INDIVIDUAL INTAKE FORM

Please provide the following information for our records. Information you provide here is held to the same standards of confidentiality as our therapy.

Name: _____

Address: _____

Gender: ☐ Male ☐ Female Birth Date: _____/_____/_____ Age: _____

Home Phone: _____ May we leave a message? _____

Work Phone _____ May we leave a message? _____

Cell/Other Phone: _____ May we leave a message? _____

E-mail: _____

Marital Status: ☐ Never Married ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐Widowed

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Insurance _____ Insurance Group Number _____

Policy Holder Name _____

Date of Birth _____ Relationship to Client _____

Are you currently receiving psychiatric services or professional counseling elsewhere? ☐Yes ☐No

Have you had previous psychotherapy? ☐Yes ☐No

Previous Therapist's Name _____ Diagnosis _____

Are you currently taking prescribed psychiatric medication (antidepressants or others): ☐Yes ☐No

If yes, please list: _____

If no, have you been previously prescribed psychiatric medication: ☐Yes ☐No

If yes, please list: _____

Referred by: _____

OCCUPATIONAL INFORMATION

Are you currently employed? ☐Yes ☐No

If yes, who is your current employer/position? _____

If yes, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

HEALTH AND SOCIAL INFORMATION

How is your physical health at present? ☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐ Very Good

List any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, diabetes, etc):

_____

Are you having trouble sleeping? ☐Yes ☐No

If yes, check where applicable:

☐ Sleeping too little ☐ Sleeping too much ☐ Poor quality sleep ☐ Disturbing dreams ☐Other_____

How many times per week do you exercise? _____ Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? ☐Yes ☐No

If yes, check where applicable: ☐ Eating less ☐ Eating more ☐Binging ☐ Restricting

Have you experienced significant weight changes in the last 2 months? ☐Yes ☐No

Do you regularly use alcohol? ☐Yes ☐No

In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

How often do you engage in recreational drug use? ☐ Daily ☐Weekly ☐ Monthly ☐ Rarely ☐ Never

Has anyone told you they were concerned about your alcohol/drug use? ☐Yes ☐No

Have you had suicidal thoughts recently? ☐ Frequently ☐ Sometimes ☐ Rarely ☐Never

Have you had them in the past? ☐Yes ☐No If yes, have you attempted: ☐Yes ☐No

Are you currently in a romantic relationship? ☐Yes ☐No

If yes, how long have you been in this relationship? _____ If yes, how long: _____

On a scale of 1-10 (with 10 high), how would you rate the quality of your current relationship?_____

YOUR MENTAL HEALTH HISTORY

In the last year, what significant life changes or stressors have you experienced: _____

_____

_____

HAVE YOU EVER EXPERIENCED?

☐Yes ☐No Extreme Depressed Mood
☐Yes ☐No Wild Mood Swings
☐Yes ☐No Rapid Speech
☐Yes ☐No Extreme Anxiety
☐Yes ☐No Panic Attacks
☐Yes ☐No Phobias
☐Yes ☐No Sleep Disturbances
☐Yes ☐No Hallucinations
☐Yes ☐No Unexplained Losses of Time
☐Yes ☐No Unexplained Memory Lapses
☐Yes ☐No Alcohol/Substance Abuse
☐Yes ☐No Frequent Body Complaints
☐Yes ☐No Eating Disorder
☐Yes ☐No Body Image Problems
☐Yes ☐No Repetitive Thoughts (e.g. obsessions)
☐Yes ☐No Repetitive Behaviors (e.g., frequent checking, hand washing, etc.)
☐Yes ☐No Homicidal Thoughts
☐Yes ☐No Suicide Attempt

YOUR FAMILY'S MENTAL HEALTH HISTORY

Have immediate family members of relatives experienced difficulties with the following: if yes, please list relationship:

☐Yes ☐No Difficult Family Member _____
☐Yes ☐No Depression _____
☐Yes ☐No Bipolar Disorder _____
☐Yes ☐No Anxiety Disorders _____
☐Yes ☐No Panic Attacks _____
☐Yes ☐No Schizophrenia _____
☐Yes ☐No Alcohol/Substance Abuse _____
☐Yes ☐No Eating Disorders _____
☐Yes ☐No Learning Disabilities _____
☐Yes ☐No Trauma History _____
☐Yes ☐No Suicide Attempts _____

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? ☐Yes ☐No If yes, what is your faith_____

If no, do you consider yourself to be spiritual? ☐Yes ☐No

OTHER INFORMATION

What are effective coping strategies that you've learned? _____

_____

_____

_____

_____

_____

What are your strengths? _____

_____

_____

_____

_____

_____

I have received, read and understand the Counseling Agreement and the Notice of Privacy Rights. I authorize the release of the minimum amount necessary of my personal health information to the above referenced insurance company in order to obtain payment for services received.

Client Signature _____Date _____

Therapist _____ Diagnosis Code _____

TREATMENT PLAN

Please complete form as best you can. If you are unsure of your answers, bring your questions in and your therapist will help you form goals and estimate timeline.

Issues (Why I'm here):

_____
_____
_____
_____
_____
_____

Goals (What I want):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Indicators (How do I know that I'm making progress):

_____
_____
_____
_____
_____
_____

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

Review Dates:_____

Therapist _____ Diagnosis Code _____

FEE POLICY

Client: _____ Date: _____

Fee Schedule: A fee of $_____ per 55 minute session (or applicable copay if utilizing health insurance) is payable at the beginning of each session. Missed appointments or late cancellation fee of $_____ will be charged for each missed appointment or appointments cancelled with less than a 24-hour notice.

- **The client is fully and directly responsible to check with their insurance company to determine their benefits for mental health coverage and verify that this therapist is an in-network provider under their policy. The client agrees that they are fully and directly responsible to Healing Lives, LLC, for the payment of services rendered with or without insurance coverage.**
- **The client is fully and directly responsible for additional fees which may be charged for psychological testing or phone consultation as discussed prior to testing or consulting.**
- **The client is fully and directly responsible to pay for missed appointments or appointments cancelled with less than a**
- **24-hour notice (except in cases of illness, emergency or severe weather).**
- **The client is fully and directly responsible for overdue payments which will be assessed at a 5% monthly interest fee.**
- **If fees change during the course of treatment, client will be given adequate notice of these changes.**

Please initial:

_____ **All Clients:** I understand agree to the current fee schedule above and my responsibility for payment of fees according fees according to the above bullet points.

_____ **Fee-for-Service Clients:** I will be paying for services out-of-pocket and will not be utilizing my insurance company or be given a diagnosis at this time. I would like a receipt of payment and understand that payment is due at time of service.

_____ **Out-of-Network Clients:** I will be utilizing my out-of-network benefits with my insurance company and will be given a dianosis. I would like a receipt to send to my insurance company for reimbursement. I understand that payment is due at time of service and that I will file my own claims for reimbursement with my insurance company.

_____ **In-Network Clients:** I have verified that my therapist is an in- network provider with my insurance company and understand that I will be given a dianosis. I also understand that benefits do not guarantee payment and that I will be responsible for payment if the insurance company doe. I give my permission for my thera-pist and their business office, Professional Services Consultants, LLC to contact my insurance company. It is my responsibility to supply and keep up-to-date the current and accurate information for insurance and patient billing purposes, which may include, but not limited to: my legal name, correct postal mail-ing address, phone number(s), and insurance policy/ identification number, group or policy number for insurance(s). . Healing Lives, LLC cannot guarantee the outcome of payment by the insurance compa-ny. Insurance companies determine eligibility for behavioral health treatment based on medical neces-sity. Initial and ongoing authorization of treatment. Even under stress or time constraints, it is extremely important to understand benefit limitations and any other insurance company requirements.

Insurance Company: _____ Employer: _____
Policy Holder's Name: _____
Policy Holder's Date of Birth: _____ /_____ /_____ Relationship to Client: _____
ID #: _____ Group #: _____ I hereby authorize Healing Lives, LLC to furnish the above named Insurance Company all information that said insurance company, may request concerning my present condition/illness. I hereby assign to Healing Lives LLC insurance proceeds to be credited against total fee for service due on my account with Healing Lives, LLC and will pay my portion of charges incurred as indicated by my insurance company. I hereby verify that all information supplied above is current and accurate. I have been given a copy of the current fee policy and Ia understand that I will be responsible for all fees as indicated on the current fee schedule and as outlined on this payment contract. I am also aware that I may be charged a late cancel/no show charge.
Client Signature: _____ Date: _____
Parent/Legal Guardian Signature: _____ Date: _____

COUNSELING AGREEMENT

This agreement is designed to help build a positive working relationship between you and me, your therapist. It also informs you of your rights and responsibilities in the therapy relationship. If you have any questions or concerns, please feel free to discuss them with me.

1. Therapeutic Relationship

Our relationship is very important and is different from other relationships in your life. You are expected to talk freely about yourself, much more so than you do in social relationships. My responsibility is to listen, select, sort, make observations, and reflect back to you behaviors, thoughts, feelings, and values or beliefs that will enable you to understand and see yourself more clearly. The goal of this process is the reorganization of your thinking, feelings, and behavior in a manner more satisfying to you. This does not predict, nor guarantee a successful outcome in therapy. While I may suggest changes, only you can choose if those changes are valuable and pertinent, and only you are able to make those changes. We will work together to establish goals for the therapy and this will be the main focus of our initial sessions. Therapy can be a very intense experience and sometimes painful. But therapy is also very supportive, reassuring, with very rewarding, life changing outcomes.

2. Appointments

In most cases, we will meet for weekly appointments. Appointments are 55 minutes in length and must be arranged with Healing Lives via www.healinglivescounseling.com or by calling 651-315-5254.

3. Cancellation Policy

If you need to cancel an appointment for any reason, please do so at least 24 hours in advance. You will be charged $125 for appointments not canceled at least 24 hours in advance.

4. Confidentiality

Client information is kept strictly confidential and the release of information about you to anyone can only be done with your written consent. State law, however, places certain limitations on the right of confidentiality and requires that any and all social services personnel report the following:

- Threats of suicide
- Threats of harming another person
- Any incidence or knowledge of suspected neglect, physical, or sexual abuse of children and/or vulnerable adults.

During therapist consultations, the therapist may discuss facts in a case, but the identity of the client will remain confidential.

Please be aware email and text messaging are not secure forms of communication.

5. Hours and Emergencies

Most often you will receive my voice mail where you can leave messages. This voice mail system is available 24 hours a day and I retrieve messages regularly throughout the weekdays. Please leave your name, number, and time you can be reached. If you need immediate assistance, please call Crisis Connection at (612) 379-6363, call 911, or go to the emergency room or hospital near you.

6. Complaints

I urge you to discuss with me any questions, concerns, or problems you may have about the therapy you receive. Often times, part of the therapeutic relationship involves working through misunderstandings or misconceptions. You also have the right to file a complaint with:

Minnesota Department of Health 121 East 7th Street, St. Paul, MN 55101. (651) 215-5800

7. Therapy Sessions

An important aspect of therapy is the relationship that develops between you and me. As with any new relationship, it takes some time to trust and feel safe. If the relationship does not develop after a reasonable amount of time (three to four sessions), you may want to talk with me about it and a referral can be made. I will be happy to help with this.

The therapeutic relationship is unique in that you will be focusing on aspects of yourself that may not ordinarily receive attention. The therapeutic approach used by the therapist comes from a variety of psychological theories. These include cognitive-behavioral, strategic, object relations, solution-focused, and psychoanalytic. As each client is different, each session varies depending on the needs of the client and the goals set by the client and therapist.

The therapist will work with the client towards healthy development, meaningful and satisfying relationships, and address conflict between mind, body, and spirit. The intention is to address relationship issues, behavioral problems, family-of-origin concerns, destructive thought patterns, and spiritual issues. Core values and beliefs are identified and based on the issues of concern, the therapist will help with insight and observations where needed. I will strive towards a safe environment in which clients can talk freely and openly about their concerns.

Therapy is a process. Initially you may feel uncomfortable, even anxious, talking about sensitive issues. This anxiety begins to reduce as the relationship between us develops and trust builds. As you learn new ways to interact with yourself and others, these new ways to interact may feel uncomfortable. Sometimes things seem to get worse before they get better. This is normal.

One of the most growth-producing times for the client can be when he/she expresses anger with the therapist. This expression of "owning" one's feelings and having the therapist respect them often results in a very affirming experience for the client. I am open to hearing about your concerns and feelings.

It is critical to stay with the therapy even during those uncomfortable times. Once you get through this phase, and we discuss the emotions around these issues, you should begin to feel more comfortable. During this stage, you will continue to apply the new skills and you will feel more courageous in meeting problems directly. As we near the end of therapy, you and I will discuss discontinuing therapy, with the understanding that you can choose to return if you feel the need.

PRIVACY POLICY

The privacy of your medical information is important to us, with the understanding that this information is personal. Therefore, we are committed to protecting it. To comply with certain legal requirements, Healing Lives, LLC creates a record of the care and services each individual receives to better provide you with quality care. This notice details the ways we may use and share medical information about you. Furthermore, we describe your rights and certain duties we have regarding the use and disclosure of medical information. This notice is effective January 1, 2017.

1. Uses of Information Obtained From You: The information we obtain from you is used to establish diagnosis, determine your treatment plans and goals, provide the services you request, and establish your ability to pay for these services.
2. Our Legal Responsibility: The law requires us to keep your medical information private, give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information, and to follow the terms of the notice that is now in effect.
3. Patient Rights: Effective April 14, 2003, the 45 CFR Health Insurance Portability and Accountability Act (HIPAA) went into effect with rules on not only disclosure but also on the use of patient information. Under this Act clients, must be given a Notice of Privacy Practices upon the arrival of their first service. The following list of rights now apply to any patient of a health care provider:

a) Right to Request Medical Records: The patient has a right to access their medical records.

b) Right to Request Additional Restrictions: You may request restrictions on our use and disclosure of protected health information for treatment, payment, and health care operations. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction. If you wish to request a restriction, please make a request in writing and submit it to your therapist. We will send you a written response.

c) Right to Receive Confidential Communications: You may request, and we will accommodate, any reasonable (written) request for you to receive protected health information by alternative means of communication or at alternative locations.

d) Right to Inspect and Copy Your Health Information: If you desire access to your records, please make a written request to your therapist. If you request copies, there will be a $2.00 charge per page. Please note, under limited circumstances we may deny you access to a portion of your records.

e) Right to Amend Your Records: You have the right to request that we amend protected health information maintained in your clinical file or billing records. If you desire to amend your records, please request in writing the amendment and submit it to your therapist. Under certain circumstances, we have the right to request to amend your records and notify you of this denial as provided by the HIPAA regulations. If your requested amendment to your records is accepted, a copy of your amendment will become a permanent part of the medical record. By “amend,” your therapist is permitted to append information to the original record, as opposed to physically remove or change the original record.

f) Right to Receive an Accounting of Disclosures: Upon request, you may obtain an accounting of disclosures of your protected health information other than those for which you gave written authorization or those related to your treatment, payment for services, or health care operations. The accounting will apply only to covered disclosures prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, a charge may apply. You will be informed of the cost prior to the request being filled.

g) Right to Receive a Paper Copy of this Notice: Upon request, you may obtain a paper copy of this privacy notice.

4. Use and Disclosure of Your Medical Information With Written Consent: We are permitted to use and disclose information about you for treatment and/or services to doctors, nurses, psychiatrists, psychologists, other mental health professionals. Also included are other people in charge of your care or health care professionals assisting in your treatment. We may also use and disclose your medical information for payment purposes to insurance companies for disability payments, etc. Furthermore, we may also use information for healthcare operations that may include information disclosed to business associates such as billing software providers or transcriptionists.
5. Use and Disclosures Without Neither Consent Nor Authorization: According to state and federal requirements, we are mandated to report information we maintain about you to other agencies or individuals without your written consent under the following circumstances:

a) If we have reason to believe there has been:

abuse of a child or vulnerable adult. victimization due to violence. victimization due to other crimes. potential or intention to seriously harm another person, we may have a legal obligation to warn the intended victim and/or the police. the possibility a pregnant woman has used a controlled substance (e.g., cocaine, heroin) for a non-medical purpose during the pregnancy.

b) If it is court-ordered.

c) If a non-custodial parent requests information, they may receive information about our services for their child, but not about services to the other parent.

d) If there is an emergency, we may communicate your condition to a family member or other appropriate persons.

e) If your account is delinquent, we may attempt to obtain reimbursement through small claims court or to collection agency. We may also report delinquent accounts to credit bureaus.

f) Examination of records for an audit or accreditation.

g) To meet federal, state, and local statistical requirements.

h) If a new statute, federal law, or State Commissioner of Administration authorizes a new use of the information after you had been given this notice.

6. Regarding Minors: Minnesota State Law authorizes that a minor has the right to request the private data about them be kept from their parents. This request will be honored if we believe it will protect the child from physical or psychological harm.
7. Providing Information About You: You are not required to provide information about yourself; however, without some information we may not be able to provide the most appropriate services. If you are here because of a court order, and you refuse to provide information, that refusal may be communicated to the court.
8. Right to Change Terms of this Notice: We may change the terms of this notice at any time. If we change this notice, we may make the new notice terms effective for all protected health information that we maintain, including any information created or received prior to issuing the new notice. If we change this notice, we will post it in public access areas, or give you a copy of the updated notice.
9. Complaints: If you desire further information about your privacy and confidentiality rights, or are concerned that we have violated these rights, or disagree with a decision that we made about access to your protected health information, you may contact your therapist or Kathy Boisjoli, LPCC, Healing Lives LLC, P at 651-315-5254. You may also file a written letter of complaint with the Secretary of the Department of Health and Human Services. We will not retaliate against you if you file a complaint.