

# Water's Edge Counseling & Healing Center

## New Client Registration

Logged \_\_\_\_\_ Referred By \_\_\_\_\_ Contact Date \_\_\_\_\_

Patient Requests \_\_\_\_\_ Appt Date \_\_\_\_\_ Time \_\_\_\_\_ AM/PM

### Patient Information

Patient Name \_\_\_\_\_

Social Security Number \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status \_\_\_\_\_

Home Address \_\_\_\_\_ Apartment# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Preferred # for scheduling concerns: Home \_\_\_ Cell\_\_\_ Work\_\_\_ OK to leave voicemail? Home \_\_\_ Cell\_\_\_ Work\_\_\_

Emergency Contact Person: Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

### Consent for Appointment Reminders from Water's Edge CHC

Please note that reminder text messages or emails will only be sent to the parent or legal guardian of all minors.

I do NOT wish to receive email or text message appointment reminders

Please send me a text message appointment reminder to the following CELL PHONE number: \_\_\_\_\_

Please send me an email appointment reminder to the following email address:

(Please print email address clearly): \_\_\_\_\_

**Please note that if for some reason your reminder does not come through successfully, you are still responsible for your appointment time. If you fail to cancel an appointment within 24 hours, you will be charged our normal late cancel/no show fees and your insurance will not cover this charge. If you need to change your appointment time, you will need to call the office as you will not be able to respond via the text message or email. It is our policy to not correspond via email/text messaging with clients for any other reason than this appointment reminder.**

**Signature of Client:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Insurance & Payment Information

▶ *All information is required to obtain benefit information* ◀

Name of PRIMARY Insurance Co. \_\_\_\_\_ Insurance Co. Phone \_\_\_\_\_  
Group/Acct # \_\_\_\_\_ Member ID# \_\_\_\_\_  
**Policy Holder's:** Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to Pt. \_\_\_\_\_  
Policy Holder's Employer (If insurance is obtained thru employer) \_\_\_\_\_  
Does the patient have secondary insurance? \_\_\_ No \_\_\_ Yes If Yes, please complete secondary insurance information on next page.  
Responsible party's address if different than client's \_\_\_\_\_

**I give Water's Edge CHC permission to discuss with the responsible party issues and information concerning billing and collections.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Secondary Insurance Information

▶ *All information is required to obtain benefit information* ◀

Name of SECONDARY Insurance Co. \_\_\_\_\_ Insurance Co. Phone \_\_\_\_\_  
Group/Acct # \_\_\_\_\_ Member ID# \_\_\_\_\_  
**Policy Holder's:** Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to Pt. \_\_\_\_\_  
Policy Holder's Employer (If Insurance is obtained thru Employer) \_\_\_\_\_  
Police Holder's Employer (If insurance is obtained thru Employer) \_\_\_\_\_

### ASSIGNMENT OF BENEFITS

**I assign all benefits from insurance or other third-party coverage to Water's Edge Counseling and Healing Center. Further, I understand that by signing this form I acknowledge that if my insurance carrier or HMO/PPO does not cover certain services, I will pay for them in full. I authorize the release of any medical information necessary to process any claim for services provided by Water's Edge Counseling and Healing Center. A photocopy of this authorization may be honored.**

**For your convenience, Water's Edge accepts cash, check, Visa, Master Card & Discover**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Water's Edge Counseling and Healing Center (Water's Edge) Treatment Contract/Registration

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WELCOME! The most important goal of therapy is to help you feel and do better in your life. As a client, you can help with your treatment by keeping the following information in mind throughout your therapy. This is a solution-focused, goal directed approach for a wide variety of problems, from crises in daily living to ongoing mental health issues. It is especially important that you keep in close contact with family or supportive friends during a crisis and that you assume responsibilities for helping yourself. Treatment will be provided in the least restrictive environment possible.

Standard therapy sessions are 45-50 minutes and dietitian follow-up appointments are 25-30 minutes in length. While this can be somewhat flexible, the time frame will be maintained as much as possible to help all involved. Also this is a courtesy to others that may be waiting. If you are dissatisfied with your progress in therapy, please discuss this openly. Your input and concerns are very important and talking about them often leads to beneficial results for all involved.

Confidentiality: Please understand that what you say is CONFIDENTIAL and will be discussed with other people only with your written permission (except in medical emergencies, under a court order, or as required by law, i.e. mandatory child abuse reporting, and vulnerable adult abuse reporting or for the purpose of consultation or supervision). If there is a clear intention to do serious harm to yourself or to another person, information will be shared in an attempt to prevent that harm from occurring. Information regarding services provided to minor children can be given to parents on request as a matter of state law. If a minor child is seen, issues regarding confidentiality will be discussed with the parents. Insurance providers often require more detailed information of your situation prior to approval of continued treatment or payment for treatment. If you wish to know the informational requirements of your insurance company, please ask.

Checking In Upon Arrival: It is **required** that all clients check-in at the front desk when they arrive for their appointments. Doing so will allow the front desk team to alert the providers that you have arrived for your appointment. It is also an opportunity for the front desk team to confirm that we are billing the appropriate insurance and to highlight any issues with your account. You will be asked to make payments on your account, update necessary paperwork and confirm future appointments.

Office Hours and Cancellation Policy: Office hours vary. Therapy time is valuable to all involved. **Cancellations or changes of an appointment must be made at least 24 hours in advance or you will be charged for your session.** Please note that insurance companies do not pay for failed or canceled appointments. This is standard practice and is intended in part to preserve the time for those who may need it. See "Fees, Phone Calls and Reports" for specific fees. Please ask about any questions you may have about this policy. You can make appointment changes by calling the office and leaving a message with your provider.

Reminder Text Messages/Emails: Please note that if you would like to receive a reminder message, you will have to choose which method of delivery you would prefer. We do not have the ability to send both a text-message and an email. Please complete the following information so that we may update your records according to your preference. Also, please note that if you do opt to have a text message or email reminder sent to you, you will be charged fees from and according to your personal messaging plan. Do not reply to the text message or email as we will not receive it. If you need to reschedule or cancel your appointment, you will need to call the office at (952)898-5020 ext 10.

Please note that is the policy of Water's Edge CHC to not correspond with clients via email or text messaging for any reason beyond the appointment reminders. If you need to communicate with your provider, you may call their extension and leave a voice message.

Consultation and Supervision: To provide you with the best possible service, WATER'S EDGE providers engage in ongoing supervision and consultation with other mental health professionals. When discussing clients in these forums, confidentiality is protected.

Crisis Situations: Steps to take during a crisis will depend upon the nature of the crisis. You may call your individual therapist at 952-898-5020 during normal business hours and then the Ceridian @1-800-366-1192 after business hours, weekends and holidays. When immediate service is required for life threatening situations, please call 911 or go to the emergency department at the closest hospital.

Electronic Health Records: As of September 21, 2011, we have transitioned to an electronic medical record format. This will only affect your care in that your providers may be completing your assessment of symptoms on a computer rather than on a paper form. The system that we are utilizing does not have the option for clients to review their medical records remotely. If you need to review your medical record, please talk with your provider about this.

Fees, Phone Calls and Reports: Fees are as follows: \$198 (Ph.D level provider) or \$175 (Master level provider) for the initial diagnostic session; \$175 (Ph.D. level provider) or \$143 for individual and/or family follow-up sessions, training and/or consultation (whether in the office or by phone), \$231 per session for group therapy and \$175 per hour for psychological assessment and/or interpretation; \$440 for a two hour intake/assessment. Dietitian fees are \$132 for the initial diagnostic session and \$66 for follow-up sessions. If you are paying private pay, the intake fee is \$\_\_\_\_\_ and follow-up appointments will be billed at \$\_\_\_\_\_.

Full payment (or co-payment if services are covered by insurance and any deductible has been satisfied) is due at the beginning of the therapy hour. There are not fees charged for phone calls, letters and reports to facilitate scheduling, information sharing, etc. and requiring up to 10 minutes of time. After 10 minutes, you are billed at a prorated \$159 (Ph.D. level provider) or \$130 (Master level provider) per hour rate. Scheduling paid telephone sessions is welcome when a situation is particularly urgent or because of travel or geographical difficulties.

When you fail to keep that appointment, your provider's livelihood is affected as well as the other individuals who may have benefitted from that time. Therefore, if you fail to attend a scheduled appointment and/or cancel an appointment without a 24 hour notice you will be charged. This charge will automatically appear on your account. Your insurance company will not cover this fee and payment of it is due at the time of your next appointment. The current no show/late cancel fee rate is: 1<sup>st</sup> time: no charge, 2<sup>nd</sup> time: \$50, 3<sup>rd</sup> time and thereafter: \$75. This rate applies for all individual provider appointment. There is a \$100 fee for unexcused absences from the Intensive Outpatient Program and for the Depression/Anxiety Day Treatment Program. The no show/late cancel fee for the once a week groups is \$50.

**Please note: All payment, including copays/co-insurance, late cancel/failed appointment fees and unpaid claims from your insurance company is due prior to or at the time of service or your appointment will be rescheduled for a time after payment is received.**

Insurance and Bookkeeping: WATER'S EDGE CHC uses an in house billing service that is managed by Tina Brault, Office Manager. If you have any questions regarding your account, please contact her at 952-898-5020 ext 16. In many cases, insurance companies provide outpatient mental health benefits to their insured customers. **Please remember that services are provided for and charged to you, not to your insurance company. You are responsible for checking with your insurance company and/or your employer to be certain that they cover the services provided.** Because of the wide variety of insurance plans available guarantee cannot be made that any particular company will provide payment for services that you receive. If your insurance company does not cover the services you receive, you are fully responsible for the amount due. If you have any questions about obtaining coverage, please ask. However, your insurance carrier will make a decision about any reimbursement. In most cases, problems with insurance processing can be significantly reduced if the claims are filed through this office.

Collections: WATER'S EDGE reserves the right to seek payment through the use of a collection agency or through other legal means. The cost of collection may be added to your bill. Return check fee is \$35 and will be billed to you. We will be using an outside collection agency if you fail to pay your balance due or default on an established payment plan. Please see the team members at the front desk if you need assistance in setting up a payment plan. **All copays and patient responsibility payments are due at the time of service.** There will be \$1.50 per month processing charge accessed to all accounts with patient responsibility balances that are not paid at the time of service.

Treatment Team: If your care includes working with a team of providers within WATER'S EDGE, (e.g., therapist, dietitian, and family therapist), one chart will be created for your care at WATER'S EDGE. All WATER'S EDGE providers will have access to this chart and document your care in this chart. If you have questions about this procedure, please inquire with your providers.

Complaints: You have the right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, your provider, or any office policy please inform us in writing immediately and discuss the situation with us. If you do not feel the complaint has been resolved, you may also inform your insurance carrier and file a complaint if you so choose.

**Consent for Treatment: By signing below, you are stating that you have read, understood and agree to abide by this 2 page policy statement and you have had your questions answered to your satisfaction.**

**I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.**

\_\_\_\_\_  
Name of client (please print)

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

**Water's Edge Counseling and Healing Center (Water's Edge)**  
**Registration: Crisis Coverage**

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Providers at Water's Edge Counseling and Healing Center (Water's Edge) understands that at times you may be in a psychological or life threatening crisis. Since our therapist are frequently in sessions with other clients and thus may not be immediately available to assist you through your crisis we ask that you follow the crisis procedures outlined below. Please discuss any questions you have about these procedures with your therapist.

**In a crisis situation please do the following:**

1. If you are in a life-threatening crisis please go the nearest emergency department or call 911 no matter what time of day it is.
2. If you are in urgent need to talk to your therapist, please call the therapist's extension during normal business hours and listen closely to the voice mail directing you through steps for urgent calls. Include in any message you leave a phone number for a return call AND indicate that it is an urgent matter.
3. If you are in crisis after 5:00 pm Monday through Friday, on the week-ends or on holidays, you may call the Ceridian @ 1-800-366-1192. This is a free charge to you. If you call this number Monday through Friday between the hours of 8:00am and 5:00pm there may be a charge (up to \$25) to your account at Water's Edge. Your insurance will not reimburse this charge.

**Signature indicates that you have read, understand and agree to the above.**

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date

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

### **Introduction**

Water's Edge Counseling and Healing Center., is committed to treating and using protected health information about you responsibly. This Notice of Health Information Privacy Practices describes the personal information I collect, and how and when I use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 5, 2003 and applies to all protected health information as defined by federal regulations.

### **Understanding Your Health Record/Information**

Each time you visit Water's Edge Counseling and Healing Center, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which I can assess and continually work to improve the services rendered and the outcomes achieved.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

### **Your Health Information Rights**

Although your health record is the physical property of Water's Edge Counseling and Healing Center., the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

**Water's Edge Counseling and Healing Center**  
**NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES/Registration (2)**

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**Responsibilities of My Practice**

Water's Edge Counseling and Healing Center is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to my legal duties and privacy practices with respect to information I collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if I am unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

I reserve the right to change my practices and to make the new provisions effective for all protected health information I maintain. Should my information practices change, I will give you in person, or mail a revised notice to the address you've supplied me.

I will not use or disclose your health information without your authorization, except as described in this notice. I will also discontinue using or disclosing your health information after I have received a written revocation of the authorization according to the procedures included in the authorization.

**For More Information or to Report a Problem**

If you have questions, would like additional information, or believe your privacy rights have been violated, you can contact the Office for Civil Rights. There will be no retaliation for filing a complaint. The address for the OCR is listed below:

*Office for Civil Rights*  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Room 509F, HHH Building  
Washington, D.C. 20201

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I have received the Health Information Privacy Practices notice and I have been provided an opportunity to review it.

Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Office Copy**

## Water's Edge Counseling and Healing Center Provider Contact/Release of Information

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Dear Client,

Water's Edge Counseling and Healing Center has a strong commitment to your holistic health. For that reason it is important to have a close working relationship with your physician, psychiatrist, or other health care provider. I am asking for your permission to communicate with your health care providers. I find that I can serve you best if they are aware of mental health and substance abuse concerns which often impact health and well-being. Please complete the attached release to enable me to communicate with them about your care. If you have more than one provider, please let me know and I will provide you with additional forms. You will need to complete a separate release of information for each provider you wish me to communicate with during the course of your care at Water's Edge Counseling and Healing Center. I will be happy to answer any of your questions or respond to your concerns regarding this matter.

If you do not wish me to communicate with your other health care providers please read and sign the bottom of this page.

Thank you.

**Please check all that apply:**

**Are you currently receiving services from another mental health therapist: \_\_\_yes \_\_\_no**

**\_\_\_Yes, please communicate information about my care with my primary care physician. I have completed the release of information (that follows this page) with the contact information.**

**\_\_\_Yes, please communicate with providers other than my primary care physician. I have completed a release of information with the contact information.**

**\_\_\_No, I do not want Water's Edge Counseling and Healing Center to communicate with my primary care physician.**

**\_\_\_No, I do not want Water's Edge Counseling and Healing Center to communicate with other providers.**

**I understand that I may sign a release of information at any time for a specific provider and at that point Water's Edge Counseling and Healing Center will initiate communication with that provider.**

**Patient signature \_\_\_\_\_ Date \_\_\_\_\_**

**Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_**

## Water's Edge Counseling and Healing Center Consent for Release of Information

This authorizes **Water's Edge Counseling and Healing Center** to use and disclose the specific health information described below concerning:

Client: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

This will authorize **Water's Edge Counseling and Healing Center** to release to/obtain from

:(Name) \_\_\_\_\_

(Address) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

(Phone) \_\_\_\_\_ (Fax) \_\_\_\_\_

Information from the medical record maintained from (please list dates such as "all" or 2/04 to 2/05): \_\_\_\_\_

The information to be disclosed is (please check all info that you are willing to have exchanged):

	History and intake information		Social/ Psychological/ Medical reports
	Consultation notes/ progress reports		Chemical dependency abuse or diagnosis, history and treatment (protected by Federal and State regulations 42 CFR Part 2 and ORS 430.399(5), 179.505)
	Treatment plan, goals, and results		Medications used in treatment
	Court or probation records		Other (specify)

The purpose of the information release is (please check all that apply):

	Diagnosis and evaluation		To facilitate treatment
	Treatment planning		Other (specify)

If I am requesting the Authorization from you for my use and disclosure or to allow another health care professional or entity to disclose information to me: (1) You have the right to inspect a copy of the protected information to be used or disclosed; (2) You may refuse to sign this authorization; and (3) I must provide you with a copy of the signed authorization at your request. You may revoke this consent at any time and that upon fulfillment of the above stated purposes(s) or within one year, this consent will automatically expire without express revocation.

By signing this authorization, you may be directing me to disclose your health information to a person or organization that does not have the same obligations to protect privacy required of health care practitioners under state and federal law. The disclosure of the information specified above may carry with it the potential for unauthorized disclosure of your protected health information and loss of protection under state and federal law.

You may request that I require the recipient of your protected health information to sign a Confidentiality Agreement in which the recipient agrees to limit its use and disclosure of your information as specified by the confidentiality agreement. If the intended recipient refuses to sign the confidentiality agreement you request, I will not release the information.

I have reviewed the Authorization and I understand it. I understand that the information used or disclosed under this Authorization may be subject to redisclosure by the recipient and may no longer be protected under federal privacy law.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent or guardian or witness

\_\_\_\_\_  
Date

## Water's Edge Counseling and Healing Center Registration and History (RH)

Date: \_\_\_\_\_ Page 1 of 3 (RH)

Client Identification Data						
Name (Last)		(First)	(M)	Age	Birthdate	Sex
Address			(City)	(State)	(Zip)	
Social Security #			Home Phone		Work Phone	
Marital Status Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/>				Religion		
Education (Highest Grade Completed)			College Degrees		Veteran Yes <input type="checkbox"/> No <input type="checkbox"/>	
Employer			Occupation		How long employed?	
Family History						
Family Members	Age	Emotional Problems		Living?		Occupation
		Yes	No	Yes	No	
Spouse's Name						
Mother's Name						
Father's Name						
Stepmother's Name (if applicable)						
Stepfather's Name (if applicable)						
Other significant person responsible for raising you						
Number of children of person completing form	Age of oldest		Age of youngest		Number deceased	
Number of brothers and sisters	Age of oldest		Age of youngest		Number deceased	
Number of other persons living in current household	Relationship					
Notify in case of emergency (Name, relationship, phone number for contact)						
Address				Home Phone		

Name: \_\_\_\_\_

Health Data			
Your Physician (Full Name):			
Address (Clinic Name)	(Street)	(City)	(State/Zip)

Date of most recent physical: \_\_\_\_\_

Do you have any current medical problems (including any infectious diseases)?  yes  no Please describe:

Are your medical problems being treated? \_\_\_\_\_ If yes, by whom? \_\_\_\_\_

What medications and dosages are you now currently taking? \_\_\_\_\_

Have you ever had a drug allergy or sensitivity?  yes  no If yes, to what drug: \_\_\_\_\_

Have you ever seen any of the following for help with a problem? Please circle all that apply:

Psychiatrist    Psychologist    Social Worker    Counselor    Minister    Chemical Dependency Counselor

For what? \_\_\_\_\_ When? \_\_\_\_\_

Previous psychiatric or chemical dependency hospitalization:  Yes  No

If yes, where? \_\_\_\_\_ When? \_\_\_\_\_

Are you currently or have you in the past been diagnosed and/or treated for? (Please check all that apply)

- |   |  |  |  |   |
|---|--|--|--|---|
| <input type="checkbox"/> stroke           | <input type="checkbox"/> seizures              | <input type="checkbox"/> migraines     | <input type="checkbox"/> liver damage    | <input type="checkbox"/> thyroid problems             |
| <input type="checkbox"/> anemia           | <input type="checkbox"/> chronic fatigue       | <input type="checkbox"/> diabetes      | <input type="checkbox"/> chronic pain    | <input type="checkbox"/> urinary track infection      |
| <input type="checkbox"/> asthma           | <input type="checkbox"/> hepatitis             | <input type="checkbox"/> tuberculosis  | <input type="checkbox"/> eating disorder | <input type="checkbox"/> persistent flu-like symptoms |
| <input type="checkbox"/> cancer           | <input type="checkbox"/> hypertension          | <input type="checkbox"/> menopause     | <input type="checkbox"/> perimenopause   | <input type="checkbox"/> poly-cystic ovarian syndrome |
| <input type="checkbox"/> cardiac problems | <input type="checkbox"/> communicable diseases | <input type="checkbox"/> Other : _____ |  |   |

### Chemical Use History

Do you drink alcoholic beverages?  Yes  No If yes, what do you drink  Beer  Wine  Hard liquor

How often do you drink?  Daily  3-5 times weekly  1-2 times weekly  Less frequently

Do you sometimes drink more than you had planned?  Yes  No

Have family and friends ever expressed concern about your drinking?  Yes  No

Have you ever been arrested for alcohol related charges: DWI, public intoxication etc.?  Yes  No

Have you ever been treated for drinking, chemical dependency or gone to AA?  Yes  No

Have you ever had periods where you were unable to remember what happened when you were drinking?  Yes  No

Have you ever overdosed?  yes  no

Do you use nicotine?  yes  no If yes, how much and for how long: \_\_\_\_\_

What has been your experience with the following?	Use currently	Used in past	Never used
<b>Tranquilizers: (for example)</b> Valium, Librium, Tranxene, Azene, Miltown, Equanil, Xanax, Ativan			
<b>Pain Pills/Narcotics: (for example)</b> Darvon, Codeine, Percodan, Demerol, Dilaudid, Heroin			
<b>Stimulants:</b> Amphetamines, Speed, Dexedrine, Ritalin, White Crosses, Zip, Cocaine and its derivatives ie, crack, crank			
<b>Sleeping Pills/Soporifics:</b> Doriden, Placidyl, Dalmane, Seconal, Tuinal, Nembutal, Amytal, Phenobarbital, Noctec, Somnos			
<b>Hallucinogens:</b> Marijuana, Hashish, THC, LSD, Mescaline, Psilocybin, MDA, PCP, Angel Dust, Mushrooms			
<b>Volatiles:</b> Aerosols, Paint thinner, Glue, Lacquer, Amyl or Butyl, Nitrate "Poppers", Gasoline			
<b>Others:</b> Please list			

Please answer the following questions from your personal perspective.

1. Who referred you to Water's Edge Counseling and Healing Center \_\_\_\_\_
2. What is the crisis or problem that brought you to see a therapist? \_\_\_\_\_

### PROBLEM LIST

Listed below are possible problems you or your family currently has. Please rate each by your degree of concern by circling the issue, rating it, and indicating why you are concerned.

1. Suicide potential or depression? (Low) 1 2 3 4 5 6 7 8 9 10 (High) Why? \_\_\_\_\_
2. Alcohol/drug abuse? (Low) 1 2 3 4 5 6 7 8 9 10 (High) Why? \_\_\_\_\_
3. Family/relationship problems? (Low) 1 2 3 4 5 6 7 8 9 10 (High) Why? \_\_\_\_\_
4. Worry/Anxiety? (Low) 1 2 3 4 5 6 7 8 9 10 (High) Why? \_\_\_\_\_
5. Verbal abuse/behavior? (Low) 1 2 3 4 5 6 7 8 9 10 (High) Why? \_\_\_\_\_
6. Sexual abuse/behavior? (Low) 1 2 3 4 5 6 7 8 9 10 (High) Why? \_\_\_\_\_
7. Physical abuse/behavior? (Low) 1 2 3 4 5 6 7 8 9 10 (High) Why? \_\_\_\_\_
8. Other problem/behavior? (Low) 1 2 3 4 5 6 7 8 9 10 (High) What and why? \_\_\_\_\_

Why do you think there are these problems for you or your family?

What is the main goal or need you have for the first session?

What are your ideas on how that goal can be accomplished?

**Water's Edge Counseling and Healing Center**  
**NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES**

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- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which I can assess and continually work to improve the services rendered and the outcomes achieved.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

**Your Health Information Rights**

Although your health record is the physical property of Water's Edge Counseling and Healing Center., the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

**Water's Edge Counseling and Healing Center**  
**NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES (2)**

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**Responsibilities of My Practice**

Water's Edge Counseling and Healing Center is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to my legal duties and privacy practices with respect to information I collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if I am unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

I reserve the right to change my practices and to make the new provisions effective for all protected health information I maintain. Should my information practices change, I will give you in person, or mail a revised notice to the address you've supplied me.

I will not use or disclose your health information without your authorization, except as described in this notice. I will also discontinue using or disclosing your health information after I have received a written revocation of the authorization according to the procedures included in the authorization.

**For More Information or to Report a Problem**

If you have questions, would like additional information, or believe your privacy rights have been violated, you can contact the Office for Civil Rights. There will be no retaliation for filing a complaint. The address for the OCR is listed below:

*Office for Civil Rights*  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Room 509F, HHH Building  
Washington, D.C. 20201

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I have received the Health Information Privacy Practices notice and I have been provided an opportunity to review it.

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Client Copy**

**Water's Edge Counseling and Healing Center**  
**Bill of Rights/Registration**

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**BILL OF RIGHTS**

Consumers of services offered by psychologists licensed by the State of Minnesota have the right:

1. to expect that the practitioner has met the minimal qualifications of training and experience required by state law.
2. to examine the public records maintained by the Board of Psychology which contain the credentials of the practitioner.
3. to obtain a copy of the rules of conduct from the Minnesota Board of Psychology.
4. to report complaints to the practitioner, and if not satisfactorily resolved, to file a complaint with the Minnesota Board of Psychology.
5. to be informed of the cost of professional services before receiving the services.
6. to privacy as defined by rule and law. This means that no information will be released from the facility in which the practitioner works without the client's informed, written consent, except for the following:
  - a. The practitioner is required by law to report instances of abuse or neglect of a child or a vulnerable adult.
  - b. The practitioner is required by law and professional codes of ethics to notify proper persons and/or authorities if the practitioner believes there is a danger to a client or another identified person.
  - c. The practitioner is required to report admitted prenatal exposure to harmful controlled substances.
  - d. In the event of a client's death, the spouse or parents of the deceased have a right to access the client's records.
  - e. The practitioner must produce records or testimony in response to a Court Order and potentially to a subpoena.
  - f. Parents or legal guardians of a non-emancipated minor client have the right to access their child's records.
  - g. Case discussions with other staff through case management, consultation, testing, and treatment are confidential and are to be conducted as such by all staff.
7. to be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving psychological services.
8. to respectful, considerate, appropriate, and professional treatment.
9. to see information in his/her record upon request.
10. to be involved in the formulation of the treatment plan, the periodic review of plans and progress, and the formulation of the discharge plan.
11. to be informed of treatment options, expected outcome of treatment, expected length of treatment, and cost in language that he/she can understand.
12. to discuss needs, wants, concerns, and suggestions with the practitioner.
13. to be advised as quickly as possible if a scheduled appointment time cannot be kept due to illness or emergency.

**Signature acknowledges receipt and understanding of these rights.**

\_\_\_\_\_  
**Signature of client**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Date**

# Water's Edge Counseling and Healing Center Client Responsibilities/Registration

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## Client Responsibilities

Each client has the responsibility to:

1. Refrain from physical (and other) abuse of self, others, and property. Clients are responsible for repair or replacement of any property they damage in the facility.
2. Devote reasonable energy and time to therapy work. Therapy is generally "hard (emotional) work." For progress to occur, we recommend making your therapy a high priority in your personal life. Your therapist may regularly assign homework that is intended to help you learn about yourself, and doing your homework is expected to expedite your therapy and decrease your costs.
3. Fulfill contracted behavior.
4. Be honest with your therapist concerning your thoughts and feelings about your therapy and treatment.
5. Keep appointments as made. Your appointment time is reserved for you. Therefore, you will be charged for the appointment unless you give at least 24 hours advance notice. Exceptions may be made for emergencies and other extenuating circumstances.
6. Keep current in paying your fees (deductibles, co-payments, fee-for-service payments). You are required to pay your fee at the beginning of each session. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that occurred prior to the first visit to my office), session fees credited toward the deductible will be collected at the time of the session until the deductible payment is verified by the insurance company or third-party provider. Verification can be made through my billing coordinator, who will contact your insurance company to check your benefit status upon request.
7. Inform those involved in the treatment plan about any changes to physical health, insurance plan, or ability to pay for contracted services.
8. Parents or caregivers are responsible to supervise the activities of children with respect to use of facilities, material, etc.

I have read and understand my rights and responsibilities as noted above.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

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