Client Name:_____

Notice of Privacy Practices &

Electronic Payment Communications Disclosure

Receipt and Acknowledgment of Notice

Client Name:_____
DOB: _____
SSN:_____

I hereby acknowledge that I have received and have been given an opportunity to read Jason Schweitzer LLC's Notice of Privacy Practices and Electronic Payment Communications Disclosure Policies. I understand that if I have any questions regarding the Notice or my privacy rights or my use of electronic payment for services, I can contact Jason directly at (507) 271-0467.

I authorize Jason Schweitzer LLC to provide notice to me by telephone or verbally in the event of a breach of my protected health information (PHI) by Jason Schweitzer LLC. Such conversation shall be documented by Jason Schweitzer LLC. Pursuant to HIPPA of 1996 Final Rule modifying the HIPPA Privacy, Security, Enforcement and Breach Notification Rules, the verbal or telephonic notice provided to me pursuant to this authorization shall not be simply for the administrative convenience of Jason Schweitzer LLC.

_____

Signature of Client ***Date***

_____

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

_____

* *If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).*

❑ ***Client Refuses to Acknowledge Receipt****:*

_____

Signature of Staff Member ***Date***

Client Name:_____

FINANCIAL INFORMATION FORM

I sincerely appreciate the opportunity to work with you on the concerns that have brought you for help with your mental health. As part of providing quality services, I need to be clear about our financial arrangements. Please bring your insurance card with you to your first appointment. If you have health insurance, it may pay for all or part of the cost of your treatment here. To submit claims, I need the information requested below and your signature on the back of this page. If you do not have health insurance coverage, please complete sections A and F of this form, and return it to me.

A. Client's name: _____ Birth date:____/____/_____ Soc. Sec. #:_____

Address:_____City, Zip_____

Home Phone:_____ Mobile Phone:_____ E-mail address:_____

Insured's policy holder's name and Birth date (if other than client):_____

Occupation:_____ Employer:_____ Work Phone:_____

Address of employer: _____

B. (If applicable) Spouse/Parent Name:_____ Phone:_____

C. Private Health Insurance Information (e.g., MMSI, BCBS, UBH, etc).

Name of **primary** insurance carrier/company:_____

Location:_____ Phone Numbers:_____

Subscriber/policy holder (if other than client): _____

Identification #:_____ Group #:_____

Additional information:_____

Copayment (% or dollar amount):_____(due at the time of each scheduled session)

Name of **secondary** insurance carrier/company (if applicable):_____

Location: _____ Phone Number(s):_____

Subscriber/policy holder (if other than client):_____

Identification #:_____ Group#:_____

Additional information:_____

Copayment (% or dollar amount):_____ (due prior to each session)

D. Public Health Insurance Information (e.g., Medicare, Medical Assistance, UCare, MNCare, etc.)

Medical Assistance Number(s):_____

Medicare Number (with any letters)_____

Other public payment source(s): _____

Copayment (% or dollar amount):_____(due at the time of each scheduled session)

E. Other Third Party Payer Information

Describe payment arrangements:_____

_____

F. If you do not have health insurance, or choose not to use it, how will you pay for services?_____

_____

Client Name:_____

FINANCIAL AGREEMENT FORM

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents to LM Billing Services, Inc. I further expressly agree and acknowledge that my signature on this document authorizes my provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. My provider is given permission to release any information obtained during treatment that is necessary to support any insurance claims on this account, for certifications/case management decisions, and other purposes related to the administration of benefits for my health plan, and to secure timely payments. Ordinarily such information will include diagnosis, dates of service, and treatment goals and progress, but on occasion additional information, such as copies of the assessment report or progress notes, may need to be provided to the insurance carrier.

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the provider, Jason R. Schweitzer, LICSW. I understand that my insurance company will be billed directly by the provider. I will be financially responsible for all charges incurred including any applicable deductibles and copayments. If I am not eligible for health insurance benefits at the time services are rendered, I am responsible for full payment as agreed by pre-arrangement. A photocopy of this assignment is to be considered as valid as the original.

I_____ hereby authorize _____

(Client or Authorized Representative Signature) (Name of Insurance Company)

to pay and hereby assign directly to Jason Schweitzer all benefits, if any, otherwise payable to me for service provided as described on attached forms. _____

(Date)

APPOINTMENTS AND FEES

APPOINTMENTS: All appointments are scheduled in advance and this time is reserved for you.

CANCELLATIONS: If it becomes impossible to keep your appointment due to illness or emergency, please contact me at least **24 hours in advance.** Cancellations received less than 24 hours in advance will be billed **$40.00**. Missed appointments (appointments skipped without notice) will be billed up to the regular session rate of $160.00. Insurance companies will normally not pay for missed sessions. If you receive health insurance via a Government-Sponsored program and attendance is problematic, you may be requested to wait six or more weeks before resuming services or to schedule same day services as appointments are available.

COPIES: When Minnesota Statute 144.292 applies, http://www.health.state.mn.us/divs/hpsc/dap/maxcharge.pdf, charges for sending copies of medical records to client and non-client entities are $1.38 per page for copy fees and $18.36 for retrieval fees. Clients are responsible for these charges. Minnesota worker's compensation will be charged a $10 retrieval fee and $0.75 per page for copies of the "appropriate record" to substantiate a service being billed.

COURT FEES: Affidavits are $80 (paid in advance). Phone calls: $160/hr. Court Appearances are $285/hr.

FEES:

• Initial Interview-Diagnostic Assessment	$175.00	Letters	$25.00
• Individual Therapy Session	$160.00	Letters to Employers	$50.00
• Couples Therapy	$160.00	Treatment Summaries	$80.00
• Couples Therapy Assessment	$35.00		

Client Name:_____

ADULT PERSONAL HISTORY QUESTIONNAIRE

Please notify me at least **24 hours** in advance if you need to reschedule or cancel. I look forward to meeting you. Thank you!

The information requested is to facilitate appropriate treatment for your expressed needs. The data you provide is private and will be shared only according to laws about data privacy and confidentiality. Please respond thoroughly.

Your name:_____ Date:_____

Date of birth:_____ Age:_____

A. PRESENTING PROBLEM/S:

1. Please describe the problem for which you are seeking help:

2. When and how did your current problem(s) begin?

3. What have you already done to try and solve or cope with this problem?

4. Please check **problem areas** that pertain to you currently:

☐ Academic/School	☐ Flashbacks	☐ Parenting
☐ Alcohol/Drug Abuse	☐ Grief/Loss	☐ Religious Spiritual
☐ Anger	☐ Hallucinations	☐ Socialization
☐ Anxiety	☐ Intimacy	☐ Sexuality
☐ Criminal Behavior	☐ Legal Issues	☐ Sleep
☐ Depression	☐ Marital/Relationship	☐ Thought Processing
☐ Dissociation	☐ Mental Illness	☐ Substance Abuse
☐ Eating	☐ Mood	☐ Substance Dependence
☐ Employment	☐ Obsessions and/or Compulsions	☐ Victim of Abuse
☐ Family Conflict	☐ Oppositional Behavior	☐ _____

List previous mental health diagnosis:_____

Approximately when this diagnosis assigned:_____

B. MENTAL & MEDICAL HEALTH:

Please list current providers and their role (e.g. medical doctor, psychiatrist, marriage counselor, case manager, etc.):

NAME:	**ROLE:**	**AGENCY & LOCATION:**
_____	Primary Care Provider_____	_____
_____	Psychiatrist_____	_____
_____	Therapist_____	_____

Describe any current **medical** problems or physical symptoms you are having:

Do you have an Advanced Care Directive (Health Care Directive)? Y or N. Where is it located? _____

Last physical examination/location? _____

Any serious illnesses injuries, surgeries or head trauma? Y / N Please describe:

Dates of previous hospitalizations for mental health problems:

DATES: (FROM-TO):	**FACILITY/Practitioner & LOCATION:**	**REASON FOR TREATMENT**
_____to_____	_____	_____
_____to_____	_____	_____
_____to_____	_____	_____

(Use additional sheet if necessary)

Client Name:_____

List all current medications, including dosage if possible and who prescribes it:

MEDICATION:	DOSE:	REASON FOR USE:	PRESCRIBED BY:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Use additional sheet if necessary)

C. CHEMICAL USE/ADDICTIVE BEHAVIOR:

Do you currently drink alcohol? Yes/No: In the past? Yes/No If YES: Age of first use of alcohol? _____
What type/s of alcohol do you drink? _____ How much/often do you drink? _____
Last time intoxicated? _____ List any related legal consequences with dates: _____

Have you ever felt you ought to **cut down** on your drinking or drug use? _____Yes _____No
Have you ever had people **annoy** you by criticizing your use of drugs or alcohol _____Yes _____No
Have you ever felt bad or **guilty** about your drinking or drug use? _____Yes _____No
Have you ever had a drink or used drugs as an **eye opener** first thing upon getting up to steady your nerves, or get rid of a hangover, or to get the day started? _____Yes _____No

Used illegal drugs? Yes/No What types? _____ Date of first use: _____
Most recent use of drugs? _____How often do you use drugs? _____ Abused prescription drugs? Yes/No
Do you use tobacco products? Yes/No; If YES, what type and how much?
Please describe the amount of caffeine that you typically consume daily, include energy drinks, soda, etc.:

Please list treatments you have had for chemical abuse or dependency:

Dates: (from - to):	**Facility & Location**
_____to_____	_____
_____to_____	_____
_____to_____	_____

(Use additional sheet if necessary)

Members of your immediate/extended family experienced problems with chemical abuse/dependency? Yes/No
What type? _____Alcohol _____Drugs Explain:

Do you gamble including playing the lottery or pull tabs, etc.? Yes/No
Have you ever felt the need to bet more and more money? Yes/No
Have you ever lied to people important to you about how much you gamble? Yes/No

Please indicate whether the following statements described you during the past three (3) months?

1. I felt bad or guilty about my use of pornography Y/N
2. I was upset because I could not stop thinking about pornography Y/N
3. It was necessary for me to watch pornography to feel at ease and/or orgasm Y/N
4. I tried to cut down or stop my pornography watching Y/N

Client Name:_____

D. FAMILY HISTORY

What State/County/Country where you born? _____ Are you adopted? Yes/No

Where and by whom were you raised?

Are your parents married to one another? Yes/No. If parents divorced/separated, how old were you?

Please complete the following information regarding your parents (and step-parents, if any)

NAME	LIVING?	AGE	OCCUPATION	PLACE OF RESIDENCE
_____	Y N	_____	_____	_____
_____	Y N	_____	_____	_____
_____	Y N	_____	_____	_____
_____	Y N	_____	_____	_____

Please complete the following information regarding sibling, step-siblings, or half siblings.

Name of sibling, half-sibling, etc.	Age	Marital Status	Occupation	Place of Residence
_____	____	S M D	_____	_____
_____	____	S M D	_____	_____
_____	____	S M D	_____	_____
_____	____	S M D	_____	_____
_____	____	S M D	_____	_____
_____	____	S M D	_____	_____

Describe what it was like growing up in your family:

Was there any violence or other abuse in your family of origin? Yes/No

If YES, briefly describe the nature of the abuse (physical, sexual, emotional, etc.) and identify the perpetrator and victim:

Have members of your immediate or extended family experienced problems with mental illness? Yes/No

If YES, please indicate their relationship to you and the nature of their problems:

Describe your current relationships with your parents and siblings:

E. RELATIONSHIP AND MARITAL HISTORY

At what age did you start dating? _____ What was the longest dating relationship you had? _____

If you are currently married or have a domestic partner, please describe the following:

Name: _____ Length of relationship: _____ Years married: _____

Problems in the relationship: Strengths in the relationship:

Do you share your thoughts and feelings with close friends? Yes/No

Please provide the following information about your children:

Name	Gender	Age	Living with you?	Educational Level	Marital Status
_____	M F	_____	Yes No	_____	M S D
_____	M F	_____	Yes No	_____	M S D
_____	M F	_____	Yes No	_____	M S D
_____	M F	_____	Yes No	_____	M S D
_____	M F	_____	Yes No	_____	M S D
_____	M F	_____	Yes No	_____	M S D
_____	M F	_____	Yes No	_____	M S D

Please list and previous marriages or domestic partners:

Name	Married?	#Yrs. in relationship	Year ended	Reason for break-up
_____	Yes No	_____	_____	_____
_____	Yes No	_____	_____	_____
_____	Yes No	_____	_____	_____

Were any of the following forms of abuse in these relationships?

_____physical _____verbal _____emotional _____sexual _____financial _____intimidation; other: _____

If so, please describe:

Other traumatic experiences:

Client Name:_____

F. EDUCATIONAL HISTORY:

Name of Institution (high school, etc.)	Location	Dates	Major	Graduated?	Degree
_____	_____	___to___	_____	Y N	_____
_____	_____	___to___	_____	Y N	_____
_____	_____	___to___	_____	Y N	_____
_____	_____	___to___	_____	Y N	_____

Do your current problems have an impact on your education? Please describe:

G. OCCUPATIONAL HISTORY:

Employer (Begin with most recent)	Job Title	Date: From-to	Reason for leaving
_____	_____	_____to_____	_____
_____	_____	_____to_____	_____
_____	_____	_____to_____	_____
_____	_____	_____to_____	_____
_____	_____	_____to_____	_____

Do your current problems have an impact on your employment? Y/N Please describe:

H. MILITARY HISTORY:

Did you serve in the military? Yes/No. If "Yes", what branch/es did you serve in?_____

When did you serve? (Enlistment Date/Discharge Date)_____

What was your Military Occupational Specialty_____

ATTENTION: All military personnel, please bring a copy of your DD214 at time of discharge from service.

Any additional information that might be helpful in creating a treatment plan?

Thank you for your cooperation!

Client Name:_____

ISSUES INVENTORY Name: Date:

Below you will find a list of problems frequently listed by people who seek counseling. Look down the list and rate yourself as to the degree of severity that each subject presents. Circle the numbers from 1- (no problem) to 5 (severe problem) that apply currently.

SUBJECT	**NO PROBLEM**				**SEVERE**
Crying for no reason	1	2	3	4	5
Can't enjoy myself	1	2	3	4	5
Feeling lonely	1	2	3	4	5
Feeling down/depressed	1	2	3	4	5
Feeling hopeless	1	2	3	4	5
Low self-esteem/self-confidence	1	2	3	4	5
Feeling unhappy about myself	1	2	3	4	5
Difficulty expressing feelings	1	2	3	4	5
Dealing with traumatic experiences	1	2	3	4	5
Feeling anxious	1	2	3	4	5
Feeling angry	1	2	3	4	5
Feeling out of control	1	2	3	4	5
Absentmindedness	1	2	3	4	5
Can't make decisions	1	2	3	4	5
Intrusive thoughts	1	2	3	4	5
Difficulty concentrating	1	2	3	4	5
Racing thoughts	1	2	3	4	5
Thinking about suicide	1	2	3	4	5
Thinking about hurting someone else	1	2	3	4	5
Trouble controlling aggression	1	2	3	4	5
impulsivity or recklessness	1	2	3	4	5
Thoughts that confuse or scare me	1	2	3	4	5
Difficulty being assertive	1	2	3	4	5
Concerns re: use of pornography	1	2	3	4	5
Balancing responsibilities	1	2	3	4	5
Problems with grades/school work	1	2	3	4	5
Time management	1	2	3	4	5
Easily distracted	1	2	3	4	5
Disorganization	1	2	3	4	5

Client Name:_____

Perfectionism	1	2	3	4	5
Worried about future career	1	2	3	4	5
Feeling rejected by others	1	2	3	4	5
Trouble making/keeping friends	1	2	3	4	5
Difficulty with authority	1	2	3	4	5
Sexual issues	1	2	3	4	5
Racial/ethnic/cultural issues	1	2	3	4	5
Relationships with females	1	2	3	4	5
Relationships with males	1	2	3	4	5
Relationship with roommate/friend	1	2	3	4	5
Relationship with family	1	2	3	4	5
Relationship with romantic partner	1	2	3	4	5
Relationship with my children	1	2	3	4	5
Substance use of a family member	1	2	3	4	5
Substance use of a friend	1	2	3	4	5
Own use of alcohol/drugs	1	2	3	4	5

Please indicate those parts of your life that give you the most pain or with which you struggle the most. Identify what change you desire in yourself or your behavior that you wish to accomplish in therapy. problems and struggles may involve internal factors such as thoughts, values, feelings, intentions, etc. or issues may involve external factors such as relationships with others, school, job, etc.

PROBLEM: **DESIRED CHANGE:**

1.

2.

3.