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.

Serving the residents of Koochiching County

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 Fifth Street, Suite 305 • International Falls, Minnesota 56649
218-283-3406 • Fax 218-283-3386

AUTHORIZATION FOR TREATMENT OF A MINOR/WARD

Name:_____ Client #:_____

_____ I authorize NORTHLAND COUNSELING CENTER and its staff to administer services and/or treatment to my child.

_____ I authorize NORTHLAND COUNSELING CENTER and its staff to administer services and/or treatment to my ward.

What type of custody do you retain?

Full legal custody? _____
Joint legal custody? _____
Physical custody? _____
Other: (please specify) _____

If none of the above, name, address and phone number of person with custody:

_____
_____
_____

Responsible Party Signature _____ Date _____
Koochiching Staff Signature _____

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

Northland Counseling Center
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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

NORTHLAND COUNSELING CENTER

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☐	☐	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): _____		

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

_____

Purpose of receiving/releasing information: _____

_____

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

NORTHLAND COUNSELING CENTER, INC.

MINOR PRE-INTAKE QUESTIONNAIRE

To be filled out by parent or legal guardian. ***Date completed*** _____

Child's name: _____
(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: _____

Birthdate: _____/_____/_____ Age: _____ Gender: ☐ Male ☐Female

Social Security Number: _____

Hair Color: _____ ☐ Short ☐ Medium ☐ Long

Eye Color: _____ ☐ Glasses ☐ Contacts

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

WHO RETAINS CUSTODY: ☐ Biological parents ☐ Biological mother ☐ Biological father
☐ Social Services ☐ Other, please explain: _____

Biological Mother: _____ Birthdate: _____/_____/_____

Marital Status: ☐ Married to child's biological father ☐ Divorced ☐ Separated ☐ Widowed
☐ Living with significant other (boyfriend/girlfriend/fiancé) ☐ Single (never married)

Address: _____

Phone: _____ **Work Phone:** _____

Biological Father: _____ Birthdate: _____/_____/_____

Marital Status: ☐ Married to child's biological mother ☐ Divorced ☐ Separated ☐ Widowed
☐ Living with significant other (boyfriend/girlfriend/fiancé) ☐ Single (never married)

Address: _____

Phone: _____ **Work Phone:** _____

Legal Guardian(s): _____ **Birthdate** _____

Marital Status: ☐ Single (never married) ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
☐ Living with significant other (boyfriend/girlfriend/fiancé)

Address: _____

Phone: _____ **Work Phone:** _____

Symptoms / Relevant History

Referred by (if any): _____ Relationship: _____

Why are you seeking mental health services for this child? _____

_____

_____

Current Life Situation

Where does child live? (Apartment, house, residential facility, homeless) _____

With whom does child live? (Parents, siblings, or other individuals)

Father: _____ **Age:** _____ **DOB:** _____

Mother: _____ **Age:** _____ **DOB:** _____

Sibling: _____ **Age:** _____ **DOB:** _____

Sibling: _____ **Age:** _____ **DOB:** _____

Other: _____ **Age:** _____ **DOB:** _____

What is child's living situation like? _____

_____

Mental Health History

Has he/she ever received outpatient mental health services? ☐ No ☐ Yes

☐ Northland Counseling Center ☐ Other

(Please describe where, when and for what reason and outcome)

_____

_____

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

Previous mental health history:

_____

_____

Educational History

Level of education attained:

School currently attending: _____ Highest grade completed :_____

Special education? ☐ No ☐ Yes - specify _____

School Problems: ☐ Truancy ☐ Suspension ☐ Expulsion ☐ Poor Grades ☐ Conflict (Peers)

☐ Conflict (teacher) Other: _____

Academic History: List any barriers to learning, Special Education services, any past school testing:

_____

_____

Additional comments about educational history: _____

_____

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:_____

_____

Medical History

List significant current or past medical conditions: _____

_____

_____

_____

Has thyroid been checked? ☐ No ☐ Yes Approximate Date: _____

☐ Unknown ☐ Never been checked ☐ Yes – Normal

☐ Yes – Hypothyroidism ☐ Yes – Hyperthyroidism

Is there a family history of thyroid disorders? ☐ 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 _____

_____

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

_____

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

_____

Primary Care Physician? _____

Employment Status: ☐ Full-Time ☐Part-Time ☐ Seasonal ☐ Self-Employed ☐ Disabled ☐ Retired ☐ Unemployed ☐ Student (full-time or part-time)

Employer's Name: _____

Occupation: _____

Substance and Alcohol

Has he/she participated in a chemical dependency treatment program? ☐ No ☐ Yes – please describe when and where treatment was obtained:_____

Does he/she have a problem with substances or alcohol? ☐ No ☐Yes (if yes, do you want help with this problem? ☐ No ☐ Yes) _____

Does he/she Smoke / chew tobacco? ☐ No ☐ Yes How much?_____

Is there a family history of substance or alcohol abuse / dependence? ☐ No ☐ Yes – describe

_____

_____

County of financial responsibility:_____

Person completing Pre-Intake Questionnaire:

_____

Child's Name:_____

Date of Screening:_____

Children's Trauma Assessment Center
Screening Checklist: Identifying Children at Risk

Southwest Michigan Children's Trauma Assessment Center

Please check each area where the item is known or suspected.

1. Are you aware of or do you suspect the child has experienced any of the following:
   - _____ Physical abuse
   - _____ Suspected neglectful home environment
   - _____ Emotional abuse
   - _____ Exposure to domestic violence
   - _____ Known or suspected exposure to drug activity *aside from parental/caregiver use*
   - _____ Known or suspected exposure to any other violence *not already identified*
   - _____ Parental/caregiver drug use/substance abuse
   - _____ Multiple separations from parent or caregiver
   - _____ Frequent and multiple moves or homelessness
   - _____ Sexual abuse or exposure
   - _____ Other _____

If you are not aware of a trauma history, but multiple concerns are present in questions 2, 3, and 4, then there may be a trauma history that has not come to your attention.
Note: Concerns in the following areas do not necessarily indicate trauma; however, there is a strong relationship.

2. Does the child show any of these behaviors:
   - _____ Excessive aggression or violence towards self
   - _____ Excessive aggression or violence towards others
   - _____ Explosive behavior (Going from 0-100 instantly)
   - _____ Hyperactivity, distractibility, inattention
   - _____ Very withdrawn or excessively shy
   - _____ Oppositional and/or defiant behavior
   - _____ Sexual behaviors not typical for child's age
   - _____ Peculiar patterns of forgetfulness
   - _____ Inconsistency in skills
   - _____ Other _____

3. Does the child exhibit any of the following emotions or moods:
   - _____ Excessive mood swings
   - _____ Chronic sadness, doesn't seem to enjoy any activities
   - _____ Very flat affect or withdrawn behavior
   - _____ Quick, explosive anger
   - _____ Other _____

4. Is the child having problems in school?
   - _____ Low or failing grades
   - _____ Inadequate performance
   - _____ Difficulty with authority
   - _____ Attention and/or memory problems
   - _____ Other _____

5. Given the information provided, what is the appropriate next step? (THERAPIST ONLY)
   - _____ Trauma-informed mental health referral
   - _____ General mental health referral
   - _____ Immediate stabilization mental health referral
   - _____ No mental health referral

Strengths and Difficulties Questionnaire

P 4-10

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behavior over the last six months.

Your child's name ..... Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children, for example toys, treats, pencils	☐	☐	☐
Often loses temper	☐	☐	☐
Rather solitary, prefers to play alone	☐	☐	☐
Generally well behaved, usually does what adults request	☐	☐	☐
Many worries or often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, depressed or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often offers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets along better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Good attention span, sees chores or homework through to the end	☐	☐	☐

Do you have any other comments or concerns?

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behavior or being able to get on with other people?

No	Yes-minor difficulties	Yes-definite difficulties	Yes-severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress your child?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	A medium amount	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

Signature ..... Date .....

Mother/Father/Other (please specify:)