Family Quest, Inc. **Client Intake and Information Form**

Personal information

First Name M.I. Last Name

Spouse information, if applicable (being seen as a couple)

First Name M.I. Last Name

Street Address

City State Zip

Please check the best number to contact you

( ) - ( ) - ( ) -

Home telephone Cell phone Work phone

Email (if you wish to be contacted in this way)

Client Birthday / / Spouse Birthday / /

Month / Day / Year Month / Day / Year

Marital status (please check one)

☐ Single ☐ Engaged ☐ Married ☐ Divorced ☐ Widowed How long? _____

Reason(s) for your visit

Please briefly explain what has prompted you to come in for help.

For marriage -

For Family -

For adolescent children -

Medical & mental health background

Please include any relevant information about your medical background that would impact your therapy.

Are you or any minor children you are bringing with you currently taking any prescription medications? If so please list them below.

Have you been treated for any mental heath issues in the last five years? ☐ Yes ☐ No

If so, please briefly describe the issue(s) and nature of your treatment/therapy.

Family background

Please list the age and gender of each of your siblings

Please list the age and gender of any children

Are your parents… ☐ married ☐ divorced ☐ father previously married ☐ mother previously married

Husbands and wives please answer separately

Please describe the strengths and weaknesses in *your* relationship with your father?

Please describe the strengths and weaknesses in *your* relationship with your mother?

Current system checklist: Rate the intensity of symptoms present in the last four weeks.
None: this symptom is not present at this time
Mild: impacts quality of daily life, but no significant impairment of day to day functioning
Moderate: significant impact on quality of life and/or day to day functioning
Severe: profound impact on quality of life and/or day to day functioning

Symptom	None	Mild	Moderate	Severe	Symptom	None	Mild	Moderate	Severe
Depressed mood					Increased/decreased appetite				
Low energy					Unplanned weight gain				
Sleep disturbance					Unplanned weight loss				
Dissociation					Paranoid thoughts				
Hyperactivity					Poor concentration or indecisive				
Bingeing					Purging/over eating				
Decreased sex drive					Excessive worrying				
Unresolved guilt					Impulsive actions/speech				
Irritability					Anger management problems				
Nausea/acid indigestion					Daily stress level				
Social anxiety					Hallucinations				
Self-mutilating/cutting					Racing thoughts				
Low self-worth					Restlessness				
Nightmares					Loss of interest in normal activity				
Negative voices inside					Decreased creativity/productivity				
Losing train of thought					Unresolved anger				
Mood swings					Easily distracted				
Disorganized					Memories of trauma				
Anorexia					Marital problems				
Social isolation					Panic attacks				
Grief					Suicidal thoughts				
Phobia's					Feel panicky/anxious				
Headaches					Work problems				
Loneliness					Alcohol drug intake				
Viewing pornography					Attempted suicide				
Problems at home					Hopelessness				
Infidelity					Grief with life events				

Please describe how the above symptoms impair your ability to function:

Client acknowledgement of terms	Family Quest is required by law to obtain your signature as an indication that you have been given and have received a copy of the Client Bill of Rights and a copy of the Notice of Privacy Practices prior to the provision of service.

I, _____*Print Name Here*_____,

(if second person), _____*Print Name Here*_____,

I understand that I am responsible for any and all payments for services at the time of service, unless there has been an arrangement with the insurance providers listed below prior to the appointment, in which case I am responsible for any copays dictated by the insurance provider. I have the right to cease any session at any time for any reason and to terminate the relationship with the therapist at my discretion.

I have also received and read a copy of the Client Bill of Rights and a copy of the Notice of Privacy Practices prior to the provision of service.

Signed	Date
Signed	Date

Client Bill of Rights **provided by David Swan, MA, LMFT**

Purpose of this document

This document describes the rights you have as a client. The Minnesota Board of Marriage and Family Therapy lists your rights as a client on their web site. This document expands on those points and provides you with information to help ensure that your rights are protected. A copy of those rights appears at the end of this document for your convenience.

Training and degrees

I am licensed as a Licensed Marriage and Family Therapist (LMFT) by the Minnesota Board of Marriage and Family Therapy.

Master of Arts in Adlerian Counseling and Psychotherapy, Adler Graduate School, Richfield, Minnesota with an emphasis in marriage and family therapy.

Bachelor of Arts in Journalism Education, the University of Iowa, Iowa City, Iowa. I have been a licensed secondary school teacher in Iowa, Wisconsin and Minnesota, although I am not currently licensed or practicing as a teacher.

In addition to my training above, I spent over a decade working for a non-denominational Christian organization in various ministry capacities that involved training, mentoring and coaching people in life decisions.

I am a certified facilitator for the Prepare/Enrich couples inventory. This tool is helpful in identifying areas of strength and weakness in couple relationships.

Treatment and results

You have a right to understand my assessment, what the expected course of treatment may be, and the right to choose or refuse any treatment recommendations. The course of therapy is determined by you and me as we collaborate on your treatment. However, you are ultimately in charge of your own course of therapy. There are no guaranteed outcomes. At all times you are entitled to be treated respectfully and professionally with no verbal, emotional, physical or sexual abuse and no threat of retaliation by me, your therapist.

Fees, billing, payments and insurance

Standard fee for a 50 minute session is $140. I work on a fee for service basis, but I can provide you with invoices for services which you may try to submit to your insurance company for out of network reimbursement. For self pay clients, payment is due at the time of service. Payments are accepted in cash or by credit card. We do not accept checks at Family Quest. If you fail to notify me that you will not be able to keep an appointment less than 24 hours before the appointment, you will be billed for that appointment. It is up to you to determine whether or not your provider will reimburse you for these counseling services and submit all paper work directly to them. A sliding scale based on income level is available. Please ask if this is a potential consideration for you.

Approach to therapy

Working with a client is an opportunity for me to come alongside and work together with you to understand the difficulties you may be facing, develop insight as to the root causes of those difficulties, and identify changes that you may wish to make in order to resolve the difficulties. My approach is rooted in your intrinsic worth, dignity and value as a human being and your capacity to develop rich relationships. Difficulties in relationships arise from choices we each make to do that which we believe is in our own best interests, as we define it. My role is to help you understand those beliefs and the style of relating you have chosen and bring hope and encouragement that you can choose different beliefs and make different behavioral choices that will lead to healthier, more satisfying relationships.

Unprofessional conduct

If you believe that you have been treated unprofessionally by me you may file a complaint with my supervisor (contact information above) or with the Minnesota Board of Marriage and Family Therapy.

Confidentiality / Privacy

I strive to comply with Minnesota laws regarding your confidentiality and privacy. As a client you have the right to examine your records. I am required to hold in confidence all information about you during and after our counseling relationship.

Exceptions to this confidentiality would be:

- If you are in danger of harming yourself or someone else.
- If you are physically or sexually abusing a minor or if you are a minor who is being physically or sexually abused.
- If ordered by a judge or other judicial officers, information regarding your treatment must be released.

I will consult with other mental health professionals regarding my clients. These discussions provide me with other viewpoints that can be helpful in your therapy. At all times your confidentiality will be maintained in these discussions.

Client acknowledgement

Client must sign a written statement acknowledging that they have received their client bill of rights prior to any treatment.

Emergencies

If you are in an emergency condition and you are unable to reach me or need immediate help, please call 911.

Minnesota Board of Marriage and Family Therapy Client Rights

The following text is taken from the board's web site (http://www.bmft.state.mn.us/client_bill_of_rights.htm).

Consumers of marriage and family therapy services offered by marriage and family therapists licensed by the State of Minnesota have the right:

- To expect that a therapist has met the minimal qualifications of training and experience required by state law;
- To examine public records maintained by the Board of Marriage and Family Therapy which contain the credentials of a therapist;
- To obtain a copy of the code of ethics from the Board of Marriage and Family Therapy, 2829 University Avenue SE, Suite 330, Minneapolis, Minnesota 55414-3222;
- To report complaints to the Board of Marriage and Family Therapy by calling (612) 617-2220;
- To be informed of the cost of professional service before receiving services;
- To privacy as defined by rule and law;
- To be free from being the subject of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services;
- To have access to their records as provided in Minnesota Statutes; and
- To be free from exploitation for the benefit or advantage of a therapist.

I have received this written statement of my client bill of rights.

Client: First name Last name Date:

Client: First name Last name Date:

Notice of Privacy Practices

Effective July 1, 2010

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

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program which requires that all medical records and other individually identifiable health information used or disclosed by Family Quest Inc., in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the client, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

Family Quest Inc. has prepared this explanation, as required by HIPAA, of how we are required to maintain the privacy of your health information and how we may use and disclose your treatment information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health-care operations.

• Treatment means providing, coordinating, or managing health care and related services by one or more health-care therapists. An example of this would include treatment session notes.

• Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

• Health-care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, confirming appointments and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such an authorization at any time by notifying, in writing. We are required to honor and abide by that written request except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

• The right to request restriction on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree, in writing, to remove it.

• The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

• The right to inspect and copy your protected health information.

• The right to amend your protected health information.

• The right to obtain, and we have the obligation to provide to you, a paper copy of this notice from us at your first service delivery date.

• The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our *Notice of Privacy Practices*.

We are required, by law, to maintain the privacy of your protected health information and to provide you with a notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of July 1, 2010 and we are required to abide by the terms of the *Notice of Privacy Practices* currently in effect. We reserve the right to change the terms of our *Notice of Privacy Practices* and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised *Notice of Privacy Practices* from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:
Privacy Officer
Family Quest, Inc.
13911 Ridgedale Drive Suite 140
Minnetonka, MN 55305
952-797-4476
info@familyquest.net

For more information about HIPPA or to file a complaint:
The US Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue SW
Washington, D.C. 20201
202-619-6775
Toll Free: 1-877-696-6775