

Client Identification Data						
Client Name (Last) (First) (M)			Age	Birthdate	Sex	
Address				City/State/Zip		
Cell phone: OK to call? _____		Home Phone: OK to call? _____		Work Phone: OK to call? _____		
Marital Status Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/>			Email address:			
Education (Highest degree/grade Completed)		Health Insurance Company Name		Health Insurance Member ID #		
Health Insurance Group #		Employer/ Occupation		Secondary Insurance Information		
Family History						
Family Members	Age	Emotional Problems		Living?		Occupation
		Yes	No	Yes	No	
Spouse's Name						
Child's Name (if applicable)						
Child's Name (if applicable)						
Child's Name (if applicable)						
Child's Name (if applicable)						
Other significant person in your household						
Notify in case of emergency (Name, relationship, phone number for contact)						
Address			Home Phone			
Print Name of Client			Date			
Signature of client or legal guardian			Date			

Health Data			
Your Physician (Full Name):			
Address (Clinic Name)	(Street)	(City)	(State/Zip)

Date of most recent physical: _____

Do you have any current medical problems (including any infectious diseases)? yes no Please describe:

Are your medical problems being treated? _____ If yes, by whom? _____

Have you ever had a drug allergy or sensitivity? yes no If yes, to what drug: _____

Medications:

Current Meds: _____

Prescribing MD: _____

Past trials of psychiatric meds: _____

Chemical Use History

Do you drink alcoholic beverages? Yes No If yes, what do you drink Beer Wine Hard liquor

How often do you drink? Daily 3-5 times weekly 1-2 times weekly Less frequently

Do you sometimes drink more than you had planned? Yes No

Have family and friends ever expressed concern about your drinking? Yes No

Have you ever been arrested for alcohol related charges: DWI, public intoxication etc.? Yes No

Have you ever been treated for drinking, chemical dependency or gone to AA? Yes No

Have you ever had periods where you were unable to remember what happened when you were drinking? Yes No

Have you ever overdosed? yes no

Do you use nicotine? yes no If yes, how much and for how long: _____

Counseling and psychiatric history: (dates of treatment, hospitalization, provider/treatment and outcome, etc.)

Outpatient treatment Partial hospitalization Inpatient hospitalization Residential treatment

Name of Facility/Doctor/Address:

Additional Info: _____

Any trauma history – accidents, injuries, illness, losses, death of loved one, other

Other factors that impact client's life (e.g. cultural issues, military, spiritual and/or legal issues)

Legal issues: No Yes (describe if yes) _____

Military: No Yes (describe if yes) _____

Cultural issues: No Yes (describe if yes) _____

Spiritual beliefs/practices: _____

Abuse History

History of abuse: no yes If yes: physical sexual verbal/emotional **Legal Action:** no yes

By: _____

When: _____

Family Mental Health History: (include family history of suicide/homicide)

Maternal side: depression anxiety bipolar eating disorder alcoholism drugs suicide

Paternal side: depression anxiety bipolar eating disorder alcoholism drugs suicide

Additional information: (who, treatment, other diagnoses)

Client's name: _____ **Date:** _____

Parent/Guardian _____

CLIENT NAME _____ DATE _____

Current Symptom Checklist: Rate the intensity of symptoms present in the last 4 weeks.

None: This symptom not present at this time

Mild: Impacts quality of daily life, but no significant impairment of day to day functioning

Moderate: Significant impact on quality of life and/or day-to-day functioning

Severe: Profound impact on quality of life and/or day to day functioning

Symptom	None	Mild	Moderate	Severe	Symptom	None	Mild	Moderate	Severe
Depressed Mood					Increased/decreased appetite				
Low Energy					Unplanned weight gain				
Sleep disturbance					Unplanned weight loss				
Dissociation					Paranoid thoughts				
Hyperactivity					Poor concentration or Indecisive				
Bingeing					Purging / Over-exercising				
Decreased Sex Drive					Excessive worrying				
Unresolved guilt					Impulsive actions/speech				
Irritability					Anger management problems				
Nausea/Acid indigestion					Daily Stress Level				
Social Anxiety					Hallucinations				
Self-mutilation/cutting					Racing thoughts				
Low self worth					Restlessness				
Nightmares					Loss of interest in normal activity				
Negative voices inside					Decreased creativity/productivity				
Losing train of thought					Unresolved Anger				
Mood swings					Easily Distracted				
Disorganized					Memories of trauma				
Anorexia					Hopelessness				
Social Isolation					Marital problems				
Grief					Panic Attacks				
Phobia's					Suicidal thoughts				
Headaches					Feel panicky/anxious				
Loneliness					Work problems				
Viewing Pornography					Alcohol / drug Intake				
Problems at home					Attempted suicide in the past				

Briefly describe how the above symptoms impair your ability to function:

Treatment Contract/Registration

WELCOME! The most important goal of therapy is to help you feel and function better in your life. As a client, you can help with your treatment by keeping the following information in mind throughout your therapy. This is a solution-focused, goal directed approach for a wide variety of problems, from crises in daily living to ongoing mental health issues. It is especially important that you keep in close contact with family or supportive friends during a crisis and that you assume responsibilities for helping yourself. Treatment will be provided in the least restrictive environment possible.

Standard therapy sessions are 45-50 minutes. While this can be somewhat flexible, the time frame will be maintained as much as possible to help all involved. Also this is a courtesy to others that may be waiting. If you are dissatisfied with your progress in therapy, please discuss this openly. Your input and concerns are very important and talking about them often leads to beneficial results for all involved.

Confidentiality: Please understand that what you say is CONFIDENTIAL and will be discussed with other people only with your written permission (except in medical emergencies, under a court order, or as required by law, i.e. mandatory child abuse reporting, and vulnerable adult abuse reporting or for the purpose of consultation or supervision). If there is a clear intention to do serious harm to self or to another person, information will be shared in an attempt to prevent that harm from occurring. Information regarding services provided to minor children can be given to parents on request as a matter of state law. If a minor child is seen, issues regarding confidentiality will be discussed with the parents. Insurance providers often require more detailed information of your situation prior to approval of continued treatment or payment for treatment.

The next is not a legal exception to your confidentiality.

However it is a policy you should be aware of if you are in COUPLES or PARTNER THERAPY with us:

If you or your partner have some individual sessions as a part of couples therapy whatever you say in those individual sessions will be considered to be a part of couples therapy and can and probably will be discussed in our joint sessions.

Do not tell us anything you wish to keep secret from your partner.

Please do not email us or expect us to email you. Emails do not provide sufficient confidentiality. You may put things in writing to us, and we may do the same for you.

Office Hours and Cancellation Policy: Office hours vary by therapist. Therapy time is valuable to all involved. **Cancellations or changes of an appointment must be made at least 24 hours in advance or you will be charged for your session.** Please note that insurance companies do not pay for failed or canceled appointments. This is standard practice and is intended in part to preserve the time for those who may need it. You can make appointment changes by calling the office and leaving a message with your provider. Clients who arrive late, your therapy will end at the normal scheduled time. You must pay in full for that full session. If you cancel with less than 24 hours notice you must pay for that session. Clients who no-show or cancel twice without 24 working day hours advance notice (notice required Monday – Friday) will receive services only on same-day scheduling availability. You are responsible for paying for your session at each visit. We will bill you pro-rata for reading materials you send, writing on your behalf, and phone conversations or messages of over five minutes in length. If you are on insurance which we accept you must pay us your deductible at the beginning of each year and any co-pay at each session. Our Associates have varying rates depending on services rendered and insurance you may choose to use.

Consultation and Supervision: To provide you with the best possible service, Soul Work Counseling providers engage in ongoing supervision and consultation with other mental health professionals. When discussing clients in these forums, confidentiality is protected.

Crisis Situations: Steps to take during a crisis will depend upon the nature of the crisis. You may call your individual therapist during normal business hours and then the Crisis Connection at 612-379-6363 after business hours, weekends and holidays. When immediate service is required for life threatening situations, please call 911 or go to the emergency department at the closest hospital.

Fees, Phone Calls and Reports: Fees are as follows: \$160 for the initial diagnostic session; \$120 for individual and \$140 for family or couples sessions, fees for group therapy vary by program.

Full payment (or co-payment if services are covered by insurance and any deductible has been satisfied) is due at the beginning of the therapy hour. There are not fees charged for phone calls, letters and reports to facilitate scheduling, information sharing, etc. and requiring up to 10 minutes of time. After 10 minutes, you are billed at a prorated \$120 per hour rate. Scheduling paid telephone sessions is welcome when a situation is particularly urgent or because of travel or geographical difficulties. Failed individual/family appointments or cancellations made with less than 24 hour notice will be charged at \$60.. Please note: **All payment, including copays/co-insurance, late cancel/failed appointment fees and unpaid claims from your insurance company is due prior to or at the time of service or your appointment will be rescheduled for a time after payment is received.**

Insurance and Bookkeeping: Soul Work Counseling retains the insurance billing and bookkeeping services of Jessica Mennenga at Locolle Billing Services. Please contact her at 763-438-0383 with any questions regarding billing or collections. There may be situations that Jessica will be calling you directly regarding billing or collection issues. In many cases, insurance companies provide outpatient mental health benefits to their insured customers. **Please remember that services are provided for and charged to you, not to your insurance company. You are responsible for checking with your insurance company and/or your employer to be certain that they cover the services provided.** Because of the wide variety of insurance plans available guarantee cannot be made that any particular company will provide payment for services that you receive. If your insurance company does not cover the services you receive, you are fully responsible for the amount due. If you have any questions about obtaining coverage, please ask. However, your insurance carrier will make a decision about any reimbursement. In most cases, problems with insurance processing can be significantly reduced if the claims are filed through this office.

Collections: In case you do not pay your bill, Soul Work Counseling reserves the right to seek payment through the use of a collection agency or through other legal means. The cost of collection may be added to your bill. Return check fee is \$35 and will be billed to you. Unpaid balances may incur reasonable and customary interest charges.

Eye Movement Desensitization Reprocessing (EMDR) Clients

You acknowledge that you have been advised that Eye Movement Desensitization Reprocessing (EMDR) is a treatment approach that has been widely validated by research. Distressing and/or unresolved memories may surface through the use of the EMDR procedure. Some clients have experienced reactions during the treatment sessions that neither they nor the administering clinician may have anticipated, including a high level of emotion or physical sensation.

Subsequent to the treatment session, the processing of incidents/material may continue, and other memories, flashbacks, feelings, etc. may surface. Please visit www.emdr.com for more information if you have any questions on the subject. Before commencing EMDR treatment, you have thoroughly considered all of the above, you have obtained whatever additional input and/or professional advice deemed necessary or appropriate to having EMDR treatment. By your signature acknowledgment below you have hereby consented for us to deliver EMDR treatment to you or your custodial child. Your signature on this form is free from pressure or influence from any person or entity.

Record-keeping, Requests from Third Parties for Records, Testifying Regarding Records, and Related Costs.

We keep very brief records including only that you have been here, interventions that happened in session, and topics and goals discussed. You have a right to a copy of your file at any time. You have the right to request that we correct any errors in your file, and you may provide a copy of that file to any health care provider at any time. Our records are confidential and may not be used as evidence for litigation purposes. This includes all assessments, questionnaires, evaluations, and testing.

If a child or children are involved, you or your non-health care advisors may not subpoena our documents or use as evidence in any proceeding any communication or documents related to the therapy process. Be advised that if we are somehow compelled to release documents, you as a client acknowledge and grant the right for us to give identical documents to the opposing party.

If we are forced to further document or respond to information requests, meet with your representatives, or testify in court our fees are \$400/hour, portal to portal, plus all expenses, half day minimum, paid in advance. Agreement to this provision is required to receive therapy services from us, and is acknowledged by your signature at the end of this document.

Services NOT Offered.

We are **not qualified** and we **do not offer** the following services:

1. Custody Evaluation
2. Visitation Recommendations
3. Disability Evaluation or Recommendation
4. Services requiring testimony in legal proceedings.

Note: Therapy ends when a subpoena arrives. We will attempt to legally quash a subpoena request. Therapy summarization documents for legal purposes require written client release and cost \$250 per request. Copies will be sent to opposing counsel.

I understand and agree to abide by the policies stated above.

Client Signature

Date

Parent Signature

Date

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES/Registration

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

Soul Work Counseling is committed to treating and using protected health information about you responsibly. This Notice of Health Information Privacy Practices describes the personal information I collect, and how and when I use or disclose that information. It also describes your rights as they relate to your protected health information.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Understanding Your Health Record/Information

Each time you visit Soul Work Counseling, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which I can assess and continually work to improve the services rendered and the outcomes achieved.

Your Health Information Rights

Although your health record is the physical property of Soul Work Counseling, the information belongs to you.

You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record
- Amend your health record
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or at alternative locations

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES/Registration (2)

- Request a restriction on certain uses and disclosures of your information and revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Responsibilities of My Practice

Soul Work Counseling is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to my legal duties and privacy practices with respect to information I collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if I am unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

I reserve the right to change my practices and to make the new provisions effective for all protected health information I maintain. Should my information practices change, I will give you in person, or mail a revised notice to the address you've supplied me.

I will not use or disclose your health information without your authorization, except as described in this notice. I will also discontinue using or disclosing your health information after I have received a written revocation of the authorization according to the procedures included in the authorization.

I have received the Health Information Privacy Practices notice and I have been provided an opportunity to review it.

Name _____ Birth Date _____

Signature _____ Date _____

Office Copy

Bill of Rights/Registration

BILL OF RIGHTS

Consumers of services offered by Marriage & Family Therapists licensed by the State of Minnesota have the right:

1. to expect that the practitioner has met the minimal qualifications of training and experience required by state law.
2. to examine the public records maintained by the Board of Marriage and Family which contain the credentials of the practitioner.
3. to obtain a copy of the rules of conduct from the Minnesota Board of Marriage & Family.
4. to report complaints to the practitioner, and if not satisfactorily resolved, to file a complaint with the Minnesota Board of Marriage & Family.
5. to be informed of the cost of professional services before receiving the services.
6. to privacy as defined by rule and law. This means that no information will be released from the facility in which the practitioner works without the client's informed, written consent, except for the following:
 - a. The practitioner is required by law to report instances of abuse or neglect of a child or a vulnerable adult.
 - b. The practitioner is required by law and professional codes of ethics to notify proper persons and/or authorities if the practitioner believes there is a danger to a client or another identified person.
 - c. The practitioner is required to report admitted prenatal exposure to harmful controlled substances.
 - d. In the event of a client's death, the spouse or parents of the deceased have a right to access the client's records.
 - e. The practitioner must produce records or testimony in response to a Court Order and potentially to a subpoena.
 - f. Parents or legal guardians of a non-emancipated minor client have the right to access their child's records.
 - g. Case discussions with other staff through case management, consultation, testing, and treatment are confidential and are to be conducted as such by all staff.
7. to be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving psychological services.
8. to respectful, considerate, appropriate, and professional treatment.
9. to see information in his/her record upon request.
10. to be involved in the formulation of the treatment plan, the periodic review of plans and progress, and the formulation of the discharge plan.
11. to be informed of treatment options, expected outcome of treatment, expected length of treatment, and cost in language that he/she can understand.
12. to discuss needs, wants, concerns, and suggestions with the practitioner.
13. to be advised as quickly as possible if a scheduled appointment time cannot be kept due to illness or emergency.

Signature acknowledges receipt and understanding of these rights.

Signature of client

Date

Signature of Parent/Guardian

Date

Client Responsibilities/Registration

Client Responsibilities

Each client has the responsibility to:

1. Refrain from physical (and other) abuse of self, others, and property. Clients are responsible for repair or replacement of any property they damage in the facility.
2. Devote reasonable energy and time to therapy work. Therapy is generally “hard (emotional) work.” For progress to occur, we recommend making your therapy a high priority in your personal life. Your therapist may regularly assign homework that is intended to help you learn about yourself, and doing your homework is expected to expedite your therapy and decrease your costs.
3. Fulfill contracted behavior.
4. Be honest with your therapist concerning your thoughts and feelings about your therapy and treatment.
5. Keep appointments as made. Your appointment time is reserved for you. Therefore, you will be charged for the appointment unless you give at least 24 hours advance notice. Exceptions may be made for emergencies and other extenuating circumstances.
6. Keep current in paying your fees (deductibles, co-payments, fee-for-service payments). You are required to pay your fee at the beginning of each session. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that occurred prior to the first visit to my office), session fees credited toward the deductible will be collected at the time of the session until the deductible payment is verified by the insurance company or third-party provider. Verification can be made through my billing coordinator, who will contact your insurance company to check your benefit status upon request.
7. Inform those involved in the treatment plan about any changes to physical health, insurance plan, or ability to pay for contracted services.
8. Parents or caregivers are responsible to supervise the activities of children with respect to use of facilities, material, etc.

I have read and understand my rights and responsibilities as noted above.

Signature of Client

Date

Signature of Parent/Guardian

Date