INDIVIDUAL INTAKE FORM

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

Name: _____ Date _____

(Last) (First) (Middle Initial)

Address: _____

(Street)

_____

(City) (State) (Zip)

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

Present Living Situation: ☐ With Spouse ☐ Alone ☐ With Partner ☐ With Children ☐ With Parents

Marital Status: ☐ Never Married ☐ Partnered ☐ Married ☐ Separated ☐ Divorced When?____ ☐ Widowed When? ____

How many years together? _____ From 0-10, with 10 high, how happy are you in the marriage? _____

Previous Marriages, Reason for Divorce _____

Names and ages of children _____

Work Phone _____ May we leave a message or confirm appointments? ☐ Yes ☐ No

Cell/Other Phone: _____ May we leave a message or confirm appointments? ☐ Yes ☐ No

E-mail: _____ May we email periodic newsletters or confirm appts? ☐ Yes ☐ No

Were you referred by anyone? If so, by whom? _____

Emergency Contact Name _____ Phone _____

PSYCHOLOGICAL INFORMATION

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

Have you had previous psychotherapy? ☐ Yes ☐ No Diagnosis? _____

Previous therapist's name _____

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: _____

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OCCUPATIONAL INFORMATION

Are you currently employed? ☐ Yes ☐ No Current Employer & Position _____

Are you happy there? ☐ Yes ☐ No If no, please explain: _____

Please list any work-related stressors: _____

HEALTH AND SOCIAL INFORMATION

PHYSICAL HEALTH: How is your health at present? ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):_____

SLEEPING HABITS: Are you having any problems with your sleep habits? ☐ Yes ☐ No If yes, check where applicable:

☐ Sleeping too little ☐ Sleeping too much ☐ Poor quality sleep ☐ Disturbing dreams ☐ Other _____

EXERCISE: How many times a week do you exercise? _____ Approximately how long each time? _____

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

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

ALCOHOL/DRUG USE: Do you regularly use alcohol? ☐ Yes ☐ No Drugs (prescription, legal and illegal)? ☐ Yes ☐ No

Number of drinks per Night _____ Week _____ Month ____ Drug Use per Night _____ Week _____ Month ____

Has anyone told you they were concerned about your substance use? ☐ Yes ☐ No Age you started using _____

Have you had any problems because of your use (with friends, the law, financially, with job, sex, school, family)? Explain:

_____

Have you tried to cut down on drug/alcohol use, felt guilty about the use, used chemicals first thing in the morning? ____

SEXUAL ISSUES: Have you been struggling with sexual infidelity, masturbation, pornography? ☐ Yes ☐ No

Have you received help? ☐ Yes ☐ No Is your spouse aware of your sexual issues? ☐ Yes ☐ No Age started? _____

Have you had any problems because of your use (with friends, the law, financially, with job, sex, school, family)?

_____

Did you ever experience any inappropriate touching or sexual abuse as a child or as an adult? ☐ Yes ☐ No

Explain: _____

SAFETY CONCERNS: Do you presently have suicidal thoughts? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

Have you had them in the past? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never Any suicide attempts? ☐ Yes ☐ No

Have you engaged in self-harm (cutting, hair pulling, restricting food, binging and purging, etc.)? ☐ Yes ☐ No

What kind of self-harm? _____ How often? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

Have you ever thought about personally harming someone or their property? ☐ Yes ☐ No

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

_____

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

HAVE YOU EVER EXPERIENCED?

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

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (check any that apply and list family member, e.g., siblings, parents, uncles, aunts, etc.)

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

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 and Spirit of Hope's billing company in order to obtain payment for services received. I also agree to receive correspondence and appointment reminders sent via phone, text and/or email.

Signature _____ **Date** _____

spirit of hope
Counseling Center

TREATMENT PLAN

Name_____ Date _____

Please complete this form as best you can. If you are unsure of your answers, bring your questions in and your therapist will help you complete the treatment plan.

Problems (Why I'm Here): _____

_____

_____

_____

_____

Goals (What I Want): _____

_____

_____

_____

_____

Indicators (How Do I Know That I'm Making Progress?): _____

_____

_____

_____

_____

Signature _____

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FEE POLICY

Name _____ Date _____

Out of Pocket Payments:

- The fee per 50-minute session is payable at the beginning of each session, unless other arrangements have been made. You may use cash, check, or credit card.
- The client is fully and directly responsible to Spirit of Hope for the payment of services rendered.
- You will be charged a fee for missed appointments or appointments cancelled with less than a 24-hour notice (except in reasonable situations). If two sessions are missed without cancellation notice, the therapist has the choice to terminate sessions.
- Fees for telephone consults will be prorated, based on the standard hourly fee.
- A receipt can be provided which the client can submit to his/her insurance company, if requested.
- An extra fee of $30 will be charged for tele-health sessions or when a therapeutic modality is used. Insurance will be charged, but you will not be responsible for the remaining balance.
- If payment becomes a problem, you are encouraged to discuss this directly with your therapist to consider other alternatives.
- If fees change during the course of treatment, you will be given adequate notice of these changes.

Insurance Payments:

Insurance coverage differs, so please check with your insurance company to determine your benefits for mental health coverage. However, the information your insurance company provides to you or to Spirit of Hope Counseling Center is NOT a guarantee of the benefits provided or paid by the insurance company.

HAVE YOU MET YOUR DEDUCTIBLE? IF NOT, READ BELOW FOR PAYMENT REQUIREMENTS

Due to such high deductibles we require a $100.00 payment at each appointment if you HAVE NOT MET YOUR DEDUCTIBLE. Spirit of Hope Counseling Center will submit claims to your insurance company for your visits to be applied towards your deductible. *Check A.

_____ **A. My deductible has not been met and I agree to pay $100.00 at each visit.**

- Please keep on file my credit card information which I authorize to be used to pay for my visits and/or outstanding balance. (Credit card information is kept confidential and no unauthorized staff members have access to your credit card number.)
- This policy will also be required for my account when my new insurance plan's anniversary date comes due. I agree to notify Spirit of Hope when that new deductible is in effect.
- I accept full responsibility for all charges for services provided by Spirit of Hope Counseling Center.

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If your deductible has been met only copays, if they apply, are required to be paid at each session. *Check B.

_____ **B. I have met my deductible for this calendar year.**

- Spirit of Hope Counseling Center will bill my insurance company for my counseling sessions.
- Please keep on file my credit card information which I authorize to be used to pay my copays and/or outstanding balance after my claims have been processed. (Credit card information is kept confidential and no unauthorized staff members have access to your credit card number.)
- I will notify Spirit of Hope Counseling Center when my new deductible goes into effect.
- I accept full responsibility for all charges for services provided by Spirit of Hope Counseling Center.

My insurance carrier is _____

The main policy holder is _____ Date of birth _____

_____ **C. I will be paying out of pocket at the agreed amount of $175 for the first intake session and $150 for subsequent sessions.**

Yes, use this credit card information for copays and/or outstanding balances:

Name on Card_____ Expiration Date _____

Card # _____ Security # _____

I have discussed the fees for counseling with my therapist. I authorize the release of the minimum amount necessary of my personal health information to Spirit of Hope's billing company and to my insurance company in order to obtain payment for services received.

I accept full responsibility for all charges and understand I will be responsible for all fees as outlined on this payment contract. I am also aware that I may be charged a late cancel/no show charge. Also, I sign this with the approval of charging my credit card that Spirit of Hope has on file for copays and any outstanding balance.

Signature _____

COUNSELING AGREEMENT

This agreement is designed to help build a positive working relationship between you and 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 your therapist.

1. **Therapeutic Relationship**
The relationship between you and your therapist is very important and is different from other relationships in your life. You are expected to talk freely and openly about yourself, much more so than you do in social relationships. Your therapist's 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 your therapist may suggest changes, only you can choose if those changes are valuable and pertinent, and only you are able to make those changes.

   You and your therapist will work together to establish goals for therapy and this will be the focus of your initial session which is something that will continue to be revisited. 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**
Appointments are typically 50 to 80 minutes in length. You and your therapist will work together to personalize a schedule to fit your needs. You will receive notification of upcoming appointments via email, phone or text.

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 a full fee for appointments not canceled within 24 hours. If you miss two appointments without any notification, your counseling sessions will be terminated.

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. Different forms of communication are not confidential. The email set up at Spirit of Hope is an encrypted, safe email which has another layer of security.

   Because therapists are all mandated reporters, state law, however, places certain limitations on the right of confidentiality (see also Notice of Privacy Rights attached):
   - 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 professional consultation, the therapist may discuss facts in a case with other counseling professionals, but the identity of the client will remain confidential.

   When meeting as couples and/or families, it may be helpful to meet with your therapist individually. If individual sessions are scheduled, no confidences will be held by the therapist. Your therapist reserves the right to use his/her best judgment to share pertinent information, or will ask the individual to share the information, in the best interest of the marriage or family. In order for information to be shared between a therapist at Spirit of Hope and another individual, we require a signed release of information from both or all parties.

5. **Fees**
Payment of fees is expected at the time of each session. You may use cash, check, credit card or money order. Insurance coverages differ, so please check with your insurance company to determine the requirements for mental health coverage. A receipt will be provided which can be submitted by the client when requested. Overdue payments will be assessed a $5.00 fee for each month the payment is overdue. We will give you a 30-day notice if fees change. In court cases, we encourage information to be passed on to lawyers and the court through written reports at our hourly fee rate. If we are asked to do a deposition or appear in court, our fees are $350 per hour plus a mileage fee of $.75 per mile.

6. Hours & Emergencies

After normal business hours, you will receive our voicemail system where you can leave messages. This voicemail system is available 24 hours a day and messages are retrieved regularly throughout the weekdays. If you need immediate assistance, please call 211, or Hennepin County Crisis Center at 612.347.3161, or call 911, or go to the nearest hospital emergency room.

7. Spirit of Hope, LLC

Spirit of Hope, LLC is a limited liability corporation. If you have questions about Spirit of Hope, LLC, please contact Peg Roberts, LMFT, Spirit of Hope President at 952.546.5565 or Peg@Spiritofhopecc.com.

8. Complaints

You are urged to discuss with your therapist 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: Peg Roberts, LMFT, Spirit of Hope, President, 13911 Ridgedale Drive, Suite 320, Minnetonka, MN 55305, 952.546.5565 and Minnesota Department of Health, 121 East 7th Street, St. Paul, MN 55101, 612.623.5522.

9. Therapy Session

An important aspect of therapy is the relationship that develops between you and your therapist. 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 your therapist about it and a referral can be made. Your therapist 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. For those clients wishing to address spiritual concerns, a Christian perspective will be utilized. 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 your therapist will help with insight and observations where needed. Your therapist 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, about talking about sensitive issues. This anxiety begins to reduce as the relationship between you and your therapist 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 expected and typical of everyone making life adjustments.

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. Your therapist is open to hearing about your concerns and feelings. It is critical to stay with the therapy even during these uncomfortable times. Once you get through this phase, and as 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 you near the end of therapy, you and your therapist will discuss discontinuing the therapy, with the understanding that you can choose to return any time if you feel the need.

10. Therapy Techniques

Each therapist at Spirit of Hope Counseling Center uses a combination of psychotherapy techniques. If you have questions, please ask your therapist directly and he/she can explain things more thoroughly.

- Cognitive Behavioral Therapy is what many know as therapy addressing negative thoughts, feelings and behavior.
- Several therapists are trained and certified in EMDR (Eye Movement Desensitization and Reprocessing). This approach is very helpful when addressing trauma, abuse, post-traumatic stress disorder, anxiety and depression. When using EMDR, your therapist will outline how the therapy helps, if you are a good candidate for EMDR, and you will be given the option to participate. For a thorough explanation of EMDR, visit the EMDR.com website.

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, Spirit of Hope 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 April 14, 2003.

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. We do communicate through text, phone and email. Not all means of corresponding is private.
   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: At each intake session, you will 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, EAP companies, etc. Furthermore, we may also use information for healthcare operations that may include information disclosed to business associates such as billing software providers or our billing company.

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 Peg Roberts, LMFT, Spirit of Hope, President at 952.546.5565. 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.