



ADULT INTAKE FORM

Name (First, Last, MI): _____ Identified Gender: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Ethnicity/Race: _____ Highest level of Ed.: _____

Relationship Status: _____ Partner Name: _____

Person Completing Form: _____ Relationship to Client: _____

Home Address: _____ Phone(s): _____

Okay to Send Mail? **Y/N** Okay to Call? **Y/N** Text about Appt.? **Y/N** Emergency Contact Name & Number: _____

Email: _____ Do you need emailed/texted confirmations (circle one)? **Y/N** Who Referred? _____

Describe any considerations related to culture, faith, or identity that might help with your counseling experience: _____

Please list any individual/entity you may need a release of information for: _____

Who resides with you at primary residence? (Names, ages and relationships): _____

PRESENTING PROBLEM:

Describe your current difficulties (please complete symptoms list and assessments provided w/ this paperwork): _____

When were these problems first noticed and for how long? _____

What has seemed to help? _____ What makes things worse? _____

Please describe/list any previous evaluations or treatment for current problem(s) or similar concerns? _____

Please describe any current life stressors: _____

Have stressors seemed to trigger any changes in relationships, mood or behavior? **Y/N** If so, please explain: _____

Please describe your strengths: _____

FAMILY & SOCIAL HISTORY

Relationship status of parents: _____ Names and ages of any siblings: _____

Describe any family history of mental health concerns: _____

Describe any family history of chemical use issues: _____

Describe any family history of medical issues: _____

Describe any involvement you may have/have had in legal system: _____

List any children you may have and ages: _____

Describe your present living situation: _____

Describe your employment and/or schooling history and present status: _____

How often do you spend time with others with similar interests outside of your home? (Describe please). _____

DEVELOPMENT HISTORY

Describe any known complications during pregnancy or at birth? _____

Describe any childhood medical issues you have experienced: _____

Have you been exposed to any significant trauma? **Y/N** If so, please briefly explain: _____

Have you experienced any significant losses? **Y/N** If so, please briefly explain: _____

EDUCATIONAL HISTORY

Describe your educational experience(s) (eg. Grade school, college, challenges, strengths, bullying, truancy, etc.): _____

MEDICAL INFORMATION

Name of primary clinic/doctor: _____ Phone: (____) _____ Date and reason for last doctor's visit: _____

List contact information/name of other mental health supports being accessed: _____

Have you discussed mental health concerns with your primary care doctor? **Y/N**

Describe any significant medical issues you are experiencing: _____

CURRENT MEDICATIONS (include prescribed, over-the-counter and herbal remedies)

<i>Medicine Name</i>	<i>Dose/How Often</i>	<i>Reason</i>	<i>Doctor who prescribed it</i>

Please list any significant allergies and reactions: _____

MENTAL HEALTH/CHEMICAL HEALTH HISTORY

Describe any mental health history (who you saw and why, hospitalizations, medications tried, etc.): _____

Briefly describe if any suicide attempts, thoughts or plans or any self-harm you have engaged in present or past: _____

Briefly describe if any thoughts of wanting to/ attempts to significantly harm or kill someone? _____

Describe if you ever experience seeing or hearing things others do not: _____

Describe any chemical health history or current use (type of substances used and how often, treatment received, etc.) This may include tobacco, alcohol, and caffeine. _____

CAGE-AID (Cut down, Annoyed, Guilty, Eye-Opener)

1. Have you ever felt the need to cut down on your drinking or drug use? **Y/N**
2. Have people annoyed you by criticizing your drinking or drug use? **Y/N**
3. Have you felt bad or guilty about your drinking or drug use? **Y/N**
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hang-over (eye-opener)? **Y/N**

If you answer yes to any of the above questions, let's discuss further to determine whether added services may be appropriate to address any chemical health concerns.

SAFETY INFORMATION

If there are any guns in the home, where are these kept? _____

Do you feel safe in your relationship(s)? **Y/N** Do you feel safe in your home? **Y/N** Do you feel safe in your neighborhood and in the community? **Y/N**

OTHER INFORMATION

What kinds of activities do you enjoy? _____

Is there anything else that you would like your Counselor to know? _____

Thank you for taking time to complete this paperwork thoroughly.

If there is something that was not addressed, please include or bring up in person at your first appointment.



OUTPATIENT INFORMED CONSENT

Counseling clients and caregivers have certain rights and responsibilities when consulting a therapist for treatment and evaluation services for themselves or those they care for. This form should be carefully read prior to the first session. By you signing the attached signature form you affirm the following:

1. Prior to commencement of therapy, I was given adequate information to understand the process of Counseling. This information included, but was not limited to: the professional identity and qualifications of the Counselor, the potential risks and benefits of Counseling, confidentiality and its limits, alternative treatment options, and financial responsibilities.
2. I agree that I have sought and consent to have myself or my child participate in the therapy process. This will include the development of treatment goals and a treatment plan. I agree to be involved in the process and regularly review the treatment progress and process in person or via phone. I understand that the Counselor will continue the treatment process, if my child is engaged in therapy, even if I do not engage in therapy sessions. Reasonable attempt will be made to contact me, by the Counselor, in attempts to engage me and/or the family in therapy process.
3. I understand that I have the right to discontinue treatment and/or request a referral to another Counselor within Parasol Wellness Collaborative, or elsewhere.
4. I understand that there are no guarantees regarding the results of the therapy process and at times symptoms or behaviors may increase.
5. Contracted providers are obligated to follow their code of ethics related to their specific licensure. They are also mandated reporters. I understand that this means me and my child's safety and well-being is kept in mind with every interaction. The Therapist/Counselor may need to make reports to outside agencies or instigate increased level of care for my child or myself should my personal safety, others' safety, or my child's well-being seem to be at risk. I understand that I may or may not be notified if outside reports are made. The provider or other involved parties will make best attempts to connect if increased level of care or support is recommended or needed. (See privacy practices for any concerns related to confidentiality).
6. I understand that Parasol Wellness Collaborative is not liable for the actions of the contracted Therapists/Counselors. I understand that each contracted therapist at Parasol Wellness Collaborative is liable for their own actions and behaviors throughout the therapy process.
7. I understand that any financial obligations are my responsibility. I understand that payments towards balances are to be made in a timely manner or services may be discontinued and a collection process put into place. The definition of "a timely manner" is determined by the Counselor/Therapist providing services to your child.
8. I understand that play or art may/can be used during the therapy process. Play and art have been proven as effective therapeutic methods, therefore serve a significant purpose in Counseling/Therapy sessions.
9. I understand that a therapy animal may/can be used during therapy sessions. This will only be the case with verbal permission from you and/or the client. Therapy animals are up-to-date with shots and veterinarian recommendations. Use of therapy animals has been proven an effective method in Counseling practices.
10. I understand that Counselors/Therapists make best attempts to deter any physical contact with clients, however, on occasion, children may ask for hugs, high-fives, or other age appropriate ways of connecting. Counselors/Therapists will maintain appropriate boundaries with and refer to their code of ethics as needed. To protect both the Counselor and child, providers are encouraged to document any physical interactions between selves and clients they support.



OUTPATIENT INSURANCE FORM

Primary Insurance

Insurance Company: _____ ID#: _____
Group #: _____ Policy Holder: _____
Place of Employment: _____ Policy Holder Phone: _____
Insurance Phone: _____ Client's Relationship to Policy Holder: _____
Copay/Deductible %: _____ Policy Holder Date of Birth: _____

Secondary Insurance

Insurance Company: _____ ID#: _____
Group #: _____ Policy Holder: _____
Place of Employment: _____ Policy Holder Phone: _____
Insurance Phone: _____ Client's Relationship to Policy Holder: _____
Copay/Deductible %: _____ Policy Holder Date of Birth: _____

I grant Parasol Wellness Collaborative and the identified client's provider permission to speak with insurance representatives regarding claims and authorization as well as file a claim on my behalf to the insurance commissioner should it be necessary. I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or other benefits to the party who accepts assignment. I authorize payment of medical benefits to Parasol Wellness Collaborative. I understand that limited information will be disclosed to the insurance company in order for the insurance claims to be processed. I understand that I am responsible for any claims not paid by insurance and that it is my responsibility to confirm coverage with my insurance plan before starting services. If I do not pay my entire balance, I may be subject to added collection fees and relevant information will be given to the collecting party. I am the policyholder or the responsible party for the identified client utilizing services. I will maintain a credit card on file to secure my account, and my credit card may be charged for outstanding balances over 30 days old.

BY SIGNING BELOW, I AGREE TO AND UNDERSTAND THE ABOVE STATEMENTS REGARDING BILLING AND INSURANCE

Client Name: _____ Date: _____

Name of Person Completing Form (printed): _____

Relationship to Client: _____ Signature: _____



OUTPATIENT PROFESSIONAL SERVICES AGREEMENT

This document contains important information about the professional services at Parasol Wellness Collaborative (PWC) and business policies. Please read carefully and write down any questions you might have so that we can discuss them at our next meeting.

MENTAL HEALTH SERVICES

Psychotherapy is not easily described in general terms. It varies depending on the personalities of the therapist and client and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. There are no guarantees of what you will experience. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work may include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up another meeting with another mental health professional.

PROFESSIONAL FEE DISCLOSURE

Professional Fees

PWC charges fees based on 30-55 minute appointments. We will break down the cost based on time spent in session. Out-of-pocket service costs typically range from \$120.00 to \$220.00. Examples of other services which may require payment are listed in the "Additional Service Charges" portion of this document. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time, even if I am called to testify by another party. Because of the difficulty of legal involvement, PWC charges \$250.00 per hour fee for preparation for and attendance at any legal proceedings; this includes report writing, meetings with any relevant professionals, transportation and wait time. I will require a \$1000.00 retainer fee prior to starting any services pertaining to court related tasks.

Appointment Cancellation fees

PWC requires 24 hour cancellation notice. However, we understand that life circumstances may not always offer this opportunity. Should cancellations consistently occur without 24 hour notice, you will be required to pay half of your session fees for every cancellation. If you do not provide communication regarding your cancellation, and do not show up for your scheduled appointment, you will be charged a no show fee which reflects the type of services you were scheduled for. This cannot be billed to insurance. If cancellations and/or no shows become detrimental to your therapy progress, I may close your file and/or refer you elsewhere for services.

Additional Service Charges

You will be charged for various services provided by myself or any other professional at or affiliated with PWC that are not part of face to face appointments. These charges may include administrative materials and time spent. These services may include, but are not limited to:

- Letters, reports, medical records, form completion for other entities.
- Telephone calls or meetings with clients, parents/caregivers, or other professionals lasting longer than 10-minutes.
- Court testimony and reports required for legal proceedings. This also includes any reviewing of videotapes.
- Transportation time to and from any meetings pertaining to your care.

Insurance Reimbursement

At this time, PWC offers reimbursement through some insurance companies. Not all providers at PWC offer the same insurance reimbursement. Under those circumstances, out of network reimbursement or fee for services may be an option, if you are not involved with a Minnesota Healthcare plan. We have limited access to what insurance providers will compensate for services. Therefore, we encourage you to be well informed about your insurance and what services/providers they will reimburse for. You are responsible for any fees not covered by your insurance plan.

9201 Quaday Ave, Ste 205, Otsego MN 55330
Co-located w/ Elk River School District



Billing and Payments

If you are paying fee for services, you will be expected to pay for each session at the time it is held, prior to the session beginning, unless you have an agreed upon arrangement with provider. PWC accepts cash, check or credit/debit cards. We typically require you complete a credit card authorization form at intake. This is an agreement between you and Parasol, allowing us to automatically pay your fees through a delegated account. In the event that a payment/check is returned a \$25.00 service charge will be added to your bill and your privilege to write checks will be denied. Under those circumstances, cash or credit payment options will be available to you. Payment schedules for other professional services will be agreed upon and put into writing when they are requested. In circumstances of unusual financial hardship, PWC may be willing to negotiate a payment installment plan. A sliding-fee scale is also available for those whom it applies. If your account has not been paid for more than 60 days and arrangement for payment has not been agreed upon, we have the option of using other means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such action is necessary, costs may be included in the claim. In most collection situations, the only information released regarding the client's treatment is his/her name, the nature of the services provided, and the amount due. If there are any caregiver custody issues, one caregiver will be delegated as the responsible party for billing needs, unless otherwise agreed upon.

PROFESSIONAL RECORDS

The laws and standards require that PWC keeps treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted by/and or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Your records may also be accessible to you via a secure electronic medical records system. Please know that we are allowed to omit portions of your records, should we deem them inappropriate/unsafe for sharing.

MINORS

Minors Consent for HealthCare Act offers that minors 16 years and older may initiate mental health services without caregiver consent under the following conditions: Professional deems services are "emergency treatment", they request "voluntary institutional treatment", or if minor is "living apart from parents, managing own financial affairs" (Minnesota Statutes: 144.344; 253B.03 & 253B.04; & 144.341. If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. I ask that caregivers and their children agree that I will only provide caregivers with general information about our work together; unless I feel there is a high risk that you will seriously harm yourself or someone else or that you are at risk for abuse or neglect. In this case, I will notify them or other appropriate parties of my concern. I may also provide them with information which can be useful to increase treatment progress at home. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections that you may have about what I am prepared to discuss.

CONFIDENTIALITY & CUSTODY ISSUES

In general, federal and state law protects the privacy of most communications between a client and therapist. I can release information about our work to others only in certain instances and with your written permission. More detailed confidentiality notice and custody stipulations may be found in the client Bill of Rights or Privacy Practices documents provided prior to or at your intake session. In the area of parental custody or guardianship rights, it is important you know that PWC does not offer parenting assessments or services related to litigation. Each parent/legal caregiver is obligated to receive records, share information with whom they deem appropriate, and cancel or schedule appointments as needed, based on legal documentation and verbal agreement.



OUTPATIENT SERVICES SIGNATURE FORM

By signing this form you are agreeing that you reviewed: Bill of Rights, Professional Services Agreement, Informed Consent & HIPAA Privacy Practices forms provided to you prior to or at intake. Additionally, you agree that you discussed any questions or concerns with provider, and agree to the terms and conditions included in these documents.

Client Name: _____ Caregiver/Client Signature: _____

Relationship to Client: _____ Date: _____

Provider Signature: _____ Date: _____

Treatment plans are required as part of the psychotherapy process. These must be reviewed occasionally and created with you/your child and the provider. By signing below, you are allowing permission to the provider to electronically sign the formal treatment plan after you have discussed goals, objectives, length of treatment, and interventions with the provider.

Client Name: _____ Caregiver/Client Signature: _____

Relationship to Client: _____ Date: _____



Credit Card Authorization Form

My signature below allows Parasol Wellness Collaborative to keep my signature on file and to charge the credit card listed below for any balance that is due. I understand that Parasol Wellness Collaborative routinely runs cards on file for copayments, coinsurances, deductibles, fee for service charges and no show/cancellation charges. As a courtesy, it is our practice to send paper invoices for charges that are a result of an insurance denial so that our clients may have the opportunity to work with their insurance company to get charges covered before the credit card on file will be charged.

Credit/Debit Card Information:

Visa Mastercard Discover American Express HSA/FSA

Cardholder

Name: _____

Billing

Address: _____ **City:** _____

State: _____ **Zip Code:** _____

Credit Card #: _____

Expiration Date: ___/___/___ **Billing Zip:** _____

Security Code (the last 3 digits near the signature block on back of card): _____

X _____ **Cardholder Signature** ___/___/___ **Date**

___ Please send me an email alerting me of any transactions at: _____



THIS FORM DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW CAREFULLY.

DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for health care is considered "Protected Health Information" (PHI). Parasol Wellness Collaborative (PWC) along with independently contracted providers are required to extend certain protections to your PHI, and give you this notice about our privacy practices that explains how, when and why we may use or disclose you PHI. Expect in specified circumstances, we must use or disclose only the minimum necessary PHI to accomplish the intended purpose related to the use or disclosure. Providers are required to follow privacy policies described in this notice though we reserve the right to change our privacy practices and the terms of this notice at any time. PWC providers must abide by Minnesota and federal HIPAA regulations regarding your PHI. If alterations are made, you may request a copy of the new notice from your provider.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

PWC providers may use and disclose Personal Health Information for a variety of reasons. Providers have a limited right to use and/or disclose your PHI for purposes of treatment, payment and for our health care operations. For uses beyond that, written authorization must be obtained.

USES AND DISCLOSURES RELATING TO TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

Generally, PWC providers may use or disclose you PHI as follows: For treatment: we may disclose your PHI to doctors, nurses, and other health care personnel who are involved in your health care team. Your PHI may also be shared with ancillary services relating to your treatment such as for crisis related services, consultation purposes and/or community mental health agencies involved in the provision and coordination of your care. To obtain payment: we may use/disclose your PHI in order to bill or collect payment for your health care services. For health care operations: We may use/disclose your general PHI in the course of operating our facility. Appointment reminders & correspondence: Unless you provide us with alternative instructions, we may send appointment reminders to your personal devices or other materials to your home address.

USES AND DISCLOSURES OF PHI REQUIRING AUTHORIZATION

For uses and disclosures beyond treatment, payment and operations purposes, PWC providers are required to have your written authorization, unless the use or disclosure falls within one of the exceptions described above. Authorizations can be revoked at any time to stop future uses/disclosures except to the extent that we have already undertaken an action reliant upon your authorization.

USES AND DISCLOSURES OF PHI FROM MENTAL HEALTH RECORDS NOT REQUIRING CONSENT OR AUTHORIZATION

The law provides that PWC and EDTS providers may use/disclose your PHI from mental health records without consent or authorization in the following circumstances: When required by law: we may disclose PHI when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. Providers must also disclose PHI to authorities that monitor compliance with these privacy requirements. To avert threat to health or safety: in order to avoid serious threat to health or safety, we may disclose PHI as necessary to law enforcement and other persons who can reasonably prevent or lessen the threat of harm to self or others. For specific government functions: your provider may disclose PHI to government benefit programs relating to eligibility and enrollment, and for national security reasons.

USES AND DISCLOSURES OF PHI- FROM ALCOHOL AND OTHER DRUG RECORDS-NOT REQUIRING CONSENT OR AUTHORIZATION

When required by law: we may disclose PHI when a law requires that your provider report information about suspected child abuse and neglect, or when a crime has been committed on the program premises or against a program personnel, or in response to a court order. For research and audit purposes: In certain circumstances, PWC providers may disclose PHI for research, audit,

or evaluation purposes. To avert threat to health or safety: In order to avoid serious threat to health and safety, we may disclose PHI to law enforcement when a threat is made to commit a crime on the program premises or against program personnel.

USES AND DISCLOSURES REQUIRING YOU TO HAVE AN OPPORTUNITY TO OBJECT

In the following situation, your provider may disclose a limited amount of your PHI if we inform you about the disclosure in advance, and you do not object, as long as the disclosure is not otherwise prohibited by law. To families, friends or others involved in your care: we may share with these people information directly related to their involvements in your care, or payment for your care.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights relating to your protected health information: To request restrictions on uses/disclosures: You have the right to ask that PWC providers limit how we use or disclose your PHI. PWC providers will consider your request, but are not legally bound to agree to restriction(s). To the extent that your provider does agree to any restriction on our use/disclosure of you PHI, we will put the agreement in writing and abide by it except in emergency situations. PWC providers cannot agree to limit uses/disclosures that are required by law. To choose how we contact you: You have the right to ask that we send any information to an alternative address or by an alternate means. We must agree to your request as long as it is reasonably easy for me to do so. To inspect and request a copy of your PHI: Unless your access to your records is restricted for clear and documented treatment purposes, you have a right to see your PHI upon written request. Restrictions may be imposed if record disclosure may be determined as detrimental to yours or other's wellbeing. We will respond to your request within 30 days. If you want copies of your PHI, a charge for preparation may be imposed. You have the right to choose what portions of your information you want copied and to have prior information regarding the cost of copying. To request amendment of your PHI: If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that your provider correct or add to the record. We will respond within 30 days of receiving your request. This request may be denied if it is determined that the PHI is 1) correct and complete; 2) not created by your provider and/or not part of PWC provider's records, or; 3) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights along with any statement in response that you provide. This will be added to your PHI. If your provider approves the request for amendment, we will change the PHI; informing you and others that need to know about the change in the PHI. To find out what disclosures have been made: You have a right to get of list of when, to whom, for what purpose, and what content your PHI has been released other than instances of disclosure: for treatment, for payment, and operations; to you, your family, of the facility directory, or pursuant to your written authorization. The list will also not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or disclosures made before October 2014. PWC providers will respond to your written request for such a list within 30 days of receiving it. Your request can relate to disclosure going back as far as ten years, if applicable.

YOU HAVE THE RIGHT TO RECEIVE THIS NOTICE

You have the right to receive a paper copy of this Notice and/or an electronic copy by e-mail upon request. You may also access on our website for your convenience.

HOW TO COMPLAIN ABOUT PRIVACY PRACTICES

If you think that PWC or their providers, may have violated your privacy right, or you disagree with a decision we have made about access to your PHI, you may file a written complaint with PWC. You may file a complaint with your provider's supervisor and/or licensing board. This information can be found on your Bill of Rights. PWC providers will take no retaliatory action against you for making complaints.

For further information about Federal or State confidentiality regulations you may consult www.health.state.mn.us or www.hhs.gov

*Please note that school staff may follow different privacy guidelines than Mental Health Professionals/Practitioners. Mental Health Professionals/Practitioners will abide by HIPAA standards, even when providing services in the school setting.

