WELL SPRING Family Therapy Center

Shelly Winemiller, LLC, MA, Licensed Marriage & Family Therapist 507-244-0222
Ed Patton, LLC, DMFT, Licensed Marriage & Family Therapist 507-884-6287
Yvette Kidman, MA, marriage therapist 507-259-5210

COUPLES INTAKE FORM

Therapist _____

Please provide the following information for our records.

Information you provide here is held to the same standards of confidentiality as our therapy.

Identified Client: Gender ○M ○ F	**Spouse/Partner:** Gender ○M ○F
Client Name_____	Spouse/Partner Name_____
Street_____	Street_____
City_____ State___	City_____ State___
ZIP_____	ZIP_____
(cell)_____	(cell)_____
(home)_____	(home)_____
Leave message at what #?_____	Leave message at what #?_____
E-mail_____	E-mail_____
May we send statements via e-mail? ☐Yes ☐No	May we send statements via e-mail? ☐Yes ☐No
Date of Birth _____	Date of Birth _____
Employer_____	Employer_____
Do you have an advance directive/living will? ☐Yes ☐No	Do you have an advance directive/living will? ☐Yes ☐No
Emergency Contact Name_____	Emergency Contact Name_____
Emergency Contact Phone_____	Emergency Contact Phone_____
Previous Counselor Name_____	Previous Counselor Name_____
Diagnosis at that time_____	Diagnosis at that time_____

Number of Years Married _____

Are you separated either in-home or physically at this time? ☐Yes ☐No

Referred by _____ How did you hear about Wellspring?_____

Client's insurance carrier is: ☐Mayo Premier(BPRMR) ☐Mayo Select(BMEDS) ☐Mayo Basic(BBASC) ☐BlueCross ☐Medica ☐UCare ☐UMR ☐ Other:_____

Client's insurance MEMBER ID # is _____.

Client's insurance GROUP # is _____. **GROUP Name** _____.

Client's insurance 5-digit "EDI" code (may be listed on back of card) for claim submissions: _____

Spouse's insurance carrier: ☐MayoPremier ☐MayoSelect ☐MayoBasic ☐BC/BS ☐ Other:_____

Spouse/Partner's insurance MEMBER ID number is _____.

Spouse/Partner's insurance GROUP number is _____.

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FOR HUSBAND TO COMPLETE

Are you currently taking prescribed psychiatric medication (antidepressants or others?) ☐Yes ☐No

If Yes, please list what they are: _____

If no, have you been previously prescribed psychiatric medication? ☐Yes ☐No

If Yes, please list what they were: _____

HUSBAND'S OCCUPATIONAL INFORMATION

Are you currently employed? ☐Yes ☐No

If yes, who is your current employer/position? _____

If yes, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

HUSBAND'S HEALTH AND SOCIAL INFORMATION

How is your physical health at present? (please circle or check)

☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____

Are you having any problems with your sleep habits? ☐Yes ☐No

If yes, what problems: ☐Sleep too little ☐Sleep too much ☐Poor quality sleep ☐Disturbing dreams
☐Other _____

How many times per week do you exercise? _____ Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? ☐Yes ☐No

If yes, check where applicable: ☐Eating less ☐Eating more ☐Binging ☐Restricting

Have you experienced significant weight changes in the last 2 months? ☐Yes ☐No

Do you regularly use alcohol? ☐Yes ☐No

In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

How often do you engage in recreational drug use? ☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never

Has anyone told you they were concerned about your alcohol/drug use? ☐Yes ☐No

Have you had suicidal thoughts recently? ☐Frequently ☐Sometimes ☐Rarely ☐Never

Have you had them in the past? ☐Frequently ☐Sometimes ☐Rarely ☐Never

On a scale of 1-10 (with 10 high), how would you rate the quality of your current relationship?_____

In the last year, have you experienced any significant life changes or stressors: _____

_____

_____

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HUSBAND: HAVE YOU EVER EXPERIENCED?

Extreme Depressed Mood	◯Yes ◯No
Wild Mood Swings	◯Yes ◯No
Rapid Speech	◯Yes ◯No
Extreme Anxiety	◯Yes ◯No
Panic Attacks	◯Yes ◯No
Phobias	◯Yes ◯No
Sleep Disturbances	◯Yes ◯No
Hallucinations	◯Yes ◯No
Unexplained Losses of Time	◯Yes ◯No
Unexplained Memory Lapses	◯Yes ◯No
Alcohol/Substance Abuse	◯Yes ◯No
Frequent Body Complaints	◯Yes ◯No
Eating Disorder	◯Yes ◯No
Body Image Problems	◯Yes ◯No
Repetitive Thoughts (e.g. obsessions)	◯Yes ◯No
Repetitive Behaviors (e.g., frequent checking, hand washing, etc.)	◯Yes ◯No
Homicidal Thoughts	◯Yes ◯No
Suicide Attempt	◯Yes ◯No

HUSBAND'S RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? □Yes □No
If yes, what is your faith? _____
If no, do you consider yourself to be spiritual? □Yes □No

OTHER INFORMATION

What do you consider to be your strengths?_____
_____
_____
What do you like about yourself? _____
_____
_____
What are effective coping strategies that you've learned? _____
_____

HUSBAND'S FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (check any that apply and list family member, e.g., sibling, parent, uncle, etc.):

Difficult Family Member	□Yes □No	Relationship:_____
Depression	□Yes □No	Relationship:_____
Bipolar Disorder	□Yes □No	Relationship:_____
Anxiety Disorders	□Yes □No	Relationship:_____
Panic Attacks	□Yes □No	Relationship:_____
Schizophrenia	□Yes □No	Relationship:_____
Alcohol/Substance Abuse	□Yes □No	Relationship:_____
Eating Disorders	□Yes □No	Relationship:_____
Trauma History	□Yes □No	Relationship:_____
Suicide Attempts	□Yes □No	Relationship:_____

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FOR WIFE TO COMPLETE

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If Yes, please list what they are: _____

If no, have you been previously prescribed psychiatric medication? ☐Yes ☐No

If Yes, please list what they were: _____

WIFE'S OCCUPATIONAL INFORMATION

Are you currently employed? ☐Yes ☐No

If yes, who is your current employer/position? _____

If yes, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

WIFE'S HEALTH AND SOCIAL INFORMATION

How is your physical health at present?

☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____

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If yes, what problems: ☐Sleep too little ☐Sleep too much ☐Poor quality sleep ☐Disturbing dreams
☐Other _____

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If yes, check where applicable: ☐Eating less ☐Eating more ☐Binging ☐Restricting

Have you experienced significant weight changes in the last 2 months? ☐Yes ☐No

Do you regularly use alcohol? ☐Yes ☐No

In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

How often do you engage in recreational drug use? ☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never

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Have you had suicidal thoughts recently? ☐Frequently ☐Sometimes ☐Rarely ☐Never

Have you had them in the past? ☐Frequently ☐Sometimes ☐Rarely ☐Never

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_____

_____

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Wild Mood Swings	◯Yes ◯No
Rapid Speech	◯Yes ◯No
Extreme Anxiety	◯Yes ◯No
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Hallucinations	◯Yes ◯No
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Unexplained Memory Lapses	◯Yes ◯No
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Eating Disorder	◯Yes ◯No
Body Image Problems	◯Yes ◯No
Repetitive Thoughts (e.g. obsessions)	◯Yes ◯No
Repetitive Behaviors (e.g., frequent checking, hand washing, etc.)	◯Yes ◯No
Homicidal Thoughts	◯Yes ◯No
Suicide Attempt	◯Yes ◯No

WIFE'S RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? ☐Yes ☐No

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? ☐Yes ☐No

OTHER INFORMATION

What do you consider to be your strengths?_____

_____

_____

What do you like about yourself? _____

_____

_____

What are effective coping strategies that you've learned? _____

_____

WIFE'S FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (check any that apply and list family member, e.g., sibling, parent, uncle, etc.):

Difficult Family Member	☐Yes ☐No	Relationship:_____
Depression	☐Yes ☐No	Relationship:_____
Bipolar Disorder	☐Yes ☐No	Relationship:_____
Anxiety Disorders	☐Yes ☐No	Relationship:_____
Panic Attacks	☐Yes ☐No	Relationship:_____
Schizophrenia	☐Yes ☐No	Relationship:_____
Alcohol/Substance Abuse	☐Yes ☐No	Relationship:_____
Eating Disorders	☐Yes ☐No	Relationship:_____
Trauma History	☐Yes ☐No	Relationship:_____
Suicide Attempts	☐Yes ☐No	Relationship:_____

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COUPLES COUNSELING AGREEMENT

During the course of couple's or family therapy, there may be times when you would like to schedule an individual appointment for yourself. This can be helpful when there are issues you'd like to discuss, but you're not sure how to bring them up in front of your partner or family members. Examples include: problems with work, school, parents, in-laws, ex-spouses, sex, money, alcohol, etc. An individual session can also be helpful when something has been discussed in a couple's or family session that stirs up an issue you'd like to spend more time on.

Your therapist is happy to see you individually, as long as you agree that anything you share in an individual session may be talked about in subsequent couple's or family sessions. This doesn't mean your therapist will necessarily bring up every issue you've talked privately about. It just means you've given your therapist permission to do so if he/she believes it's important to the health of your relationship.

Knowing that your therapist doesn't keep secrets helps everyone feel safer in therapy. It also allows your therapist to be completely honest – without having to worry about who told him/her what, when. If you have any questions about whether a topic is one that will need to be shared with others, please ask your therapist before sharing any details. If you have reservations about raising an issue, he/she will be happy to refer you to another therapist for individual counseling.

This agreement also applies to phone calls and e-mails. If you contact your therapist between sessions, he/she will expect you to let your partner or other family members know you've done so. Contents of your phone calls or e-mails may be shared. By signing this agreement, you're giving your therapist permission to discuss any information shared with him/her privately with all others regularly attending therapy with you.

- **We have received, read and understand the Counseling Agreement and the Privacy Policy.**
- **We have read and agree to abide by the Safety Contract at all times.**
- **We authorize the release of the minimum amount necessary of my personal health information to our referenced insurance company and your therapist's billing company, in order to obtain any reimbursement for services received.**

Husband's Signature _____ Date _____

Wife's Signature _____ Date _____

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TREATMENT PLAN – HUSBAND

Please complete this form as best you can. If you are unsure of your answers, bring your questions in and your therapist will help you complete the treatment plan.

Problems (Why I'm Here):

_____
_____
_____
_____
_____
_____
_____

Goals (What I Want):

_____
_____
_____
_____
_____
_____
_____

Indicators (How Do I Know That I'm Making Progress?):

_____
_____
_____
_____
_____

Estimate – How Long to Achieve Goals_____ (You and your therapist will figure this out.)

Likelihood (0-100%) of Achieving Goals? _____ (You and your therapist will figure this out.)

_____ _____
Client Signature and Date Therapist Signature and Date

Review Dates: _____

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TREATMENT PLAN – WIFE

Please complete this form as best you can. If you are unsure of your answers, bring your questions in and your therapist will help you complete the treatment plan.

Problems (Why I'm Here):

_____
_____
_____
_____
_____
_____
_____

Goals (What I Want):

_____
_____
_____
_____
_____
_____
_____

Indicators (How Do I Know That I'm Making Progress?):

_____
_____
_____
_____
_____

Estimate – How Long to Achieve Goals_____ (You and your therapist will figure this out.)

Likelihood (0-100%) of Achieving Goals? _____ (You and your therapist will figure this out.)

_____ _____
Client Signature and Date Therapist Signature and Date

Review Dates: _____

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FEE POLICY

Client Name _____

Intake Date _____

- The fee of $____ per 55 minute individual, couples, or family session, or $____ for a 2-hour group therapy session, is payable at the beginning of each session, unless other arrangements have been made. You may use cash or check (made out to individual therapist name).
- Insurance coverage differs, so please check with your insurance company to determine your coverage for mental health coverage and whether your therapist is in-network or out-of-network.
- Claims will be submitted to the client's insurance company, if available, but the client is fully and directly responsible to the individual therapist for the payment of services rendered.
- If payment becomes a problem, you are encouraged to discuss this directly with your therapist to consider your options.
- If fees change during the course of treatment, you will be given adequate notice of these changes.
- You will be charged for missed appointments or appointments cancelled with less than a 24-hour notice (except in cases of illness, emergency or severe weather).
- Fees for telephone or interactive internet-based contacts are prorated based on standard hourly fee.
- Overdue payments will be assessed a 5% monthly interest fee.

Check one of the following to indicate you understand the current fee schedule & responsibility for payment:

☐ I give permission for my therapist to contact and submit charges to my insurance company for services provided. **I understand that services may be out-of-network with my insurance company**. I understand that I am responsible to pay the cost of therapy that is not reimbursed by my insurance company (such as deductible, coinsurance, non-covered amounts). At my request, therapist will provide receipts that I may submit for possible medical Flexible Spending Account reimbursement.

☐ I understand that services will be provided on a private-pay basis and that payment is due at the time of service. At my request, therapist will provide a summary receipt that I may submit for possible medical Flexible Spending Account reimbursement.

I understand the current fee policy and have been given the opportunity to discuss my financial situation with my therapist. I understand I will be responsible for all fees as indicated on the current fee schedule and as outlined on this payment contract. I am also aware that I may be charged a late cancel/no-show charge.

_____ _____
Signature of Client or Guardian Date

_____ _____
Signature of Client or Guardian Date

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COUNSELING AGREEMENT

This agreement is designed to help build a positive working relationship between you and your therapist. It also informs you of your rights and responsibilities in the therapy relationship. If you have any questions or concerns, please feel free to discuss them with your therapist.

1. Therapeutic Relationship

The relationship between you and your therapist is very important and is different from other relationships in your life. You are expected to talk freely and openly about yourself, much more so than you do in social relationships. Your therapist's responsibility is to listen, select, sort, make observations, and reflect back to you behaviors, thoughts, feelings, and values or beliefs that will enable you to understand and see yourself more clearly. The goal of this process is the reorganization of your thinking, feelings, and behavior in a manner more satisfying to you. This does not predict, nor guarantee a successful outcome in therapy. While your therapist may suggest changes, only you can choose if those changes are valuable and pertinent, and only you are able to make those changes.

You and your therapist will work together to establish goals for therapy and this will be the focus of your initial session which is something that will continue to be revisited. Therapy can be a very intense experience and sometimes painful. But therapy is also very supportive and reassuring, with very rewarding, life changing outcomes.

2. Supervision

Ed Patton has completed his graduate degree in Master of Arts in Psychotherapy but is not yet licensed therapist. He has accumulated the required 2000 hours of clinical counseling as required for licensure (LMFT) in the state of Minnesota and anticipates licensure to be completed in late 2013. Roger Ballou, LMFT and Peg Roberts, LMFT are supervising Ed, so your case may be discussed with either of these supervisors individually or in the group supervision sessions required by the state licensing board. Your identity will be protected in accordance with all governmental and ethical regulations.

3. Appointments

Appointments are typically 50 to 80 minutes in length. You and your therapist will work together to personalize a schedule to fit your needs.

4. Cancellation Policy

If you need to cancel an appointment for any reason, please do so at least 24 hours in advance. **You will be charged a full fee for appointments not canceled within 24 hours.**

5. Confidentiality

Client information is kept strictly confidential and the release of information about you to anyone can only be done with your written consent. Because therapists are all mandated reporters, state law, however, places certain limitations on the right of confidentiality (see also Notice of Privacy Rights attached):

- Threats of suicide
- Threats of harming another person
- Any incidence or knowledge of suspected neglect, physical, or sexual abuse of children and/or vulnerable adults

During professional consultation, the therapist may discuss facts in a case, but the identity of the client will remain confidential.

When meeting as couples and/or families, it may be helpful to meet with your therapist individually. If individual sessions are scheduled, no confidences will be held by the therapist. Your therapist reserves the right to

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use his/her best judgment to share pertinent information, or will ask the individual to share the information, in the best interest of the marriage or family.

For couples and families, in order for information to be shared between your therapist at Wellspring and another individual, we require a signed release of information from both or all parties.

When children are being seen by a therapist, the custodial parent(s) will be informed of their child's progress for children under 18 years of age.

6. Fees

Payment of fees is expected at the time of each session. You may use cash, check (or credit card for Shelly). Insurance coverage differs, so please check with your insurance company to determine your coverage for mental health coverage and whether your therapist is in-network or out-of-network. Upson request a receipt will be provided that may be submitted for possible Flexible Spending Account or other reimbursement.

Overdue payments will be assessed a $5.00 fee for each month the payment is overdue. There is a charge for written reports of files based on an hourly fee structure. Your therapist will give you a 30-day notice if fees change.

In court cases, you are encouraged to pass information on to lawyers and the court through written reports, which can be generated by your therapist at the hourly fee rate. If your therapist is asked to do a deposition or appear in court, the fees are $350 per hour plus a mileage fee of $0.75 per mile

7. Hours & Emergencies

After normal business hours, you may try to contact your therapist by leaving phone messages on his/her number as listed above. Messages are retrieved regularly throughout the weekdays but not consistently after hours. If you need immediate assistance, please call 2-1-1 (United Way's Alliance of Information & Referral), or Olmsted County Crisis Services hotline at (507) 281-6248, or call 9-1-1, or go to the nearest hospital emergency room.

8. Wellspring Family Therapy Center, LLC

Wellspring Family Therapy Center, LLC is a limited liability corporation. Although you may see one or more therapists working under the name, each therapist has an independent practice and is covered individually with their own private liability insurance. If you have questions or concerns about your therapy process, please contact your therapist directly.

9. Complaints

You are urged to discuss with your therapist any questions, concerns, or problems you may have about the therapy you receive. Often times, part of the therapeutic relationship involves working through misunderstandings or misconceptions. You also have the right to file a complaint with your therapist at: Wellspring Family Therapy Center, 1530 Greenview Drive SW, Rochester, MN 55902, or the Minnesota Department of Health at: 121 East 7th Street, St. Paul, MN 55101, 612.623.5522.

10. Therapy Session

An important aspect of therapy is the relationship that develops between you and your therapist. As with any new relationship, it takes some time to trust and feel safe. If the relationship does not develop after a reasonable amount of time (three to four sessions), you may want to talk with your therapist about it and a referral can be made. Your therapist will be happy to help with this.

The therapeutic relationship is unique in that you will be focusing on aspects of yourself that may not ordinarily receive attention. The therapeutic approach used by the therapist comes from a variety of psychological theories. For those clients wishing to address spiritual concerns, an eclectic approach from an ecumenical Christian perspective will generally be utilized. As each client is different, each session varies depending on the needs of the client and the goals set by the client and therapist.

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The therapist will work with the client towards healthy development, meaningful and satisfying relationships, and address conflict between mind, body, and spirit. The intention is to address relationship issues, behavioral problems, family-of-origin concerns, destructive thought patterns, and spiritual issues. Core values and beliefs are identified and based on the issues of concern your therapist will help with insight and observations where needed. Your therapist will strive towards a safe environment in which clients can talk freely and openly about their concerns.

Therapy is a process. Initially you may feel uncomfortable, even anxious, about talking about sensitive issues. This anxiety begins to reduce as the relationship between you and your therapist develops and trust builds. As you learn new ways to interact with yourself and others, these new ways to interact may feel uncomfortable. Sometimes things seem to get worse before they get better. This is expected and typical of everyone making life adjustments.

One of the most growth-producing times for the client can be when he/she expresses anger with the therapist. This expression of "owning" one's feelings and having the therapist respect them often results in a very affirming experience for the client. Your therapist is open to hearing about your concerns and feelings.

It is critical to stay with the therapy even during these uncomfortable times. Once you get through this phase, and as we discuss the emotions around these issues, you should begin to feel more comfortable. During this stage, you will continue to apply the new skills and you will feel more courageous in meeting problems directly. As you near the end of therapy, you and your therapist will discuss discontinuing the therapy, with the understanding that you can choose to return any time if you feel the need.

11. Therapy Techniques

Each therapist at Wellspring Family Therapy Center uses a combination of psychotherapy techniques. These include Cognitive Behavioral Therapy (addressing negative thoughts, feelings and behavior), Psychodynamic Therapy, Emotionally-focused Therapy, Systems Approach, Virginia Satir Change Process, and Solution-Focused Therapy, among others. If you have questions, please ask your therapist directly and he/she can explain things more thoroughly.

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PRIVACY POLICY

The privacy of your medical information is important to your therapist(s), with the understanding that this information is personal. Therefore, we are committed to protecting it. To comply with certain legal requirements, your therapist creates an individual record of the care and services you receive to better provide you with quality care. This notice details the ways that your medical information may be used or shared. Furthermore, it describes your rights and certain duties we have regarding the use and disclosure of medical information. This notice is effective April 14, 2003.

1. Uses of Information Obtained From You: The information your therapist obtains from you is used to establish diagnosis, determine your treatment plans and goals, provide the services you request, and establish your ability to pay for these services.
2. Therapist's Legal Responsibility: The law requires your therapist to keep your medical information private, give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information, and to follow the terms of the notice that is now in effect.
3. Patient Rights: Effective April 14, 2003, the 45 CFR Health Insurance Portability and Accountability Act (HIPAA) went into effect with rules on not only disclosure but also on the use of patient information. Under this Act clients, must be given a Notice of Privacy Practices upon the arrival of their first service. The following list of rights now applies to any patient of a health care provider:
    a) Right to Request Medical Records: The patient has a right to access their medical records.
    b) Right to Request Additional Restrictions: You may request restrictions on the use and disclosure of protected health information for treatment, payment, and health care operations. While your therapist will consider all requests for additional restrictions carefully, they are not required to agree to a requested restriction. If you wish to request a restriction, please make a request in writing and submit it to your therapist, who will send you a written response.
    c) Right to Receive Confidential Communications: You may request, and your therapist will accommodate, any reasonable (written) request for you to receive protected health information by alternative means of communication or at alternative locations.
    d) Right to Inspect and Copy Your Health Information: If you desire access to your records, please make a written request to your therapist. If you request copies, there will be a $2.00 charge per page. Please note, under limited circumstances your therapist may deny you access to a portion of your records.
    e) Right to Amend Your Records: You have the right to request that your therapist amend protected health information maintained in your clinical file or billing records. If you desire to amend your records, please request in writing the amendment and submit it to your therapist. Under certain circumstances, he/she has the right to deny your request to amend your records and notify you of this denial as provided by the HIPAA regulations. If your requested amendment to your records is accepted, a copy of your amendment will become a permanent part of the medical record. By "amend," your therapist is permitted to append information to the original record, as opposed to physically remove or change the original record.
    f) Right to Receive an Accounting of Disclosures: Upon request, you may obtain an accounting of disclosures of your protected health information other than those for which you gave written authorization or those related to your treatment, payment for services, or health care operations. The accounting will apply only to covered disclosures prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, a charge may apply. You will be informed of the cost prior to the request being filled.
    g) Right to Receive a Paper Copy of this Notice: Upon request, you may obtain a paper copy of this privacy notice.

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Ed Patton, LLC, DMFT 507-884-6287
Yvette Kidman, MA, marriage therapist 507-259-5210

4. Use and Disclosure of Your Medical Information With Written Consent: Your therapist is permitted to use and disclose information about you for treatment and/or services to doctors, nurses, psychiatrists, psychologists, other mental health professionals. Also included are other people in charge of your care or health care professionals assisting in your treatment. Your therapist may also use and disclose your medical information for payment purposes to insurance companies for disability payments, etc. Furthermore, he/she may also use information for healthcare operations that may include information disclosed to business associates such as billing software providers or transcriptionists.
5. Use and Disclosures With Neither Consent Nor Authorization: According to state and federal requirements, your therapist is mandated to report information he/she maintains about you to other agencies or individuals without your written consent under the following circumstances:
    a) If your therapist has reason to believe there has been:
        - abuse of a child or vulnerable adult.
        - victimization due to violence.
        - victimization due to other crimes.
        - potential or intention to seriously harm another person, they may have a legal obligation to warn the intended victim and/or the police.
        - the possibility a pregnant woman has used a controlled substance (e.g., cocaine, heroin) for a non-medical purpose during the pregnancy.
    b) If it is court-ordered.
    c) If a non-custodial parent requests information, they may receive information about your therapist's services for their child, but not about services to the other parent.
    d) If there is an emergency, your therapist may communicate your condition to a family member or other appropriate persons.
    e) If your account is delinquent, your therapist may attempt to obtain reimbursement through small claims court or to collection agency. Your therapist may also report delinquent accounts to credit bureaus.
    f) Examination of records for an audit or accreditation.
    g) To meet federal, state, and local statistical requirements.
    h) If a new statute, federal law, or State Commissioner of Administration authorizes a new use of the information after you had been given this notice.
6. Regarding Minors: Minnesota State Law authorizes that a minor has the right to request the private data about them be kept from their parents. This request will be honored if your therapist believes it will protect the child from physical or psychological harm.
7. Providing Information About You: You are not required to provide information about yourself; however, without some information your therapist may not be able to provide the most appropriate services. If you are here because of a court order, and you refuse to provide information, that refusal may be communicated to the court.
8. Right to Change Terms of this Notice: Your therapist may change the terms of this notice at any time. If this notice is changed, your therapist may make the new notice terms effective for all protected health information that is maintained, including any information created or received prior to issuing the new notice. If your therapist changes this notice, they will post it in public access areas, or give you a copy of the updated notice.
9. Complaints: If you desire further information about your privacy and confidentiality rights, or are concerned that your rights may have been violated, or disagree with a decision that was made about access to your protected health information, you are encouraged to contact your therapist directly. You may also file a written letter of complaint with the Secretary of the Department of Health and Human Services. Your therapist(s) will not retaliate against you if you file a complaint.

WELL SPRING
Family Therapy Center

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SAFETY CONTRACT

All of us at Wellspring Family Therapy Center very much value your personal safety at all times. This is an important and heartfelt concern that we take very seriously -- both professionally and personally. To that end, we have developed this Safety Contract for you to review, sign, and refer to in the future throughout our time together.

Sincerely,
Shelly Winemiller, Ed Patton, Yvette Kidman

1. My comments and conduct during sessions should never be attacking or threatening, but rather constructively focused. If I am ever feeling attacked or threatened by anyone during a session, I will discuss my concerns with my therapist.
2. If at any time I am feeling hopeless, despondent, or like I may want to give up, I will let my therapist know.
3. If I ever have thoughts or plans about ending my life or hurting someone else, I will dial 911 to get professional help immediately.
4. If I express a specific intention of harming myself or hurting someone else, I understand that my therapist is obliged to break confidentiality in order to provide safety to myself and others around me.

I agree to abide by this Safety Contract at all times, both during and between sessions.

_____ _____
(Client signature) (date)

_____ _____
(Spouse signature) (date)

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*The following questions are for **the identified CLIENT** to complete. Responses you provide to these outcomes measures is held to the same standards of confidentiality as our therapy. Your therapist may periodically ask you to complete these measures in the future.*

Client Name _____ Today's Date: _____

Please respond to each question or statement by marking one box per row.

		Excellent	Very good	Good	Fair	Poor
Global04	In general, how would you rate your mental health, including your mood and your ability to think?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global05	In general, how would you rate your satisfaction with your social activities and relationships?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

PROMIS GlHe-Me2a: ____/10; t=___

	CURRENT level of confidence…	I am not at all confident	I am a little confident	I am somewhat confident	I am quite confident	I am very confident
SEMEM015	I can handle negative feelings.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
SEMEM018	I can find ways to manage stress	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
SEMEM016	I can handle upsetting situations	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
SEMEM012	I can avoid feeling discouraged	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
SEMEM017	I can keep emotional distress from interfering with things I want to do	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
SEMEM010	I can bounce back from disappointment	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
SEMEM003	I can relax my body to reduce my anxiety	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
SEMEM019	I can handle the stress of going for treatment of my medical conditions	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

PROMIS SeEffMaEm-SF8a: ____/40; t=___

In the past 7 days…

		Never	Rarely	Sometimes	Often	Always
EDANX01	I felt fearful	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANX40	I found it hard to focus on anything other than my anxiety	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANX41	My worries overwhelmed me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANX53	I felt uneasy	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

PROMIS ED-An-SF4a: ____/20; t=___

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In the past 7 days...

		Never	Rarely	Sometimes	Often	Always
EDDEP04	I felt worthless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP06	I felt helpless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP29	I felt depressed	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP41	I felt hopeless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP22	I felt like a failure	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP36	I felt unhappy	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

PROMIS De-SF6a: ____/30; t=___

		Not at all	A little bit	Somewhat	Quite a bit	Very much
SRPSAT06r1	I am satisfied with my ability to do things for my family	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
SRPSAT33_CaPS	I am satisfied with my ability to do things for fun with others	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
SRPSAT34r1	I feel good about my ability to do things for my friends	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
SRPSAT49r1	I am satisfied with my ability to perform my daily routines	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

PROMIS SwSoRocA-SF4a: ____/20; t=___

		Never	Rarely	Sometimes	Usually	Always
FSE31053x2	I have someone who will listen to me when I need to talk	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
FSE31059x2	I have someone to confide in or talk to about myself or my problems	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
SS12x	I have someone who makes me feel appreciated	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
SSQ3x2	I have someone to talk with when I have a bad day	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

PROMIS EmSu-SF4a: ____/20; t=___