

Wellness Counseling Services
www.wellnesscounselingmn.com
612-746-7701

CONFIDENTIAL INTAKE INFORMATION SHEET

Client Name _____ Today's Date: _____

Birth Date: _____ Age: _____ Race / Lineage: _____

Gender: Male Female Non-binary Transgender Other Pronoun: _____
Explain if you choose to: _____

Home Address: _____

Phone: Home (____) _____ Cell(____) _____ Work(____) _____

I give my permission to be called at:

home No Yes cell No Yes work No Yes

May I leave a message on voicemail? No Yes

I understand that if I have caller ID, the therapist's name will be disclosed to others. Please initial _____

E-mail*: _____ May I email you? Yes No

*Please be aware that email might not be confidential

Emergency Contact Name & Relationship to Client: _____

Emergency Contact Phone #: _____

Current Occupation: _____

Employer: _____

Do you enjoy your work? Is there anything stressful about your current work?

What would you like to accomplish out of your time in therapy?

How did you find Wellness Counseling Services (WCS)? Please place a check by the options below.

Online? If you remember, which online listing did you use?

WCS Website PsychologyToday.com Theravive.com Good Therapy.org
 Google

Friend/Family Member **School** **Current or Former Client** **County**

Other *Name of person who referred you _____

Presently I am (check all that apply)

Single / Dating

In a monogamous exclusive relationship
 Note type: Married Engaged Cohabiting Living Separately

In non-monogamous / polyamorous relationship(s)
 Note type: Married Engaged Cohabiting Living Separately

Separated as of _____ after _____ years of marriage/relationship.

Divorced / Broken up as of _____ after _____ years of marriage/relationship.

Current Spouse or Partner(s)

Name	Age (if deceased, check the box)	Occupation	Comments
_____	_____	_____	_____
_____	_____	_____	_____

Previous Spouse(s) or Partner(s) of Note

Name	Age (if deceased, check box)	Dates of Relationship	Occupation	Comments
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

My Children Name Age (if deceased, check box) Occupation Comments

#1 _____

#2 _____

#3 _____

#4 _____

Please list additional children on the back of this sheet.

Education (Check Appropriate Level)

____ High School or Pre-GED grade ____

____ High School/GED

____ Some College; ____ Years

____ B.A. - B.S.: Major Field _____

Graduate Work - Highest Degree _____ Major Field _____

Family of Origin

My Parents Name Age (if deceased, check box) Occupation Comments

Parent _____

Parent _____

Share a few words about your parents' relationship. Were they married? Yes / No

Were they divorced? Yes / No

Step-parents or Impactful Parental Figures (Identify relationship: ie. Step-parent on mom's side)

1. _____

2. _____

3. _____

4. _____

Siblings Name Age (if deceased, check box) Occupation Comments

Begin with the oldest through the youngest; include yourself.

Sib 1 _____

Sib 2 _____

Sib 3 _____

Sib 4 _____

Sib 5 _____

Military Service (check one): Yes / No If yes, list branch and deployment history:

Have you had previous therapy? Where? When? Please note if the therapy was in some way harmful or problematic to you. _____

Other Workers or Therapists Involved in Current Treatment (e.g. County, School, Etc.)

Treatment History (past and present):

	Past	Present	When	Where	Was it helpful, unhelpful, or harmful
Counseling/ Psychiatric treatment					
Treated after Suicide Attempt(s) / Self-Harm					
Drug/Alcohol treatment					
Hospitalizations for mental health reasons					
Involvement with self-help groups					

Date of last Physical Exam _____

Have there been recent changes in your physical condition? No Yes Please specify:

Do you have any chronic medical ailments? Please specify and indicate the date of onset.

List any medications (and dosages) you are presently taking:

Present and Past Substance Use

Check following substances that you have used:	Amount of and Frequency of use (ie. 2 drinks daily 3 times per week)	Past or Present	I am concerned that I am using this substance too much.	My loved one is concerned I am using this substance too much.	I no longer use this substance due to past problems with it.
___ Alcohol					
___ Marijuana					
___ Cocaine/Crack/Meth.					
___ Inhalants					
___ Stimulants					
___ Hallucinogens					
<input type="checkbox"/> Heroin/Opiates					
___ Prescription Drugs (if you have abused them) (specify)					
___ Other (specify)					

Does family history include substance abuse? No Yes (describe) _____

Client Concerns Checklist

Please check any of the following that concern you currently.

Individual Concerns

<input type="checkbox"/>	Depressed mood	<input type="checkbox"/>	Anxiety or panic attacks	<input type="checkbox"/>	Poor self-esteem/ Body shame
<input type="checkbox"/>	Crying spells	<input type="checkbox"/>	Perfectionistic thinking	<input type="checkbox"/>	Problems with eating
<input type="checkbox"/>	Sleep difficulties	<input type="checkbox"/>	Intrusive memories of past painful/ traumatic experiences	<input type="checkbox"/>	Weight loss or gain
<input type="checkbox"/>	Difficulties with motivation	<input type="checkbox"/>	Generalized dissatisfaction	<input type="checkbox"/>	Restrictive eating
<input type="checkbox"/>	Irritability	<input type="checkbox"/>	Confusion	<input type="checkbox"/>	Binge eating
<input type="checkbox"/>	Mood swings	<input type="checkbox"/>	Problems with anger	<input type="checkbox"/>	Health problems
<input type="checkbox"/>	Suicidal thoughts	<input type="checkbox"/>	Aggressive or violent behavior	<input type="checkbox"/>	
<input type="checkbox"/>	Self injurious behavior	<input type="checkbox"/>	Unwanted behavior: habits or compulsions	<input type="checkbox"/>	Muscular tension
<input type="checkbox"/>	Grief/loss	<input type="checkbox"/>	Trouble with memory or concentration	<input type="checkbox"/>	Frequent headaches
<input type="checkbox"/>	Substance use problems	<input type="checkbox"/>	Struggle to organize and complete tasks	<input type="checkbox"/>	Menstrual difficulties
<input type="checkbox"/>	Work-related concerns	<input type="checkbox"/>	Family of origin problems	<input type="checkbox"/>	Financial management
<input type="checkbox"/>	School-related concerns	<input type="checkbox"/>	Parenting problems	<input type="checkbox"/>	

Relationship Concerns

<input type="checkbox"/>	Communication	<input type="checkbox"/>	Conflict management	<input type="checkbox"/>	Concerns with partner's substance use
<input type="checkbox"/>	Lack of emotional intimacy / Closeness	<input type="checkbox"/>	Escalated fighting with intimate partner	<input type="checkbox"/>	Navigating relationship with our parents
<input type="checkbox"/>	Struggle with sexual intimacy	<input type="checkbox"/>	Feeling unsafe with intimate partner	<input type="checkbox"/>	Coparenting
<input type="checkbox"/>	Codependency / Overly dependent	<input type="checkbox"/>	Feeling out of control with intimate partner	<input type="checkbox"/>	Blending family with children
<input type="checkbox"/>	Fear of intimacy / Closeness	<input type="checkbox"/>	Conflict avoidance	<input type="checkbox"/>	Infertility

Please share more if you are having suicidal thoughts or feel unsafe with your partner:

Sexual Concerns

<input type="checkbox"/>	Lower sexual desire than partner		Higher sexual desire than partner		Performance anxiety- "In my head about how sex is going"
<input type="checkbox"/>	Partner initiates sex too often		Partner doesn't initiate sex often enough		Pain during sex
<input type="checkbox"/>	Sex feels disconnected		Feeling rejected / unwanted after initiating sex		Premature ejaculation
<input type="checkbox"/>	Lack of arousal/pleasure		Lack of passion / Sex feels boring		Cannot get or maintain erection
<input type="checkbox"/>	Difficulty with Orgasm		Feeling numb or disconnected from your body during sex		Body feels tense, anxious, or scared before, during, and/or after sex
<input type="checkbox"/>	Feeling pressured for sex and like I "should/have to" have sex		Concerns with porn use		Concerns with infidelity

Please note if you have experienced any of the following in your history:

<input type="checkbox"/>	Sexual abuse / Sexual assault		Past attempted suicide		Past chemical dependency
<input type="checkbox"/>	Physical abuse		Past hospitalization for suicide		Past treatment for substance use
<input type="checkbox"/>	Physical neglect		Suicide in your family		Chemically dependent sibling
<input type="checkbox"/>	Emotional abuse		Traumatic birth experience		Chemically dependent parent
<input type="checkbox"/>	Emotional neglect		Traumatic experience around injury, illness, or medical experiences		Chemically dependent grandparent
<input type="checkbox"/>	Family history of mental illness		Near death experience		Traumatic death of family member
<input type="checkbox"/>	Experiences of discrimination or harm due to your race, ethnicity, or national origin.		Experiences of discrimination or harm due to your age.		Experiences of discrimination or harm due to your socioeconomic status.
<input type="checkbox"/>	Experiences of discrimination or harm due to disability or health status.		Experiences of discrimination or harm due to gender, gender identity, sexual orientation, or relationship status.		Other experiences of discrimination or harm not listed

Please share further information about any of the experiences checked above if you choose to.

Please list any severe emotional or medical problems of your parents or siblings:

Do you consider yourself to be spiritual or religious? Past Present **If you are currently spiritual or religious, please describe your faith or belief:**

What do you consider to be some of your strengths?

What do you consider to be some of your growth areas?

Please state anything else that you believe may be useful background information about yourself:

WELLNESS COUNSELING SERVICES

Therapeutic Contract

I/we, _____ the client(s), agree to participate in therapy with Rebekah Miller for (circle one) individual/couple/family therapy at the appointment times and places we agree on, starting on (date) _____. The intake session is 60 minutes. Each session after that is 50 minutes in length.

Responsibility of the client

I agree to schedule all appointments with my therapist, arrive on time, participate in therapy, and take medications prescribed by doctors or other mental health professionals. I will keep my therapist fully up to date about any changes in my feelings, thoughts, and behaviors. I expect us to work together on any difficulties that occur, and to work them out in my long-term best interest.

Fees

I agree to pay \$280 for my initial 60-minute intake session. I agree to pay \$240 for each 50-minute session, unless another fee has been negotiated. Note alternate agreed upon fee if applicable: _____. I agree to pay at the beginning of my session. I agree to pay for appointments that I fail to attend or fail to give more than 24-hour notice of cancellation. I understand that WCS does not accept insurance payments for services. I understand that checks, cash, HSA/FSA, or credit cards are accepted forms of payments. Checks can be written out to Wellness Counseling Services and given directly to my therapist, who can provide a receipt for services when requested. I also agree to pay a \$25 fee for any returned checks. I understand that failure to pay for 2 consecutive sessions will result in therapy being placed on hold until the balance on my account is paid.

*I understand that if I discontinue services and return at a later date, the fee may have increased, or the low fee slot may no longer be available.

*I understand that sliding scale and low fee slots are based on need and will be reviewed quarterly.

*I understand that fees are reviewed yearly and may be increased with a 30-day notice to the client.

Initial: _____

Cancellation

I understand that I can cancel via phone, voicemail, text, email, or in person. I agree to pay full fee for appointments that I fail to attend or fail to give more than a 24-hour notice of cancellation.

Initial: _____

Illness

I understand that I am able to late cancel a session without charge due to illness, but I will attempt to give as much notice as possible. I agree to request a telehealth session over an in-person session if I have been in close contact with a loved one who has been sick or if I am concerned that I may be getting sick.

Initial: _____

Telehealth

I understand that video or phone therapy is available, and it is my responsibility to ensure that I am in a location that allows privacy and provides good internet or phone service. **Initial:** _____

Page 1 of therapeutic contract

Client last names: _____

Confidentiality & Exceptions

I understand that my records are kept private, confidential, and secure. I understand that I have the right to access my records. I understand that information can only be released to a third party with a signed release. My therapist has gone over the limits of confidentiality with me, and I understand the limits of confidentiality.

Limits to Confidentiality and Mandated Reporting

The limits of confidentiality have been explained to me. I understand that I have access to the "Notice of Privacy Practices" for a complete description of the uses and disclosures of my Protected Health Information (PHI). I understand that my WCS therapist can be mandated to report or release my records, which means that under certain circumstances, she is required by law to release information without my consent. These circumstances are described below.

- 1. If you make a specific threat to harm yourself or someone else (and the risk of danger is deemed imminent), your therapist must take the appropriate steps to protect you or warn the appropriate parties.**
- 2. If you report the abuse or neglect of a child or vulnerable adult, your therapist must report it to the appropriate authorities.**
- 3. If you are pregnant and using controlled substances (heroin, cocaine, phencyclidine, methamphetamine or their derivatives), your therapist must report it to the appropriate authorities.**
- 4. Court order or subpoena for client records.**
- 5. Any Ethical investigation into your therapist by the board of Marriage and Family Therapy.**

Consultation

I understand that my WCS therapist consults with other mental health professionals about clients that she is working with in therapy. I understand that my therapist will not disclose personal information about me but will share enough case information in consultation with others in order to gain helpful advice for working with me in therapy.

Informed Consent for Treatment

A copy of "WCS Informed Consent and Notice of Privacy Practices" has been offered to me. I understand its contents and agree to abide by its terms to include giving general consent for treatment. I may at any time decline specific recommendations. General consent for treatment includes evaluation, psychotherapy, involvement in treatment planning, and psychological testing (if indicated).

Concerns with Therapy

I understand that my therapist is always open to feedback and will attempt to address any of my concerns about the therapeutic process. I understand that if I have any concerns about the practice of marriage and family therapy that I do not feel comfortable discussing with my therapist, I can contact the MN Board of Marriage and Family Therapy (this process is referenced in the client bill of rights found in the WCS Informed Consent and Notice of Privacy Practices form).

Page 2 of therapeutic contract

Client last names: _____

Court involvement

I understand that if I request my therapist to appear in court on my behalf, I must give a full 60-day notice and pre-pay \$5000 per day for each single appearance in court. I understand that my therapist will not testify regarding who is at fault in a divorce, and my therapist will not make recommendations about custody, as both are outside of the scope of practice.

Ending Therapy

I understand that the length of therapy is dependent upon my needs as the client and that ending therapy is a collaborative process between the therapist and client. I understand that I can request to end therapy at any time, due to achievement of goals, desire to be referred to another professional or specialist, or any other reason. I understand that therapy will end and my case will be suspended or clinically closed if I fail to attend 3 scheduled appointments in a row without proper cancellation, have not attended therapy for 30 days, or have not paid my fee for 2 consecutive sessions. In these circumstances, my therapist will make a reasonable attempt to notify me that my case is being suspended or closed via phone and/or email. I understand that I can request for my therapist to give me referrals for services. I understand that I can request for my case to be reopened in order to resume services.

Signature indicates acceptance and agreement of the above stated WCS policies and practices.

I have received and understand the contents of this therapeutic contract, the WCS Informed Consent, and the Notice of Privacy Practices. I give my consent to treatment.

Printed Name and Signature(s) of client(s) or guardian(s)

Date

Printed Name and Signature(s) of client(s) or guardian(s)

Date

Printed Name and Signature(s) of client(s) or guardian(s)

Date

Printed Name and Signature(s) of client(s) or guardian(s)

Date

I have discussed the issues above with the client(s).

Signature of therapist

Date

Page 3 of therapeutic contract

Client last names: _____

WCS Couples Confidentiality Statement

About couples therapy

Couples therapy is a distinct form of therapy. The treatment unit is the relationship, and not the individuals. It is common in couples therapy that both partners will experience different levels of agreement and disagreement with the therapist. The goal is to change and improve the relationship, by helping the couple become a “team against the problem” and by empowering the individual to change their role and reactivity in their relationship patterns and cycles. To support this goal, couples therapy will include individual sessions as part of supporting relational change. **Initial:** _____

Secrets, privacy, and confidentiality

Due to the nature of couples therapy, your therapist maintains a “no secrets” policy. A “no secrets” policy means that information obtained by the therapist in any manner is to be used to foster the therapeutic process. WCS, in general, does not believe that secrets in couples therapy are helpful. Individual sessions are part of the couples therapy process. Both partners are offered privacy in their individual sessions, with the understanding that what is learned in those sessions will be used to better help the couple. Both partners agree to have their couples therapy discussed in individual sessions.

There are times when one partner shares a “secret” with the therapist that they are unwilling to disclose to their partner. Your therapist will use professional discretion in assessing whether this is information will harm the therapeutic process. If failure to share the information will negatively impact the couples therapy, your therapist may need to put therapy on hold or end therapy as a result. **Initial:** _____

Since the couple is the treatment unit, all consent and confidentiality resides with both partners. Specifically, both partners participating in treatment are required to sign all releases of information and to mutually agree to the treatment. If one partner chooses not to sign or give consent, information will not be released from the file except for when required by law. **Initial:** _____

Respecting couples therapy confidentiality in the event of relationship dissolution

The focus of couples therapy is the couple. Therefore your therapist will have no opinion on matters outside of that scope. Specifically, your therapist will make no recommendations on parenting or who may be at fault if a couple chooses to end their relationship. The choice to end a relationship is a serious matter and resides solely with the couple, and needs to be made with great care and caution. Both partners agree to do everything in their power to allow the couples therapy to remain confidential. Both partners agree not to use legal means in an attempt to obtain files from couples therapy to win a legal argument in a breakup or divorce process. **Initial:** _____

I am attending couples therapy with (Name of Partner) _____ and agree to the couples confidentiality statement. By signing this form, I acknowledge that I understand this statement.

Printed Name and Signature(s) of client(s) or guardian(s)

Date

Printed Name and Signature(s) of client(s) or guardian(s)

Date

Signature of Therapist

Date

Wellness Counseling Services

Good Faith Estimate

Rebekah Miller LMFT,
4900 Hwy 169, Ste 300
New Hope, MN 55428 Ste 300
Email: admin@wellnesscounselingmn.com
Phone: 612-746-7701

We are committed to providing you with high-quality therapy services that meet your unique needs. To ensure transparency and clarity regarding the financial aspects of your therapy, we are pleased to provide you with this Good Faith Estimate.

The estimate below is the range of costs for most new patients. Until I do an initial evaluation and we start to work together, I will not have a clear picture of your specific diagnosis, issues and needs. The cost of therapy varies based on individual needs, treatment goals, and session frequency. Some clients may require only a few sessions, while others may need ongoing support, with adjustments discussed as needed.

The current fee is \$280 for the initial intake session and \$240 for the normal session. I am able to accept HSA/FSA cards, credit cards, checks, or cash. I am out-of-network with insurance companies, and could provide you a receipt for your therapy to be submitted to insurance. If you attend therapy weekly for 52 weeks, the estimate for the year will be \$13,000.

Contact: If you have questions about this estimate, please contact the Wellness Counseling Services' office at **612-746-7701** or email at **admin@wellnesscounselingmn.com**

Details of the Estimate

The following is a detailed list of expected charges for psychological services. The estimated costs are valid for 12 months from the date of this Good Faith Estimate, unless I send you an updated Estimate. **(if your fee is changed you will be sent an updated Good Faith Estimate)**

Service	Service code	Cost per unit	Expected cost
Initial evaluation	90791	\$280	\$280
Psychotherapy (60 Minute Sessions)	90837	\$240	\$240
Psychotherapy (30 Minute Sessions)	90832	\$120	\$120
Psychotherapy (50 Minute Sessions)	90847	\$240	\$240

Client name _____ DOB _____

Disclaimer

This Good Faith Estimate shows the costs of services that are reasonably expected for the expected services to address your mental health care needs. The estimate is based on the information known to the provider when she did the estimate.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

If you are billed for \$400 more (per provider) than this Good Faith Estimate (GFE), you have the right to dispute the bill

You may contact Rebekah at the contact listed above to let them know the billed charges are at least \$400 higher than the GFE. You can ask them to update the bill to match the GFE, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a \$25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this GFE. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to:

www.cms.gov/nosurprises or call CMS at 1-800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call CMS at 1-800-985-3059 .

This GFE is not a contract. It does not obligate you to accept the services listed above.

Signing this form means you understand the Good Faith Estimate and the fees involved with therapy.

Client Signature: _____ **Date:** _____

Client name _____ DOB _____