not refuse or restrict treatment if I choose not to sign this authorization or if I choose not to sign this authorization or if I revoke it. A photocopy /fax of this authorization will be treated as if it were an original.

Diamond Lake Clinic cannot prevent the re-disclosure of records released as a result of the request and the records may not be subject to privacy rule protections; therefore, Diamond Lake Clinic is released from any and all liability resulting from re-disclosure.

Signature (If signing for a minor patient, I hereby state I have legal authority to sign for the minor.) **Date**

Relationship to patient (If not patient signing)

www.diamondlakeclinic.org

info@diamondlakeclinic.org



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Release of Billing Information

I authorize Diamond Lake Clinic to disclose and release to my insurance carrier(s), including Medicare, Medicaid, Medigap/Supplemental benefits providers, and private insurers, as applicable, any medical and treatment information needed for payment purposes for services rendered. I authorize use of this form for the release of information needed to process claims to all my insurance carrier(s) and its authorized agents. I authorize my provider/practice to act as my agent in helping obtain payment from my insurance companies.

Assignment of Benefits

I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s) directly to my provider or practice for services rendered. I understand I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after insurance has met its obligation.

Medication History Authority

I, Patient's Full Name (First & Last), permission to access and obtain a patient's medication history from various sources, including pharmacies, health insurers, and prescription drug monitoring programs. This information is intended to enable the best care for each of Diamond Lake Clinic's patients.

By signing below I acknowledge that I have received and understood all of the information provided.

Patient (or guardian) Signature

Date

Patient full name

Patient Date of Birth

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Diamond Lake Clinic's Financial Policy

1. Insurance. Diamond Lake Clinic participates in most insurance plans, including Medicare. If you are not insured, full payment by credit card, debit card, or money order is expected at each visit. If you do not have up-to-date insurance, you will be given 90 days after your uninsured appointment to have your coverage reinstated. If your insurance is still inactive after 90 days (3 months), the full amount of each uninsured visit will then become the patient's responsibility. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for all uncovered services; it is your responsibility to verify with your insurance that services are covered.

4. Proof of insurance. All patients must complete our patient information (Intake) form before seeing any Diamond Lake Clinic provider. We must obtain a copy of your valid government photo-ID and current valid insurance. If you fail to provide us with the correct insurance information, you will be responsible for the balance of the claim.

5. Claims submission. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. We will submit your claims and assist you to get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to supply this information. Be aware that the balance of your claim is your responsibility.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum insurance benefits.

7. Nonpayment. If your account is over 90 days past due, you and your immediate family members with the same insurance plan may be discharged from the practice. If

this occurs, you will be notified that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Diamond Lake Clinic is committed to providing the best treatment to all of our patients. Our prices are representative of the usual and customary charges for our area. **Please call the clinic to discuss a partial payment plan if you are unable to pay your balance in full. If you do not make a payment plan, Diamond Lake Clinic will charge the full amount accrued to your credit card.**

Credit Card Charges

I understand that my signature below allows Diamond Lake Clinic to charge the credit card on file for any balance that is due on my account as they accrue. The following are some reasons for patient responsibility charges:

- copayments,
- coinsurance amounts,
- deductibles,
- insurance denials of claims/charges,
- cash-pay services, and
- no-show/late cancellation charges (\$100).

Patient (or guardian) Signature

Date

Patient full name

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HIPPA Privacy Notice

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information. Minnesota

Law requires consent for disclosure of treatment, payment, or operations information.
[Minn. Stat. § 144.293 subd. 2]

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us NOT to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Minnesota Law also requires consent for most other sharing purposes.

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways. We need your consent before we disclose protected health information for treatment, payment, and operations purposes, unless the disclosure is to a related entity, or the disclosure is for a medical emergency and we are unable to obtain your consent due to your condition or the nature of the medical emergency. [Minn. Stat. § 144.293, subd. 2 and 5]

Treat you

We can use your health information and share it with other professionals who are treating you only if we have your consent. We can only release your health records to health care facilities and providers outside our network without your consent if it is an emergency and you are unable to provide consent due to the nature of the emergency. We may also share your health information with a provider in our network. [Minn. Stat. § 144.293, subd. 2 and 5]

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary. We are required to obtain your consent before we release your health records to other providers for their own health care operations. [Minn. Stat. § 144.293, subd. 2 and 5]

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities only if we obtain your consent. [Minn. Stat. § 144.293, subd. 2 and 5].

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: <https://www.hhs.gov/hipaa/for-individuals/index.html>

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research if you do not object. [Minn. Stat. § 144.295 subd. 1]

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. [Minn. Stat. § 144.293 subd. 2]

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations only with your consent. [Minn. Stat. § 525A.14]

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies. We need consent to share information with a funeral director. [Minn. Stat. § 390.11 subd. 7 (a)]

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official with your consent, unless required by law. [Minn. Stat. § 144.293, subd. 2]
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services with your consent, unless required by law. [Minn. Stat. § 144.293, subd. 2]

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena. [Minn. Stat. § 144.293 subd. 2]

Other State Law

In Minnesota, we need your consent before we disclose protected health information for treatment, payment, and operations purposes, unless the disclosure is to a related entity, or the disclosure is for a medical emergency and we are unable to obtain your consent. [Minn. Stat. §§ 13.386, 254A.09]

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: <https://www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html>

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

Effective Date of this Notice: May 1, 2025

Privacy official/contact at Diamond Lake Clinic: Christina Botts, Director of Administration, Christy.Botts@DiamondLakeClinic.org, (612) 351-4841.

We never market or sell personal information.

By signing below I acknowledge that I have received and understood the information provided.

Patient (or guardian) Signature

Date

Patient full name

Patient Date of Birth

Attach Government Issued Photo ID

Attach Front and Back of your Insurance Card