CHILD INTAKE FORM

Child's Name: _____ Age: _____ Date of Birth: _____ Date: _____

Sex: ☐ Male ☐ Female ☐ _____ Your name and relationship to child: _____

Who has current legal guardianship of child: _____

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Hispanic/Latino

☐ Native Hawaiian/Pacific Islander ☐ Alaskan/Native American Tribe: _____

Cell #: _____ Home #: _____ Work #: _____

Physical Address: _____ Mailing Address: _____

City: _____ State: _____ Zip: _____ County of Residence: _____

Who referred this child to Lake Country Associates? _____

Child currently Lives:

☐ at home with family (Names of Parents): _____

☐ at a relative's home (Name and Relationship of custodial adults in this home): _____

☐ in a foster home (Name of foster parents): _____

☐ at a group home or residential facility (Name of Facility): _____

☐ other (please explain): _____

Length of time the child has been at current placement? _____

People residing in the same household with child:

Name	Age	Occupation	Relationship to child

Health Current physician: _____ Location: _____

When was your child's last physical examination? _____ Results: _____

Does your child have any known allergies? ☐ Yes ☐ No If yes, please list: _____

School Current School/Childcare: _____ Grade: _____

School Contact: _____

In case of emergency, who may we contact? *

_____

Name Relationship to Child Phone Number

Initial: _____ **I authorize Lake Country Associates, Inc. to release necessary information to my emergency contact in the event of an emergency.*

Child's Name: _____Date: _____ CHILD ADDITIONAL INFORMATION

Welcome to Lake Country Associates

This form is meant to provide your therapist information to help in providing thorough and relevant therapy services, as well as to make the best use of the initial intake session.

Main concerns for which services are being sought:
Goals you hope to achieve by coming for services:

How much are each of the following currently a concern for this child? (Please circle)

	Not at all	A little	Somewhat	Considerably	Always
Anxiety	1	2	3	4	5
Physical Problems	1	2	3	4	5
Sleep Problems	1	2	3	4	5
Depression	1	2	3	4	5
Alcohol or Substance Abuse	1	2	3	4	5
Parent-Child Conflicts	1	2	3	4	5
Sibling Conflicts	1	2	3	4	5
Social Relationships	1	2	3	4	5
Hyperactivity	1	2	3	4	5
Anger	1	2	3	4	5
School Problems	1	2	3	4	5
Self-Harm	1	2	3	4	5
Suicidal Ideation	1	2	3	4	5
Sexual Problems	1	2	3	4	5
Spiritual/Religious	1	2	3	4	5
Legal Problems	1	2	3	4	5
Feeding/Eating Concerns	1	2	3	4	5
Abuse **(**Physical, Emotional, Sexual)	1	2	3	4	5
High Caffeine Use	1	2	3	4	5
Hearing/Vision Challenges	1	2	3	4	5
Dental Problems	1	2	3	4	5
History of Trauma Experiences	1	2	3	4	5

Additional information regarding above areas:
Has this child received mental health services in the past: ☐ No ☐ Yes If 'Yes', where and when were services received:

Child's Name: _____Date: _____ CHILD ADDITIONAL INFORMATION

Do any members of the child's biological, adoptive, or extended family have a history of the following:

	YES	Relationship to Child
Anxiety (General)	☐	
Obsessive Compulsive Behavior	☐	
Depression	☐	
ADHD	☐	
Autism	☐	
Personality Disorder	☐	
PTSD	☐	
Suicide History	☐	
Bipolar/Manic Depressive	☐	
Alcoholism	☐	
Substance Abuse	☐	
Domestic Violence	☐	
Eating Disorders	☐	
Schizophrenia	☐	
Counseling or Psychotherapy	☐	
Psychiatric Hospitalizations	☐	
Other Family Mental Health History:	☐	

Cultural/ethnic/religious beliefs/practices of child/family and impact on mental health and mental health services:

Has this child experienced any major illnesses, medical services, or do they have any ongoing medical conditions:

☐ No ☐ Yes: _____

Has this child ever been hospitalized: ☐ No ☐ Yes: _____

Has this child ever had a head injury, loss of consciousness, or seizures: ☐ No ☐ Yes: _____

Current medications, dosages, and prescribing provider/s (include over-the counter items and supplements):

☐ No Current Medications

Any significant family health or medical history: ☐ No ☐ Yes:

Child's Name: _____Date: _____ CHILD ADDITIONAL INFORMATION

Current Living Environment

☐ Comfortable
☐ Positive family relationships
☐ Home in good repair
☐ Safe neighborhood
☐ Financially stable
☐ Chaotic
☐ Supportive
☐ Family relational problems
☐ Home needs repair
☐ Safety concerns in the neighborhood
☐ Financially stressed
☐ Abusive

Comments:

Complications during the pregnancy: ☐ No ☐ Yes: _____

Maternal substance/alcohol use prior to knowledge of being pregnant or during the pregnancy: ☐ No ☐ Yes

Maternal tobacco use during the pregnancy: ☐ No ☐ Yes

Length of Pregnancy: ☐ Full Term ☐ Premature Birth: _____

Complications during delivery: ☐ No ☐ Yes: _____

Birth Weight: _____ Length: _____

Mastery of Developmental Milestones	**Early**	**Average**	**Delayed**
Sitting without support	☐	☐	☐
Rolling over	☐	☐	☐
Crawling	☐	☐	☐
Walking alone	☐	☐	☐
First words	☐	☐	☐
2–3-word sentences	☐	☐	☐
Toilet trained – Daytime	☐	☐	☐
Toilet trained – Nighttime	☐	☐	☐

School History:

Attendance:	☐ Rarely Absent	☐ Sometimes Absent	☐ Frequently Absent
Academic Abilities:	☐ Above Average	☐ Average	☐ Below Average
Peer Relations:	☐ Above Average	☐ Average	☐ Below Average
Behavior:	☐ Above Average	☐ Average	☐ Below Average

Has this child been tested for special education: ☐ No ☐ Yes
Does this child have a current IEP/IFSP/504 Plan: ☐ No ☐ Yes

Additional information that you would like for the therapist to know about or to discuss during intake appointment:

Form Completed By: _____

Acceptance of Financial Responsibility

Client Name:_____ DOB:_____

1. Clients are required to pay for services received. A client may choose to bill a third-party insurance including Medical Assistance and Medicare. In the event that the third-party insurance is billed, clients will be required to pay for all services which are not covered by insurance. Exceptions will include those items which are not appropriate to bill the client under the terms of the provider contract.
2. If clients choose to use insurance, they agree to provide insurance information to Lake Country Associates and agree to assist in billing for insurance reimbursement.
3. Self-pay clients are expected to pay for services at the time they are received. A 10% discount is offered for full cash payment at the time of service. LCA offers a Sliding Fee for those who qualify, please ask LCA Representative for more information.
4. Any services provided by LCA not covered by client's insurance which are 60 days in arrears may be charged monthly interest at a rate of 1.5% of the balance.
5. In the event of non-payment, the bill may be sent to collections.
6. LCA reserves the right to decline service or to require cash payment if a previous billing arrangement has not been honored.
7. The client agrees that if circumstances such as income, number of dependents, insurance or eligibility for various programs change, the client will notify LCA immediately.
8. No show or late cancellation (less than 24 hours) may result in a late cancellation/no show fee for the missed session.
9. I understand that I am financially responsible for all services provided by this clinic, including any amounts not covered by my insurance plan. This may include deductibles, co-pays, co-insurance, non-covered services, missed appointment fees, or services deemed medically unnecessary by my insurance carrier.

***I agree to pay all charges in a timely manner and authorize the clinic to bill my insurance on my behalf. I understand that receiving insurance benefits is not a guarantee of payment, and I am responsible for verifying my coverage and benefits.**

_____	_____	_____
Client or Guardian Signature	**Date**	**LCA Representative**

Charges for services are to be billed to the following sources:

☐ Insurance (primary) Company_____Subscriber Name/Relationship _____
Group #_____Subscriber DOB _____
Policy # _____Subscriber Phone #_____
Co-Pay Amount _____Subscriber Address _____

☐ Insurance (secondary) Company_____Subscriber Name/ Relationship_____
Group #_____Subscriber DOB _____
Policy # _____Subscriber Phone #_____
Co-Pay Amount _____Subscriber Address _____

☐ Medical Assistance Carrier_____ MA#_____

☐ EAP Provider Name_____ Number of sessions_____

☐ **Responsible party for private-pay charges (if different from client): _____**
Relationship_____
Address _____
Phone # _____

Informed Consent for Assessment and Treatment

Name: _____ Date of Birth: _____

1. I understand that as a participant in mental health services at Lake Country Associates (LCA) I am eligible to receive a range of mental health services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks.
2. I understand that all information shared with the clinicians at LCA is confidential and no information will be released without my consent. During the course of treatment at LCA, it may be necessary for my clinician, ARMHS Mental Health Practitioner or mental health provider to communicate with other LCA staff and clinical business associates of LCA. My authorization for the release of information within LCA acknowledges my awareness of this communication. The purpose of this communication is to provide for continuity of care, consult on diagnosis, treatment planning or recommendations and is always done with the goal of providing the best and most appropriate services for my needs. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:
    a. When there is risk of imminent danger to me or to another person; the clinician is ethically bound to take necessary steps to prevent such danger.
    b. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child or elder and to inform the proper authorities.
    c. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.
3. I understand that a range of mental health professionals and practitioners, some of whom may be in training, provide LCA services. All professionals-in -training are supervised by licensed staff. I will be informed if the professional I am seeing is receiving supervision and is in training.
4. I understand that while psychotherapy may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories.
5. The Counselor-Client relationship is unique in that it is exclusively therapeutic. In other words, it is almost always inappropriate for a client and a counselor to spend time together socially, to give each other gifts, or to attend functions together. The purpose of these boundaries is to ensure that you and your counselor are clear in understanding your roles for treatment and that your confidentiality is maintained.
6. If there is ever a time when I believe that I have been treated unfairly or disrespectfully, I can discuss the situation with my mental health provider. Any issues that might interfere with the counseling process should be identified and discussed as quickly as possible. This includes personal, family, administrative, financial and other issues.
7. Office Policies: Most counseling sessions last 53 minutes. We attempt to end each session promptly. Payment of co-pays or uncovered services is requested at the time of your appointment. We can accept cash, checks or credit cards for your payment. If you must cancel an appointment, we ask that you call our office at least 24 hours in advance. A late cancel or no-show appointment may result in a no-show fee. Repeated No Shows or Late Cancels may also result in limited availability for you to reschedule future appointments.

If I have any questions regarding this consent form or about the services offered at Lake Country Associates, I may discuss them with my mental health provider. I have read and understood the above. I consent to participate in the evaluation and treatment offered to me by Lake Country Associates. It is understood that either of us may discontinue the evaluation and treatment at any time and that I am free to accept or reject the treatment provided.

_____ _____

Client or Legal Guardian Signature **Date**

***In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.**

_____ _____

Parent, Guardian or Personal Representative Signature* **Date**

Notice of Privacy Practices
Receipt and Acknowledgement of Notice

Client Name: _____ Date of Birth: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Lake Country Associates' Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Ellie Anderson, MSW, LICSW at 218-366-9229 (Park Rapids) or Jessica Niemi, MSSW, LICSW at 218-444-2233 (Bemidji).

_____ _____
Client Signature Date

***In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.**

_____ _____
Parent, Guardian or Personal Representative Signature* Date

☐ Patient/Client refuses to acknowledge receipt:

_____ _____
Signature of LCA staff Date

Lake Country Associates, Inc.

Notice of Privacy Practices

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

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors, clinical business associates, or other treatment team members. We may disclose PHI to any other consultant only with your authorization. We may also contact you to remind you of your appointments or to provide information to you about treatment alternatives or other health-related benefits and services that may be of interest to you.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations. As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

- **Child Abuse or Neglect.** We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

- **Judicial and Administrative Proceedings.** We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

- **Deceased Patients.** We may disclose PHI regarding deceased patients as mandated by state law. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate.
- **Medical Emergencies.** We may use or disclose your protected health information in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.
- **Family Involvement in Care.** We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.
- **Health Oversight.** If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.
- **Law Enforcement.** We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.
- **Specialized Government Functions.** We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.
- **Public Health.** If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.
- **Public Safety.** We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- **Research.** PHI may only be disclosed after a special approval process.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at Lake Country Associates, Inc., P.O. Box 806, 515 Bridge Street East, Park Rapids, MN 56470 Telephone: 218-366-9229.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Breach Notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at 218-366-9229, or with the MN Department of Human Services, Attn: Privacy Official, PO Box 64998, St. Paul, MN 55164-0998, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

Additional Client Rights

Quality treatment:
You have the right to be treated in a professional, respectful manner. You have the right to expect quality and effective treatment.

Equal Access:
Lake Country Associates, Inc, provides equal access to employment, programs, and services without regard to race, color, creed, religion, age, gender, disability, marital status, sexual orientation, HIV status, public assistance, criminal record or national origin.

Minor Rights:
If you are a minor, you have a legal right to request that information about you not be shared with your parents. You will need to make this request in writing, state your reasons for withholding this information, and show that you understand the consequences of doing so. In a few cases we can withhold this information without your formal request. Feel free to discuss this with your therapist.

Treatment Planning and Goals:
You have the right and responsibility to participate in helping determine your treatment plan and reaching your goals. If you feel you have not been allowed to help in this process, or that a change in counselors might be helpful to you, please advise your counselor or contact the Clinic Director.

Supplying Information:
You have the right to refuse to supply the information we request. However, without certain information, we may not be able to provide you the services you request. If you feel certain information that we request is an unwarranted invasion of privacy, please ask us for clarification.

Staff Rights*:*
Staff have the right:
- *To preserve their personal life and to receive respect for their personal privacy;*
- *To courtesy and freedom from verbal abuse, harassment and threats;*
- *To your full cooperation and participation in the therapy process;*
- *To your reliability and promptness in keeping appointments;*
- *To 24 hour notice when you must cancel an appointment;*
- *To terminate treatment or recommend a transfer if reasonable progress is not being made.*

The effective date of this Notice is April 1, 2010.
Revised August 16, 2012.

Telehealth & Nonsecure Electronic Communication Consent

Name of Client: _____ DOB: _____

Text messages, email, phone, telehealth, and the patient portal provide convenient methods of communication. Please be advised that these methods, in its typical form, are not confidential means of communication. Therefore, Lake Country Associates prefers to use electronic communication only with your permission. Given that many electronic communications now show up on computers as well as phones, the latest HIPAA rules consider them to be Protected Health Information (PHI) if associated with your treatment here, and we cannot guarantee the security of such unencrypted electronic communications. While this is an easy and convenient way to access services ,reduce travel, and continuity of care, please consider the risks to your confidentiality. Below is a list of potential risks associated with the use of electronic communication:

1. Communication issues can arise when communicating via electronic communication due to the lack of access to visual or voice cues, as well as the possibility of limited space, and the chance of misunderstanding when using "shorthand" words or characters to represent meaning.
2. A lost or misplaced cell phone, or a phone simply left in an insecure location, can inadvertently communicate to others that you are in counseling.
3. Text messages and emails are intended to be used for booking, rescheduling, or cancelling appointments and for links to resources to be made accessible to you. Should they be used inappropriately (for example to "chat" or to engage in emotional support), the messages will not be responded to and this may be discussed for clarification.
4. Telehealth sessions should be in a private and safe space, to reduce risk. Telehealth sessions are not recorded but rather are set in real time between client and the clinician.
5. Electronic communication (text messages, phone, email) will not be used for the provision of mental health services.
6. All text messages and emails may become part of your counseling records and as such may be subject to being shared along with your record should the documents be subpoenaed by the courts, or other governing agencies.
7. I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), and it is my responsibility to check with my insurance plan to determine coverage.
8. You may revoke your consent for electronic communication at any time. You are also welcome to discuss any questions or concerns with your clinician.
9. Phone calls, text messages, emails, and voicemails will be responded to within 1-2 business days, unless staff is unavailable for some reason. If you are in a crisis you need to contact crisis lifeline call or text 988, go to your nearest ER or please call 911.

I consent to the following forms of communication for scheduling, documents, or clinical follow up:

☐ **Phone Calls:** Phone number _____ ☐ **Voicemail Messages**

☐ **Text Messages:** Phone Number _____ ☐ **Email:** Email Address _____

☐ **Patient Portal** ☐ **Telehealth**

By signing below, I acknowledge that I:

- Have read and understand this Telehealth and Electronic Communication Consent.
- Have had the opportunity to ask questions.
- Voluntarily consent for myself and/or my child to receive telehealth services.
- Consent to the checked forms of communication above.

Client Signature: _____ **Date:** _____

***In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.**

_____ _____

Signature of client's guardian **Date**