WELL SPRING
Family Therapy Center

Shelly Winemiller, LLC, MA, Licensed Marriage & Family Therapist 507-244-0222
Ed Patton, LLC, MA, Licensed Marriage & Family Therapist 507-884-6287
Kate Szostek, MA, Psychotherapist 651-235-9347

ADOLESCENT INTAKE FORM

Please provide the following information for our records. Today's Date: ____________________

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

Your Name ____ Therapist's Name: ________________

Address ____

City ____________________________________ State ____________ ZIP ______________________________

Birth date _____ / _______ / _________ Age _________ Gender □M □F

Marital Status: □ Never Married □ Partnered □ Married □ Separated □ Divorced □Widowed

Number of Children: ________ Names/Ages____

____

Adolescent's Home Phone: ___________________________________ May we leave a message? □Yes □No

Adolescent's Cell: (□ Don't have my own) _______________________ May we leave a message? □Yes □No

E-mail: (□ Don't have my own) ____

How Did You Hear About Wellspring Family Therapy Center? ____

Adolescent's Biological Parent(s): Married Divorced Separated Deceased Other

Names of Parent(s) or Guardian(s) of Minor: ____

I prefer paperless correspondence, so please send my statements via email. □Yes □No

Mom's Home Phone: ______________________________________ May we leave a message? □Yes □No
Mom's Cell/Other Phone: __________________________________ May we leave a message? □Yes □No

Mom's E-mail: ___________________________________

Dad's Home Phone: ____ May we leave a message? □Yes □No

Dad's Cell/Other Phone: ___________________________________ May we leave a message? □Yes □No

Dad's E-mail: ___________________________________

Insurance Policy Holder Name ______________________________ Policy Holder's Date of Birth ______________

Relationship to Client ____

□ No Insurance

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INTAKE QUESTIONS FOR MINOR:

What are your issues of concern today? ____

____

Are you currently receiving psychiatric services or professional counseling elsewhere? □Yes □No

Have you had previous counseling or therapy? □Yes □No With whom? ___________________________________

Diagnosis at that time? ______________________ Why did you discontinue/stop? __________________________

____

What concerns brought you in to counseling at that time? ____

____

Are you currently taking prescribed medication? □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: ____

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? ____

HEALTH AND SOCIAL INFORMATION

Are you or others 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

Have you had thoughts of harming others? □ Frequently □ Sometimes □ Rarely □Never

Have you experienced physical abuse? □Yes □No Sexual Abuse? □Yes □No Emotional Abuse? □Yes □No

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

____

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

Are you currently in a romantic relationship?____________

What school do you attend? ____Grade ________________

What are your favorite subjects in school? ____

Any issues with school? ____

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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

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? ____

____

FAMILY MENTAL HEALTH HISTORY

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

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

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COUNSELING AGREEMENT

- **I have received, read and understand the Counseling Agreement and the Notice of Privacy Rights. 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.**
- **I also understand that counseling is being provided by a graduate trained individual who is being supervised as part of the requirements to become licensed by the state of Minnesota.**

Signature of Parent/Guardian ____ Date ____________________

Signature of Minor ____ Date ____________________

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TREATMENT PLAN

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 or couples session, or $_____ for a 2-hour group therapy session, is payable at the beginning of each session, unless other arrangements have been made. An adjusted hourly rate equal to current total household income divided by 1000 may be arranged in case of financial hardship. You may use cash or check (made out to individual therapist name).
- The client is fully and directly responsible to the individual therapist for the payment of services rendered.
- Insurance coverage differs, so please check with your insurance company to determine the requirements for mental health coverage.
- A receipt will be provided which the client can submit to his/her insurance company.
- If payment becomes a problem, you are encouraged to discuss this directly with your therapist to consider other alternatives.
- 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 contacts will be prorated based on the standard hourly fee.
- Overdue payments will be assessed a 5% monthly interest fee.

I understand the current fee schedule and my responsibility for payment of fees.

______ 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 that services will be out-of-network with my insurance company. I would like a receipt to send to my insurance company. I understand that payment is due at time of service and I will be reimbursed from my insurance company.

______ I have discussed the fees for counseling and understand that my therapist is a provider for my insurance. I give my permission for my therapist to contact my insurance company to determine insurance coverage.

My insurance carrier is: [ ]Mayo Premier [ ]Mayo Select [ ]Mayo Basic [ ]BC/BS [ ]________________________

My insurance policy number is ____.

My insurance GROUP number is ____.

I have been given a copy of 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

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Yvette Kidman, MA, marriage therapist 507-259-5210

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

Yvette Kidman has completed her Masters degree in Marriage and Family Therapy but is not yet licensed. She is working under supervision while accumulated hours of clinical counseling, so if you are seeing Yvette, your case may be discussed confidentially with her supervisor individually or in group supervision sessions required by her degree & 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 money order. Insurance coverages differ, so please check with your insurance company to determine the requirements for mental health coverage. A receipt will be provided which can be submitted by the client.

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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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.