CLIENT REGISTRATION FORM

Client Name _____ Client Number _____

RIGHTS AND RESPONSIBILITIES:

1. I have been informed of my rights and if I feel I have been discriminated against because of race, religion, national origin, sex or age, I may complain to this agency or to the State or Federal agencies listed in the "Notice of Privacy Practices".
2. I have been informed regarding my rights; have been read the Tennessen Warning; have had my initial questions answered regarding these issues; and have been given the handout "Client's Bill of Rights", "Notice of Privacy Practices", and a copy of the grievance procedure. I understand that I may request further information at any time.
3. I have been informed, and I understand that management personnel reserves the right to be in attendance at clinical staffings where my case may be reviewed. This is to insure that appropriate services are being offered and provided and insure an effective interdisciplinary team approach.

I. INCOME

Number of Family Members _____
Yearly Income _____
Sliding Fee Percent _____
Verification of Income _____
Referred to MA _____
Bill to Name _____
Address _____
_____
Phone # _____
Pay Code(s) _____
EAP _____

Insurance Co. _____
Address _____
_____
_____
Group # _____
ID # _____
Subs. Name _____
Policy Holder DOB _____
Address _____
_____
Relationship _____

Insurance Co. _____
Address _____
_____
_____
Group # _____
ID # _____
Subs. Name _____
Policy Holder DOB _____
Address _____
_____
Relationship _____

II. PAYMENT PLAN

- ☐ Each month I will pay a minimum of 25% of the total balance due until all charges are paid.
- ☐ Following each visit, I will pay the charges for that visit.
- ☐ Upon receipt of a monthly statement, I will remit the amount due.
- ☐ I will be responsible for payment for any services denied by my insurance company, including but not limited to deductibles, co-pays and exclusions.
- ☐ Other (specify) _____

I understand that I am responsible for the charges in full, forfeiting my opportunity to be placed on the sliding fee scale, if I do not comply with the following (when applicable):

a. Provide verification of income documentation
b. Obtaining a physician referral when my insurance requires one.
c. Applying for medical assistance and notifying NCC of disposition if referred.
d. A fee may be charged for any missed appointments which are not canceled at least 24 hours in advance.

I recognize that it is my responsibility to be aware of my insurance benefits and payment by insurance is not guaranteed.

In the event the Center has been unable to collect payment from me for services within a reasonable period of time, the Center then reserves the right to turn the account over to an attorney or collection agency. I understand that interest, finance charges and other costs as allowed by law, will be added to my account. A 15% processing fee will be added to any account sent to collections.

III. RELEASE OF INFORMATION

I authorize Northland Counseling Center, Inc. to release information to my insurance company regarding my treatment here. This could include my social security number, diagnosis, prognosis, dates of treatment, narrative notes and types of treatment and permit a facsimile or photographic reproduction of this authorization in place of the original. This is for the purpose of validating claims submitted to _____. I also authorize _____ to make payments to Northland Counseling Center, Inc. for all insurance benefits to which I or my dependents are entitled for services received at Northland Counseling Center, Inc. I understand that my consent terminates one year from the date of signature, unless I choose to revoke it earlier.

I affirm that the information reported above is accurate and that the fee, payment method and release of information have been discussed. If my financial status changes, an update of this agreement may be renegotiated.

CLIENT SIGNATURE _____ DATE _____

RESPONSIBLE PARTY SIGNATURE _____

NORTHLAND STAFF SIGNATURE _____

Northland
COUNSELING CENTER, INC

Telemedicine Client Consent/Refusal Form

CLIENT NAME: _____

PURPOSE: The purpose of this form is to obtain your consent to participate in telemedicine services in connection with the following services provided by Northland Counseling Center, Inc. and all satellite offices associated within.

Services <u>may</u> include: Individual Therapy, Diagnostic Assessments, Medication Management, Psychiatric Consultations, Adult Rehabilitative Mental Health Services (ARMHS), Peer Support Services (PSS), Housing Services, Employment Services through Northern Opportunities Works (NOW), Crisis Assessments, Crisis Interventions, Crisis Stabilization, Intakes, Clinical Care Consultation, Case Management, DBT Services, Substance Use Disorder (SUD) treatment (assessments, treatment planning, individual/group services) and Children's Therapeutic Supports and Services (CTSS).

Service(s) if not listed: _____

INTRODUCTION: Telemedicine involves the use of electronic communications to enable office visits from a site other than Northland Counseling Center, Inc. 'Telemedicine' means using electronic systems to allow communication between a client and a provider who are in different locations.

CONFIDENTIALITY: Northland Counseling Center, Inc. utilizes Zoom, which incorporates networking software security protocols to protect confidentiality of patient identification and will include measures to safeguard data and to ensure the integrity against intentional or unintentional corruption.

Reasonable and appropriate efforts have been made to illuminate any confidentiality risks associated with the telemedicine consultation and all existing confidentiality protections under Federal and Minnesota State Law applied information disclosed while utilizing telemedicine services.

RIGHTS: You may withhold or withdraw consent to telemedicine services at any time without affecting your right to future services with Northland Counseling Center, Inc. or risk the loss or withdrawal of any program benefits to which you would otherwise be entitled.

RISKS, CONSEQUENCES and BENEFITS: In rare cases, the information transmitted may be inadequate quality or, if the equipment is not working, there could be delays in evaluation and treatment. In these cases, the visit maybe rescheduled or your provider will discuss Face-to-Face visit needs. You or your mental health provider may discontinue the telehealth visit if the connections are not adequate for the situation. Very rarely, security protocols could fail, causing a breach of privacy of medical information. Northland Counseling Center, Inc. has implemented appropriate security measures to mitigate against this rare situation.

By signing below, I indicate that Northland Counseling Center, Inc. has my permission to use a web-based video-conferencing application to facilitate my care and treatment.

- I understand the expiration date of this authorization is 1 year from today's date:_____
- I understand that my Protected Health Information (PHI) will be transmitted by a third party web-based video conferencing vendor to my provider during my telehealth visits.
- I understand that I have the right to revoke my permission at any time. I understand I must make my request in writing to Northland Counseling Center, Inc.

Signature:_____ Date:_____

If signed by someone other than the client, indicate relationship:_____

If you **<u>REFUSE</u>** to participate in telemedicine services please check this box: □

Northland

Counseling Center, Inc.

CLIENT NAME: _____

Dear Client,

I want to applaud you for having the courage to come in for therapeutic services. This decision can be difficult and scary but is a step toward improving your health and quality of life. To maximize the benefit of psychotherapy, it is important that all scheduled appointments are attended. Missing appointments disrupts the therapeutic process and makes it more difficult to improve symptoms and functioning. This also affects other clients who may be on the waiting list for an appointment.

Time is a valuable commodity at Northland Counseling Center and we dedicate time to your treatment and expect that you do the same. Attending therapy and completing therapeutic work outside of session, is very much like taking medication. If you are not taking a medication as prescribed, it is not reasonable to expect it to work.

It is understandable that an appointment may need to be missed for planned or unplanned reasons. Please be courteous and responsible and notify us as soon as you are able when you realize you cannot attend a scheduled appointment. Many agencies charge a fee to clients for late cancelations or no-showed appointments. At this point, Northland Counseling Center has elected not to charge a fee to clients but this does result in our agency absorbing the cost of missed appointments, which does add up. It is also important to be on time for an appointment as arriving late also interferes with the therapeutic process. Most importantly, you are not able to benefit from therapy if tardiness or absences becomes frequent. Additionally, we try to do reminder calls but clients are still responsible for remembering their appointment.

By signing below, I am agreeing to try my best to provide at least 24 hour notice if I am to miss a scheduled appointment. I will not schedule an appointment at a time when I know I am not able to attend. I understand that two consecutive no-shows or frequent late cancelations may result in me being placed on the waiting list for an appointment. Also, these behaviors will be addressed in therapy with my therapist.

Client Signature _____ Date _____

Parent or Guardian Signature _____ Date _____

Clinician Signature _____ Date _____

900-5th Street, Suite 305 • International Falls, Minnesota 56649

Northland Counseling Center
900 5th Street, Suite 305
International Falls, MN 56649

COORDINATION WITH MEDICAL PROVIDER

Client Name:_____ Date:_____

____ I do not have a primary medical provider.

____ I **do not** consent to coordination of care with my medical provider at this time.

____ I do consent to coordination of care with my medical provider and have signed a Release of Information.

_____
Client or guardian signature

NORTHLAND COUNSELING CENTER

900 5th Street, Suite 305
International Falls, MN 56649
Phone: (218) 283-3406 Fax: (218) 283-3386

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ authorize **Northland Counseling Center to:**
(Client or responsible person)

☑ Give information to ☐ Give information only upon request to ☑ Receive information from

_____
(Agency or individual's name and address)

_____ Attention: _____

Regarding: _____ _____
(Client's Name) (date of birth)

Information may be released and/or received by mail, telephone, fax or verbally and limited as follows:

Give/Receive		Give/Receive	
☑	☑ Diagnostic Assessment	☑	☑ Physician/medical health records
☑	☑ Narrative/Progress Notes	☑	☑ Scheduling/Confirmation of attendance
☑	☑ Treatment Plan or Planning	☑	☑ School/Educational Information
☑	☑ Psychological Testing	☑	☑ Chemical Use Assessment/records
☑	☑ Medication Regimen/ records	☑	☑ Inpatient records/Discharge Summary
☑	☑ Treatment Summary	☐	☐ Court Order/legal documents
☑	☑ Other (specify): Electronic and Verbal Communication		

✱ **Approximate date(s) of Information to be released/received:** _____

_____

Purpose of receiving/releasing information: Coordination of Care/ Referral/References

I understand that information shared may relate to ☑Substance Abuse (including alcohol/drug use or ☑Behavioral Health (mental health) and I specifically authorize the release of this information. I understand that my authorization terminates one year from the date of my signature. I understand that I have the right to revoke this authorization in writing prior to the termination date. I understand that Northland Counseling Center cannot release information disclosed by this authorization to anyone other than listed above, unless I give written permission. I realize that Northland Counseling Center and its therapists cannot prevent the re-disclosure of records released to other parties, releasing them from any and all liability resulting from re-disclosure. Northland Counseling Center will not condition treatment on my signing this authorization. A copy of this authorization shall be considered as valid as the original. A fee may be required for the retrieval and photocopying of records.

_____ _____
Client/Guardian Signature date

_____ _____
Witness date

If signing as the authorized representative of the patient, I am: (please check one)
_____ Court appointed Guardian
_____ Custodial parent of minor child
_____ Other: (explain) _____
_____

dlj/Aug 2015

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☐	☐ Psychological Testing	☐	☐ Chemical Use Assessment/records
☐	☐ Medication Regimen/ records	☐	☐ Inpatient records/Discharge Summary
☐	☐ Treatment Summary	☐	☐ Court Order/legal documents
☐	☐ Other (specify): _____		

Approximate date(s) of Information to be released/received: _____

_____

Purpose of receiving/releasing information: _____

_____

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_____ _____
Client/Guardian Signature date

_____ _____
Witness date

If signing as the authorized representative of the patient, I am: (please check one)
_____ Court appointed Guardian
_____ Custodial parent of minor child
_____ Other: (explain) _____
_____

dlj/Aug 2015

NORTHLAND COUNSELING CENTER, INC.

ADULT PRE-INTAKE QUESTIONNAIRE

Name: _____ Date: _____
(Last) (First) (M.I.)

Address: _____
(Number & Street) (City) (State) (Zip)

Primary Phone Number: _____ May we leave a message or text message? ☐ Yes ☐ No

Email Address: _____ Gender: ☐ Male ☐ Female ☐ Transgender

Birthdate: _____/_____/_____ Age: _____ Social Security Number: _____

Hair Color: _____ Length: ☐ Short ☐ Medium ☐ Long

Eye Color: _____ Do you wear: ☐ Glasses ☐ Contacts

RACE: ☐ Asian ☐ American Indian/Alaska Native ☐ Black/African American
☐ Native Hawaiian ☐ White ☐ Some Other Race

ETHNICITY: ☐ Hispanic/Latino

MILITARY SERVICE: ☐ Non-Vet ☐ Vietnam Vet ☐ Other Vet ☐ Disabled Branch: _____

TELL US WHY YOU ARE HERE: ☐ Self-Referred ☐ Referred by Health Provider/Mental Health Provider
☐ Court Ordered ☐ Chemical Dependency/Drug Court ☐ Employment Requirement

Please explain: _____

The reason(s) you are seeking mental health services? _____

_____

_____

Current Life Situation

MARITAL STATUS: ☐ Single (never married) ☐ Married ☐ Divorced ☐ Re-Married ☐ Separated
☐ Widowed ☐ Living with significant other (boyfriend/girlfriend/fiancé)

Spouse/Significant other name: _____

Where do you live? (Apartment, house, residential facility, homeless) _____

With whom do you live? (Alone, spouse, parents, children, friends, or other individuals)

Name	Age	Relationship	Name	Age	Relationship

Please use the back of the page for additional persons you live with.

How would you describe your living situation? _____

_____

Current Source of Income: (wages, social security, pension, etc): _____

EMPLOYMENT: ☐ Full-Time ☐ Part-Time ☐ Seasonal ☐ Self-Employed ☐ Disabled ☐ Retired

☐ Unemployed ☐ Student (full-time or part-time)

Employer's Name: _____

Occupation: _____

Educational History

EDUCATION: ☐ did not complete high school Highest Grade Completed: _____

☐ High School Diploma ☐ GED ☐ Vocational ☐ Some College ☐ College Graduate ☐ Post Graduate

Degree: _____ School currently attending: _____

Special education as a child? ☐ No ☐ Yes - specify_____

List any barriers to learning, Special Education services, any past school testing, etc_____

_____

_____

SCHOOL PROBLEMS: ☐ Truancy ☐ Suspension ☐ Expulsion ☐ Poor Grades ☐ Conflict (Peers)

☐ Conflict (teacher) Other: _____

Additional comments about educational history: _____

_____

Symptoms / Relevant History

Have you ever received outpatient mental health services? ☐ No ☐ Yes (if yes, describe below:

1). Agency: _____

Dates: _____

2). Agency: _____

Dates: _____

Was a Psychiatrist seen? ☐ No ☐ Yes Doctor's Name: _____

Early Childhood Developmental History (list anything unusual):_____

_____

Normal Birth? ☐ Yes ☐ No (list any complications, birth defects, etc) _____

_____

Were early childhood milestones met on time? ☐ Yes ☐ No (list any delays): _____

_____

List any special needs in childhood:_____

_____

Substance or Alcohol Abuse History

Have you participated in a chemical dependency treatment program? ☐ No ☐ Yes

1). Agency: _____

Dates: _____

2). Agency: _____

Dates: _____

Do you feel you have a problem with substances or alcohol? ☐ No ☐ Yes

If yes, do you want help with this problem? ☐ No ☐ Yes

NICOTINE: ☐ Smoke ☐ Chewing tobacco How much? _____

Any family history of substance or alcohol abuse / dependence? ☐ No ☐ Yes – describe _____

_____

Medical History

List significant current or past medical conditions: _____

_____

_____

_____

Have you had your thyroid checked? ☐ No ☐ Yes Approximate Date: _____

☐ Unknown ☐ Never been checked ☐ Yes – Normal

☐ Yes – Hypothyroidism ☐ Yes – Hyperthyroidism

Any history of thyroid disorders in family? ☐ No ☐ Yes (if yes, who):_____

Most recent medical doctor appointment? ☐ Within the past month ☐ Within six months

☐ Over a year ☐ Over 5 years

Current Medications (list names and dosages if known, or attach list):

List significant surgeries and dates: _____

_____

List known allergies: (include severity and reaction): _____

_____

Significant disabilities/limitations: Are you disabled? ☐ No ☐ Yes _____

_____

Head trauma/concussions: ☐ No ☐ Yes – explain: _____

_____

Significant medical problems of immediate family members and/or medical problems that run on your side of extended family? _____

_____

FOR NORTHLAND COUNSELING CENTER TO SERVE YOU BETTER

Please list to the best of your knowledge, any people with whom you have a significant relationship that currently or previously attend/attended therapy at Northland Counseling Center to avoid conflict of interest for your clinician/therapist.

Name	Relationship	Name	Relationship

Who is your Primary Care Physician/Clinic _____

Emergency Contact: _____

Address _____

Phone: _____ Relationship _____

Global Appraisal of Individual Needs-Short Screener (GAIN-SS)

Version [GVER]: GSS 3.0.1

Name: _____ **Date:** _____

First/Middle/Last

The following questions are about common psychological, behavioral and personal problems. These problems are considered significant when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on.

After each of the following questions, please tell us the last time you had this problem, if ever, by answering (circling) whether it was in the past month (4), 2-3 months ago (3), 4-12 months ago (2), 1 or more years ago (1), or never (0). Be sure to choose only one response.	Past Month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
IDSscr					
When was the last time you had significant problems...					
• with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	4	3	2	1	0
• with sleep trouble, such as bad dreams, sleeping restlessly or falling asleep during the day?	4	3	2	1	0
• feeling very anxious, nervous, tense, scared, panicked or like something bad was going to happen?	4	3	2	1	0
• becoming very distressed and upset when something reminded you of the past?	4	3	2	1	0
• thinking about ending your life or committing suicide?	4	3	2	1	0
• seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?	4	3	2	1	0
EDSscr					
When was the last time that you did the following things two or more times?					
• Lied or conned to get things you wanted or to avoid having to do something?	4	3	2	1	0
• Had a hard time paying attention at school, work, or home?	4	3	2	1	0
• Had a hard time listening to instructions at school, work, or home?	4	3	2	1	0
• Had a hard time waiting for your turn?	4	3	2	1	0
• Were a bully or threatened other people?	4	3	2	1	0
• Started physical fights with other people?	4	3	2	1	0
• Tried to win back your gambling losses by going back another day?	4	3	2	1	0

(Continued) After each of the following questions, please tell us the last time you had this problem, if ever, by answering (circling) whether it was in the past month (4), 2-3 months ago (3), 4-12 months ago (2), 1 or more years ago (1), or never (0). Be sure to choose only one response.	Past Month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
SDSscr When was the last time that…					
• you used alcohol or other drugs weekly or more often?.....	4	3	2	1	0
• you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (feeling sick)?.....	4	3	2	1	0
• you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?.....	4	3	2	1	0
• your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events?	4	3	2	1	0
• you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?.....	4	3	2	1	0
CVSscr When was the last time that you…					
• had a disagreement in which you pushed, grabbed, or shoved someone?.....	4	3	2	1	0
• took something from a store without paying for it?.....	4	3	2	1	0
• sold, distributed or helped to make illegal drugs?.....	4	3	2	1	0
• drove a vehicle while under the influence of alcohol or illegal drugs?..	4	3	2	1	0
• purposely damaged or destroyed property that did not belong to you?..	4	3	2	1	0

Do you have other significant psychological, behavioral or personal problems that you want treatment for or help with? If yes, please describe: _____ Yes _____ No

_____

_____

_____ _____

Client Signature Date

Staff Use Only

Number of 2's, 3's, and 4's: IDSscr: _____ EDSscr: _____ SDSscr:_____ CVSscr: _____ TDSscr: _____

Referral: _____ MH _____ SA _____ ANG _____Other: _____

 GAIN-SS/dla/10/18

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Patient Health Questionnaire (PHQ-9)

Name:_____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "X" to indicate your answer.)	Not at all (0)	Several Days (1)	More than half the days (2)	Nearly every day (3)
Little Interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself - or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead, or of hurting yourself in some way				
Add Columns				
Total Score				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?			
	Not difficult at all	_____	(0)
	Somewhat difficult	_____	(1)
	Very difficult	_____	(2)
	Extremely difficult	_____	(3)

WHODAS 2.0

World **H**ealth **O**rganization

Disability **A**ssessment **S**chedule 2.0

Name:_____ Date: _____

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please check only one response.

		None (1)	Mild (2)	Moderate (3)	Severe (4)	Extreme or cannot do (5)
S1	Standing for long periods such as 30 minutes?					
S2	Taking care of your household responsibilities?					
S3	Learning a new task, for example, learning how to get to a new place?					
S4	How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?					
S5	How much have you been emotionally affected by your health problems?					
S6	Concentrating on doing something for ten minutes?					
S7	Walking a long distance such as a mile (or equivalent)?					
S8	Washing your whole body?					
S9	Getting dressed?					
S10	Dealing with people you do not know?					
S11	Maintaining a friendship?					
S12	Your day-to-day work?					
	Add Columns					
	Total Score					

H1	Overall, in the past 30 days, how many days were these difficulties present?	Record number of days _____
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	Record number of days _____
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	Record number of days _____

This completes the questionnaire. Thank you.