Soul Work Counseling

MINOR (Child/Adolescent) Form - LONG

11925 Central Ave NE, Blaine, MN 55434
11188 Zealand Ave N, Champlin, MN 55316
Phone: 763-746-0842 Fax: 763-220-6025

Client Identification Data

Child Name (Last)	(First)	(M)	Age	Birthdate	Identified Gender

Address | City | State | Zip

Mom/Parent/Guardian 1 Cell Phone: ☐ Can we call? (check)	Dad/Parent/Guardian 2 Cell Phone: ☐ Can we call? (check)	Mom/Parent/Guardian 1 **Email** address:

Parent/Guardian Marital Status
Single ☐ Cohabit ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Dad/Parent/Guardian 2 **Email** address:

Child's administrative Sex, for insurance purposes, may be different than Gender: ☐ **M** ☐ **F**	If divorced who has legal/medical authorization?	Who is the primary parent covering health care? Employer:

Family History

Family Members (mom, dad, siblings, step-family, other) Including siblings NOT living with child	**Age**	**Date of Birth**	**Living in Household** **Yes**	**No**	**Occupation**
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
*** More space on the top of page 4**			☐	☐	

Notify in case of emergency (Name, contact information, and relationship to minor)

Address	Home and/or Cell Phone
* By writing in emergency contact information, you are authorizing us to contact this person when needed in the future for emergency situations, which supersedes confidentiality.	Relationship to Minor

Presenting Situation **(include reason for making appointment, precipitating events, onset of when difficulties started)**

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Counseling and Psychiatric History (dates of treatment, hospitalizations, providers/treatment and outcome, etc.)

☐ Outpatient treatment ☐ IOP ☐ Partial hospitalization ☐ Inpatient ☐ Residential treatment

Previous Mental Health Diagnoses: _____

Describe past mental health treatment (dates, providers/addresses, outcomes): _____

_____

_____

Reason forTreatment: _____

Abuse History

History of Abuse: ☐ no ☐ yes, If yes: ☐ physical ☐ sexual ☐ verbal/emotional ☐ Other **Legal Action:** ☐ no ☐ yes

By: _____

When: _____

For Adolescents age 12-17 years old, include sexual behavior history: _____

_____

Trauma History or Significant Changes – accidents, injuries, illnesses, losses, death of a loved one, and other

(Please also include information about any traumatic or violent event this child may have Witnessed)

_____

_____

_____

_____

_____

Family Mental Health History (include family history ofsuicide/homicide)

Maternal side: ☐ depression ☐ anxiety ☐ bipolar ☐ eating disorder ☐ alcoholism ☐ drugs ☐ suicide

Paternal side: ☐ depression ☐ anxiety ☐ bipolar ☐ eating disorder ☐ alcoholism ☐ drugs ☐ suicide

Additional information: (which family members, treatment received, other diagnoses, etc.):

_____

_____

_____

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Physical Health Data			
Child's Physician (Full Name):			
Address (Clinic Name)	(Street)	(City)	(State/Zip)

Date of most recent physical for the child: _____

Does this child have any current medical problems (including any infectious diseases): ☐ Yes ☐ No

Please describe: _____

_____

Are the medical problems being treated? ☐ Yes ☐ No If yes, by whom? _____

Have they ever had a drug allergy or sensitivity? ☐ Yes ☐ No If yes, to what drug: _____

Has this child had any surgeries? ☐ No ☐ Yes If yes, what: _____

Perinatal Information for Child: Was the pregnancy and delivery of the child within normal limits? ☐ Yes ☐ No

Other information about pregnancy and delivery: _____

_____

Medications

Current Medication(s) AND Reason it was prescribed:

_____

Prescribing Provider: _____

Hospitalization Name or Facility/Doctor/Address: _____

_____

_____

Reason For Treatment: _____

_____

Substance Use and Abuse History

Is this Child or Adolescent using any of the following NON-prescribed chemicals:

☐ Alcohol ☐ Tobacco ☐ Vaping/Nicotine ☐ Marijuana ☐ Methamphetamine ☐ Pills/Synthetic ☐ Other

Has this child received any chemical abuse or dependency treatment? ☐ No ☐ Yes If yes, where: _____

_____

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Additional Family History or important family members, and extended family members, in this child'slife

_____

_____

Social History

Friends: _____

Group Affiliations: _____

Religious/Spiritual Beliefs/Church: ☐ No ☐ Yes Describe: _____

Cultural Factors Influencing Mental Health? ☐ No ☐ Yes If yes, what? _____

ROTC History, or plans to join the military? ☐ No ☐ Yes If yes, what and when? _____

Hobbies/Enjoyable Activities: _____

List any Community Resources currently used (such as support groups, social services, school-based services or other support):

_____

Developmental History

Did this child reach developmental milestones within normal limits? (i.e., walk on time, talk on time) ☐ Yes ☐ No (describe):

_____

If school aged, has this child needed any extra support at school (learning disorders, IEP, special education) ☐ No ☐ Yes (describe):

_____

Has this child ever experienced a head injury? ☐ No ☐ Yes (explain)_____

Educational/Occupational History

For 0-3 years old: ☐ Home with a caregiver? (who)_____ ☐ Daycare (where)_____

For 3-5 years old: ☐ Home with a caregiver? (who)_____ ☐ Preschool (where)_____

School Age: What grade is this child in, or most recently finished? _____Held back any years?_____

Describe how school is going: _____

Any paid work for an adolescent? ☐ No ☐ Yes If yes, where and hours _____

Legal History

Any legal issues going on in this child's life? ☐ No ☐ Yes If yes, what: _____

Child's Strengths

What are some of this child's personal strengths: _____

_____

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CLIENT NAME_____**DATE**_____

Form completed by: _____

Current Symptom Checklist: Rate the intensity of symptoms present in the last 4 weeks.

None: This symptom not present at this time.
Mild: Impacts quality of daily life, but no significant impairment of day to day functioning.
Moderate: Significant impact on quality of life and/or day-to-day functioning.
Severe: Profound impact on quality of life and/or day to day functioning.

[Mark choice with an "X"]

Symptom	None	Mild	Moderate	Severe	Symptom	None	Mild	Moderate	Severe
Depressed Mood					Increased/decreased appetite				
Social Isolation					Unplanned weight gain or loss				
Sleep Disturbance					Cruelty to Animals				
Dissociation (Zoning out)					Paranoid Thoughts				
Hyperactivity					Poor concentration or Indecisive				
Purging (throwing up)					Over-exercising				
Nightmares					Excessive Worrying				
Unresolved Guilt					Impulsive actions/speech				
Irritability (crabby moods)					Anger management problems				
Nausea/Acid indigestion					Vandalism / stealing				
Social Anxiety					Hallucinations				
Self-mutilation/cutting					Racing Thoughts				
Low Self-worth					Restlessness				
Developmental Delays					Loss of interest in regular activity				
Truancy (skipping school)					Lying				
Losing train of thought					Soiling/Wetting				
Mood Swings					Easily Distracted				
Disorganized					Bothersome Memories of Trauma				
Restricting food or not eating					Hopelessness				
Drug Experimentation					Poor Grades/Problems at School				
Grief					Panic Attacks				
Phobias					Feel panicky/anxious				
Smoking Cigarettes/vape					Suicidal Thoughts				
Bullying / Being bullied					Attempted Suicide in the Past				
Problems at Home					Problems with Parent				
Inappropriate Internet use					Physical Complaints				

Briefly describe how the above symptoms impact this child's daily functioning:

_____
_____
_____
_____

Goal(s) for Counseling/Intervention (i.e., What would be different after counseling?):

_____
_____
_____
_____

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Treatment Contract/Registration

WELCOME! The most important goal of psychotherapy, or psychological testing and evaluation, is to help you feel and function better in your life. As a client, you can help with your treatment by keeping the following information in mind throughout your therapy. This is a solution-focused, goal directed approach for a wide variety of problems, from crises in daily living to ongoing mental health issues. It is especially important that you keep in close contact with family or supportive friends during a crisis and that you assume responsibilities for helping yourself. Treatment will be provided in the least restrictive environment possible.

Standard therapy sessions are either 45-60 minutes. While this can be somewhat flexible, the time frame will be maintained as much as possible to help all involved. Also, this is a courtesy to others who may be waiting. If you are dissatisfied with your progress in therapy, please discuss this openly. Your input and concerns are very important and talking about them leads to beneficial results for all involved.

Confidentiality: Please understand that what you say is CONFIDENTIAL and will be discussed with other people only with your written permission (except in medical emergencies, under a court order, or as required by law, i.e. mandatory child abuse reporting, and vulnerable adult abuse reporting, or for the purpose of consultation or supervision). If there is a clear intention to do serious harm to self or to another person, information will be shared in an attempt to prevent that harm from occurring. When a minor child is seen for mental health services, issues regarding confidentiality will be discussed with the minor client and parents/guardians.

Consultation and Supervision: To provide you with the best possible service, Soul Work Counseling providers engage in ongoing supervision and consultation with other mental health professionals. Pre-licensed therapists receive additional supervision to provide the highest quality treatment in accordance with state law. When discussing clients in these forums, confidentiality is protected. If adults associated with this minor client are participating in their own individual or couple's therapy at Soul Work Counseling, all individual therapists and family therapists for the family will consult on all therapy.

If my clinician is Pre-licensed, I understand my clinician might be under supervision and not yet fully credentialed.

Crisis Situations: Steps to take during a crisis will depend upon the nature of the crisis. You may call your individual therapist during normal business hours and then use the Crisis Line to connect to a crisis counselor by texting HOME to 741741 after business hours, on weekends and holidays. When immediate service is required for life threatening situations, please call 911 or go to the emergency department at the closest hospital.

Emails and text messages do not provide sufficient confidentiality. You may put things in writing to us and request that we do the same for you. However, we cannot guarantee that our security will never be breached.

Guardian Understands and Accepts this security limit to electronic communication.

Office Hours and Cancellation Policy: Office hours vary by therapist. Therapy time is valuable to all involved. Please note that insurance companies do not pay for no-shows or late canceled appointments. This is standard practice and is intended in part to preserve the time for those who may need it. You can make appointment changes by calling the office and leaving a message with your provider. Should you arrive late, your therapy will end at the normal scheduled time. You must pay in full for that session. If you cancel less than 24 hours' notice you must pay for that session. Clients who no-show or cancel twice without 24 hours advance notice will receive services only on same-day scheduling availability. If you are using insurance, which we accept, you must pay us your deductible at the beginning of each year and any co-pay at each session. We do not want to see you in the office if you have any infectious illness or lice. Please let us know ASAP at no charge.

I understand that, in most situations, cancellations or changes of an appointment must be made at least 24 hours in advance, and I accept the responsibility of being charged $100 for a late fee if cancellation does not occur then.

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Fees, Phone Calls and Reports: Fees are as follows: $250 for the initial Diagnostic Assessment session, which is the initial Intake session prior to starting psychotherapy or prior to starting psychological testing and assessment.

For psychotherapy services, fees are $225 for each individual psychotherapy session and $225 for each couples session or family session, and $80 for group psychotherapy, per session. It is difficult to predict duration of treatment, but, for mild to moderate difficulties, a common number range of sessions for outpatient mental health treatment is anywhere between 8-15 sessions. However, some people who have more complex issues may require 30+ sessions over an outpatient treatment period.

Psychological testing and evaluation costs are discussed upfront and/or determined by your insurance company. Below is a list of common CPT psychological test billing codes that you can use to check with your insurance company to help estimate your expected deductible/co-insurance. If paying cash for psychological testing, cost for each unit of CPT codes is as follows and will fluctuate depending on tests utilized and time needed to complete the entire evaluation:

96130 = $225 (first hour of test interpretation/writing time/additional clinical interview time in addition to the intake)
96131 = $175 (multiple units probable, a unit for each additional hour of test interpretation/writing/feedback time)
96136 = $100 (first 30 minutes of direct test set-up and instructions and/or test administration/scoring time)
96137 = $85 (multiple units probable, a unit for each additional 30 minutes of test administration/scoring time)

Fees are not charged for phone calls, letters and reports to facilitate scheduling, information sharing, etc. requiring up to 10 minutes of time. After 10 minutes, you are billed at a prorated $200 per hour rate. Scheduling paid telephone sessions is welcome when a situation is particularly urgent or because of travel or geographical difficulties and must be cash or credit card as insurance will not always pay for an audio only phone session.

Consent details for Telehealth sessions with your provider are outlined in Soul Work Counseling's Telehealth Signature Form, which can be found on the Forms page of the company website: https://www.soulworkcounseling.com/forms/

Insurance and Bookkeeping: You may call with any questions regarding your billing. **Please remember that services are provided for and charged to you, not your insurance company**. **You are responsible for checking with your insurance company and/or your employer to be certain that they cover the services required.** Because of the wide variety of insurance plans available, guarantees cannot be made that any particular company will provide payment for services that you receive. If your insurance company does not cover the services you receive, you are fully responsible for the amount due. If you have any questions about obtaining coverage, please ask. However, your insurance company will make a decision about any reimbursement.

Collections: In the event you do not pay your bill, Soul Work Counseling reserves the right to seek payment through the use of a collection agency or through other legal means. The cost of collection may be added to your bill. Return check fee is $35 and will be billed to you. Unpaid balances may incur reasonable and customary interest charges.

Record-keeping, Requests from Third Parties for Records, Testifying Regarding Records, and Related Costs. Our records are confidential and may not be used as evidence for litigation purposes. This includes all assessments, questionnaires, evaluations, and testing.

If a child or children are involved, you or your non-health care advisors may not subpoena our documents or use documents or communication as evidence in any proceedings related to the therapy process. Be advised that if we are somehow compelled to release documents, you as a client acknowledge and grant the right for us to give identical documents to the opposing party.

If we are forced to further document or respond to information requests, meet with your representatives, or testify in court, our fees are $400/hour, portal to portal (travel from our starting location to the meeting location), plus all expenses, half day minimum, paid in advance. Agreement to this provision is required to receive therapy services from us, and is acknowledged by your signature at the end of this document.

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Bill of Rights/Registration

BILL OF RIGHTS

Consumers of services offered by Behavioral Health Care therapists licensed by the State of Minnesota have the right:

1. to expect that the practitioner has met the minimal qualifications of training and experience required by state law.
2. to examine the public records maintained by the therapist's licensing board which contain the credentials of the practitioner.
3. to obtain a copy of the rules of conduct from the therapist's licensing board.
4. to report complaints to the practitioner, and if not satisfactorily resolved, to file a complaint with the therapist's licensing board.
5. to be informed of the cost of professional services before receiving theservices.
6. to privacy as defined by rule and law. This means that no information will be released from the facility in which the practitioner works without the client's informed, written consent, except for the following:
    a. The practitioner is required by law to report instances of abuse or neglect of a child or a vulnerable adult.
    b. The practitioner is required by law and professional codes of ethics to notify proper persons and/or authorities if the practitioner believes there is a danger to a client or another identifiedperson.
    c. The practitioner is required to report admitted prenatal exposure to harmful controlled substances.
    d. In the event of a client's death, the spouse or parents of the deceased have a right to access the client's records.
    e. The practitioner must produce records or testimony in response to a Court Order and potentially to a subpoena.
    f. Parents or legal guardians of a non-emancipated minor client have the right to access their child's records.
    g. Case discussions with other staff through case management, consultation, testing, and treatment are confidential and are to be conducted as such by all staff.
7. to be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving psychological services.
8. to respectful, considerate, appropriate, and professional treatment.
9. to see information in the client's record upon request.
10. to be involved in the formulation of the treatment plan, the periodic review of plans and progress, and the formulation of the discharge plan.
11. to be informed of treatment options, expected outcome of treatment, expected length of treatment, and cost in language that the client can understand.
12. to discuss needs, wants, concerns, and suggestions with the practitioner.
13. to be advised as quickly as possible if a scheduled appointment time cannot be kept due to illness or emergency.

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Services NOT Offered.
We are **not qualified** and we **do not offer** the following services:

1. Custody Evaluation
2. Visitation Recommendations
3. Disability Evaluation or Recommendation
4. Services requiring testimony in legal proceedings.

Note: Therapy ends when a subpoena arrives. We will attempt to legally squash a subpoena request. Therapy summarization documents for legal purposes require written client release and cost $250 per request. Copies will be sent to opposing counsel.

I understand and agree to abide by the policies stated above.

Health Information Privacy Practices

I have received information on accessing Soul Work Counseling's Health Information Privacy Practices notice and I have been provided an opportunity to review.

* Soul Work Counseling's HIPAA document can be found at www.soulworkcounseling.com/forms/

Signature acknowledges receipt and understanding of the Treatment Contract, the Bill of Rights, HIPAA information, Telehealth Consent (if needed), and above documented limitations to services at Soul Work Counseling. Returning this signature page indicates you have read and understand the entire Intake Packet, even if only returning this signature page to Soul Work Counseling.

_____ _____

Signature of Parent/Guardian **Date**

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Parent/Guardian Authorization to work with Child/Minor

The State of Minnesota allows parents the legal right to have access to a child's records. One of the most important aspects of **Psychotherapeutic Counseling** is the relationship between the client and the therapist. It may take time to build a relationship of trust with a minor. Often many sessions are needed for the minor child to feel comfortable with the psychotherapy process and with the therapist.

Children and teens need to feel safe and trusting to be able to open up about issues that concern them. If minor children know that parents have access to their records and can request access to their records it will hinder the therapeutic process.

Your therapist will not keep critical information from parents. We make it clear in our intake process that, as mandated reporters, we must report any behavior that is considered risk taking or life threatening such as suicidal ideation, self-mutilation, plans to run away, or any threats made to harm others or being harmed by someone else.

We also strongly encourage and facilitate children and teenagers having their parents/guardians participate in psychotherapy when it is appropriate and helpful, such as through brief parent check-ins or full family sessions, when needed.

For minors undergoing **Psychological Testing and Assessment** at Soul Work Counseling, parents/legal guardians can request a copy of that psychological evaluation for family records.

However, for psychotherapy services at Soul Work Counseling, we ask parents or guardians to waive the right to access the minor's psychotherapy progress notes to protect their minor child's privacy in psychotherapy. We will supply records to court directly if needed. We will supply records to other health care professionals directly if requested on condition that they protect the records of the child as well.

I have read and understand the waiving of my rights to have access to psychotherapy progress note records, and agree to have Soul Work Counseling work with my child.

_____

Minor's Name

_____

Parent/Guardian 1 Name Signature Date

_____

Parent/Guardian 2 Name Signature Date

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CONFIDENTIAL EXCHANGE OF INFORMATION FORM
THIS IS NOT A REQUEST FOR MEDICAL RECORDS

Best practice requires contracted behavioral health practitioners and facilities to coordinate treatment with other behavioral health practitioners, primary care physicians (PCPs), and other appropriate medical practitioners involved in a member's care. Please complete this form and send it to the appropriate care provider(s) treating the member.

PATIENT NAME:_____ **DOB:**_____

A. Treating Behavioral Health Practitioner/Facility Information:
Name:_____ **Phone:**_____
Address:_____ **Fax:**_____

B. PCP/Medical Practitioner or Other Behavioral Health Practitioner/Facility Information:
Name:_____ **Phone:**_____
Address:_____ **Fax:**_____

C. Patient Clinical Information:
1. The patient is being treated for the following behavioral health condition(s):

_____
2. The patient is taking the following prescribed psychotropic medication(s):

_____
3. Expected length of treatment: ☐ **3 months** ☐ **3-6 months** ☐ **6-12 months** ☐ **>1 year**
4. Coordination of care issues/Other relevant information impacting care: _____

_____
I hereby freely, voluntarily and without coercion, authorize the behavioral health practitioner listed above in Section A to release the information contained on this form to the practitioner/provider listed in section B above. The reason for disclosure is to facilitate continuity and coordination of treatment. This consent will last one year from the date signed. I understand that I may revoke my consent at any time.

Check any that apply BELOW:
☐ Please DO NOT contact this child's PCP. ☐ DO NOT contact any of this child's other mental health providers.
☐ This minor client DOES NOT have a regular Primary Care Provider (PCP) or any other medical service provider.
☐ This minor client currently DOES NOT have any other behavioral health practitioner or psychotherapist/counselor.

_____ _____
Patient Signature **DATE**

_____ _____
Behavioral Health Practitioner/Facility Representative Signature **DATE**

For Patient Records Applicable Under Federal Law 42 CFR Part 2:To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42) CFR Part 2 prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Date Mailed or Faxed to Other Practitioner/Facility: _____