TRAVERSE COUNSELING & CONSULTING

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## General Client Information – Child and Adolescent

Date: _____ Child's Name: _____

Date of birth: _____ Clinician child is seeing today: _____

Parent #1 Name: _____ Date of birth: _____

Cell phone number: _____ Home phone #: _____

Complete Address: _____

Email: _____ Soc. Sec. #: _____

Employer: _____ Employer's Address: _____

Parent #2 Name: _____ Date of birth: _____

Cell phone number: _____ Home phone #: _____

Complete Address: _____

Email: _____ Soc. Sec. #: _____

Employer: _____ Employer's Address: _____

(If parents have separate addresses, please put an * next to the address to use for billing.)

Are parents married? Circle: YES NO Date of divorce/separation: _____

Legal Custody? Circle Joint Sole, who holds custody? _____
Please provide documentation.

Other children (names, ages): _____

**Presenting Problem**

1. What is/are the reason(s) you are seeking therapy today?

_____

2. Did a specific event lead to this request for service? ☐Yes ☐No (If yes, please describe the incident.)

_____

3. Please describe what you hope your child to accomplish in this therapy or what you hope will be different in their life as a result of attending therapy.

_____



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1000 Shelard Parkway Ste 220 * St. Louis Park, MN 55426
Office: 952-595-5967 * Fax: 952-322-7037 * Web: www.traversecc.org

4. How long has the problem been present?

_____

5. What solutions to the problem have you tried, and what were the results?

_____

_____

6. How much does this problem affect your life? (Please circle the number that best applies)

| | Not at all | A little bit | Half the time | Almost/all the time |
|---|---|---|---|---|
| **Personally** | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| **Family life** | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| **Social/Friends** | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| **School** | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |

7. How were you referred to this service? (Please circle)

Self Spouse/Other Physician Employer Court

Other (Please specify): _____

8. Please list previous therapy experiences for your child and close family members.

_____

9.Please list medical conditions that impact your child or close family members.

_____

10. Please list current and past medications for your child

_____

11. Does your family have involvement with any of the following people or services? _____yes _____no
(If yes, please circle all that apply.)

County Social Worker Probation Officer Adult/Child Protection Guardian Ad Litem PC/PTE

Worker's Compensation

If so, please describe.

_____



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12. Are any of the following concerns affecting your family?

(Check all that apply)

___ Family move to a new home
___ Death of a family member
___ Alcohol/Substance
___ Dishonesty
___ Compulsive gambling/spending
___ Birth of child or sibling
___ Adjustment to school
___ Anger/Violence
___ Suspect physical/sexual/emotional abuse
___ Substance misuse/abuse
___ Mental Health Issues
___ Pornography use
___ Spiritual issues
___ Surgeries
___ Chronic Illness/Medical Condition
___ Other: _____

___ Post-divorce adjustment
___ Law violations
___ Financial/employment stress
___ Chronic illness
___ Developmental problems
___ Fighting with spouse
___ Adjustment to new job
___ Incarcerated household member
___ Other trauma
___ Marital unfaithfulness
___ Career concerns/unemployment
___ Parenting problems
___ Previous therapy
___ Hospitalizations/ER
___ Overinvolved family members

13. Are any of the following resources and supports available to your child and family?

(Check all that apply)

___ extended family
___ network of friends
___ peer friendships
___ community-based support groups
___ Ability of family members to positively influence each other
___ Other: _____

___ neighborhood supports
___ spiritual community
___ school staff supports
___ Flexibility in the family system



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14. If you parent with another adult, do you share similar parenting perspectives? _____yes _____no

If no, are you able to reach agreement or resolve conflicts away from your child/ren? _____yes _____no

Comments_____

15. What interests, strengths, and passions give meaning to your child/ adolescent's life?

_____

16. Are there any aspects of your culture, heritage, ethnicity, or religion that you would like the therapist to be aware of?

_____

17. Is there anything else that you would like the therapist to know and that you have not written about on any of these forms? Yes_____ No_____ (Please share here or on another piece of paper.)

_____

Filled out by _____ Date filled out_____

Relationship to client_____

I acknowledge that the information on this form is accurate to the best of my knowledge, and that I will inform the therapist of any changes in my or my child's personal circumstances including address, symptoms experienced, suicidal thoughts and substance use.

Parent Signature _____ Date _____

Parent Signature _____ Date _____



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**Child's Name:** _____ **Child's DOB:** _____

**Person Providing Information Below:** _____

**Relationship to Child:** _____

**Today's Date:** _____

| SYMPTOMS | NEVER | OCCASIONALLY | OFTEN | VERY OFTEN |
|---|---|---|---|---|
| 1. **Does not pay attention to details or makes careless mistakes with, for example, homework** | 0 | 1 | 2 | 3 |
| 2. Has difficulty keeping attention to what needs to be done | 0 | 1 | 2 | 3 |
| 3. Does not seem to listen when spoken to directly | 0 | 1 | 2 | 3 |
| 4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand) | 0 | 1 | 2 | 3 |
| 5. Has difficulty organizing tasks and activities | 0 | 1 | 2 | 3 |
| 6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort | 0 | 1 | 2 | 3 |
| 7. Loses things necessary for tasks or activities (toys, assignments, Pencils, or books.) | 0 | 1 | 2 | 3 |
| 8. Is easily distracted by noises or other stimuli. | 0 | 1 | 2 | 3 |
| 9. Is forgetful in daily activities. | 0 | 1 | 2 | 3 |
| 10. Fidgets with hands or feet or squirms in seat | 0 | 1 | 2 | 3 |
| 11. Leaves seat when remaining seated is expected. | 0 | 1 | 2 | 3 |
| 12.Runs about or climbs too much when remaining seated is expected. | 0 | 1 | 2 | 3 |
| 13. Has difficulty playing or beginning quiet play activities. | 0 | 1 | 2 | 3 |
| 14.Is "on the go" or often acts as if "driven by a motor." | 0 | 1 | 2 | 3 |
| 15. Talks too much. | 0 | 1 | 2 | 3 |
| 16. Blurts out answers before questions have been completed. | 0 | 1 | 2 | 3 |
| 17. Has difficulty waiting his or her turn. | 0 | 1 | 2 | 3 |
| 18. Interrupts or intrudes in on others' conversations and/or activities. | 0 | 1 | 2 | 3 |
| 19. **Argues with adults.** | 0 | 1 | 2 | 3 |
| 20. Loses temper. | 0 | 1 | 2 | 3 |
| 21. Actively defies or refuses to go along with adults' requests and/or activities. | 0 | 1 | 2 | 3 |

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| | | | | |
|---|---|---|---|---|
| 22. Deliberately annoys people. | 0 | 1 | 2 | 3 |
| 23. Blames others for his or her mistakes or behavior. | 0 | 1 | 2 | 3 |
| 24. Is touchy or easily annoyed by others. | 0 | 1 | 2 | 3 |
| 25. Is angry or resentful. | 0 | 1 | 2 | 3 |
| 26. Is spiteful and wants to get even. | 0 | 1 | 2 | 3 |
| 27. **Is fearful, anxious, or worried.** | 0 | 1 | 2 | 3 |
| 28. Finds it difficult to control the worry. | 0 | 1 | 2 | 3 |
| 29. Is restless or feels keyed up or on edge. | 0 | 1 | 2 | 3 |
| 30. Is easily fatigued. | 0 | 1 | 2 | 3 |
| 31. Has difficulty concentrating or mind goes blank. | 0 | 1 | 2 | 3 |
| 32. Is irritable. | 0 | 1 | 2 | 3 |
| 33. Has muscle tension. | 0 | 1 | 2 | 3 |
| 34. Has sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep). | 0 | 1 | 2 | 3 |
| 35. Has severe recurrent temper outbursts verbally or behaviorally (inconsistent with developmental level). | 0 | 1 | 2 | 3 |
| 36. Has irritable mood between outbursts. | 0 | 1 | 2 | 3 |
| 37. Is afraid to try new things for fear of making mistakes. | 0 | 1 | 2 | 3 |
| 38. Is self-conscious or easily embarrassed. | 0 | 1 | 2 | 3 |
| 39. **Is sad, unhappy, or depressed.** | 0 | 1 | 2 | 3 |
| 40. Has markedly diminished interest or pleasure in almost all or all activities | 0 | 1 | 2 | 3 |
| 41. Feels worthless or inferior. | 0 | 1 | 2 | 3 |
| 42. Blames self for problems, feels guilty. | 0 | 1 | 2 | 3 |
| 43. Feels lonely, unwanted or unloved; complains that "no one loves him or her." | 0 | 1 | 2 | 3 |
| 44. **Often bullies, threatens, or intimidates others.** | 0 | 1 | 2 | 3 |
| 45. Often initiates physical fights. | 0 | 1 | 2 | 3 |
| 46. Has been physically cruel to people. | 0 | 1 | 2 | 3 |
| 47. Has been physically cruel to animals. | 0 | 1 | 2 | 3 |
| 48. Has deliberately destroyed property. | 0 | 1 | 2 | 3 |
| 49. Has broken into someone else's house, building, or car. | 0 | 1 | 2 | 3 |
| 50. Has committed theft. | 0 | 1 | 2 | 3 |

**Other Observations:**

_____

_____

_____

_____

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# Traverse Counseling & Consulting Fee Policies

**Fee Structure**

**Intake** – $155.00 per 50-minute session or $232.50 per 75-minute session (+ 2% MN-Care tax)

**Therapy** – Individual/couple/family therapy $155.00 per 50-minute session, or $232.50 per 75-minute session (+ 2% MN-Care tax)

**Intake Couples Therapy** – $232.50 per 75-minute session (+ 2% MN-Care tax)

**Collateral time** – Collateral time (emails, phone calls, written communication, reading/reviewing documents) will be billed in .2 hour (12 minute) increments at the rates above.

**Policy: *Payment***

Traverse Counseling & Consulting request the following:

1. Clients pay **at time of service.**
2. That **full payment** be made unless the client negotiates another arrangement.
3. That if a client has a balance that is older than 30 days and credit arrangements have not been made, the client will pay a **1.5% late fee per month.**
4. Referral to a Professional Collection Service will be made for accounts with **balances older than 90 days.**
5. If your account is placed with an outside collection agency, you will be charged the full amount of the collection fees, attorney fees and allowable court costs.
6. There will be a $40.00 service fee for returned checks.

**Policy: *Payment for child therapy***

Invoices and Statements will be mailed to the address we have on file or are provided in person to the parent bringing the child to therapy. If there is a second party responsible for sharing payment, the party to whom the invoice is mailed or given is responsible for sharing this information with the other party.

**Policy: *Missed Appointments***

In the event of a missed appointment without notification or extenuating circumstances, the client will be charged **half the session fee for the first missed appointment and the full fee thereafter.**

**Policy: *Cancellation of Appointments***

Traverse Counseling and Consulting requests a 24-hour notice of appointment cancellation. Failure to provide 24-hour notice will be treated as a missed appointment.

**Policy: *Lateness***

Therapy is prescheduled for a definite time, to last for 50 minutes or 75 minutes. Clients are charged for the full appointment when they arrive late.


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**Policy:** ***Audio Recording***

Client may not record any of their sessions or phone calls, unless prior permission is given by the therapist.

**Policy:** ***Insurance***

Traverse Counseling & Consulting, GBC does **not** submit invoices to any insurance company. We are an **out of network** provider for all health insurance companies. Clients pay for services and we provide an invoice, also known as a "Superbill", to submit to their insurance company. Services may be covered in full or in part by health insurance or employee benefit plan. Clients are encouraged to check their coverage carefully by asking the following questions:

1. Do I have mental health insurance benefits?
2. What are my out-of-network benefits?
3. What is my deductible and has it been met?
4. How many sessions per year does my health insurance cover?
5. What is the coverage amount per therapy session?
6. Is approval required from my primary care physician?

In addition, many clients have access to FSA or HSA accounts that can cover these expenses.

**Policy:** ***Scheduling***

Clients may schedule by phone or by email with our administrative staff.

**Policy:** ***Clients with Unusual Financial Situations***

Traverse Counseling & Consulting therapists have established a fee structure for individual, couple, family and group therapy. In families with documented financial need, clients may enquire with their provider to identify other options for covering the costs of services. Some options may include, a payment plan, and in limited cases, a provider may be able to negotiate a reduced rate for services.

I have read and understand the above stated "Therapy Policies" of Traverse Counseling & Consulting, GBC

_____ _____

Signature of Client Date

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# Client Rights and Responsibilities Agreement

**You, as a client, have a right:**

1. To ask about the credentials, education, and training of your therapist(s).
2. To expect that information about you is kept confidential unless you ask that it be shared with someone else. (Please be aware that in the case of divorce or child custody cases following marriage counseling, the court may require the therapist(s) to share information from the marriage counseling sessions.)
3. To be informed of the cost of all professional services prior to receiving the service.
4. To expect professional treatment that does NOT include actions with sexual overtones or innuendo.
5. To be free of any discrimination on the basis of religion, gender, race, color, or any other unlawful category.
6. To request information from the counselor about diagnosis, treatment plan, records, or other services which may be helpful to you.
   *Please note: Additional rights of Marriage and Family Therapy, Psychology, and Social Work clients are posted in the TCC lobby.*

**Client responsibility:**
**The therapist(s) may expect that:**

1. The client will complete any assignment or task agreed upon by the therapist(s) and the client.
2. No mood-altering chemical be used prior to any therapy session.
3. The client will treat the therapist with respect and in a non-abusive manner.
4. The client will adhere to rules of confidentiality concerning fellow members of a group, family member of a group, family members, and spouses. PLEASE NOTE: The above responsibility rest with each individual and the therapist(s) have little control over what is shared outside of the therapy session. However, if it becomes known that the rule of confidentiality has been broken, it will be discussed in the session, and the individual may be asked to terminate.
5. Each client sincerely enters into the therapeutic relationship with honesty and a willingness to share his/her concerns openly and directly.
6. Each client is responsible for keeping an appointment time and seeing that financial obligations are met.

**Exceptions to the Rules of Confidentiality:**
In general, the law protects the privacy of all communication between a client and a therapist. The therapist(s) may only release information about your treatment to others if you sign a written authorization form. You can revoke such authorizations at any time in writing. However, in the following situations, the therapist(s) is/are legally obligated to release information without requiring your authorization:

1. Therapist's duty to warn another in the case of potential suicide, homicide, or threat of imminent, serious harm to another individual.
2. Therapist's duty to report suspicion of abuse or neglect of children or vulnerable adults.
3. Therapist's duty to report prenatal exposure to cocaine, heroin, phencyclidine, methamphetamine, amphetamine, or their derivatives, THC, and excesses and habitual use of alcohol.
4. Therapist's duty to report the misconduct of mental health or health care professionals.
5. Therapist's duty to provide a spouse or parent of a deceased client access to their child or spouse's records.
6. Therapist's duty to provide parents of minor children access to their child's records. The Therapist reserves the right to decline the request for records if it may result in harm to the child or to the therapeutic relationship. In addition, the therapist will often recommend a Safe Harbor agreement for minor's therapy.
7. Therapist's duty to release records if court-ordered or bound by law.
8. Therapist's obligations to contracts (e.g. providing diagnostic information to an insurance carrier or health plan).


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**Initials and Signatures**

_____ I acknowledge that I have received, read, signed, and consent to abiding by the Client Rights and Responsibilities laid out above.

_____ I consent to treatment from Traverse Counseling & Consulting for services relating to the mental health field. I understand that I have the right to terminate treatment, in writing, at any time.

_____ I acknowledge that I have read and consent to the Notice of Privacy Policies (HIPAA) document, which explains, in detail, my rights to access my Personal Health Information and how, when, and with whom that information may be shared.

_____ I recognize that therapy has benefits and risks. I understand that therapy may involve exploration of my personal and family experiences and has the potential to be emotionally unsettling. I realize that although therapy may lead to better relationships, solutions to specific problems I may have, and/or a significant reduction of feelings of distress, there is no guarantee of any potential outcome of therapy.

_____ I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

_____

Client (or Parent/Guardian) Name (Please Print Legibly)

_____ _____

Signature of Client (or Parent/Guardian) Date

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## Notice of Privacy Policies

This notice describes how health-related information about you may be used and disclosed under the federal Health Insurance Portability and Accountability Act (HIPAA) and how you can gain access to this information.

**Obligations & Commitment to You:**

Traverse Counseling & Consulting (TCC) takes the privacy of your health information seriously. The information collected about you and your mental and physical health issues is considered "private", and is protected by state and federal laws. This information is referred to as "Protected Health Information", or "PHI", and includes individually identifiable information such as your name, address, date of birth, past, present, or future health conditions, the provision of health care to you, and payment information.

TCC not only follows all state and federal laws protecting your PHI, but also attempts to limit any disclosure of information about you to the minimum necessary. It is further expected that any consultants, volunteers, or business partners working with TCC, will also respect your privacy and abide by the same laws.

As part of your healthcare, TCC originates and maintains paper and/or electronic records describing your health history, symptoms, examination and test results, diagnoses, treatment and any plan for future care or treatment. This information serves as a basis for planning your care and treatment, a source of information for applying your diagnosis and treatment information to your bill, a means by which a third-party payer can verify that services billed were actually provided, and as a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

This notice informs you of the ways that your PHI may be disclosed and to whom, and what rights you have regarding your PHI.

**How Your Health Information May Be Used and Disclosed:**

Described below are the ways TCC may use and disclose health information that identifies you:

- **For treatment:** It may be necessary to consult with a doctor, medical specialist, or another therapist you are seeing to provide the most effective treatment. TCC may disclose your PHI to doctors, and other health care personnel who are involved in providing your healthcare with your written consent.

- **For payment:** In order to be reimbursed for services and determine eligibility for coverage, your health insurance company may require details of your diagnosis, the number of sessions in which you participate, and potentially other information, such as your treatment plan. TCC may disclose this information with your written consent.

- **For health care operations:** Your information may be used for normal health care operations, such as entry into a billing system, to evaluate the quality of services provided, and for audit purposes. TCC employs administrative staff and, in most cases, needs to share your PHI for administrative purposes, such as scheduling and billing. All staff members have been given training about protecting your privacy.

- **To contact you:** Unless otherwise specified by you, your information may be used to contact you by telephone, voicemail, email, or fax in order to return a message or relay information to you.

- **For consultation:** Periodically, your therapist(s) may consult with other licensed professionals to ensure that we are offering the best services to you, as a client. These professionals are bound by the same rules of confidentiality, and your therapist(s) take great care to protect your privacy by changing identifying details.

Described below are special circumstances in which your PHI may be used or disclosed without your consent or authorization:

- **As required by law:** Information will be disclosed when required by federal, state, or local law. For example, therapists are obligated by law to report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. TCC must also disclose PHI to authorities that monitor compliance with these privacy requirements.

- **To avert a serious threat to health or public safety:** Information will be disclosed when necessary to prevent a serious threat to your health and safety or to the health and safety of the public or of another person. However, disclosures in these areas will only be made to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

- **For health oversight activities:** Information may be disclosed for purposes regarding health-care delivery as authorized by law. These activities may include audits, investigations, inspections, and licensure.

- **For lawsuits and disputes:** If you are involved in a lawsuit or a dispute, information may be disclosed in response to a court order. Any other disclosures of your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, must have your written authorization.

- **In response to a complaint or lawsuit:** Information may be disclosed in order to answer a complaint or lawsuit.

- **Worker's Compensation:** Information may be disclosed as authorized by and to the extent necessary to comply with worker's compensation laws or laws relating to similar programs.

**Special Uses and Disclosures Requiring Authorization**

For purposes beyond treatment, payment, and health care operations, including communication to family, friends, or others involved in your care and/or payment of your care, your written authorization is required unless the use and disclosure falls within one of the exceptions listed above. Authorizations can be revoked at any time to stop further uses/disclosures except to the extent that we have already undertaken an action in reliance upon your authorization.

**Your Rights Regarding Your Protected Health Information**

You have the following rights regarding your PHI:

- The right to request restrictions on uses and disclosures of your PHI, upon your written request. TCC is not legally required to agree to a requested restriction. To the extent that TCC does agree to any restriction on our use/disclosure of your PHI, we will put that agreement in writing and abide by it except in emergency situations. TCC will not agree to limit uses/disclosures that are required by law.

- The right to inspect and request a copy of your PHI, upon your written request. Unless your access to your records is restricted for clear and documented treatment reasons, TCC will respond to your request within 30 days. TCC's policy on accessing minor's files is located in the Client Rights and Responsibilities Agreement document and may be discussed with the minor's therapist(s) at intake or at any point during treatment. If TCC agrees to your request to inspect your file, we will contact you to schedule a regular therapy session with your therapist(s). This session will be used to review the file with you and to discuss any questions or concerns you may have. TCC does require a reasonable amount of time to review the file prior to scheduling a session. If TCC denies your access, we will give you written reasons for the denial and explain any right you may have to have the denial reviewed. If you request copies of your PHI, a charge for copying may be imposed. In addition, family therapy files require all adults involved to sign an authorization for copying or releasing PHI.

- The right to request amendment of your PHI, upon your written request. If you believe that the PHI TCC has about you in incorrect or incomplete, you may request that we correct or add to your record. TCC will respond within 60 days of receiving your request. TCC may deny your request if we determine that the PHI is (1) correct and complete; (2) not created by us and/or not part of our records; or (3) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you may provide, appended or linked to

your PHI. If TCC approves the request for amendment, we will change the PHI and so inform you, and tell any necessary personnel about the change in the PHI.

- The right to receive an accounting for disclosures of your PHI, upon your written request. You may receive a list of when, whom, for what purpose, and what content of your PHI has been released other than instances of disclosure (for treatment, payment, and health care operations). This list will not include any disclosure made for national security purposes, to law enforcement officials or correctional facilities, or disclosures made before April 2003. TCC will respond to your written request for such a list within 60 days of receiving it. Your request can relate to disclosures going back as far as six (6) years. There will be no charge for up to one (1) such list each year. There may be a charge for more frequent requests.

- The right to receive a copy of this Notice upon your request.

**Requesting Copies of Your PHI**

You have a right to request, in writing, a copy of your patient record in accordance with Minnesota Statute 144.292. Unless the file information is requested for a review of your current medical care, a worker's compensation claim, or a Social Security disability claim, you will be charged a per-page copy fee and a retrieval fee. 2017 rates set by the Minnesota Department of Health allow for a per-page copy fee of $1.35 and a retrieval fee of $17.96. These fees will be adjusted on an annual basis to follow the current Minnesota Department of Health rates. TCC will provide you an estimate prior to making copies. In addition, family therapy files require all adults involved to sign an authorization for copying or releasing PHI. In order to receive your file, full payment for the copies and the retrieval fee must be received. Please note that HIPAA regulations allow providers up to 30 days to retrieve, prepare, and dispatch requested information.

**Changes to This Notice:**

TCC is required to abide by the terms of the Notice currently in effect, and reserves the right to change this Notice at any time and to make the new Notice apply to the Health Information already held as well as any information received in the future. Revised Notices are made available at www.TraverseCC.org.

**Questions/Complaints**

If you have any questions about this Notice, are concerned that your privacy rights may have been violated, or disagree with a decision that TCC has made about access to your Protected Health Information, you may contact Michael Borowiak at 952/595-5967. You may also send a written complaint, without retaliatory action against you, to the Secretary of the U.S. Department of Health and Human Services or to the appropriate Minnesota state licensing board.