Counseling Center
707 Highway 33 South, Suite 9B, Cloquet, MN 55720 (218) 878-9352

Please complete and **bring this form to your first appointment**.

Name:_____**Age:**_____**Birthdate:**_____**S.S.#**_____

Address_____**City**_____**State**_____**Zip**_____

Phone# _____ **Is it OK to call you/leave messages at this number? YES NO**

Please circle: Married Single Living with partner Divorced Widowed

Names & ages of others in the home _____

Are you currently in school? YES NO If yes, name of school _____

Please circle: Employed part time Employed full time Unemployed Retired

Currently involved in any legal matters? (custody, criminal charges, divorce, etc.) YES NO

Did someone suggest you seek counseling? (social services, friend, clergy, court, family member)_____

Reason for seeking services?

Have you received any other help concerning this issue?

Your History

Have you ever been in counseling/therapy before? Yes No (circle)

Approximate dates	Where	Reason	Was it helpful?
_____	_____	_____	_____

Have you ever been hospitalized for psychiatric reasons? Yes No (circle)

Approximate dates	Where	Reason	Was it helpful?
_____	_____	_____	_____

Have you ever taken medication for psychiatric reasons? ("nerves" "depression" etc.) YES NO

Approximate dates	Who prescribed	Reason	Were they helpful?
_____	_____	_____	_____

Do you have any history of suicide attempts? YES NO

Do you have any history as a child, teenager, or adult of physical, sexual or emotional abuse? Any other trauma? YES NO

Family History

Please indicate any major mental health issues for any close relatives. (anxiety, depression, alcohol/ drug problems suicide etc…)

Relative	YES	NO	If yes, describe
Mother	____	____	_____
Father	____	____	_____
Sister(s)	____	____	_____
Brother(s)	____	____	_____
Mother's Father	____	____	_____
Mother's Mother	____	____	_____
Father's Father	____	____	_____
Father's Mother	____	____	_____
Uncles	____	____	_____
Aunts	____	____	_____
Cousins	____	____	_____

Do you have supportive family and/or friends?

Medical

Primary Physician_____

Address and phone_____

Phone number_____

Please describe any significant physical health problems you have.

List all prescription and over-the-counter medications you currently take.

Medication Dosage Reason Name of Prescribing Physician

Are you taking any "natural" or "herbal" remedies or supplements?

Name Reason Recommended by Physician?

Please complete the following checklist. We will discuss these issues at your first session.

Check any issue/problem that is a current concern (within the last 2 weeks)

Issue/Problem	**NO**	**YES**	**# of days**	**How long has**
How does it affect it been a problem?			**your daily functioning (at work, home)**	**per week?**
Sleep too much	____	____	_____	_____
Sleep too little	____	____	_____	_____
Lack of interest	____	____	_____	_____
Guilt feelings	____	____	_____	_____
Tired, Weak	____	____	_____	_____
Poor concentration	____	____	_____	_____
Appetite changes	____	____	_____	_____
Weight changes	____	____	_____	_____
Less active	____	____	_____	_____
Withdrawal from family, friends	____	____	_____	_____
Depressed mood	____	____	_____	_____
Irritability	____	____	_____	_____
Upward mood swings	____	____	_____	_____
Morbid thoughts	____	____	_____	_____
Thoughts about suicide	____	____	_____	_____
Suicide plans	____	____	_____	_____
Self-harming behavior	____	____	_____	_____
Aggressive behavior	____	____	_____	_____

Excessive worrying	____	____	_____	_____
Panic attacks	____	____	_____	_____
Social discomfort	____	____	_____	_____
Perfectionism	____	____	_____	_____
Preoccupation	____	____	_____	_____
Fear (phobia)	____	____	_____	_____
Nightmares	____	____	_____	_____
Flashbacks of trauma	____	____	_____	_____

Check any issue/problem that is a current concern (within the last 2 weeks)

Issue/Problem	**NO**	**YES**	**# of days**	**How long has**
How does it affect it been a problem?			**your daily functioning (at work, home)**	**per week?**
Strict dieting	____	____	_____	_____
Strict exercise regimine	____	____	_____	_____
Binge eating	____	____	_____	_____
Food purging (vomiting, laxatives)	____	____	_____	_____
Overeating	____	____	_____	_____
Lack of physical exercise	____	____	_____	_____
Memory loss	____	____	_____	_____
Disorientation/confusion	____	____	_____	_____
Hallucinations	____	____	_____	_____
Thoughts being controlled	____	____	_____	_____

Gambling	____	____	_____	_____
Sexual orientation concerns	____	____	_____	_____
Other sexual concerns	____	____	_____	_____
Violence in your home	____	____	_____	_____
Sexual abuse in your home	____	____	_____	_____
Verbal abuse in your home	____	____	_____	_____
Alcohol/drug abuse in your home	____	____	_____	_____

SUBSTANCE USE

QUESTION #1
Do you use alcohol? YES NO
If "NO", go to question #2 If "YES"", please answer questions below.
How often do you use alcohol? _____ times per day/ week/ month (circle one)
Have you ever been concerned about your own alcohol use?_____
Has a friend, spouse, or other loved one expressed concern about your alcohol use?_____
Do you ever experience blackouts or times that you couldn't remember what happened when drinking?
_____
Does it take more alcohol now to become intoxicated than it used to?_____
Have you ever received a DUI/DWI?_____

QUESTION #2
Do you use any drugs? YES NO
If "NO", go to question # 3 If "YES", please answer questions below.
Have you ever been concerned about your drug use?_____
Has a friend, spouse, other loved one expressed concern about your drug use?_____

QUESTION #3
Do you use tobacco products? (cigarettes, chewing tobacco, cigars, etc) YES NO
If "NO", go to question #4. If "YES", please answer questions below.
How many cigarettes/cigars/cans per day? _____
Have you ever tried to quit?_____

QUESTION #4
Do you use any caffeine? YES NO
If "NO", go to question #5. If "YES", please answer questions below.

_____sodas per day _____cups of coffee per day _____other per day

QUESTION #5
Have you ever been in chemical dependency treatment for alcohol/drug use? YES NO

QUESTION #6
Is another person's substance use creating difficulty for you?

QUESTION #7
Do you gamble? YES NO

Counseling Center

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Cloquet, MN 55720
Phone (218)-878-9352
FAX (218)-878-9342

Credit Policy and Patient Responsibility

Thank You for Choosing the Counseling Center. We are committed to your treatment being successful. Please understand that prompt payment of your bill is considered part of your treatment. We have put together the details of our Credit and financial Policies below. Please read carefully and sign below to begin treatment.

All patients must complete our information and insurance forms.

FULL PAYMENT IS DUE AT TIME OF SERVICE

We accept cash, checks, and all major credit cards.

Credit Card payments will incur an additional 3% convenience fee on the amount paid.

We offer payment plans with prior credit approval and signed agreement.

A finance charge of 18% annually (1.5% per month) will begin accruing after 60 days from the date of service.

PATIENTS WITH INSURANCE COVERAGE

We may accept assignment of insurance benefits after your second visit. However, we do require your copayment be paid at the time of service. The balance incurred is your personal responsibility whether your insurance company pays or not. Coverage amounts vary from policy to policy and we cannot guarantee the amounts of coverage offered by your insurance carrier. It is your responsibility to seek coverage amounts and limits of liability on your insurance policy. You understand that your insurance policy is a contract between you and your insurance company. This office holds no party to that contract and will not be held responsible in the event your insurance company denies any claim.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. Your are responsible for any balance regardless of what your insurance company's arbitrary discrimination of usual and customary rates, unless we are under contract with your insurance company for specified allowable charges.

Delinquency (90 days past due)

In the event your account becomes past due and is referred to an outside collection agency or attorney, you will be responsible for the collection costs (up to 33% of the balance due), along with reasonable attorney fees and court costs incurred by this office.

I have read and understand the Counseling Center's Credit and Financial policy with respect to payment on my account. I understand and agree to the terms of this agreement.

_____ _____

Print patient name Date

_____ _____

Patient/Guardian signature Chart #

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Cancellation/Missed Appointment Policy

We recognize that in today's busy world, adhering to a schedule is important in order to maximize time and meet the demands of daily life. Our goal is to provide quality care in a timely manner. In order to do so, we have had to implement a missed appointment/cancellation policy. Missed appointments, late cancellations, and late arrivals are disruptive to our schedule and other patients. This policy enables us to better utilize available appointments for our patients.

In order to be respectful of the needs of other patients, please be courteous and call your therapist at the Counseling Center or email them promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in need of an appointment. ***If it is necessary to cancel your scheduled appointment, it is require that you call or email at least 48 hours prior to your appointment to avoid a "Late Cancellation" charge.*** Monday appointments must be cancelled by noon the Friday before your appointment to not be considered a Late Cancellation. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely care. Appointments not cancelled as directed above will be considered a "Late Cancellation". Late cancellations will be considered the same as a "no-show".

To cancel appointments, please call 218-878-9352 or email your therapist directly. Your therapist email address can be found at www.counselingcenter.me. If you do not reach someone by phone you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please be sure to leave your phone number and the best time and method to contact you.

A failure to be present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". ***A fee of $100.00 will be charged to the patient and will be charged to the patients credit card on file for missed appointments and for late cancellations***. This fee is not covered by your insurance and it will be your responsibility to pay before your next visit if it is not taken from your credit card. We reserve the right to dismiss patients from the practice after two missed/ late cancelled appointments in a twelve month period. New Patients that miss or late cancel appointments are also held to this policy and must provide valid credit card information or make a refundable deposit to secure a time for their first appointment. Credit cards will not be charged for other fees unless prior authorization is given by card holder.

By signing below I have read and understand the above policy.

_____	_____
Print patient name	Date
_____	_____
Patient/Guardian signature	Chart #
_____	_____
Staff initials	Date

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CONSENT and ACKNOWLEDGEMENT

Consent for Treatment I request treatment at the office of the Counseling Center that includes the provision, coordination or management of mental health services and related care for me or for a person whom I have the legal right to give such consent.

Consent for Disclosure of Protected Health Information As explained in the Notice of Privacy Practices, I consent to the disclosure of my information for the purposes of this office's Treatment, Payment and Healthcare Operations. I may revoke this consent at any future time upon written notice to the office of the Counseling Center.

Assignment of Benefits I authorize all insurance, Medicare or Medicaid benefits or benefit payments from other sources for claims originating from this office to be paid directly to the Counseling Center.

Medicare/Medicaid If I am a participant in Medicaid or Medicare programs, I understand the laws, rules and regulations of such shall apply or I may contact the Medicare Coordination of Benefits Contractor at 1-800-999-1118.

ACKNOWLEDGEMENT of Receipt of Privacy and Rights Information
I have received the information packet including description of services, cost, Patient Rights and Grievance procedure.

__X__ I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES POLICY that explains how my health information will be handled in various situations. A copy of this policy can additionally be found at http://www.counselingcenter.me/ESW/Files/Privacy_Policy.pdf

I have been given the chance to discuss my concerns and questions about the privacy of my health information.

Signature_____ Date_____

Printed Name_____

Client Name (if different from above)_____

Relationship to client if signing as legal representative of client _____

Must have documentation of guardianship, conservatorship, Attorney-in-fact for healthcarei
Staff must document any refusal to sign.

COUNSELING CENTER
707 HIGHWAY 33 SOUTH , SUITE 9B
CLOQUET, MN 55720

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Name: _____
Last First MI Previous Name

_____ _____
Birth Date Phone

Address:_____
Street City State Zip

The individual has the right to restrict the disclosure of any of the types of information.

I authorize disclosure of my medical, psychiatric, mental health, substance abuse information,

____**TO:** Counseling Center **and/or** ____**FROM:** Counseling Center

____**TO:** and/or ____ **FROM:** (Agency or individual name/title)_____
(Address)_____

The following information may be disclosed: (Pertinent, minimum necessary to accomplish the stated purpose)

_____Medical History / lab results
_____Diagnostic assessment, Psychiatric Evaluation
_____Treatment Plan
_____Progress notes
_____Discharge / Termination Summary
_____Social Service Reports / Interventions
_____School Reports: Grades / Behavior Reports
_____Evaluation / Testing results
_____Other:_____

_____ I agree that information that may be disclosed may include AIDS / HIV infection.

The Purpose of this disclosure is for:

_____Continuing care / treatment planning
_____Litigation
_____Social Services involvement
_____Other:_____
_____Personal Records

I understand this is a valid lifetime authorization while actively participating in therapy or for a shorter time period I specify.
I may withdraw this authorization at any time by notifying in writing the agency disclosing the information.
Information is disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by HIPPA.
I understand I have the right to inspect or copy (for reasonable cost) the information I have authorized to be disclosed.
I have a right to a photocopy of this signed authorization.
A photocopy of this authorization shall be valid with Signature and Date* written by the authorized individual.

*_____ *_____
Signature of client or Legal Representative Date signed

*_____
Relationship to client