CLIENT INFORMATION FORM

Name: _____ Date: _____

DOB: _____ Gender: _____

How did you hear about us? _____

Ethnic/Racial Background (optional): _____

_____ _____ _____

Street Address City/State Zip Code Phone #

_____ _____

Employer/School Occupation/Year in School

E-Mail: _____

Would you like to receive appointment reminders via **email**? ☐ Yes ☐ No

For communication purposes, may I **call** ☐ **email** ☐ and/or **text** ☐?

For calls, or texts what number may I use: _____

For calls, may we leave a detailed message: ☐ Yes ☐ No

For billing, we use electronic invoices. Check here ☐ to **opt out** (if opting out, we will send paper invoices by mail)

Contact person in the event of an emergency:

Name: Relationship to You: Phone #

INSURANCE INFORMATION (if applicable)

_____ _____

Subscriber's Name Relationship to You

_____ _____ _____

Subscriber's Gender Subscriber's Address Subscriber's DOB

_____

Subscriber's Phone Number

_____ _____

Insurance Company (name and address) Phone #

Group Number: _____ ID Number: _____

MEDICAL INFORMATION

Physician's Name: _____ Phone #: _____

Physician's Address _____

Street City/State Zip Code

Have you ever received psychological, psychiatric, drug or alcohol treatment (including psychiatric hospitalization), or counseling services before? ☐ No ☐ Yes. If yes, please indicate:

Dates of Service	From Whom?	Where (City/State)	Presenting Concerns	Outcome?

Have you ever taken medication for psychiatric or emotional problems? ☐ No ☐ Yes. If yes, please indicate

Medication	Dosage	Frequency	Start Date	End Date	Physician	Phone

Please list any health conditions for which you have received or are currently receiving treatment (including surgeries):

_____

_____

Relationship status:

- ☐ single, never married
- ☐ dating for ___ ☐ mo ☐ yr
- ☐ engaged ___ ☐ mo ☐ yr
- ☐ married for ___ ☐ mo ☐ yr
- ☐ divorced for ___ ☐ mo ☐ yr
- ☐ separated for ___ ☐ mo ☐ yr
- ☐ widowed for ___ ☐ mo ☐ yr
- ☐ live-in for ___ ☐ mo ☐ yr
- ☐ ___ prior marriages (self)
- ☐ ___ prior marriages (partner)

Current relationship satisfaction:

- ☐ very satisfied with relationship
- ☐ satisfied with relationship
- ☐ somewhat satisfied with relationship
- ☐ dissatisfied with relationship
- ☐ very dissatisfied with relationship

Intimate relationship:

- ☐ never been in a serious relationship
- ☐ not currently in a relationship
- ☐ currently in a serious relationship
- ☐ concerns about intimate relationships

Social support system:

- ☐ supportive network
- ☐ few friends
- ☐ substance-use-based friends
- ☐ no friends
- ☐ concerns about friendships

Sexual Orientation:

_____

Dependent Children (Names and Birth Dates) _____

Cultural identity (e.g., ethnicity, religion): _____

Describe any cultural issues that contribute to current problem: _____

Currently participate in spiritual activities? ☐ Yes ☐ No Explain: _____

Describe current living situation (e.g., roommate, spouse, etc.) _____

Please indicate what brings you to therapy now.

What do you hope to accomplish in therapy?

Substance Abuse History

Substance	Amount	Frequency	Duration	First Use	Last Use
Caffeine					
Tobacco					
Cannabis					
Heroin					
Opium					
Methamphetamines					
Amphetamines					
MDMA (e.g., ectasy)					
Cocaine					
Ketamine					
PCP					
Mushrooms					
Alcohol					
Others:					

1. Have you ever felt you ought to cut down on your drinking or drug use? ☐ Yes ☐ No
2. Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No
3. Have you ever felt bad or guilt about your drinking or drug use? ☐ Yes ☐ No
4. Have you ever had a drink first thing in the morning (as an "eye opener") to steady your nerves or get rid of a hangover? ☐ Yes ☐ No

Do you have thoughts of harming your self or anyone else? ☐ Yes ☐ No

Have you ever gotten into trouble because of temper/violence? ☐ Yes ☐ No

If YES to any, please elaborate:

INSTRUCTIONS: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth.

	Never	Rarely	Sometimes	Frequently	Almost Always
1. I have trouble falling asleep or staying asleep	☐	☐	☐	☐	☐
2. I feel no interest in things.	☐	☐	☐	☐	☐
3. I feel stressed at work, school, or other daily activities	☐	☐	☐	☐	☐
4. I blame myself for things.	☐	☐	☐	☐	☐
5. I am satisfied with my life.	☐	☐	☐	☐	☐
6. I feel irritated.	☐	☐	☐	☐	☐
7. I have thoughts of ending my life.	☐	☐	☐	☐	☐
8. I feel weak.	☐	☐	☐	☐	☐
9. I find my work/school or other daily activities satisfying.	☐	☐	☐	☐	☐
10. I feel fearful.	☐	☐	☐	☐	☐
11. I use alcohol or a drug to get going in the morning.	☐	☐	☐	☐	☐
12. I feel worthless	☐	☐	☐	☐	☐
13. I am concerned about family troubles.	☐	☐	☐	☐	☐
14. I feel lonely.	☐	☐	☐	☐	☐
15. I have frequent arguments	☐	☐	☐	☐	☐
16. I have difficulty concentrating.	☐	☐	☐	☐	☐
17. I feel hopeless about the future.	☐	☐	☐	☐	☐
18. I am a happy person.	☐	☐	☐	☐	☐
19. Disturbing thoughts come into my mind that I cannot get rid of.	☐	☐	☐	☐	☐
20. People criticize my drinking or drug use. (If not applicable, mark "never")	☐	☐	☐	☐	☐
21. I have an upset stomach.	☐	☐	☐	☐	☐
22. I am not working/studying as well as I used to.	☐	☐	☐	☐	☐
23. I have trouble getting along with friends and close acquaintances.	☐	☐	☐	☐	☐
24. I have trouble at work/school or other daily activities because of drinking or drug use. (If not applicable, mark "never")	☐	☐	☐	☐	☐
25. I feel that something bad is going to happen.	☐	☐	☐	☐	☐
26. I feel nervous.	☐	☐	☐	☐	☐
27. I feel that I am not doing well at work/school or in other daily activities.	☐	☐	☐	☐	☐
28. I feel something is wrong with my mind.	☐	☐	☐	☐	☐
29. I feel blue.	☐	☐	☐	☐	☐
30. I am satisfied with my relationships with others.	☐	☐	☐	☐	☐

NOTICE OF PRIVACY PRACTICES

This notice describes how your medical information may be used and disclosed, and how you can access your information. Please review it carefully.

Our practice's commitment to your privacy

The privacy and protection of your health information is as important to our practice as it is to you. Twin Cities Psychological Services, Ltd. (TCPS) is dedicated to maintaining the privacy of your health information. In providing you with healthcare, records are created about the treatment and services that are provided to you.

We are required by the Health Insurance Portability and Accountability Act (HIPAA) to protect and maintain the confidentiality of health information that is maintained by our practice. In accordance with HIPAA, our practice has developed written policies regarding the use and disclosure of your health information.

As a client of our practice, you are entitled to receive notice about privacy practices and how we may use and disclose your health information in different circumstances. This Notice explains how TCPS may use and disclose your health information, the rights you have about how your health information is disclosed, and our obligation to protect the privacy of your health information.

Introduction. When you become a client of our practice, you provide us with information about your health. Each time you visit, a record of your visit is created. Your health record is the information that we use to plan your care, provide treatment, and receive payment for our services. It is important for you to understand that your health record contains personal health information that is protected by federal and state laws.

Our Responsibility. Our practice is required to maintain the privacy of your personal health information and to provide you with a notice about legal duties and privacy practices with respect to your health information. We are also required to accommodate reasonable requests that you make to communicate personal health information by alternative means or at alternative locations. Any time we use or disclose your personal health information, we must follow the terms of this Notice.

How the Practice May Use and Disclose Your Protected Health Information

Uses and Disclosures for Treatment, Payment, and Healthcare Operations

After making a good faith effort to provide you with this Notice, TCPS may use your health information to provide you treatment, to obtain payment for your treatment, and for our internal health care operations. TCPS may use and disclose your personal health information in the following situations:

1. For Treatment. TCPS may use and disclose your personal health information to plan, provide, and coordinate your healthcare services.
2. For Payment. TCPS may use and disclose your personal health information to obtain payment for healthcare services we have provided to you.
3. For Healthcare Operations. TCPS may use or disclose your protected health information for our healthcare operations. For example, to perform risk assessments and other administrative tasks to monitor the quality of care that we provide.

Patient's Rights and Provider's Duties:

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of protected health information about you. You have the right to restrict certain disclosures of PHI to health plans/insurance companies if you pay out of pocket in full for the health care service. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask us to disclose information to another party, you may request that we limit the information we disclose. However, we are not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell us: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations. You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. Upon your request, we will send your bills to another address. You may also request that we contact you only at work, or that we do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to be notified following a breach of unsecured protected health information. You have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, we will discuss with you the details of the accounting process.

Right to Inspect and Copy. In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, we may charge a fee for costs of copying and mailing. We may deny your request to inspect and copy in some circumstances. We may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.

Right to Amend. If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must be made in writing, and submitted to us. In addition, you must provide a reason that supports your request. We may deny your request if you ask us to amend information that: 1) was not created by us; We will add your request to the information record; 2) is not part of the medical information kept by us; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

Right to a Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Changes to this notice: We reserve the right to change our policies and/or to change this notice, and to make the changed notice effective for medical information we already have about you as well as any information we receive in the future. The notice will contain the effective date. A new copy will be given to you.

Complaints:

If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

Privacy Officer.

Dr. Grace Kim
825 Nicollet Mall, Suite 1455
Minneapolis, MN, 55402
Phone: (612)-345-5194

Effective Date of This Notice.

July 1, 2014

Therapist-Client Treatment Information and Agreement

Please be sure to read this information sheet carefully so that you will know what to expect when entering into therapy at Twin Cities Psychological Services, Ltd. This document contains important information about our professional services and business policies. Also please be sure to read the additional HIPAA privacy notice supplied by this provider. When you sign this information sheet it will represent an agreement between you and Twin Cities Psychological Services, Ltd.

Psychological Services.
Psychotherapy is not easily described in general statements. It varies depending upon the personalities of the therapist and the client, and the concerns you wish to address. There are many different methods your therapist may use to deal with the issues that you hope to address. In order for therapy to be most successful, you will need to be committed to the therapy process and work on things we discuss, both during our sessions and at home.

Psychotherapy can have benefits and risks. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. However, since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, and loneliness during the therapeutic process. If these feelings arise, please discuss them in session so that you and your therapist may discuss them fully.

Confidentiality.
All information that you share with your therapist and Twin Cities Psychological Service, Ltd. is strictly confidential (with exceptions noted below). Confidentiality means that the information you share will not be shared with anyone other than whom you designate by written release of information. There are times, however, when we are legally and ethically required to disclose information with or without your permission: (1) in the event that we believe that you demonstrate a clear and imminent danger to either yourself or another person; (2) when there is suspicion of child or vulnerable adult abuse or neglect, which must be reported to the appropriate authority; and (3) when the court requires that we share information, and all attempts to block such a motion have failed. This last circumstance is a rare occurrence and would not happen without your knowledge. In addition, if you are under the age of 18, your legal guardian has a right to be informed about your course of treatment and to have access to your records. Finally, administrative information may be released to a collection agency, if necessary.

In addition, the psychologists and providers at Twin Cities Psychological Services, Ltd. work as a team. The providers will consult with each other as needed and may have access to your information if needed to provide you quality care. Also, the providers at Twin Cities Psychological Services, Ltd. may be involved in professional consultation groups. These groups are to provide you the best care possible. If your case is discussed in these settings, the provider will leave out any identifying information so that your confidentiality is not compromised.

Record Keeping.
Twin Cities Psychological Services, Ltd. uses Theranest.com for its electronic record keeping. TheraNest is HIPAA compliant. All data is stored securely using Amazon Web Services. Amazon's servers infrastructure are certified, ensure the highest physical security and guarantee a 99.9% uptime. You can read more at https://aws.amazon.com/compliance. Amazon Web Services are also, HIPAA, and SOC compliant. AWS has achieved ISO 27001 certification and is a Level 1 service provider under the PCI DSS standards. Theranest.com performs continuous data backups and snapshots. All data in TheraNest are also encrypted using SSL in transit, and encrypted at rest.

Twin Cities Psychological Services, Ltd. also uses an insurance clearinghouse to do all insurance claim submissions. The clearinghouse interfaces directly with our electronic record keeping software and also is HIPAA compliant.

Twin Cities Psychological Services, Ltd. shall retain clinical records for eight years after the date of the provider's last professional service to the client in accordance with Minnesota laws and regulations, except as otherwise provided by law. If the client is a minor, the records retention period shall not commence until the client reaches the age of 18, except as otherwise provided by law.

Assessment/Appointments.
Our first few sessions will involve an assessment of the concerns that bring you to therapy and to determine the best course of treatment for your needs. You will be asked a variety of questions so that we may obtain as much background information as possible. Though the primary focus of this evaluation time is to identify the issues that have precipitated your contact with our office, it is also a time where you and your therapist both will evaluate whether they are the most appropriate clinician to provide the services that will help you meet your treatment goals. By the end of the evaluation period, and if a mutual decision to continue therapy is made, we will offer you some first impressions of what your work may include (this may include a treatment plan to follow). You should evaluate this information along with your own opinions of whether you feel comfortable working with your therapist. Therapy involves a commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, you and your therapist should discuss them whenever they arise. If psychotherapy is begun, we will typically schedule sessions on a regular weekly basis.

Office Hours.
Sessions are held by scheduled appointment between the hours of 7 AM and 7 PM. If you need to reach your therapist between sessions, you may leave a message at any time at 612-345-5194. For crisis situations your therapist will provide 24-hour community resources and discuss a plan for after hour response.

Cancellation Policy.
Sessions are held by scheduled appointment. At the beginning of treatment you and your therapist will agree on a regular meeting time. Because we tend to make appointments long in advance, we ask for a minimum of **24-hour notice** for cancellations. Absences without notice, frequent absences, or cancellation with less than 24 hours notice will result in your being **charged up to $150** for the missed appointment. You should be aware that insurance companies do not reimburse for missed appointments and as such you will be responsible for the payment of this charge.

Fees.
As participating, in-network providers with many insurance plans, we will do all the billing and typically all you have to pay is your copay or co-insurance. We also work with plans that include out-of-network coverage. For individuals without insurance or not covered by an insurance company with which we participate, our standard fee is $250 for the initial appointment and is $220 for ongoing appointments.

Our billing department is available to address payment, billing and authorization matters as needed.

Billing Information.
You are responsible for the payment of all charges rendered to you. You will be expected to pay for each session at the time of service unless some alternative arrangement has been made with me. Payment may be made via cash, check, or credit card, and a weekly or monthly statement for all sessions can be provided to you upon request.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, a collection agency or any other legal means necessary may be used to secure payment, and legal costs will be included in the claim. This will occur only after such a notice of intended action is provided to you.

Insurance Information.
If your insurance or health care provider will be covering all or part of the expenses for services rendered, reimbursement for fees will be arranged by our office. Our office will complete any documentation required by your provider for this purpose. You are still ultimately responsible for the full payment of your account when billed, and you will await reimbursement from your insurance company. If claims are denied or not paid by the insurance company, you agree to be responsible for the full amount of charges incurred. **Further, if you are using health insurance, please understand that you are authorizing us to release to your insurance carrier such information as is specifically required for processing claims.** Such information includes, but is not limited to, diagnosis, dates, of service, type of treatment, progress reports, etc.

If you change your insurance provider or plan, please let the office know as soon as possible.

****

☐ I have read and understand the information contained in this document. I have had the opportunity to discuss my questions and concerns regarding services with Twin Cities Psychological Services, Ltd. during our initial interview, and my signature below indicates that I consent to services and policies outlines in this document.

☐ I have received and read the Notice of Privacy Practices and the Minnesota Patient Bill of Rights

_____ _____
Signature Date

_____
Printed Name

_____
Provider signature

_____
Legal Guardian (if necessary)

_____
Legal Guardian's Printed Name (if necessary)

TELEHEALTH CONSENT FORM

Client Name:_____Date of Birth_____

Address_____Phone #_____

As a client of Twin Cities Psychological Services (TCPS), I understand that services are provided remotely, as described below. I understand and agree to the following with respect to the use of TCPS's telehealth services:

1. Telehealth services are provided on a HIPAA-compliant video system that is attached to our electronic health record (Theranest). My information provided in the telehealth session is subject to the same rules of confidentiality as an in-person session, with exceptions to confidentiality the same as noted in my signed TCPS informed consent. I also agree that if I need hospitalization or additional services, I will work with my TCPS therapist to obtain this higher level of care.
2. Theranest does not record or store the audio or video of Telehealth sessions. By agreeing to participate in a Telehealth session with TCPS, I also agree not to record, store, or share the audio, video, or images of my Telehealth sessions in order to maintain boundaries and confidentiality.
3. Although all reasonable efforts are made to keep my information secure and confidential, there is a risk of my health information being disrupted, distorted or intercepted by or accessed by unauthorized persons. At this time, I agree to participate in telehealth sessions despite these risks. If I do not accept the risks, my TCPS provider can work to set up an in-person session at a time or date agreeable to both parties.
4. Telehealth sessions are completed by Licensed Psychologists, Licensed Independent Clinical Social Workers, Licensed Professional Clinical Counselors, and Licensed Marriage and Family Therapists.
5. Telehealth services may not be the same as my in-person services. It is understood that there could be a loss of non-verbal communication which could impact the interaction. We may lose some of the non-verbal communication and I will discuss the difference with my TCPS provider.
6. Telehealth therapy sessions may not be covered by my individual insurance plan. I agree that I have verified coverage or will pay the full fee for the session.
7. If our telehealth session abruptly terminates, my TCPS therapist will call or e-mail me at the number or email address on file. We will attempt to reconnect to the telehealth platform. It is important to note that TCPS does not have control over my end of the transmission, and the quality of my internet connection may affect the quality of the video/audio.

I have read and understand the information provided above. I have asked the TCPS therapist any questions I had and all of my questions have been answered to my satisfaction. I hereby consent to participate in telehealth services under the terms described above.

Client Signature_____Date:_____

Parent/Guardian Signature:_____Date:_____