Fireside Counseling, LLC

Adult Intake Packet

Date _____ Who referred you to Fireside Counseling? _____

Individual Counseling

Name (First, MI, Last) _____

DOB _____ Gender (circle one) Male Female _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____ Other _____

May we identify ourselves by using the clinic name? (circle one) Yes No

If No, how should we identify ourselves? _____

May we leave a message? (circle one) Yes No

Marital Status (circle one)

Never Married Married Separated Divorced Widowed Other

Employment Status (circle one)

Employed Student Other

Employer

Name _____ City _____

Emergency Contact

Name _____ Phone _____

Relationship _____

Treatment

To best coordinate your care, may we contact your primary physician? (circle one)

Yes No

Do you have a psychiatrist? (circle one)

Yes No

To best coordinate your care, may we contact your primary psychiatrist? (circle one)

Yes No

Have you worked or are you working with any other mental health professionals? (circle one)

Yes No

Would you like us to contact this professional regarding your counseling sessions? (circle one)

Yes No

If you answered YES to any of the above, please complete the Fireside Counseling form titled "***Release of Information Consent Form***".

BIOPSYCHOSOCIAL HISTORY

PRESENTING PROBLEMS

Presenting problems	**Duration** (months)	**Additional information**:

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present on a scale from 1-10 according to the following guides)

0 - None = This symptom not present at this time • **10 - Severe =** Profound impact on quality of life and/or day-to-day functioning

depressed mood		emotionality		hyperactivity	
appetite disturbance		irritability		physical pain	
sleep disturbance		grief		self-injury	
fatigue/low energy		anxiety		medical conditions	
psychomotor retardation		panic attacks		aggressive behavior	
poor concentration		phobias		conduct problems	
poor grooming		obsessions/compulsions		oppositional behavior	
mood swings		bingeing/purging		emotional trauma victim	
hopelessness		laxative/diuretic abuse		sexual trauma victim	
social isolation		anorexia			
worthlessness		paranoid ideation			
guilt		delusions			
significant weight loss/gain		hallucinations			
sexual dysfunction		dissociative states			
agitation		elevated mood			

PSYCHIATRIC HISTORY

[ ] [ ] Prior outpatient psychotherapy?

No Yes If yes, on _____occasions. Longest treatment by _____ for _____ sessions from ____/_____ to _____/_____
Provider Name Month/Year Month/Year

Prior provider name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?

[ ] [ ] Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?

No Yes If yes, on _____occasions. Longest treatment at _____ from ___/_____ to _____/_____
Name of facility Month/Year Month/Year

Inpatient facility name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?

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[ ] [ ] Prior or current psychotropic medication usage? If yes:

No	Yes	Medication	Dosage	Frequency	Start date	End date	Physician	Side effects	Beneficial?

MEDICAL HISTORY (check all that apply for patient)

Describe current physical health: [ ] Good [ ] Fair [ ] Poor

List name of primary care physician:

Name _____ Phone _____

List name of psychiatrist: (if any):
Name _____ Phone _____

List any medications currently being taken (give dosage & reason):

Please feel free to discuss what brings you in for services at this time:

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Office Information and Policies

Welcome to Fireside Counseling. This is an opportunity to acquaint you with information relevant to treatment, confidentiality, and office policies. Fireside Counseling will offer you courteous and professional treatment by a competent, caring psychologist. Making appointments, determining financial commitments, urgent requests, and resolution of your concerns will be handled in a timely manner, with confidentiality, courtesy, and respect. Your psychologist will answer any questions you have regarding any of these policies.

Office Information

Fee Policy

You are responsible for determining benefits, costs and co-payments as they pertain to your treatment. Any amount that your insurance company will not be paying is due from you at the time services are rendered. If there are any problems with meeting the financial obligations, please speak with Gary J. Freitas. You are responsible for providing this office with copies of your insurance card(s) or any changes in your insurance or coverage. Failure to do so may result in a denial of your claim, and you may become liable for any charges. Payment is due at the time of the session unless other arrangements have been made. The standard rate is $175 for a diagnostic session and $150-$175 for subsequent meetings depending on session length. A sliding fee scale is available and can be discussed with your therapist.

Billing

Fireside Counseling uses a billing service, Paragon Billing, located in Edina, Minnesota. To complete the billing process, Paragon requires information such as patient name, address, date of birth, insurance details, type of services, dates/times of services, and diagnosis. Details of service are not disclosed to the billing service, and billing services are required by law to keep your information confidential. Questions or concerns about bills or payments can be directed to Paragon Billing. Please inform Dr. Freitas if Paragon Billing and/or your insurance provider do not adequately assist you in your inquiries.

Appointments

Appointments are usually scheduled for 50 minutes.

Office Hours

Standard hours are Monday through Friday from 9:30AM – 4:30PM, with the exception of one night per week when the office is open until 9:30pm. It is important that you are on time for your appointments.

Cancellations

If you cannot make an appointment, please notify the office at least 24 hours in advance. **If you do not give 24 hours notice when cancelling an appointment, a $50 fee may be applicable. This fee is NOT billable to insurance.**

After Hours

If you are suicidal or need to be hospitalized due to a crisis situation, you may contact the 24-Hour Carver/Scott County Crisis Line at 952-442-7601. If your situation requires immediate attention, you may be referred to the nearest emergency room. Otherwise, please call 9-1-1.

Client Rights

Freedom From Abuse

Fireside Counseling offers dependable treatment of all clients and strictly follows the Vulnerable Adults Protection Act as described in its respective statute, section 626.557, subdivision 2D. This requirement is a protection from assault, sexual exploitation, and criminal sexual conduct.

Other Rights
You have the right to respectful care as it relates to your family's ethnic, social, religious and psychological well-being. Our responsibility is to provide your family with those services that best meet your needs in a professional and ethical manner. You have the right to seek an outside opinion from another agency and an explanation for any referral recommendations made.

Other Responsibilities
You have a responsibility to give your therapist the information needed in order to care for you. You also have the right to participate in the planning of your mental health care, and it is expected that you will follow the treatment plan and instructions needed in order to care for you.

Additional Information

Fireside Counseling's Provider
Gary J. Freitas Ph.D., LP is licensed with the State of Minnesota as a psychologist.

Treatment Process
You and your therapist will work together to identify treatment options and goals. The length of treatment will vary according to individual needs and will be discussed throughout the course of your care. You are encouraged to talk as openly as possible about the problems you are experiencing so that your clinician may better assist you in treatment planning. You have the right to refuse treatment.

Clinic Responsibilities
Fireside Counseling is responsible for providing you with quality professional service. This includes treating you with respect, maintaining your confidentiality, and informing you about your condition/diagnosis and treatment options. Information about treatment options will include potential benefits and risks associated with those options. In order to meet these responsibilities, your clinician may consult with other clinicians (which would be discussed with you).

Confidentiality
Your therapist takes seriously the responsibility to hold in confidence what you discuss with him/her. Information about clients and their families is protected and confidential. Written permission is required to release any information to another agency. Exceptions to this policy only occur under certain circumstances. These are discussed in more detail on the HIPAA/Terms and Limits of Confidentiality form included in the introductory packet.

Request for Paperwork
There are times when you may need paperwork completed by the clinician. There may be a fee for filling out forms and reports. The fees vary according to the document(s) needed. Paperwork and forms can take up to 8 business days to be completed. Please deliver each paperwork request to this office as early as possible.

Record Keeping
Clinical information is maintained describing your current condition, treatment, progress, dates, notes, etc. Your records will not be released without your written consent or otherwise noted in the HIPAA/Limits of Confidentiality form in the introductory packet. Confidential records are locked/secured and kept on site.

Your Satisfaction is Important to Me
Please feel free to raise any concerns with your therapist at any time.

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HIPPA—Health Insurance Portability and Accountability Act
Terms and Limits of Confidentiality

This notice describes in detail how we use and disclose your protected health information (PHI) for treatment, payment, and health care operations. It also describes your rights under the federal privacy regulations and explains how you can request a copy of your personal health information. If you have any questions about this notice, please contact the Director of Fireside Counseling, Gary J. Freitas Ph.D., LP.

Uses and Disclosures for Treatment, Payment, and Health Care Operations
In accordance with HIPAA (Health Insurance Portability and Accountability Act), we may use or disclose your protected health information (PHI) for treatment, payment, and health care operations with your consent. Following is a clarification of these terms:

- *We* – refers to Fireside Counseling.
- *Use* - applies only to activities within our clinic such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *Disclose* - applies to activities outside of our clinic such as releasing, transferring, or providing access to information about you to other parties.
- *PHI* - refers to information in your health record that could identify you.
- *Treatment, Payment,* and *Health Care Operations:*
    - *Treatment* refers to when we provide, coordinate, or manage your health care and other services related to your health care. This could include consulting with or referring your case to another health care provider (e.g., a family physician, another psychologist, or a psychiatrist).
    - *Payment* refers to when we obtain reimbursement for your health care. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. We may also need to notify your health insurance carrier about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
    - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, arranging for audits and administrative services, and care coordination. For example, we may conduct audits of the billing process we use for you or contact you as a reminder that you have an appointment for treatment.

Uses and Disclosures with Neither Consent nor Authorization
Both verbal information and written records about a client are considered confidential and cannot be shared with another party without the written consent of the client or the client's legal guardian. However, federal and state laws either permit or require us to disclose PHI about you for several reasons. The *limits of confidentiality* in which we may disclose your PHI without your consent or authorization are as follows.

Suspected Abuse, Neglect, or Harmful Intention

- Child Abuse: If we have knowledge of any child who is suffering from or has sustained any wound, injury, disability, or physical or mental condition of such a nature as to reasonably indicate that it has been caused by brutality, abuse, or neglect, we are required by law to report such harm immediately to the Minnesota Department of Children's Services, to a judge having juvenile jurisdiction, or to the office of the sheriff or the chief law enforcement official of the municipality where the child resides. Also, if we have reasonable cause to suspect that a child has been sexually abused, we must report such information, regardless of whether the child has sustained any injury.
- Adult and Domestic Abuse: If we have reasonable cause to suspect that a vulnerable adult has suffered abuse, neglect, or exploitation, we are required by law to report such information to the Minnesota Department of Human Services.
- Self-Harm: If we believe you represent a clear and imminent danger to yourself, or you are not able to care for yourself, we are obligated to seek hospitalization for you or to contact family members or others who can provide protection.
- Serious Threat to Health or Safety: If you communicate to us a threat of bodily harm against a reasonably identified victim, and we have determined that you have the apparent ability to commit such an act and are likely to carry out the threat unless prevented from doing so, we are required to take reasonable care to predict, warn of, or take precautions to protect the identified victim from your violent behavior.

Health Oversight Activities and Judicial and Administrative Proceedings - If we receive a subpoena or other lawful request from the Department of Health or the Minnesota Board of Social Work, we must disclose the relevant PHI pursuant to that

subpoena or lawful request. If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and we will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered.

Worker's Compensation - We may disclose PHI regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Prenatal Exposure to Controlled Substances - Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Professional Misconduct - Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

In the Event of a Client's Death – In the event of a client's death, the spouse or parents of a deceased client have the right to access their child's or spouse's records.

Minors/Guardianship - Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Other Provisions - When fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, case notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, time frame, and the name of the clinic.

Insurance companies, billing agencies, and other third-party payers are given information that they request regarding services to clients. Information that may be requested may include the following: type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed.

In some cases, notes and reports are dictated/typed within the clinic or by outside sources specializing (and held accountable) for such procedures.

When couples, groups, or families are receiving services, separate files are kept for individuals for information disclosed that is of a confidential nature. The information includes (a) testing results, (b) information given to the mental health professional not in the presence of other person(s) utilizing services, (c) information received from other sources about the client, (d) diagnosis, (e) treatment plan, (f) individual reports/summaries, and (h) information that has been requested to be separate. The material disclosed in conjoint family or couples sessions, in which each party discloses such information in each other's presence, is kept in each file in the form of case notes.

Uses and Disclosures Requiring Authorization

We will ask for your specific authorization before using or disclosing any PHI for purposes outside of treatment, payment, or heath care operations. An *authorization* is written permission above and beyond the general consent that permits only specific disclosures. You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization or (2) if the authorization was obtained as a condition of acquiring insurance coverage (other law provides the insurer the right to contest the claim under the policy).

Patient's Rights and Therapist's Duties

Patient's Rights:

- *Right to Inspect and* Copy - In most cases, you have the right to inspect and/or obtain a copy of PHI in our mental health and billing records used to make decisions about you as long as the PHI is maintained in the record. You must make this request in writing. We may deny you access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- *Right to Receive Confidential Communications* - You have the right to request and receive confidential communications of PHI by alternative means and alternative locations (e.g., we can send your bills to another address if you do not want a family member to know that you are seeing us).
- *Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of PHI. You must make this request in writing. We will consider your request but are not required by law to agree to your request.
- *Right to Correct or Update (Amend) Your Medical Records* - You have the right to ask us to correct existing information or add missing information to your records. You must make this request in writing and provide a reason for your request. We will consider your request but are not required by law to agree to your request if we believe the record to be correct and complete.

- *Right to an Accounting* - You generally have the right to receive an accounting of disclosures of PHI that have been made to persons or entities other than for treatment or health care operations in the last six (6) years, but not prior to April 14, 2003.
- *Right to a Paper Copy* - If this Notice of Privacy Practices was sent to you electronically, you also have the right to request a paper copy of this notice.

Therapist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, the changes will be effective for information we have about you as well as any information we receive in the future. We will provide individuals with the opportunity to review the revised notice at the time of their next scheduled appointment.

Questions and Complaints

If you have any questions about this notice, disagree with a decision about access to your records, or have other concerns about your privacy rights, you may file a complaint with Fireside Counseling, LLC and/or the U.S. Department of Health and Human Services at the addresses listed below. Under no circumstances will you be retaliated against for filing a complaint.

To file a complaint with Fireside Counseling, LLC contact:

Gary J. Freitas Ph.D., LP
gary@firesidecounseling.net

To file a complaint with the U.S. Department of Health and Human Services, contact:

U.S. Department of Health and Human Services
Office for Civil Rights
233 N. Michigan Street, Suite 240
Chicago, IL, 60601
Phone: 312-886-2359; TDD: 312-353-5693

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I. Consent for Treatment

By signing below, you are giving informed consent for treatment.

By signing below, you are also stating that you have received, read, and understood the *Client Information and Office Policy Statement* and agree to its terms, unless otherwise stated in writing.

I, (the client **or** parent/guardian of minor) _____ give my consent for treatment with Fireside Counseling, LLC and its associated professional staff to include evaluation, psychotherapy, testing (if indicated) and involvement in the treatment planning process. I understand that the client may decline at any time specific treatment recommendations.

Client's Signature
(or parent/guardian if minor): _____ Date _____

Spouse's Signature
(for marital counseling): _____ Date _____

Name of minor being treated
(if applicable): _____

II. HIPAA/Limits of Confidentiality Statement

By signing below, you are stating that you have received, read, and understood the *HIPAA/Limits of Confidentiality* and agree to its terms, unless otherwise stated in writing.

Client's Signature
(or parent/guardian if minor): _____ Date _____

Spouse's Signature
(for marital counseling): _____ Date _____

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Name(s) of client(s) receiving services _____

Person responsible for payment (if different) _____

Federal Truth in Lending Disclosure Statement

Clients With Insurance Coverage

Some Insurance companies have incorporated your Social Security number as a part of your ID number. Please check your card to see if this is required and fill in your full ID number here.

Insurance Carrier	
Full ID Number	
Group Number	

Deductible amount: $ _____

Co-payment: % or $ _____

We suggest you confirm your benefits and eligibility with your insurance company. Your insurance company may not pay for services that they consider to be not effective, not medically or therapeutically necessary, or ineligible. You are responsible for any amount not covered by insurance. It is your responsibility to know if the desired therapist is accepted by your insurance.

Clients <u>Without</u> Insurance Coverage

I (we) agree to pay Fireside Counseling, LLC a rate of $ _____ per clinical unit (defined as 45–50 minutes for assessment, individual, family, and relationship counseling).

All Clients: Please read and sign below

Payments and co-payments are due at the time of service. Any amount due on the client's account will be issued a statement showing the balance. Statement charges are due within 15 days. There may be an interest surcharge posted to overdue accounts, which will be included on the statement.

I authorize Fireside Counseling, LLC to disclose case records (diagnosis, case notes, psychological reports, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment directly to Fireside Counseling, LLC. I understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I understand that I may revoke this consent at any time by providing written notice, and after one year this consent expires.

By signing below, I agree that I have received, read, and agree to the conditions of this form including the **Federal Truth in Lending Disclosure Statement** for Professional Services.

_____ _____

Signature of person responsible for payment **Date**