Center for Counseling & Wellness

Serving Individuals, Couples, & Families with an Integrative Approach

Located in the Grand Hill Professional Building • 333 Grand Avenue • Suite 205
Saint Paul, Minnesota 55102 • Phone: 651-294-2307 • Fax: 651-233-5641
•www.centerforcounselingandwellness.com

CLIENT INFORMATION FORM

GENERAL INFORMATION

Name: ____ Date: ____________
Address: ____ Apt. #: ____________
City/State: _____________________________ Zip: ___________

Birth date: ____________ Gender: M ___ F ___ T ___ Ethnicity: ________________________
Home/Cell Phone: __________________________Work Phone: ________________________
Is it O.K. to leave a message on your home/cell phone? _____ At work? _____
Is it O.K. to use email or texting for scheduling? ____ Yes ____ No
If yes, what is your email address? ____

What are the best times to reach you? ____
Employment: ______________________________ Level of Education: _________________

How did you hear of our clinic? Or referral source: _____________________________________
____

What are the three most important concerns that have brought you to our program at this time?
____
____
How have you addressed these concerns in the past?
____
____
What would you like to accomplish in therapy now?
____
____

MEDICAL INFORMATION

Describe your current health including diet, exercise, chronic health problems, etc.
____
____

Please check all of the symptoms you are currently experiencing:

_____Depression _____Weight changes _____Difficulty concentrating
_____Panic attacks _____Perfectionism _____Difficulty sleeping
_____Body aches/pains _____Nightmares _____Anxious/tense
_____Lonely/isolated _____Suicidal _____Inferiority feelings
_____Hear voices _____Low energy _____Confusion
_____Rage _____Feelings of hopelessness

Date of last physical exam: _______________
Name of your health care provider: ____
Have you ever been treated for a mental health concern with?
_____Therapy _____Medication _____ Hospitalization
List current medications: ____

List current involvement with other mental health professionals: ___________________________

____

FAMILY AND OTHER INFORMATION

List parents, siblings, or any other significant members in your household *while growing up*:

Name	Gender	Current Age	Relationship to you

What was it like for you growing up in your family? ______________________________________

____

List *current* partner, children, and/or others in your household:

Name	Gender	Current Age	Relationship to you

What is it like for you in your current living situation? _________________________________

____

	You		**Family or Partner**	
Check if appropriate:	Past	Present	Past	Present
Substance abuse/alcohol				
Neglect/abuse/family violence				
Sexual abuse/assault				
Emotional abuse				
Chronic physical illness				

Describe your current support system: ____

____

Describe any spiritual or meditative activities you are involved in:

____

____

Is there anything else you would like us to know about you? ______________________________

____

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CLIENT SELF-EVALUATION

Client: ____________________DOB: _______ Today's Date: _________Therapist:________________

To assist us in providing you with the best service, it would be helpful if you would rank the following items below by placing an X next to the selected number. We may ask you to complete the same questions in a few months and will ask you to complete a similar version before you end therapy to see how these areas might have changed. This information will remain confidential. Please raise any questions you have with your therapist.

	Mild	------------	------------	------------	------------	**Severe**
Anxiety	None	1	2	3	4	5
Depression	None	1	2	3	4	5
Thoughts of suicide	None	1	2	3	4	5
Thoughts of self-harm	None	1	2	3	4	5
Low self-esteem	None	1	2	3	4	5
Substance Abuse	None	1	2	3	4	5
Problems in relationships	None	1	2	3	4	5
Family Problems	None	1	2	3	4	5
Problems related to rape or sexual abuse	None	1	2	3	4	5
Health Problems	None	1	2	3	4	5
Difficulty controlling anger	None	1	2	3	4	5
Difficulty knowing what is real	None	1	2	3	4	5
Domestic abuse	None	1	2	3	4	5
Problems with isolation or social support	None	1	2	3	4	5
Difficulty coping with stressors	None	1	2	3	4	5
Grief/Loss	None	1	2	3	4	5
Work/School Problems	None	1	2	3	4	5

Other problems: ____

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INFORMED CONSENT

Welcome to the Center for Counseling and Wellness. We believe that it is important for you to be actively involved in your care and this document provides information about our services. We ask that you read it carefully so that you can benefit the most from your experience here. If you have any questions, please feel free to ask your therapist.

Session Timing and Fees.
Individual, couple and family sessions are typically 60 minutes in length. We expect that you will attend scheduled sessions and provide your therapist with a minimum of 24 hour notice if you are unable to keep your appointment. If you are unable to provide such notice, in most cases you will be charged a cancellation fee for that session. Fees for services were established during your initial intake via phone or email and will be confirmed during your session today. You are expected to pay the fee quoted to you at the time of service. This may include copays or deductible amounts.

If you wish to use your insurance you will need to speak with your therapist to determine if she/he can accept that insurance plan. If not, you will be given a receipt for your payment which can be submitted to your insurance company for payment as an out-of-network provider. We also accept a limited number of clients on a sliding fee scale. If you believe that this option would best suit your needs, you may discuss this with your therapist.

The Process of Therapy
When people begin therapy, they often have questions and anxieties about what the process will be like. Typically your therapist will begin by asking more generally about concerns you would like to address in therapy. Some time will be spent getting to know more about you as a person or couple and how the concerns you bring to therapy are related to your life history. If you and your therapist feel that you can establish a good working relationship, you will set up a treatment plan that outlines specific goals. It is important to periodically review how therapy is going and to discuss any necessary changes.

Therapy often ends when you and your therapist decide jointly that your goals have been met. A planned termination is established which allows time to review progress, identify future goals and say good-bye. It is your right to end therapy at any time; however, we would encourage you to discuss concerns with your therapist if you are not satisfied with the care you are receiving. Your therapist has an ethical responsibility to end treatment if she believes you are not benefiting from the process. If this is the case, every effort will be made to help you find appropriate care, which may include a referral to another therapist or program

It is important to know that psychotherapy has both potential risks and benefits. Therapy involves talking about problematic areas of your life and you may experience uncomfortable feelings such as sadness, anger, guilt, etc. Therapy has been shown to have benefits such as finding solutions to specific problems, identifying patterns that lead to unhappiness, improving relationship satisfaction, identifying new coping skills, and reducing symptoms of depression and anxiety. However, there are no guarantees about what you might experience. Because of these risks and benefits, it is important to have an open dialogue with your therapist about how both of you feel the therapy is progressing.

Client Bill of Rights

You have a right to:

- Be treated with respect, dignity and consideration.
- An assessment of the nature of your concerns and reasonable expectations about the outcome of therapy.
- Request a transfer to another therapist.
- Obtain referrals to other appropriate services.
- Be free from exploitation for the benefit or advantage of your mental health professional.
- Examine public records maintained by the respective boards if your therapist is licensed, which contain credentials of the Psychologist, Marriage and Family Therapist, or Licensed Professional Counselor/Clinical Counselor.
- Obtain a copy of the rules of conduct from the State Register and Public Documents Division, Department of Administration, 117 University Avenue, St. Paul, MN 55115

Client Records and Confidentiality

Client records are treated as private and confidential information falling under the jurisdiction of the Minnesota Data Privacy Act. Client records are legally the property of the Center for Counseling and Wellness and are securely maintained in locked filing cabinets as well as in a HIPAA compliant Electronic Health Record system. *However, client information may be shared in individual supervision or consult groups as it may benefit you as a client.*

Information that identifies you as a client may only be released to a third party with your written consent or by court order. You can have access to the information in your file except when the release of that information might be harmful to you as determined by your therapist. Client files are professional records and may contain technical language that could be upsetting to the untrained reader. Therefore if you wish to review your records we ask that you do so in the presence of your therapist so that any questions can be answered. You have the right to add comments to your record. You may request copies of your record and will be charged for those copies.

Electronic Communication

Communication between you and your therapist outside of session will typically be done over the phone. However, email and text messaging are also options if you choose to communicate in this way. It is important for you to know that most email is not secure or confidential due to system administrators of the email service providers having access to

these records. For these same reasons, text messaging is also not secure or confidential. If you feel more comfortable communicating with your therapist in this way, please limit electronic correspondence to session scheduling or cancellations and save content related to your work in therapy for when you meet with your therapist in person. Any email or text message received from you will be documented and become a part of your therapy record.

Social Media

Please know that your therapist is unable to accept friend requests from you on social media sites such as Facebook, Twitter, LinkedIn, etc. Adding clients as friends on these sites can cause confusion in the boundaries of the therapeutic relationship as well as compromise your confidentiality. Therefore, your therapist will decline or ignore a friend requests made on these sites.

The Center for Counseling and Wellness does have a business Facebook page that you are welcome to "Like." Please be aware that posts on this page are public and therefore we recommend that you do not post anything personal about yourself or your therapy on this page.

Supervised Providers

Some therapists here at the Center for Counseling and Wellness are considered Supervised Providers. This means that this therapist is working towards completion of requirements set by the state of Minnesota to become fully licensed. Part of this process is to receive clinical supervision by a board approved supervisor. Due to this, your supervised provider may share aspects about your therapy experience with their supervisor. This information is focused on issues you are experiencing and ways your therapist can be of help to you. Your therapist's supervisor is also held to the same standards of confidentiality as your therapist.

Emergency and After Hours Resources

Therapists are not usually available for after-hours or emergency drop-in services. If a crisis situation should arise, please contact one of the resources below, go to an emergency room, or call 911.

- Ramsey County Crisis Response — 651.266.7900 (Available 24/7)
- Acute Psychiatric Services — 612.873.3161 (Available 24/7)
- Hennepin County mobile crisis — 612.596.1223
- Walk-In Counseling Center — 612.870.0565
- National Suicide Prevention Lifeline — 800.273.8255

Questions and/or Complaints

Please direct any questions or complaints about your care to your therapist. If your concerns remain unresolved you may contact the following licensing boards:

Minnesota Board of Psychology
2829 University Avenue SE, Suite 320
Minneapolis, MN 55414

Minnesota Board of Behavioral Health and Therapy
2829 University Avenue SE, Suite 210
Minneapolis, MN 55414

Minnesota Board of Marriage and Family Therapy
2829 University Avenue SE, Suite 330
Minneapolis, MN 55414

My signature below indicates that I have read and understand the information in this document. I agree to abide by its terms while receiving services from the Center for Counseling and Wellness.

Electronic Client Signature: ___________________________   Date:_____________

Print name: ______________________________________

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LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

____
Client Electronic Signature (Client's Parent/Guardian if under 18)

____
Today's Date

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Notice of Privacy Practices

NPP/HIPAA

This notice describes how your medical/mental health information is maintained and disclosed, and how you can have access to this information. Federal law requires us to distribute this notice to you. Please read it carefully.

At the Center for Counseling and Wellness, we follow strict rules to protect your confidentiality. We use the private information in your file to provide individual, couples, family, and group therapy. The information may be used to collect insurance payment when applicable, and to collect anonymous data for health care operations as required by federal law. If you would like information from your file to be shared with another professional, we will ask you to sign a form to release the information.

Your health information is confidential; however, therapists are mandated reporters, which means that in certain circumstances, we are required by law to release information without your consent. These situations are described below. If you have questions about any of these situations, please ask your therapist:

1. If you make a specific threat to harm yourself or someone else (and the risk of danger is imminent), a staff member must take appropriate steps to protect you or warn the appropriate parties.

2. If your therapist suspects you have physically or sexually abused or neglected a child or vulnerable adult, they must make a report to the appropriate authorities. This includes some cases of domestic abuse when a child is exposed to weaponry or is physically threatened and/or used as a weapon.

3. If using health insurance to cover services, most insurance companies will require access to information in client files (ex: diagnosis, treatment plan, or other documentation) with a signed release by client.

4. If you are pregnant and using a controlled substance (heroin, cocaine, phencyclidine, methamphetamine, or their derivatives).

5. When there is a court order to release your records to the legal authorities.

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Your Rights Regarding Your Health Information

1. You have the right to decide how we can contact you (by phone at home or work, through e-mail, or through the postal service).

2. You have the right to review your file and to receive a copy of your file. There is a form you are required to complete and submit to your therapist.

3. You have the right to add a correction to your file if you feel it is inaccurate. There is a form you are required to complete and submit to your therapist requesting a correction be added.

4. You have the right to request a list of where your health records have been sent.

5. You have the right to revoke any authorization to release your records at any time. There is a form you are required to complete and submit to your therapist.

6. You have a right to receive a copy of this notice. If we change this notice, your therapist will let you know as soon as possible.

If you have any questions regarding this notice, or believe your privacy rights have been violated, you may also file a complaint with the Secretary of the Department of Health and Human Services; Hubert H. Humphrey Bldg.; 200 Independence Ave. SW; Washington D.C. 20201. You will not be treated badly if you make a complaint.

The effective date of this notice is October 15, 2011
NPP /HIPAA

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Acknowledgment of Receipt of Notice of Privacy Practices

The Center for Counseling and Wellness Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

In addition to the copy we provide you, copies of the current notice are available by accessing our website at www.centerforcounselingandwellness.com

_______________________________________ _________________________
Electronic *Signature of Client* *Date*

_______________________________________ _________________________
Electronic *Signature of Legal Guardian (if applicable)* *Date*

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CLIENT EMERGENCY INFORMATION

Client Name: ____

Address: ____

Home Phone: ___________________________ Work Phone: _____________________________

Cell Phone: ______________________________

In an emergency, please contact:

Name: ____

Address: ____

Home Phone: ___________________________ Work Phone: _____________________________

Cell Phone: ______________________________

If the person above is not available, please contact:

Name: ____

Address: ____

Home Phone: ___________________________ Work Phone: _____________________________

Cell Phone: ______________________________

Medical Information

Physician: ____

Hospital: ____

Medical conditions we should be aware of: ____

Current medications: ____

In the event of an emergency, I authorize my therapist to use the above information. It is accurate to the best of my knowledge.

_____________________________________   ___________________________
Client Electronic signature   Date

_____________________________________   ___________________________
Therapist Electronic signature   Date

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FEE CONTRACT

Client Name: ________________________ Therapist: _______________________

Type of Service: Individual / Group / Family / Couple

_____ Client electing to use insurance benefits to cover services.

Insurance company name: ____

Deductible Amount: __________________ Co-pay: ______________________

Clients are responsible to pay for any deductible or co-pay amounts at the time of service unless other arrangements have been discussed and agreed upon.

______ Client electing not using insurance benefits. A fee of: ___________________
has been determined with my therapist to be paid at the time of services.

Cancellation Policy

I acknowledge that by signing this form I agree to the following cancellation policy:

I agree to give 24-hours notice by phone if I need to cancel my scheduled appointment. If I am unable to give a 24-hour notice, I will be charged a cancellation fee of ______________ as determined by my therapist. If I am ill or have an unexpected emergency, the fee will be waived.

__________________________ _______________________ _________
Client's Name Electronic Signature Date

__________________________ _______________________ _________
Therapist's Name Electronic Signature Date

________________________ _______________________ _________
Clinical Supervisor's Name Electronic Signature Date

Assignment of Benefits and
Authorization to Release Information

I authorize payments of my benefits to the Center for Counseling & Wellness for mental health services rendered.

I also authorize the release of pertinent information (e.g. diagnosis) regarding these claims to my insurance company, as requested by the company.

A photocopy of this authorization shall be as valid as the original.

______________________	______________________	_________
Client Name	Electronic Signature	Date
______________________	______________________	_________
Therapist's Name	Electronic Signature	Date
______________________	______________________	_________
Clinical Supervisor's Name	Electronic Signature	Date

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Teletherapy Policy and Consent (effective 1/1/2019)

Services Provided

Teletherapy is offered by Center for Counseling and Wellness as a limited option for clients who might need to miss in-person appointments due to situations that make it impossible or unsafe to travel, unable to make it into the office due to health, childcare, or occupational related issues.

Teletherapy is not meant as a substitute for face-to-face therapeutic sessions.

It is to be used only for continuation of ongoing regular therapy, and will not be used for new patient intakes.

Teletherapy, using HIPAA compliant software, is available to clients under the following conditions:

1) Inclement weather that may cause hazardous driving conditions.
2) Illness or medical treatment that has physically immobilized the client on a temporary basis.
3) Travel that would entail missing an appointment for two consecutive weeks.

Appointments for teletherapy will be used only under the conditions listed above.

Patient Confidentiality

Teletherapy is provided through a HIPAA compliant online service that is guaranteed to protect client privacy. The therapist will use a secure, password protected online services and will interact with the client from a private location.

The client will be provided a link to the software in advance of the scheduled appointment. The client is responsible for ensuring his/her/their own private setting for the therapeutic session, and using a secure online connection. If the therapist determines that the privacy is being disrupted, the therapist may choose to end the session.

All information exchanged during the session is confidential and protected, and documentation will be generated and stored in the same HIPAA compliant manner as during a face-to-face session.

Billing and Cancellations

Teletherapy is billed as a regular appointment. Copays and out of pocket payments will be collected using a secure online system.

A 24-hour notice is required for cancellations or clients will be charged a $50 cancellation fee.

Discontinuation of Teletherapy Sessions

Discontinuation of teletherapy sessions will occur at the request of the client or if:

1) Sessions are not conducive to effective treatment.
2) Privacy and confidentiality is not established for any reason.
3) Technical issues interfere with communication.
4) Teletherapy dissuades attempts to make in-person appointments.
5) Client is living out of the state or country.

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Quality Review

A review of the quality of the teletherapy service will take place every six months and may result in a change of service provider if HIPAA compliance is found to be insufficient.

I have read and agree to this policy.

________________________________ ______________

Electronic Client Signature **Date**

________________________________ ______________

Electronic Therapist Signature **Date**