INTAKE FORM

Serenity Circle COUNSELING

Welcome to Serenity Circle Counseling. These forms will give you the chance to describe your story. Please fill them out as completely as possible and bring them to your first session. Please be aware that you may leave blank any part that you feel uncomfortable sharing at this time.

Client name: _____

Date of Birth: _____ Age: _____ Marital/Relational Status: _____

Address: _____

Primary Phone: _____ Home Work Cell

Optional Information: Race/Ethnicity: _____ Religious Affiliation: _____

How did you hear about Serenity Circle Counseling? _____

REASON FOR SEEKING COUNSELING

Briefly describe the reason you have decided to try counseling at this time. _____

_____

_____

How long have you been having difficulties? _____

What would you like to see happen or change as a result of counseling? _____

_____

RISK ASSESSMENT

Have you been having suicidal thoughts recently? Y N If so, do you have a plan? Y N

Have you ever had suicidal thoughts? Y N If so, when? _____

Have you ever attempted suicide? Y N If so, when? _____

Do you currently, or have you ever, engaged in self harm behavior (ex. cutting)? Y N Current Past

Has anyone physically hurt you or threatened to hurt you recently? Y N

Do you feel safe at home? Y N

Do you intend to or are considering to physically harm another person? Y N

CURRENT SYMPTOMS AND LIFESTYLE (in the past week or two)

How many days per week:	NONE	1-2 DAYS	3-4 DAYS	5-6 DAYS	7 DAYS	**HOW LONG?**
ANGER OR TEMPER						
ANXIOUS, NERVOUS, OR PANICKY						
AVOIDING PLACES OR SITUATIONS						
BINGING OR PURGING						
CHANGE IN EATING HABITS						
CHANGE IN SPENDING HABITS						
CHANGE IN WEIGHT						
CHANGE IN WORK HABITS						
CHEMICAL USE (ALCOHOL OR DRUGS)						
CONFUSION OR DISORGANIZED THOUGHTS						
DEPRESSED, SAD, OR CRYING						
DIFFICULTY SLEEPING						
FLASH BACKS						
GUILTY FEELINGS						
HALLUCINATIONS						
HOARDING						
HOPELESSNESS						
HYPERACTIVITY						
IMPULSIVE						
INFERIORITY (LOW SELF WORTH)						
INSECURITY						
IRRITABILITY						
LOSS OF INTEREST OR ENERGY						
MEMORY PROBLEMS						
NIGHTMARES						
OVER EXERCISING						
PARANOID THOUGHTS						
PHYSICAL PROBLEMS, PAIN, OR ILLNESS						
REPETITIVE THOUGHTS OR BEHAVIORS						
REFUSING TO EAT (FEAR OF WEIGHT GAIN)						
SEXUAL WORRIES OR PROBLEMS						

CONTRIBUTING FACTORS

Which of the following do you think contribute to the problem(s)? *(Circle all that apply)*

Family move to a new home	Death of family member or friend	Developmental problems
Birth of child or sibling	Financial stress	Spiritual problems
Parental arguing	Adjustment to school	Dishonesty
Post-divorce adjustment	Law violations	Career change
Martial unfaithfulness	Work problems	Empty Nest
Violence	Medical problems	Drugs or alcohol use
Parenting problems	Anger	Other _____

MENTAL HEALTH HISTORY

Have you been to counseling before? Y N

Therapist	Location	Approximate Dates

Please list any known mental health diagnoses that you were given? _____

_____

Have you ever been in treatment for mental health reasons? Y N

If yes, when, where, and reason: _____

_____

Have you ever been hospitalized for mental health reasons/concerns? Y N

If yes, when, where, and reason: _____

_____

TRAUMA HISTORY

Have you ever experienced the following *(please circle)*:

Car Accident	Domestic Violence	Serious Injury or Illness
Death of Loved One	War	Violence
Emotional Abuse	Terrorism	Bullying
Physical Assault	Natural Disaster	Witnessing a traumatic event
Sexual Abuse/Assault	Child Abuse	Threats
Miscarriage/loss of child	Loss of pet	Homelessness

Other: _____

FAMILY PSYCHIATRIC HISTORY

Do any members of your family (parents, siblings, etc.) have mental health challenges? Y N

If yes, whom and what do they struggle with (ex. depression): _____

_____

Is there any history of suicide in your family? Y N

MEDICAL CONDITIONS AND HISTORY

List any significant health problems, past or present, including surgeries and/or illnesses with

corresponding dates: _____

_____

When was your last Dr's visit approximately? _____

MEDICATIONS (INCLUDING MENTAL HEALTH PRESCRIPTIONS):

Medication	What is it for?	Dose	Prescribing Doctor

Who is your Primary care physician: _____

Primary care clinic and location: _____

Who else do you regularly see as part of your routine for health care? _____

_____

SUBSTANCE USE

Do you consume alcohol? Y N

If so, what do you drink, how much and how often? _____

Do you use illegal drugs? Y N If so, what, how much and how often? _____

Have you ever been to treatment for drugs or alcohol? Y N If yes, when? _____

Has anyone complained about your drug or alcohol use? Y N

Have you felt guilty or bad about using drugs or alcohol? Y N

Have you ever been arrested for drugs or alcohol? Y N

FAMILY OF ORIGIN (FAMILY YOU GREW UP WITH)

Name	Relation to you	Age	Gender

What word would you use to describe your family of origin? _____

Do you have any significant issues with anyone in your family of origin? Y N

Is there any significant conflict between other members of your family? Y N

Does anyone in your family abuse drugs or alcohol? Y N

Was there violence in your family home? Y N

FAMILY OF CREATION (FAMILY YOU CREATED — partner/spouse and/or children)

Name	Relation to you	Age	Living with you?
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N

What word would you use to describe your family of creation? _____

Do you have any significant issues with anyone in your family of creation? Y N

Is there any significant conflict between other members of your family? Y N

Does anyone in your family abuse drugs or alcohol? Y N

Was there violence in your family home? Y N

SOCIAL HISTORY

Who do you consider a part of your support system?

First name	Relationship (ex. friend, sister)	Age	Gender

What type of activities do you like to do with your friends? _____

_____

How often do you go out with your friends? _____

DEVELOPMENTAL HISTORY

To your knowledge, were there any complications when your mother was pregnant with you? Y N

If yes, please describe: _____

Do or did you have any developmental disabilities or challenges? Y N

If yes, please describe: _____

EDUCATION AND WORK HISTORY

Employment Status: Employed (full/part) Unemployed Stay-at-home parent

Occupation: _____ Employer: _____

Are you currently attending school? Y N

If yes, where? _____

What are you studying? _____

Highest level of education: Grade _____ High school College Graduate Degree

If college, what was your major/degree? _____

LEGAL HISTORY

Have you ever been arrested? Y N

If so, please explain: _____

Are you currently on probation or parole? Y N

If so, who is your PO? _____

PERSONAL STRENGTHS

According to yourself and others, what are your best personal qualities? _____

_____

_____

What activities do you enjoy and feel you are successful at when you try? _____

_____

OTHER

Is there anything else you would like your therapist to know? Y N

_____

_____

_____

PARENT/GUARDIAN (IF APPLICABLE) CONTACT INFORMATION

Parent/ Gardian: _____ Phone: _____

Parent/ Gardian: _____ Phone: _____

EMERGENCY CONTACT PERSON:

Name: _____ Relation to client: _____

Phone number: _____

By providing an emergency contact person, you are giving permission to contact them in case of emergency. An example of an emergency is if the therapist has concern for your safety or others.

SIGNATURE AND DATE

"I acknowledge that the information on this form is accurate to the best of my knowledge, and that I will inform my therapist of any changes in my personal information":

Client/Parent/Guardian Signature: _____ Date: _____

Thank you for choosing Serenity Circle Counseling

Guidelines for Therapy

Therapy is a process that allows you the freedom and privacy to discuss issues that may be painful or difficult to discuss with family and/or friends.

The following are a few suggestions to help make your counseling experience most effective:

- When questions, topics or issues arise that you would like to focus on in your sessions, write them down and bring them to your next scheduled appointment.
- Communicate your expectations to your therapist so that we are working together toward your goals.
- Provide ongoing feedback to me so that I know how you are doing (example, "I want to focus on my anger more" or "I like doing relaxation exercises").
- If you feel a need to increase or decrease the frequency of your sessions, or to end counseling, feel free to communicate that to your therapist.
- If you feel the need to bring a partner, relative, or friend in with you for your sessions in order to work on interpersonal issues, feel free to do so. Please discuss it with your therapist prior to their arrival.
- If you have another professional involved in your care (i.e., physician, chiropractor, attorney, etc.), your therapist would be happy to coordinate with him/her if you wish. It is not advisable to have more than one mental health counselor involved in your treatment at one time (unless for another goal such as couples counseling).
- Try to make a commitment to yourself to remain in therapy and attend regular sessions for as long as you feel necessary. If you wait until you have a crisis, it will be more difficult to build long-lasting coping skills.
- If for any reason you or another family member would like to see a different therapist, please feel free to tell your therapist. She can provide you with names of other therapists.

Expectations of You

- Be honest and open.
- Trust in the process.
- Show up for all of your appointments on time.
- Work towards the therapeutic goals as outlined in the treatment plan.
- Allow at least 24-hours notice for canceling or rescheduling your appointment in order to avoid getting charged for the session.
- Refrain from wearing strong perfumes or lotions to session due to allergies

Introduction To The Therapeutic Process

Intake	Background and information gathering;
Assessment	Gathering of additional information regarding presenting problem, family background personal history, relationship dynamics, etc.;
Treatment Planning	Goals for therapy set;
Intervention(s)	Sessions and homework utilized to attain those goals;
Termination	Summary of your accomplishments and future recommendations.

There are certain circumstances where we may need to refer you. If this is necessary, we will assist you with the referral. The following are examples of times where we may need to refer:

- ✓ A conflict of interest.
- ✓ Recommending a specialist for presenting problem(s).
- ✓ Psychological or Psychiatric evaluations.
- ✓ Not progressing towards therapeutic goals

INFORMED CONSENT STATEMENT

Description of Services

Welcome to Serenity Circle Counseling, an in office psychotherapy clinic. Therapy is an interactive process and many different methods may be used depending on the presenting issue(s). At times there may be homework requested to be completed between sessions for purposes of gathering more information.

Each session is 45 or 55 minutes. Clients are generally seen on a weekly or every other week basis. Therapy will be evaluated frequently and sessions may increase or decrease depending on need.

The therapeutic process is one of trust, respect and growth, encouraging the individual to examine feelings and thoughts and to change behaviors. Some of these changes may be uncomfortable for you and for those close to you. If this happens during treatment, you are encouraged to discuss this with your therapist.

Psychotherapy is not an exact science and outcomes cannot be guaranteed. Most therapeutic methods and techniques do not have generally recognized standards. However, based on your therapist's experience, he/she will utilize the best methods known for your presenting problem(s). Unless court ordered, therapy is voluntary and you have the right to terminate therapy at any time. We do encourage you to discuss this with your therapist first in order to discuss and risks or benefits of stopping treatment.

Expectations of You
In return, you agree to show for your appointments, be open and honest, to pay your bill and to work toward the therapeutic goals you outline with your therapist. If you do not show for a session and do not make contact with your therapist, you will be taken off of the schedule.

Allergy Possibility
Occasionally one of the therapists brings her therapy dog, Daisy, to the office. Vanilla melts are occasionally used in session.

Privacy Policy
State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights and our duties. We are required to abide by these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information
Information about you may be used by the personnel associated with this clinic for diagnosis, treatment planning, treatment and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals and interns. We may also disclose information to mental health professionals and interns or business associates affiliated with this clinic such as billing, quality enhancement, training, audits and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client, the client's legal guardian or personal representative. It is the policy of this clinic not to release information about a client without a signed release of information except in certain emergency situations or exceptions, these situations are noted below and there may be other provisions provided by legal requirements.
Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person or persons, the therapist is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the therapist is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Public Safety
Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military and when complying with worker's compensation laws.

Abuse
If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the therapist or mental health professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and aid in the capture of the perpetrator.

Prenatal Exposure to Controlled Substances
Mental health professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death
In the event of a client's death, the spouse or parent of a deceased client has a right to access their child's or spouse's records.

Professional Misconduct
Professional misconduct by a mental health professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the mental health professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings
Mental health professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. However, parents or legal guardians would be encouraged you to talk with your therapist before doing so, breaking the minors privacy could hinder the therapeutic process; the risks and benefits should be discussed.

Other Provisions
Payment for services are the responsibility of the client, or a person who has agreed to provide payment and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) are not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time frame and the name of the clinic or collection source.

Insurance companies, managed care and other third-party payers are given information that they request regarding services to the client. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures.

In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality.

Your Rights
You have the right to request to review or receive your medical files. The procedure for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by a custodial parent or legal guardian. The charge for this service is $.50 per page, plus postage.

You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing. You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them. You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing.

You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file. You have the right to know what information in your record has been provided to whom by requesting this in writing.

Complaints
If you are dissatisfied with the services you receive, you should first discuss your concerns with your therapist. Your therapist needs honest feedback to be most effective. If you are uncomfortable doing this, you may submit a complaint to the Minnesota Board of Marriage and Family Therapy. If you file a complaint we will not retaliate in any way. Direct all correspondence to:

Serenity Circle Counseling 200-5th Street NW, Ste E, Elk River, MN 55330

PLEASE NOTE

Due to allergies:

please do not wear perfumes or scented lotions to session and please do not smoke immediately prior to your counseling session

LIMITS OF CONFIDENTIALITY

Under the rules governing Marriage and Family Therapists in the state of Minnesota, a therapist, and employees and professional associates of the therapist, must not disclose any private information that the therapist, employee, or associate may have acquired in rendering services except as follows.

- When the Board of Marriage and Family Therapy is reviewing a therapist. The Board shall be allowed access to records of a client treated by a therapist under review if the client signs a written consent permitting access. If no consent form has been signed, the hospital, clinic, or licensee shall first delete data in the record that identifies the client before providing it to the board.
- When disclosure is required by state law like prenatal exposure to drugs and alcohol, reports of child abuse and neglect and vulnerable adults abuse and neglect.
- When failure to disclose the information presents a clear and present danger to the health or safety of an individual.
- When the person, employee, or associate is a defendant in a civil, criminal, or disciplinary action arising from the therapy.
- When the patient is a defendant in a criminal proceeding and the use of the privilege would violate the defendant's right to a compulsory process or the right to present testimony and witnesses in that person's behalf.
- When a patient agrees to a waiver of the privilege accorded by this section, and in circumstances where more than one person in a family is receiving therapy, each such family member agrees to the waiver. Absent a waiver from each family member, a marital and family therapist cannot disclose information received by a family member.

All other private information can only be disclosed only with a written release of information from the client.

Serenity Circle Counseling 200 5th Street NW, Ste E, ELK RIVER, MN 55330 (612) 701-9689

CLIENT BILL OF RIGHTS

Consumers of professional counseling services have the right to:

1. expect that the provider has met the minimal qualifications of training and experience required by state law;
2. examine public records maintained by the Board of Marriage and Family Therapy or the Board of Behavioral Health and Therapy that contain the credentials of the provider;
3. obtain a copy of the Rules of Conduct from Minnesota's Bookstore, Department of Administration, 660 Olive Street, St. Paul, MN 55155, or its current location;
4. report complaints to the Board of Marriage and Family Therapy or the Board of Behavioral Health and Therapy;
5. be informed of the cost of professional services before receiving the services;
6. privacy as defined and limited by rule and law;
7. be free from being the object of unlawful discrimination while receiving counseling services;
8. have access to their records as provided in part 2150.7520, subpart 1, and Minnesota Statutes, section 144.292, except as otherwise provided by law;
9. be free from exploitation for the benefit or advantage of the provider;
10. terminate services at any time, except as otherwise provided by law or court order;
11. know the intended recipients of assessment results;
12. withdraw consent to release assessment results, unless this right is prohibited by law or court order or is waived by prior written agreement;
13. a nontechnical description of assessment procedures; and
14. a nontechnical explanation and interpretation of assessment results, unless this right is prohibited by law or court order or this right was waived by prior written agreement

NOTICE OF PRIVACY RIGHTS

This notice, effective April 14, 2003, describes how health information and other private information about you may be used and

shared with others and how you can get access to this information. Please review it carefully.

You have privacy rights under the Minnesota Government Data Practices Act and the Federal Health Insurance Portability and Accountability Act (HIPAA). These laws protect your privacy, but also let us give information about you to others if a law requires it. We must tell you before we give the information.

What is Private Health Information (PHI)?

- Information about your mental or physical health, health care services, or payment for health care services.
- Information that identifies you or could be used to identify you, such as address, phone number, social security number, age, date of birth, names of family members, and health history.
- Information that is shared by you, created by Serenity Circle Counseling staff, or shared with us by related organizations.

Why do we ask you for this information?

- To determine if we are able to provide the treatment that you need, to develop treatment plan with you, and to give you mental health treatment.
- To collect payment from insurance companies, HMOs or other payment sources.
- To assist in carrying out administrative, financial, legal and quality improvement activities necessary to run Serenity Circle Counseling and to support the core functions of treatment and payment.

Do you have to answer the questions we ask?

- There is no law that says you must give us any information. However, if you choose not to give us some information, it can limit our ability to serve you.
- If you are here because of a court order, and you refuse to provide information, that refusal may affect your status with the court.

When Serenity Circle Counseling may use and share your PHI with others:

With Your Permission:

- Treatment. To provide, coordinate, or manage mental health care and related services for you and to ensure that you are receiving appropriate and effective services. For example, we share information and consult with your other service providers.
- Serenity Circle Counseling Operations. To assist in carrying out administrative, financial, legal and quality improvement activities necessary to run our business and to support the core functions of treatment and payment.
- Payment. To obtain payment or reimbursement for services provided to you. For example, we may need to disclose PSI to determine whether insurance will cover your treatment.
- Business Associates. Our business associates perform some health care administration and operation activities for us. An example of a business associate is our billing service. We may disclose private information to our business associates so that the can perform the job we have asked them to do. We require our business associates to protect PHI and to follow our privacy practices.
- Individuals involved in your care or payment for your care. We may disclose health information to a family member, service provider, relative or any person you identify, who is, based on your (or your guardian's) judgment, believed to be involved in your care or payment related to your treatment.

Without your permission, we may use and disclosure PHI for these reasons:

- As required by law. We must disclose PSI about you when required to do so by law or legal statute.
- Abuse or Neglect. We may make disclosures to government authorities or social service agencies as required by law in the reporting of abuse, neglect, or domestic violence.
- To avert serious threat to public health and safety. We may disclose PHI to avoid a serious and imminent threat to your health or safety or to the health or safety of others.
- Legal proceedings. We may disclose PHI for a judicial or administrative proceeding in response to a court order, written notice, or protective order.
- To government agencies for compliance purposes. We may use or disclose PHI to the Secretary of Health and Human Services to assist with a complaint investigation or compliance review.
- For client and community safety purposes, it is likely that we will report the client's name, history of harmful behaviors and functional level to local authorities. Also, any criminal activity engaged in at Serenity Circle Counseling will be reported to local authorities.

Your written permission

We are required to get your written permission (authorization) before using or sharing your PHI for purposes other than those provided above, or as otherwise permitted or required by law. If you do not want to authorize a specific request for disclosure, you may do so without fear of being treated poorly.

You may withdraw your permission

If you do provide your written authorization and later want to take it back, you may do so in writing at any time. As soon as we receive your written revocation, we will stop using or sharing the PHI specified in your original authorization, except to the extent that we have already used it based on your written permission.

You have the right to the information we have about you

- You may ask to see any information we have about you and get copies. You may have to pay for the copies.
- You may give other people permission to see and have copies of private information about you.
- You may question the accuracy of any information we have about you.
- You have the right to ask us to share mental health information with you in a certain way. For example, you may ask us to send information to your work address instead of your home address. You must make this request in writing. You do not have to explain why you are making the request. If we find that your request is reasonable, we will grant it.
- You can ask us to restrict uses or disclosures of your health information. Your request must be in writing. You must explain what information you want to restrict from being disclosed and to whom you want these restrictions to apply. You can request to end these restrictions at any time by writing to us. We are not required to agree to your restrictions.
- You have a right to receive a record of the people or organizations with whom we have shared your health information. We must keep a record of each time we share your health information from April 14, 2003. This record will NOT include those times when we have shared your information in order to treat you, bill for your services or to run our programs. If you want a copy of this record, you must send a request in writing to our HIPAA Officer.
- If you do not understand the information, you may ask to have it explained to you.

What if you believe the information we have about you is wrong?

Send us your concerns in writing, telling us why the information is not accurate or complete. You may send your own explanation of the facts you disagree with. Your explanation will be attached any time that information is shared with another agency.

Filing a complaint about your health information rights

If you believe your privacy rights have been violated, you can file a complaint with our HIPAA Officer or with the United States Department of Health and Human Services at:

HIPPA Officer
Serenity Circle Counseling
401 E. Dual Blvd, Ste 120
Isanti, MN 55040

Medical Privacy Complaint Division
Office for Civil Rights
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019

We cannot deny you services or treat you poorly because you have filed a complaint against us. If you have any questions about this information, ask any Serenity Circle Counseling staff member.

THERAPIST SELF-DISCLOSURE

DEANNA AUSTIN, MA, LMFT

My name is Deanna Austin and I am passionate about what I do. I am a Licensed Marriage and Family Therapist (# 1893) and a board approved Supervisor with the Minnesota Board of Marriage and Family Therapy.

I specialize in helping people heal from trauma; trauma resolution. Some traumatic experiences are more obvious, such as a car accident or assault, which are considered the "big T" traumas. However trauma can happen from a variety of circumstances. Some "smaller t" traumas can include: bullying, a demeaning comment made years ago, or feeling unimportant in a significant relationship. The majority of people have trauma in their history and don't even realize it. Counseling can help discover and fix where the actual problem lies, and not just the symptoms. Although I may pull from different therapeutic modalities, my primary focus for trauma is EMDR (Eye Movement Desensitization and Reprocessing, see www.emdria.org). Occasionally I will be seeking professional consultation regarding cases.

TRACI PAGE, MA, LPCC, LADC

I, Traci Page, am a Licensed Professional Clinical Counselor (LPCC license number 940) and a Licensed Alcohol and Drug Counselor (LADC license number 303916). I work with adults and teens in the areas of anxiety, depression, trauma, domestic violence and substance abuse. I come from a strength-based, family systems approach with clients' goals in mind. I specialize in treating clients with Co-Occurring disorders (Mental illness and chemical dependency). I work collaboratively with clients to develop the tools and skills to help them find solutions to stressors they are dealing with, whether that is mental health symptoms, substance use or both.

Traci Page is an independent contractor for Serenity Circle Counseling. Traci accepts Blue Cross/Blue Shield, Cigna, Health Partners, Medica, Preferred One, and Ucare insurances.

CAROL DOBSON, MDIV, LAMFT

I love walking along side of individuals, couples, and families as they reach out for change, healing, and hope. I use a family systems perspective while working with people who have relationship, grief, trauma, pregnancy, adoption, anxiety, and depression issues. I have had training in crisis intervention, brainspotting, and am a certified Prepare and Enrich facilitator.

Carol completed her post-graduate certificate in Marriage and Family Therapy at Bethel Seminary and is a Licensed Associate Marriage and Family Therapist. Carol is happy to be working as an independent contractor under supervision at Serenity Circle Counseling at the Elk River office. Carol accepts Blue Cross/Blue Shield, Medical Assistance, Preferred One, and Ucare insurances; as well as self pay (cash, check, credit/debit cards).

ASHLEY VOGEL, LPCC, LADC

Through compassion and empathy, I value creating a safe and comfortable therapeutic environment. I am a Licensed Professional Clinical Counselor (LPCC) & a Licensed Alcohol & Drug Counselor (LADC). I am passionate about working with individuals, couples, and families in the areas of mental health and chemical dependency. I have experience working with individuals struggling with grief, shame, anxiety, depression, attachment, bipolar, schizophrenia, and other mental health issues. I also complete chemical dependency assessments (Rule 25). Ashley is an independent contractor at the Isanti office location.

KATHRYN SCHESSO, LMFT

Kathryn is a Licensed Marriage and Family Therapist and has experience working with children, teens, adults, couples, and families. Kathryn is an independent contractor at the. Isanti office location. Kathryn accepts Health. Partners insurance; as well as self pay (cash, check, credit/debit cards). Kathryn uses play therapy interventions for children . She sees children 5 years old and older.

FEDERAL TRUTH IN LENDING STATEMENT

Fees for Professional Services

Service/Insurance Code	Description	Unit	Rate

90791	Intake/Assessment	53-55 min	$195
90834	Individual Therapy	38-52 min	$155
90846/90847	Family Therapy	45-53 min	$175
Self Pay	Couples/Family Therapy with Intern	53+ min	$75
90837	Individual Therapy	53+ min	$175
90832	Individual Therapy	16-37 min	$135
90853	Group Therapy	50-60 min	$50
90785	Complexity Add-on	n/a	$25
90839/90840	Crisis Session	60 min/30 min	$195/$135
96127	Brief assessment	n/a	$10
Not billable to insurance	Late Cancel/No show	n/a	$45
Not billable to insurance	Returned Check Fee	n/a	$25
Not billable to insurance	Phone call/letters/reports	15 min	$25
Not billable to insurance	Court prep, appearances, drive time. (If a whole day of sessions is canceled, 8 hours will be billed.)	per hour	$175
Not billable to insurance	Mileage	1 mile	$0.56

ALL CLIENTS

Payments are due at the time of service. Serenity Circle Counseling accepts cash, check, Visa, Mastercard, and Discover for payment. Make checks payable to *Serenity Circle Counseling*. Serenity Circle Counseling will not hold checks or accept post-dated checks. Clients with Insurance (Co-pays and/or deductibles are due at the beginning of each session, any unpaid balance will be put on your credit/debit card on file.)

PLEASE CALL YOUR INSURANCE COMPANY FOR YOUR BENEFIT COVERAGE PRIOR TO YOUR FIRST APPOINTMENT.

APPOINTMENT POLICY

For you convenience, we will offer you a free appointment reminder via email or text. We require a minimum of 24 hour notice for cancellations or reschedules. We will charge your account a $45 fee for a 38-52 minute scheduled session or $65 for 53+ minute scheduled session for no-shows or cancellations with less than 24 hours notice. Exceptions to this policy include: sickness, severe weather, and emergencies. If you do not show for your scheduled session and do not contact your therapist within 24 hours, you will forfeit your future appointment times. It is your responsibility to contact your therapist directly to insure he/she gets the information in time.

THERAPEUTIC CONTRACT

Client's name (please print) _____ DOB ___/___/___

I understand the **limits of confidentiality**, privacy policies, my (child's) rights and their meanings and ramifications. I understand that outcomes of psychotherapy are **not guaranteed.**

I (we) agree to pay Serenity Circle Counseling **fees** as specified in the Federal Truth in Lending Disclosure Statement for Professional Services.

I understand that I am required to give **24 hours notice via telephone if I need to cancel or reschedule** my appointment; otherwise I will be charged $45 for 45-50 minute session or $65 for 60 minute session.

I understand that unless court ordered, **therapy is voluntary** and I can terminate the therapeutic relationship at any time. I further understand that Serenity Circle Counseling encourages me to talk with my therapist before ending treatment.

I HEREBY CERTIFY that I have received copies of the following, have read and **understand** them, and agree to their contents:

- ☑ Informed Consent Statement
- ☑ Notice of Privacy Practices
- ☑ Limits of Confidentiality
- ☑ Client's Bill of Rights
- ☑ Self-Disclosure of Therapist
- ☑ Federal Truth in Lending Disclosure Statement

BILLING (*please mark one*):

____ **Insurance;** I understand that I am financially responsible for co-pays, deductibles, no-show fees, and any other charges that my insurance provider does not cover and my balance as stated by my insurance company will be **automatically** put on my credit/debit card on file with Serenity Circle Counseling.

____ **Self pay;** I understand that full payment is due the day of session.

Here for (please circle *one)*: Individual Therapy Family Therapy

Can we send correspondence by mail to your home address? YES NO

Client/Parent SIGNATURE: _____

Signed by: ___ Client(s) ___ Parent/Guardian ___ Personal Representative

Therapist Signature _____ Date _____

THIRD PARTY INFORMATION

It is your responsibility to know and understand your benefits for out-patient mental health care services. Please call your insurance company prior to your first appointment for benefit information in order to prevent any financial charges you were not expecting.

Client Name and Date of Birth	
Insurance Company Name	
Policy Holder Name and Date of Birth	
Identification Number	
Policy or Group Number	
Deductible Amount	
Co-Pay Amount	
Have you met your deductible?	

BILLING POLICY

It is Serenity Circle Counseling's policy to bill a client's insurance company, EAP, managed care group, or other paying organization for therapy services performed. Any additional payments (i.e., co-pays, deductibles, etc.) are due prior to therapy. Any balance due after insurance will be automatically put on your credit/debit card on file. Serenity Circle Counseling does not offer payment plans.

All payments collected prior to therapy are estimates based on information received from insurance company/paying organization. Therefore, additional payments may be required (or amounts may be due to the client) based on the accuracy of the insurance company/paying organization's estimate. Benefit information is received prior to sessions and is not a guarantee of coverage from your insurance. Ultimately, the client is responsible for any unpaid claims. Serenity Circle Counseling uses an online billing clearing house, Therapy Notes, this means that employees of Therapy Notes will be able to see a patient's, as well as policy holder's, confidential information for the purposes of billing.

RELEASE/EXCHANGE

I authorize the release or exchange of information from Serenity Circle Counseling to my insurance company, EAP, managed care group, and/or other paying organization to facilitate payment and continued coverage under the mental health benefit of my policy.

ASSIGNMENT OF BENEFITS

I consent to have Serenity Circle Counseling submit claims on my behalf to my insurance company, EAP, managed care group, and/or other paying organization and receive payment according to the guidelines of my policy.

I understand that there may be a limited number of sessions covered by my insurance company, EAP, managed care group, and/or other paying organization. I further understand that in order for sessions to be covered, the identified client will need to receive a mental health diagnosis.

NO SHOW

Serenity Circle Counseling requires a 24-hour notice for cancellation. If notice has not been received, a cancellation fee of $45 (45 minute session) or $65 (55 minute session) will be charged to your account (not covered by insurance).

Signature indicates acceptance and agreement of the above stated Serenity Circle Counseling policies and practices:

_____ _____

Client's/Guardian's Signature Date

Serenity Circle COUNSELING

AUTHORIZATION FOR RELEASE OF INFORMATION

I understand the information released may be subject to release by the person(s)/agency receiving it and no longer protected by the federal privacy regulations. I also understand that I may revoke this authorization by notifying Serenity Circle Counseling, LLC, in writing, of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions taken by Serenity Circle Counseling, LLC in reliance on it before I revoked it. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment. A photocopy of this authorization will be treated in the same manner as the original. This release is active for one year unless I revoke it.

Client Name**:**_____ DOB:_____

Address: _____

I authorize Serenity Circle Counseling, LLC to receive and release information to:

Client's Primary Doctor: _____ and staff at

Clinic name and address: _____

Phone: _____ Fax: _____

How information will be released: ____ verbally and/or ____ in writing

What information is to be released: ___ ALL RECORDS and Ongoing Communication

OR

___ Diagnostic Report ___Treatment Plan ___ Progress Report ___ School Records

___ Testing Results ___Medical History ___ Case Records ___ Family History

___ Psychology Evaluation ___ Psychiatric Evaluation ___ Discharge Summary ___ Other _____

Purpose of this release:

___ Coordination of services ___ Planning appropriate treatment ___ Social service involvement

___ Continue/ follow-up care ___ Case review ___ Other _____

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

___ 200-5th Street, Ste E, ELK RIVER, MN 55330 (612) 701-9689, Fax (763) 244-1243

___ 401 E. Dual Blvd, Ste 120, ISANTI, MN 55040 (763) 600-2911, Fax (763) 244-1243

CLIENT CONSENT FOR USE OF ELECTRONIC COMMUNICATIONS

1. RISK OF USING ELECTRONIC COMMUNICATIONS (EMAILS, TEXTS, ETC.)

Serenity Circle Counseling and it's independent contractors (Provider) offers clients the opportunity to communicate occasionally with her using electronic means (i.e. email, text). Transmitting information electronically, however, has a number of risks that clients should consider before communicating personal information electronically and giving consent to the Provider to engage in two-way electronic communications. These risks include, but are not limited to:

- Email and other electronic communications can be immediately broadcast worldwide and received by both intended and unintended recipients.
- Email senders can misaddress email.
- Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.

2. CONDITIONS FOR THE USE OF ELECTRONIC COMMUNICATIONS

Serenity Circle Counseling and it's independent contractors will use reasonable means to protect the security and confidentiality of electronic communications sent and received. However, because of the risks outlined above, Serenity Circle Counseling and it's independent contractors cannot guarantee the security and confidentiality of electronic communication and will not be liable for improper disclosure of confidential information that is not caused by the Provider's intentional misconduct. Thus, clients must consent to the use of electronic communication with Serenity Circle Counseling and it's independent contractors.

3. EXPECTATIONS FOR ELECTRONIC COMMUNICATION

Electronic communication should only be used by clients for non-urgent matters. Serenity Circle Counseling and it's independent contractors will make every effort to read and return emails and/or texts within 72 business hours. If a matter is regarding a crisis or imminent risk of suicide, individuals should not use electronic communication. Instead they should call 911 or go to their nearest hospital emergency room. No information regarding symptoms or diagnosis will be transmitted through electronic communication means.

CLIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with electronic communication between the Provider and me, and consent to the conditions outlined herein. In addition, I agree to the expectations outlined herein, as well as to any other instructions that the Provider may impose to communicate with clients electronically. Any questions I may have had were answered.

☐ I WOULD LIKE TO ACCEPT TEXTS

☐ I WOULD LIKE TO RECEIVE EMAILS

☐ I WOULD NOT LIKE TO RECEIVE TEXTS OR EMAILS

PHONE NUMBER FOR TEXT APPOINTMENT REMINDERS: _____

EMAIL ADDRESS FOR BILLING: _____

_____ _____

Client Parent/Guardian

THIS FORM IS REQUIRED

CREDIT/DEBIT CARD AGREEMENT

Client Name: _____

It is Serenity Circle Counseling's policy to keep a credit/debit card on file for overdue balances; think of it as a small business way of collections. Please complete this form in full, it is required for services.

I authorize Serenity Circle Counseling to keep my signature on file and charge my credit/check card listed below for any balance applied to my account such as:

- ☑ Session fee, copay or co-insurance (when not paid by other means)
- ☑ No show/cancellations fees (with less than 24 hours notice)
- ☑ Books checked out and not returned
- ☑ Balance due

CREDIT CARD INFORMATION

Cardholder: _____

Billing Address: _____

City: _____ State: _____ Zip code: _____

Email address for electronic bills or receipts: _____

( ) VISA ( ) MASTERCARD ( ) DISCOVER

Credit Card # ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

Expiration Date: _____ / _____ V-Code (3 digit code on back): ____ ____ ____

X _____ _____/_____/_____

Cardholder Signature Date

ANY BALANCE DUE AFTER INSURANCE WILL AUTOMATICALLY BE PUT ON THE CREDIT/ DEBIT CARD ON FILE. SERENITY CIRCLE COUNSELING DOES NOT OFFER PAYMENT PLANS.