VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

13637 60th Street SW • Cokato, Minnesota 55321 • (320) 286-2922 • Fax (320) 286-2875

WELCOME TO VILLAGE RANCH!

Thank you for choosing services provided by Village Ranch, Inc. These services may be in the form of individual therapy, family therapy, group therapy, and skills-based therapy (CTSS), and/or a combination of any of the available services through in-home, residential or foster care placement with Village Ranch or another organization.

HISTORY

The Village Ranch began in 1988 in Cokato, Minnesota offering adolescent males a place to live (group home) as well as outpatient therapeutic services. Since then, our original group home has grown to a Residential Group Home with a 34-bed capacity and onsite school. In 2009, we expanded to Anoka, Minnesota where outpatient individual, family, group therapy, and skills-based therapy is offered. In 2010, we opened our first "Independent Living Program" for adolescent males in Hutchinson, Minnesota with 12 beds and, most recently in April of 2015 we opened a similar 12-bed Independent Living Program for adolescent males in Rochester, Minnesota. All three of these residential locations offer a 24/7 staffed living environment, skills-based therapy services and outpatient therapeutic services.

Because we agree with you that consistency in therapy is important in addressing the challenges you and your family may be having, we try to schedule therapy sessions as convenient as possible; however, we understand emergencies happen and there will be times you will need to cancel appointments.

SERVICES AVAILABLE

Village Ranch, Inc. provides the following outpatient services: in-home individual and family skills-based therapy services, outpatient individual and family therapy, and diagnostic assessment services. We also offer residential group home and foster care placement which works in tandem with our outpatient therapeutic services. The children and families we support are in need of a rehabilitative mental health package and require varying therapeutic and skills-based therapy levels of intervention with the overarching design to enhance and support overall functioning.

The therapists you and your family will be working with are all master's level and/or licensed professionals with many years of experience in the field and use a variety of therapeutic techniques. All mental health practitioners who provide skills-based services and training meet the state requirements for training and experience in providing skills-based services to your child/adolescent. Please note, skills-based therapy services are not available to those individuals over the age of 18.

Our philosophy is that every family system is unique, important, and has strengths. We believe that working as partners through relationships, support, and caring, families are

strengthened and experience greater success. The services provided, areas covered, and goals established are mutually agreed upon between client, family and provider.

FINANCIAL RESPONSIBILITY (OUTPATIENT THERAPY SERVICES ONLY)

Copays, if applicable, are due at the time of your scheduled appointment and will be collected by your provider. The amount of your copay is listed on your insurance card.

NO-SHOW POLICY (OUTPATIENT THERAPY SERVICES ONLY)

If you are unable to keep your scheduled appointments, please notify us at least 24 hours in advance so we can offer that time slot to someone on the waiting list. You may reschedule your appointment when you call us to cancel.

If there is a second no-show you will be required to meet with your therapist and, if applicable, your county worker and others involved with your treatment to discuss options about resolving the no-show issue and possibly transfer to another agency.

LATE CANCEL POLICY

If you cancel your appointment with less than a 24-hour notice occasionally, we do understand. However, if a late cancel pattern develops, you will be required to meet with your therapist and, if applicable, your county worker and others involved with your treatment to discuss options about resolving the late cancel issue and possibly transfer to another agency.

(OUTPATIENT THERAPY SERVICES ONLY - *Not applicable to residential, group home, or foster care placements)*

After the first no-show appointment (without a phone call to cancel) you will receive a phone call to remind you of the missed appointment and to reschedule your appointment. You (not your insurance company) will be charged $50 (using the credit card information that you provided to us during intake) for the time slot we were not able to fill when you were a no-show.

If there is a second no-show occurrence you will be required to meet with your therapist, county worker and others involved with your treatment to discuss options about resolving the no-show issue and possibly transfer to another agency.

We want to keep services available to you and your family. Please feel free to address issues with your therapist or skills worker so we can all work together to resolve issues.

PARENTAL INVOLVEMENT

Through our experience, as well as available research, clients who do the best in treatment have involved families or support systems. Family involvement means actively supporting the therapeutic process which may include monthly family therapy sessions and general consistent contact with the client.

If the client is a child/adolescent involved with skills-based therapy services, please complete all the paperwork in a timely manner as we cannot hold the skills-based therapy spot longer than three (3) weeks due to our current waiting list for these services.

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VILLAGE RANCH
INFORMED CONSENT/CLIENT RIGHTS & RESPONSIBILITIES

CONFIDENTIALITY

The Minnesota Data Practices Act seeks to protect the privacy of the individuals when governmental agencies or private agencies under contract with public agencies collect data about them. The Minnesota Data Practices Act also helps people get information with this facility, whether the contact is in person, by mail, email, or by phone.

Every effort will be made to keep the information clients share with Village Ranch Inc. staff confidential. All client information is maintained as private and/or confidential, consistent with ethical guidelines of professional practice, and the statutes of the laws of the State of Minnesota. A written consent must be signed before outside persons or agencies can obtain information in records or from family workers.

The Clinical Supervisor supervises all casework and serves as a secondary source of support for families in crisis when practitioners and/or therapists are not available.

CLIENT RECORDS

The client information we collect from you, or that you authorize us to collect from others, is used for the purposes listed below. Because this list of purposes covers a variety of services and programs, some of the purposes will not apply to your information.

- To determine your eligibility for services provided by this agency;
- To provide effective care and treatment of medical/social/psychological/educational needs;
- For other purposes specifically authorized by you;
- To make referrals to other agencies or professionals to provide additional services to you;
- To collect reimbursement from other agencies or individuals for services we give you;
- The legal or statute requirements, if any, of providing information;
- To evaluate and monitor our performance as an agency licensed by the State of Minnesota;
- To conduct evaluations and prepare statistical reports;
- We cannot guarantee confidentiality of data transmitted (i.e. video, voice, email, etc.)

RELEASE OF CLIENT INFORMATION:

Access by Client:

As a client you have access to all public and private records about yourself or your children. (See section on "Minors" for exceptions regarding children.) Upon request you may review your records in the presence of one of our professional staff, and may request copies of records at your expense.

Access by Others:

The professional staff of Village Ranch Inc. will have access to information about you when their work requires it and for purposes of billing and collection of accounts in association with other professional consultation (e.g. accountant, attorney) if necessary. For training, supervision and/or consultation purposes, some clients may be asked to have their sessions observed and/or audio/video recorded. Such observations and/or recordings will only be conducted after the client has been fully informed of the specific uses of the observations/recordings and has consented to participate. All audio/video recordings will be destroyed following the training, supervision or consultation.

Individuals or entities outside of Village Ranch, Inc. who are authorized with a release signed by you (or guardian), may share information for purposes of consultation, evaluation, diagnosis, and program planning, when necessary to account for federal funds and program, when law enforcement personnel are investigating or prosecuting a criminal or civil proceeding, and with or without a release with appropriate personnel in an emergency.

MINORS: Under certain circumstances, minor clients have the legal right to request that client information be withheld from their parents. This request must be in writing, must explain the reasons for withholding the information, and what you expect the consequences could be if it is not withheld. Your therapist, in consultation with the professional staff will consider the request and a decision as to whether to withhold information will be made by Village Ranch, Inc. based on the best interests of the requesting minor.

In some cases, the law permits minors to consent to treatment and to withhold information from their parents with a formal request. This may be appropriate for a minor who is over the age of 16 and is financially independent and/or married, or when services relate to pregnancy, drug abuse or sexually transmitted disease. If you have any questions about this, ask the therapist who works with you.

As a rule, we do not encourage the withholding of information from parents except when it is our clinical judgment that it would be clearly detrimental to the minor's welfare to disclose information.

MULTI-PARTY COUNSELING: If you are involved in multi-party counseling such as couples or family therapy, our staff will treat all information acquired in that process in accordance with this confidentiality policy. In addition, Village Ranch, Inc. will stress the importance of maintaining confidentiality with all members of the family or couples therapy process, but we cannot be held responsible for breaches of confidentiality by other participants. Finally, records of such session belong to all participants and cannot be released without the consent of all participants.

In some circumstances individuals participating in couples or family counseling will also be involved in individual sessions with members of our professional staff. At times an individual may share information in individual sessions, which is of central importance to the couples or family therapy process. It is our belief that the family therapist should not place himself or herself in the position of holding secrets of families or couples. Thus by signing this policy you give the therapist permission to disclose information when it is our clinical judgment that such disclosure is in the best interest of the couple or family.

LEGAL REQUIREMENTS

In most cases, you are not legally required to provide the information requested. If there is such a legal requirement, you will be informed of the specific law that requires it. Generally, if you do not provide the information requested, the Court and/or your caseworker will be notified.

MANDATED REPORTING:

Although each provider uses their own judgment regarding the safety of the client and family and decisions to report are made in consultation with the Clinical Supervisor, all employees of Village Ranch, Inc. are mandated reporters and are required by law to report any of the following situations:

- Instances of abuse or neglect of a minor or vulnerable adult
- Behavior that may be a threat to one's life or that of another person
- Receipt of a court order
- Report of sexual abuse by a health professional

OUR RESPONSIBILITIES:

- To meet with you/your family in your home or our office weekly at a convenient time for you.
- To be prompt and accessible for scheduled meetings.
- To listen respectfully and be culturally sensitive.
- To provide you with appropriate support and information.
- To provide collaborating agencies or the court with reports regarding your progress.
- To provide crisis counseling during emergency situations.

YOUR RESPONSIBILITIES:

- To commit to scheduled meetings.
- To communicate and cooperate with staff respectfully.
- To report changes in your condition or symptoms.
- To participate in the choice of goals and progress towards them.
- To notify your provider at least 24 hours in advance if you are unavailable for an appointment and need to reschedule.

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YOUR RIGHTS:

- To be treated with respect, dignity, consideration and compassion
- Be informed of the qualifications of your practitioner and/or therapist (education, experience, professional counseling certifications, and license(s))
- Be informed of the limitations of the practitioner and / or therapist's practice to special areas of expertise (career development, ethnic groups, etc.) or age group (adolescents, older adults, etc.)
- Receive an explanation of services offered, your time commitments, fee scales, and billing policies prior to receipt of services.
- Confidential treatment of personal and medical records and the approval of refusal of their release to any individual outside of our agency.
- To see the contents of my file, the reasons for its retention, and any part of the file explained.
- To contest inaccuracies or incompleteness of the data maintained in the client record by submitting a written request to the author of said record. Village Ranch, Inc. replies to such requests within 30 days of receipt.
- Ask questions about the skills/therapy techniques and strategies and be informed of your progress.
- Participate in setting goals and evaluating progress toward meeting them.
- Be informed of how to contact the practitioner and/or therapist in an emergency situation.
- Request a referral for a second opinion at any time.
- Terminate the relationship at any time.
- Prompt and reasonable response to your questions and requests.
- Contact the appropriate professional organization with concerns or complaints relative to the professional's conduct.
- The right to initiate a complaint or grievance procedure and the appropriate means of requesting a hearing or review of the complaint. It is our hope that the client will approach our agency employee first to try resolving the issue directly. A complaint regarding the violation of client's rights may be filed by contacting Village Ranch, Inc. at 13637 60th St. SW, Cokato, MN 55321, or 320-286-2922 Ext. 202. You will receive a written response by our Director in 15 working days. If you are not satisfied with the actions taken, you may register a complaint with the Dept. of Human Rights, State Office Building, St. Paul, MN 55155, or 651-296-5663, or the Division of Licensing, Dept of Human Services Building, 444 Lafayette Road North, St. Paul, MN 55155 or 651-296-3971.
- You have the right to file a complaint with the appropriate state licensing Board.
  Board of Psychology: (612) 617-2230 Board of Social Work: (888) 234-1320
  Board of Marriage & Family Therapy: (612) 617-2220 Board of Behavioral Health & Therapy: (612) 617-2178

OUR RIGHTS:

- Staff have a right to privacy.
- To be contacted by a client only to cancel or reschedule an appointment or in time of family crisis.
- Staff should have the right as for consultation on your case.
- Staff has the responsicility to report to authorities if the client has committed a crime or threatened to commit a crime while receiving services from Village Ranch, Inc.
- Staff have the right to not be harassed by the client, specifically sexual harassment. This includes suggestive sexual language, kissing, dating, sexual touching, sexual penetration, and/or any other type of sexual contact while they are providing treatment to you.

CONSENT TO TREATMENT: I affirm that prior to becoming a client of Village Ranch, Inc., I was given sufficient information to understand the nature of mental health services. I consent to participate in evaluation and treatment and I understand I may refuse services at any time. I am aware the service provider will participate in case consultation/ supervision, as required at the clinic. My signature below affirms my informed and voluntary consent to receive therapy/outpatient services.

_____	___/___/20___	_____	___/___/20___
Client Signature	Date	Legal Guardian Signature	Date
_____	___/___/20___	_____	___/___/20___
Therapist/Mental Health Practitioner	Date	Clinical Supervisor	Date

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VILLAGE RANCH APPLICATION FOR SERVICES

Today's Date: ___/___/_____

A. CLIENT INFORMATION:

_____ ____ _____ ____/____/_____
First Name MI Last Name Date of Birth

_____ _____ _____ _____ _____
Street Address City State Zip Code County

(____) ____ - _____ Living with: _____ Relationship to Client: _____
Phone First, Last Name (Parent, Foster Parent, etc.)

Office Location: ❒ Cokato ❒ Hutchinson ❒ Rochester ❒ Anoka

SERVICES REQUESTED:

❒ CTSS Services: ❒ Individual Skills ❒ Family Skills ❒ Group Skills

❒ Individual Therapy ❒ Family Therapy ❒ Group Therapy ❒ Family Focus

❒ Adolescent Sexual Health Curriculum ❒ Sexuality-Specific Treatment ❒ RISE ❒ CLIMB

1) Are you currently receiving therapy or skills services? ❒ **YES** ❒ **NO** (If you answered YES, please provide the name and address of the agency providing the services)

_____ _____
Agency Street Address/City/State/Zip

2) Have you completed a past Diagnostic Assessment? ❒ **YES** ❒ **NO** (If you answered YES, please provide the name and address of the agency with the Diagnostic Assessment (DA) on file)

_____ _____
Agency Street Address/City/State/Zip

B. REFERRAL REASON/GOALS:

❒ Supportive Services ❒ Psychoeducation ❒ Prevent Placement ❒ Reunification ❒ Assessment Only

_____

Estimated Length of Service(s): _____

C. CLIENT AND CLIENT'S FAMILY *(if applicable)* STRENGTHS/ASSETS:

_____

_____

D. REFERENT: ❒ Self ❒ Therapist ❒ Social Worker ❒ Probation Officer ❒ Foster Parent

_____ _____
First Name/Last Name Agency

_____ _____ _____ _____ (____) ____-_____
Street Address City State Zip Code Phone

(_____) ____-_____ (_____) _____-_____ _____
Phone Alternate Phone Email Address

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VILLAGE RANCH FACE SHEET

I. CLIENT

Client's Name: _____ Nickname: _____

Race: _____ Sex: ❒ M ❒ F Ethnicity: _____

Age: _____ Date of Birth: ___/___/_____ Place of Birth: _____

Social Security Number (optional): _____-____-_____ Religion: _____

Special Medical Problems, Safety Concerns or Allergies: _____

_____

_____

_____

_____ _____ _____ _____ (____) ____-_____

Current Address: Street City State Zip Code Phone

Current Student: ❒ Yes ❒ No

Name of Last School Attended: _____

Currently Employed: ❒ Yes ❒ No

Employment Experience: _____

IN CASE OF EMERGENCY, CALL:

Name: _____ Phone: (_____) _____-_____

Name: _____ Phone: (_____) _____-_____

II. SOCIAL HISTORY

DESCRIPTION OF THE PROBLEM (PLEASE INCLUDE FREQUENCY, INTENSITY, DURATION AND ONSET):

Currently suicidal ideation? ❒ Yes ❒ No

If yes, please explain (onset, frequency, intensity, duration, plan, attempts, hospitalizations):

_____

_____

_____

_____

_____

Have you had suicidal ideation in the past? ❒ Yes ❒ No

If yes, please explain (onset, frequency, intensity, duration, plan, attempts, hospitalizations):

_____

_____

_____

_____

_____

III. MEDICAL HISTORY (Please include names and clinics of all providers)

_____

_____

_____

_____

_____

_____

Are you currently on medication? ❒ Yes ❒ No

If yes, please list below:

Medication	Dose (MG)	Time	Prescriber	For:	% Compliance

IV. BRIEF FAMILY HISTORY

V. TRAUMA HISTORY (i.e., abuse, death, car accidents, divorce, neglect, disease, etc.)

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VI. CURRENT LIVING SITUATION (i.e., who do you live with, their relation to you, conditions of living situation, etc.)

Is your housing stable/permanent? ❒ Yes ❒ No
If no, please explain:

Are all living areas usable? (Bedroom, kitchen, living/dining room, bathrooms, etc.) ❒ Yes ❒ No
If no, please explain:

Are the firearms in the home? ❒ Yes ❒ No
If yes, are they secure? ❒ Yes ❒ No
If no, please explain:

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VII. PAYMENT INFORMATION FOR CLIENT: _____

PARTY RESPONSIBLE FOR PAYMENT:

❒ County of Residence
❒ County Different than County of Residence
❒ Self-Pay
❒ Other: _____
❒ Primary Insurance Company
❒ Secondary Insurance Company

Responsible Party: _____ Relation: _____

Social Security Number: _____-____-_____ Date of Birth: ____/____/_____

Employer: _____ Work Phone: (____) ____-_____

Employer: _____ Work Phone: (____) ____-_____

Primary Insurance Company: _____ Group #: _____

Policy/Contract #.: _____ ID #.: _____

RXBIN#: _____ Phone: _____

Claims Address: _____ City, State, Zip: _____

Insurance Coverage: ❒ Dental Eye ❒ Exams/Glasses ❒ Prescriptions ❒ Others _____

Secondary Insurance Company: _____ Group #: _____

Policy/Contract #.: _____ ID #.: _____

RXBIN#: _____ Phone: _____

Claims Address: _____ City, State, Zip: _____

Insurance Coverage: ❒ Dental Eye ❒ Exams/Glasses ❒ Prescriptions ❒ Others _____

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BILLING AND PAYMENT POLICY

INSURANCE BILLING

Village Ranch, Inc. requires all insurance information be provided before services begin. This means any, and all, primary and secondary insurance policies on which the client is listed, i.e. mother, father, step-parents, etc., as well as medical assistance, so that claims can be properly submitted and processed.

CO-PAYS, CO-INSURANCE, AND DEDUCTIBLES

Co-Pays, if applicable, are due at the time of your scheduled appointment and will be collected by your provider. The amount of your co-pay is listed on your insurance card. If your policy is subject to a deductible, you will receive a bill from Village Ranch if you have not yet met any deductibles for your policy/policies. Any co-insurance due after claims are processed will be billed to the client as well. It is highly recommended that you apply for medical assistance, so that, if you qualify, your financial responsibility can be reduced or perhaps eliminated.

COVERAGE LAPSES

If, at any time and for any reason, your policy is terminated, it is your responsibility to inform Village Ranch immediately so steps can be taken to ensure services are not interrupted. This applies to commercial policies (ones for which a monthly premium is paid) **AND** medical assistance. If coverage is not reinstated, you will be responsible for any, and all, fees for services. Talk to your social worker or county contact for information regarding medical assistance lapses. If you are unable to meet these requirements, services may be suspended.

SLIDING FEES

If you do not have insurance or medical assistance of any kind, a sliding fee schedule is available for those who qualify. Please speak to your provider for assistance.

By signing below, I understand this Billing & Payment Policy:

____/____/_____ _____ _____

Date Signature of Client or Authorized Person Authorized Person's Authority to Sign (proof required)

Reason client is unable to sign: ❒ Minor ❒ Deceased ❒ Other: _____

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VILLAGE RANCH, INC. RELEASE OF INFORMATION

Village Ranch Residential
13637 60th St. SW
Cokato, MN 55321
Phone: (320) 286-2922 Fax: (320) 286-2875

Village Ranch Cokato Outpatient
13637 60th St. SW
Cokato, MN 55321
Phone: (320) 286-2922 Fax: (320) 286-5140

Village Ranch Foster Care
13637 60th St. SW
Cokato, MN 55321
Phone: (320) 286-2922 Fax: (320) 286-5140

Village Ranch Hutchinson Group Home
851 Dale Street SW, PO Box 305
Hutchinson, MN 55350
Phone: (320) 587-3447 Fax: (320) 286-2875

Village Ranch Rochester Group Home
1117 1st Ave NE
Rochester, MN 55906
Phone and Fax: (507) 258-3447

Village Ranch Anoka Outpatient
12 Bridge Square, Suite 207
Anoka, MN 55303
Phone: (763) 712-9209 Fax: (763) 712-9200

Client's Legal Name: (please print) _____
Date of Birth: ___/____/_____ Previous Names: _____
Address: _____ City, State, Zip: _____
Phone (home/main): (____) _____-_____ Work: (____) _____-_____ Other: (____) _____-_____

1. **I would like Village Ranch, Inc. to:** ❒ Exchange information with
   ❒ Release my records to
   ❒ Obtain my records from

   Person, Clinic, Organization Name: _____

   Address: _____ City, State, Zip: _____

   Phone: (____) _____-_____ Fax: (____) _____-_____

2. **I would like the following records released:** All pertinent records, or check all that appy below:

   ❒ Discharge Summary ❒ School Reports ❒ Medical Reports
   ❒ Mental Health Records ❒ Progress Notes ❒ Treatment Plans
   ❒ Evaluations/Assessments ❒ Legal Records ❒ Social History
   ❒ Social Service Records ❒ Other: _____

3. **Purpose:**

   ❒ Care Coordination ❒ Treatment Planning ❒ Evaluation/Assessment
   ❒ Personal Use *(mark personal and confidential)*
   ❒ Other: _____

4. **Staff member requesting information:** _____ (___)____-_____
   Name Phone

5. **I understand the following:**
   - Except for psychotherapy notes (which are not included in my medical record), all records will be released to the hospital, clinic or person named above. This includes details about treatment for mental health, chemical dependency, sickle cell anemia, genetic conditions, and AIDS/HIV.
   - If I do not want these to be released, I will place a check mark here: ❒ I do not want the following records released: _____
   - If I change my mind, I may write to the address in Section 1 to stop the release of my records. This will not apply to records that have already been released.
   - This form expires one year after I sign it, or on (expiration date): ____/____/_____
   - There may be a fee for releasing these records.
   - Once the records are released to the hospital, clinic or person named above, the clinic or hospital releasing my records cannot prevent them from being shared by a third party. At that point, the records may no longer be protected by state or federal privacy laws.
   - To be valid, this form must be filled out completely and signed. A copy is valid if it has not been altered.
   - If I do not sign this form, I will still be treated, unless treatment is part of a research project.

____/____/_____ _____ _____
Date Signature of Client or Authorized Person Authorized Person's Authority to Sign (proof required)

Reason client is unable to sign: ❒ Minor ❒ Deceased ❒ Other: _____

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TEXT AND EMAIL NOTIFICATIONS FROM PROCENTIVE SOFTWARE

Client's Name: _____

OVERVIEW

Procentive is the trusted electronic health records system (EHR) for behavioral health. This system allows us to communicate with parents through text and email. With the input of your text number and/or email address our system allows us to set up notifications that will be directly sent to your phone and/or email address to remind you of an upcoming appointment or to review a document that requires a signature.

HOW IT WORKS

- Text/Email Notifications: Our system will automatically send you a text and/or email reminder two (2) days before and the day of your scheduled appointment, reminding you of your upcoming appointment.

- Email Notifications: Using the kiosk feature we are also able to send documents that require a signature electronically through email. The provider will send an email with the subject line "Village Ranch Paperwork". There will be a link directing you to the document.
  *(Note this document can only be opened once). Once opened you can review the document and sign it in the designated signature box using your mouse.

With your permission, we ask that you provide us with your text number and email address:

Text Number: (_ _ _) _ _ _ - _ _ _ _

Email Address: _____@_____._____

How would you prefer to be notified for an upcoming appointment? ❒ Text ❒ Email

_____ ___/___/_____
Client/Legal Guardian Signature Date

_____ ___/___/_____
Client/Legal Guardian Signature Date