Private Pay Intake Form

Attention: Please do not email this form.

Download to your computer, complete, and then upload to the portal you downloaded it from.

Or complete, print, sign and deliver directly to your therapist.

Thank you for choosing Fern Counseling.

This intake form is for clients who choose not to use insurance to pay for their FCTS sessions. This form includes an insurance waiver that ensures you understand that you are foregoing insurance reimbursement.

Please fill all applicable text and click boxes, and please read all informational forms. This PDF should take approximately 20 minutes to complete.

Use your keyboard to fill in where signatures are required. When you upload your document, you will be instructed to electronically sign.

This All-In-One Document Includes:

- Fern Counseling General Intake Questionnaire
- Teletherapy Payment Agreement
- Credit Card Authorization Form
- Health Insurance Waiver
- Patient Rights and HIPAA Authorizations
- Notice of Privacy Practices
- Acknowledgement of Receipt of HIPAA Notice of Privacy Practices
- CAGE-AID Questionnaire
- Columbia Suicide Severity Rating Scale
- World Health Organization Disability Assessment Schedule 2.0 (WHODAS)

Health Insurance Waiver

Fern Counseling recognizes that some clients choose to pay directly for their sessions for a variety of reasons. Your signature of this Health Insurance Waiver indicates that you agree to pay full fees before each session begins. As such, you agree to the following terms an conditions:

1. I am knowingly and actively declining to use my health insurance coverage for services received at Fern Counseling.
2. Fern Counseling is not responsible to bill my health insurance company.
3. I am responsible to Fern Counseling for the full or sliding fee rate assigned to me in accordance to the payment stipulations outlined in Fern Counseling policies.
4. It is my responsibility to submit any receipts, invoices, or other documentation to my health insurance company for reimbursement purposes, application towards my deductible, or for other health insurance company reasons that will benefit me.
5. Fern Counseling will provide me with a superbill to submit to my insurance upon request. I understand that submission for reimbursement through my insurance requires a diagnosis code that will be submitted to my insurance company.

Sign:_____ **Date:** _____

Fern Counseling

Please complete and bring the forms to your first session. Please note, information provided on this form is confidential.

Name: _____ Date: _____

Parent/Legal Guardian (if under 18): _____

Address: _____City: _____ Zip: _____
Text reminders? □ Yes □ No
Phone: cell (___) _____home (___)_____other (___)_____
May we leave a phone message? □ Yes □ No
Email: _____
May we leave a message? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

DOB: _____Age: _____Gender: F □ M □ NB□ T□
Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated
□ Divorced □ Widowed □ Other _____

History
Have you previously received any type of mental health services (psychotherapy, psychiatric, etc.)? □ No □ Yes,
Previous therapist/practitioner: _____

Are you taking any prescribed psychiatric medications □ Yes □ No
Please list:

General and Mental Health Information

1. How would you rate your current physical health?
□ Poor □ Unsatisfactory □ Satisfactory □ Good Very □ good
Please list any specific health problems you are currently experiencing:

-

2. How would you rate your current sleeping habits?
□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Good Very

Any specific sleep issues or other problems you are currently experiencing or would to address?

3. How many times per week do you generally exercise?
What types of exercise do you participate in?

4. Any difficulties with your appetite or eating problems:

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
If yes, for approximately how long?

6. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this?

7. Are you currently experiencing any chronic pain? □ No □ Yes
If yes, please describe:

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never
Any recreational drug use history? □ No □ Yes
please list if yes: _____

10. Are you currently in a relationship? □ No □ Yes If yes, for how long? _____
How would you rate your relationship?
□ Poor □ Unsatisfactory □ Satisfactory □ Good □Very good
please explain any difficulties:

11. Have you had any recent stressful life events, changes, or losses?

Fern Counseling

Please list any family health and/or mental health, or addiction history below:

CLIENT'SFAMILY

Name:	**Relationship to you:**	**Age:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What would you like to address in therapy?

What goals would you like to accomplish in therapy?

Referred by: _____

Is there any other information you would like to share, of feel is important to share? (surgeries, traumas, etc.):

Fern Counseling

Cancellation fee agreement

I agree to a 48-hour notice for non-emergency/illness cancellations or I will be responsible for the full cost of session. I understand that private practice therapists do not get paid if I do not show.

Initials: _____

Illness/Emergencies

From time to time, clients may experience an emergency or serious illness. In these circumstances, Fern Counseling does not charge for late-cancel or missed appointments. However, Fern Counseling reserves the right to decide whether an illness or circumstance constitutes an excusable late cancel or missed appointment.

Initials: _____

Fees for missed therapy

I understand the fee for a missed session or late cancellation will be the full session fee. I understand that Fern Counseling will automatically charge me for missed appointments. I understand I will pay for a full session if I am late to therapy.

Initials: _____

I have read, understand, and agree to the above policy. I understand that I am responsible for canceling my appointments at least 48 hours in advance. I understand that I will be charged automatically by Fern Counseling for the full fee for late cancellations and/or missed sessions.

Sign:_____ Date: _____

For Teletherapy clients

I understand that Fern Counseling will automatically charge me before the start of each teletherapy session. I understand the teletherapy session will not begin without payment. I understand that Fern Counseling will automatically charge me for missed appointments. I understand I will pay for a full session if I am late to therapy.

Sign:_____ Date:_____

Fern Counseling

Credit Card Authorization Form

Fern Counseling requires credit card information and authorization, even if you choose to use other methods of payment. Fern Counseling requires payment at the time of service. Automatic charges will apply for session in which there are: no-shows, late cancellations, and as agreed upon by client as a method of payment. Payment is due before each session. If payment has not been collected by the end of a session; I agree to allow my credit card payment to be made by Fern Counseling. Charges will be run through Square card reader and/or Stripe. Please complete the form below.

Card Type:

□ VISA □ Master Card □ Discover □ AMEX □ Other _____

Card holder Name (as shown on card): _____ Zip code: _____

Card Number 1: _____ Security Code: _____

Card Number 2: _____ Security Code: _____

Expiration Date (card 1) (mm/yy): _____

Expiration Date (card 2) (mm/yy): _____

Your signature below indicates that you have read and understand the payment agreement of charges for: no-shows, late cancellations, and as agreed upon by you, the client.

Sign:_____ Date: _____

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

5. If this office initiated this authorization, you must receive a copy of the signed authorization.

6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes***. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

   In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.

Date: ----------

Signiature : ----------

Notice of Privacy Practices

Health Insurance Portability and Accountability Act (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Fern Counseling Therapy Services (FCTS) understands that health information about you is personal. We are committed to protecting the privacy of your health information by complying with applicable federal and state privacy and confidentiality laws.

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future mental and/or physical health is referred to as Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

FC is required by law to maintain the privacy of PHI and to provide you with notice of its legal duties and privacy practices with respect to PHI. We are required by law to abide by the terms of this Notice of Privacy Practice. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practice by sending a copy to you in the mail upon request or providing one to you at your next appointment. We are also required to notify you if there is a breach of your health information.

FCTS Uses and Disclosures

Treatment, Payment and Health Care Operations

FCTS may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your general consent. To help clarify these terms, here are some definitions and explanations as they relate to our practice:

- PHWE refers to information in your health record that could identify you.
- Treatment is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician.
- Payment is when we obtain reimbursement from insurance companies for your healthcare.
- Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.
- Use applies only to activities within our practice such as sharing, employing applying, utilizing, examining and analyzing information that identifies you.
- Disclosure applies to activities outside of our practice such as releasing, transferring or providing access to information about you to other parties.

Requiring Your Authorization

Fern Counseling Therapy Services (FCTS) may use or disclose your PHI for purposes outside of treatment, payment or health care operations listed above when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances, when we are asked for information for purpose outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We also will need to obtain an authorization before releasing any psychotherapy notes we may have taken in our sessions. "Psychotherapy notes" are notes we have made about our conversation during an individual, couples, family or group psychotherapy session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations of your PHI at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

Requiring Neither Your Consent nor Your Authorization

In general, the law protects the privacy of communication between a client and a therapist. FCTS can only release information about your treatment to others if you sign a release of information form. You can revoke any such authorization at any time in writing. However, in the following situations your authorization is not required for FC to release information:

- When we have our client's written authorization to do so.

- Therapist's duty to warn another in the case of potential suicide, homicide or threat of imminent, serious harm to another individual.
- Therapist's duty to report suspicion of abuse or neglect of children or vulnerable adults.
- Therapist's duty to report prenatal exposure to cocaine, heroin, phencyclidine, methamphetamine, amphetamine or their derivatives, THC, and excesses and habitual use of alcohol.
- Therapist's duty to report the misconduct of mental health or health care professionals.
- Therapist's duty to provide a spouse or parent of a deceased client access to their child or spouse's records.
- Therapist's duty to release records if subpoenaed by the courts.
- Therapist's obligations to contracts (e.g. to employer of client, worker's compensation).
- Therapist's duty to provide parents of minor children access to their child's records. Minor clients can request, in writing, that particular information be disclosed to parents. Such a request should be discussed with the therapist.

Please discuss any questions or concerns you have about confidentiality with your psychotherapist at any time. If you have specific legal questions about the law regarding confidentiality, the exceptions and how it may relate to your situation, please seek formal legal advice form an attorney.

Client Rights and Responsibilities

When it comes to your health information, you have certain rights. This section explains your rights and some of FCTS's responsibilities to help you.

Right to inspect and copy of your mental health and billing records.

- You can inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions for as long as long as the PHI is maintained in the record.
- We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed.
- We will provide a copy or a summary of your therapy within a reasonable time.

Right to amend a therapy record.

- You can ask us to correct health information about you that you think is incorrect or incomplete.
- We may deny your request.
- On your request, FCTS will discuss with you the details of the amendment process.

Right to request and receive confidential communications by alternative means and alternative locations.

- We will agree to all reasonable requests.

Right to request restrictions.

- You can request restriction on certain uses and disclosures of your protected health information.
- We are not required to agree to your request, and we may deny your request if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment with health insurer. We will agree to this request unless a law requires us to share that information.

Right to an accounting.

- You generally have the right to receive an accounting or list of those with whom we have shared information about you without your consent or authorization.
- You may also request why we shared information with them (i.e. billing, mandated reporting etc.)

Right to request a paper copy of this notice.

- You can request a copy of this privacy notice at any time, even if you have agreed to receive the notice electronically. You will also be given a copy at your first meeting. Right to file a complaint if you feel your rights have been violated.

If you disagree with a decision we have made regarding your rights, please contact Fern Counseling, 763-222-5327, so we can discuss your concerns and respond appropriately.

If you believe your privacy rights have been violated and wish to file a complaint, you may do so with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave SW, Washington, DC 20201; calling 1-877-696-6775; or visiting http://www.hhs.gov/ocr/privacy/hipaa/complaints/.

FCTS understands these rights and will not retaliate against you for filing a complaint.

In addition to those rights and expectations mandated by federal, state and local law, FCTS also believes that, as a client, you have the right to know and inquire about the following:

- The cost of psychotherapy, time frame for payment, access to billing statements, billing procedure for missed appointments and any issues related to insurance coverage.
- When the therapist is available and where to call during off hours in case of an emergency.
- The manner in which the therapist conducts sessions concerning intake, treatment and termination. Clients may take an active role in the process by asking questions about relevant therapy issues, specifying therapeutic goals, and renegotiating goals when necessary.
- The nature and perspective of the therapist's work, including techniques used and alternative methods of treatment.
- The purpose and potential negative outcomes of treatment. Clients may refuse any treatment intervention or strategy.
- The anticipated length and frequency of treatment and limitations that may arise due to difficulties in financing.
- The liberty of clients to discuss any aspect of their therapy with others outside the therapy situation, including consultation with another therapist.
- The status of the therapist, including the therapist's training, credentials and years of experience.
- The maintenance of records, including security and length of time they are kept, client's rights to access personal records and release policies.
- The right to request a referral and the right to require the current therapist to send a written report regarding services to the qualified, referred therapist or organization upon the client's written authorization.
- The procedure followed in the event of the therapist's death/illness.
- Be aware of Privacy Practices and HIPAA regulations.
- According to Minnesota law, therapists must provide parents of minor children access to their child's records. The law also states that minor children can request, in writing, that particular information not be disclosed to their parents. Such a request should be discussed with the therapist.

Therapist Rights and Responsibilities

In addition to those rights and expectations mandated by federal, state and local law, FCTS also believes that, we have the responsibility to provide care appropriate to your situation, as determined by prevailing standards. To accomplish this goal, FCTS also has certain rights:

- Follow the NASW Code of Ethics in our professional practice.
- Follow Notice of Privacy Practices and HIPPA regulations.
- The right to information needed to provide appropriate care.
- The right to be reimbursed, as agreed, for services provided.
- The right to provide services in an atmosphere free of verbal, physical or sexual harassment.
- The right and ethical obligation to refuse to provide services which are not indicated.
- The right to change the terms of this notice at any time, with the understanding that we will inform our clients of any changes.

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

This form is an agreement between you, and me. When I use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written the person's name here:

When I examine, test, diagnose, treat, or refer you, I will be collecting what the law calls "protected health information" (PHI) about you. I need to use this information in my office to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let me use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read my notice of privacy practices, which explains in more detail what your rights are and how I can use and share your information.

If you do not sign this form agreeing to my privacy practices, I cannot treat you. In the future, I may change how I use and share your information, and I may change my notice of privacy practices. If I do change it, I will notify you.

If you are concerned about your PHI, you have the right to ask me not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to accept these limitations. After you have signed this consent, you have the right to revoke it by notice in writing. I will then stop using or sharing your PHI.

Date _____

Signature:_____

CAGE-AID Questionnaire

Patient Name:

When thinking about drug use, include illegal drug use and the use of prescription drugs other than prescribed.

Questions:	**YES**	**NO**
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

Date: Client Signature:

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Client Name:

For the following questions, in the past 30 days have you experienced any of the following issues:

1) Wish to be Dead:

Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.

Have you wished you were dead or wished you could go to sleep and not wake up? Yes No

2) Suicidal Thoughts:

General non-specific thoughts of wanting to end one's life/commit suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan.

Have you actually had any thoughts of killing yourself? Yes No

If YES to 2, ask questions 3,4,5, and 6. If NO to 2, go directly to question 6.

3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act):

Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out.
"I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it."

Have you been thinking about how you might kill yourself? Yes No

4) Suicidal Intent (without Specific Plan):

Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "I have the thoughts but I definitely will not do anything about them."

Have you had these thoughts and had some intention of acting on them? Yes No

5) Suicide Intent with Specific Plan:

Thoughts of killing oneself with details of plan fully or partially worked out and persona has some intent to carry it out.

Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? Yes No

6) Suicide Behavior Question:

Have you ever done anything, started to do anything, or prepared to do anything to end your life? Yes No

Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was

grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.

IF YES, ask: How long ago did you do any of these?

Over 1 year ago:
Between 3 months and 1 year ago:
With the last 3 months:

Total Score:

The following form is the World Health Organization Disability Assessment Schedule, also known as the "WHODAS 2.0." This form askes about difficulties due to health and mental 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 of the **past 30 days** and answer these questions, thinking about how much difficulty you had doing the following activities.

WHODAS 2.0

World Health Organization Disability Assessment Schedule 2.0

12-item version, self-administered

Patient Name:

Age:

Sex: Male Female

For each question, please select only **one** response.

Numeric scores assigned to each of the items:		1	2	3	4	5	Raw Item Score
In the LAST 30 DAYS, how much difficulty did you have in:							
S1	STANDING for LONG PERIODS such as 30 MINUTES?	None or can't do	Mild	Moderate	Severe	Extreme	
S2	Taking care of your HOUSEHOLD RESPONSIBILITIES?	None or can't do	Mild	Moderate	Severe	Extreme	
S3	LEARNING a NEW TASK, for example, learning how to get to a new place?	None or can't do	Mild	Moderate	Severe	Extreme	

S4	How much of a problem did you have in JOINING IN COMMUNITY ACTIVITIES (for example, festivities, religious, or other activities) in the same way as anyone else can?	None or can't do	Mild	Moderate	Severe	Extreme	
S5	How much have YOU been EMOTIONALLY AFFECTED by your health condition?	None or can't do	Mild	Moderate	Severe	Extreme	

In the LAST 30 DAYS, how much difficulty did you have in:

S6	CONCENTRATING on doing something for TEN MINUTES?	None or can't do	Mild	Moderate	Severe	Extreme	
S7	WALKING A LONG DISTANCE such as a KILOMETRE [or equivalent]?	None or can't do	Mild	Moderate	Severe	Extreme	
S8	WASHING your WHOLE BODY?	None or can't do	Mild	Moderate	Severe	Extreme	
S9	Getting DRESSED?	None or can't do	Mild	Moderate	Severe	Extreme	
S10	DEALING with people YOU DO NOT KNOW?	None or can't do	Mild	Moderate	Severe	Extreme	
S11	MAINTAINING A FRIENDSHIP?	None or can't do	Mild	Moderate	Severe	Extreme	
S12	Your day-to-day WORK?	None or can't do	Mild	Moderate	Severe	Extreme	

Total Item Score ____ /60

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 TOTAL 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***	

Date: Client Signature:

Attention:

Please do not email this form

Download to your computer, complete, and upload to the portal from which you got it. Or complete, print, and deliver directly to your therapist.