Jason Schweitzer, LICSW
Licensed Independent Clinical Social Worker
421 1st Avenue SW Suite 300W, Rochester, MN 55902
Ph: (507) 271-0467 Web: www.counselingwithjason.com

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 a copy of Jason Schweitzer's Notice of Privacy Practices and Electronic Payment Communications Disclosure. 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.

____

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***

NATIONAL ASSOCIATION OF SOCIAL WORKERS
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Rochester, MN 55902
507-271-0467

CONSENT FOR TREATMENT OF A MINOR

Minor Client's Name: ______________________________________

Date of Birth: ____

Parent/Legal Guardian Name: __________________________________

Relationship to Minor client: __________________________________

Note: divorced parents please include the relevant pages of the divorce decree stating you have full or partial legal custody of this minor.

I do hereby authorize Jason Schweitzer LLC to provide Outpatient Counseling Services to this minor. These services may include, but are not limited to diagnostic assessments, symptom screenings, individual psychotherapy, and family therapy.

I understand the consent of both parents is not necessary, but it is the responsibility of the parent giving consent to notify the other parent that their minor is receiving treatment.

____ ________________
Parent/Guardian signature Date

____ ________________
Minor client's signature (required if minor is 16 years old) Date

Jason R. Schweitzer, LICSW
Licensed Independent Clinical Social Worker
421 1st Avenue SW Suite 300W, Rochester, MN 55905
Phone: (507) 271-0467

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? ______________

____

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
- Individual Therapy Session $160.00
- Couples Therapy $160.00
- Couples Therapy Assessment $35.00

Letters $25.00
Letters to Employers $50.00
Treatment Summaries $80.00

OFFICE USE ONLY

Therapist Name: Jason R. Schweitzer, LICSW   Diagnostic Code:________________

Type of Service: ____

JASON R. SCHWEITZER, MSW, LICSW
Licensed Independent Clinical Social Worker
421 1st Avenue SW Suite 300W, Rochester, MN 55902
Ph: (507) 271-0467 Web: www.CounselingwithJason.com

Adolescent Personal History Questionnaire

Form completed by: (name & relationship):____Date:____________

Adolescent's Name:____________________________________ Age: ______ DOB:______________ Adopted?________

Address:____City/State/Zip:____________________________

Social Security Number:____________________________ Home Phone: ______________________________________

What are some examples of behavior that are concerning to you?____

____

When did the behaviors begin?____

How would you like things to be different?____

What have you already done to solve the problem?____

Check behaviors that apply to your adolescent:

_____Argues	_____Physical Aggression	_____Easily Annoyed	_____Steals
_____Rebellious	_____Cruel to Animals	_____Destroy Property	_____Lies
_____Lights Fires	_____Easily Frustrated	_____Overreacts	_____Tense
_____Misses School	_____Physical Complaints	_____Worries	_____Fearful
_____Temper Tantrums	_____Defies Requests	_____Blames Others	_____Fidgets
_____Vindictive	_____Distractible	_____Deceptive about Homework	_____Forgetful
_____Impulsive	_____Short Attention Span	_____Cries Easily	_____Sad
_____Withdrawn	_____Suicidal Thoughts	_____Suicide Attempts	_____Moody
_____Motor or vocal tics	_____Sleep Problems	_____Apathy	

_____Peculiar behaviors(please describe):____

_____Other concerns (please describe):____

- **ACADEMIC HISTORY:**

Grade:____________ School:____ Teacher:__________________________

Other school staff involved:____
Principal, counselor, or other school staff involved

Does your adolescent have an Individualized Education Plan (IEP)?_____Yes _____No

If "YES", what are the special needs and what services are provided?______________________________

____

____

Special School programs?____

How do you think your adolescent performs in school (academics, teachers, peers)?______________________________

- **SOCIAL HISTORY**

Please describe how your adolescent does with friends:______________________________

Does your adolescent make friends easily?__________ How many friends are close to the same age?__________

With whom does your adolescent spend the most time?______________________________

- **MEDICAL HISTORY**

Name and address of health care provider and facility:______________________________

____

How often does your adolescent visit a health care provider per year?______________________________

Date of last physical examination:______________________________

Serious illnesses/Serious injuries:______________________________

Current medications:______________________________

Hospitalizations:______________________________

List any concerns you have currently about your adolescent's health:______________________________

Please indicate any major illnesses or physical conditions that your adolescent's parents, sibling, grandparents, aunts, or uncles have had, and who has experienced them:______________________________

____

Please check if you adolescent has experienced the following:

_____Asthma	_____Frequent Ear Infections	_____Hearing Problems	_____Vision Problems
_____Dental Problems	_____Skin Problems	_____Hay fever/Allergies	_____Severe Headaches
_____Seizures	_____High Blood Pressure	_____Dizziness	_____Bed Wetting
_____Soils Underwear	_____Urinary Infections	_____Constipation	_____Diarrhea
_____Nightmares	_____Sleepwalking	_____Tiredness/Fatigue	_____Broken Bones
_____Poor Appetite	_____Stomach Problems	_____Weight Loss	_____Obesity
_____Thumb sucking	_____Nail Biting	_____Menstrual Problems	

Other medical issues:______________________________

- **MENTAL HEALTH**

Please list any psychological or behavioral evaluation, counseling, or other treatment your adolescent has had, or been advised to have (please give dates, locations, and reasons):______________________________

____

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Has your adolescent ever been abused (physically or sexually) or neglected? Has any report of this been previously made to authorities?________________________________

____

- **DEVELOPMENTAL HISTORY**

Any problems with the pregnancy or birth?____________________________

Was there any use of drugs or alcohol during the pregnancy? _____Yes _____No

What age did your adolescent do the following?

Walk alone_____ Dress self_____

Complete toilet training_____ Stop wetting the bed_____

Speak single words_____ Speak phrases_____

Are there any other developmental issues that concern you?____________________

____

- **FAMILY HISTORY**

Adolescent's Parents are:

_____Married _____Separated _____Divorced _____Remarried _____Never Married

Name of Mother:____________________________ Age:__________

Name of Father:____________________________ Age:__________

Name of step-parent(s):________________________ Age(s):__________

Principal guardian, if other than parent:__________________________

Are there any others who regularly care for your adolescent?____________________

Siblings (names, ages, full/half or step):__________________________

____

____

Who lives in the home with the adolescent:__________________________

Mother's work schedule:________________________________

Father's work schedule:________________________________

If the parents are divorced, when did this occur?________________________

What are the custody and visitation arrangements?________________________

____

Is there any history of emotional problems, depression alcoholism, substance abuse, suicide, or academic problems in the adolescent's biological family? _____No _____Yes;

If "Yes", who and

what:____

Do any of your other children have behavioral, emotional or learning problems? _____Yes _____No

If "Yes", please describe:

____

How do you discipline and reward your child(ren)?______________________________________

____

Is this usually effective?____

- **INTERESTS AND ACTIVITIES**

Activities outside of school (church, sports, special skills, etc.)_________________________

What does your adolescent enjoy doing the most?_____________________________________

____

What is your adolescent best at doing?____

What does your adolescent need to improve upon the most?________________________________

____

Is there anything else you would like to mention about your adolescent, or that you think would be helpful in understanding and helping them?____

____

____

Thank you for the time and effort in providing this information. It will help greatly in providing the best services for your adolescent.

CYW Adverse Childhood Experiences Questionnaire Teen (ACE-Q) Teen

To be completed by Parent/Caregiver

Today's Date: ______________________

Child's Name: ______________________ *Date of birth:* ______________________

Your Name: ______________________ *Relationship to Child:* ______________________

Many children experience stressful life events that can affect their health and wellbeing. The results from this questionnaire will assist your child's doctor in assessing their health and determining guidance. *Please read the statements below. Count the number of statements that apply to your child and write the total number in the box provided.*

Please DO NOT mark or indicate which specific statements apply to your child.

1) Of the statements in Section 1, HOW MANY apply to your child? Write the total number in the box. ☐

Section 1. *At any point since your child was born...*

- Your child's parents or guardians were separated or divorced
- Your child lived with a household member who served time in jail or prison
- Your child lived with a household member who was depressed, mentally ill or attempted suicide
- Your child saw or heard household members hurt or threaten to hurt each other
- A household member swore at, insulted, humiliated, or put down your child in a way that scared your child OR a household member acted in a way that made your child afraid that s/he might be physically hurt
- Someone touched your child's private parts or asked them to touch that person's private parts in a sexual way that was unwanted, against your child's will, or made your child feel uncomfortable
- More than once, your child went without food, clothing, a place to live, or had no one to protect her/him
- Someone pushed, grabbed, slapped or threw something at your child OR your child was hit so hard that your child was injured or had marks
- Your child lived with someone who had a problem with drinking or using drugs
- Your child often felt unsupported, unloved and/or unprotected

2) Of the statements in Section 2, HOW MANY apply to your child? Write the total number in the box. ☐

Section 2. *At any point since your child was born...*

- Your child was in foster care
- Your child experienced harassment or bullying at school
- Your child lived with a parent or guardian who died
- Your child was separated from her/him primary caregiver through deportation or immigration
- Your child had a serious medical procedure or life threatening illness
- Your child often saw or heard violence in the neighborhood or in her/his school neighborhood
- Your child was detained, arrested or incarcerated
- Your child was often treated badly because of race, sexual orientation, place of birth, disability or religion
- Your child experienced verbal or physical abuse or threats from a romantic partner (i.e. boyfriend or girlfriend)

CYW ACE-Q Teen (13-19 yo) © Center for Youth Wellness 2015

CYW Adverse Childhood Experiences Questionnaire (ACE-Q) Teen Self-Report

To be completed by Patient

Today's Date: ______________________

Your Name: ________________________________ Date of birth: ______________________

Many children experience stressful life events that can affect their health and development. The results from this questionnaire will assist your doctor in assessing your health and determining guidance. Please read the statements below. Count the number of statements that apply to you and write the total number in the box provided.

Please DO NOT mark or indicate which specific statements apply to you.

1) Of the statements in section 1, HOW MANY apply to you? Write the total number in the box. ☐

Section 1. *At any point since you were born...*

- Your parents or guardians were separated or divorced
- You lived with a household member who served time in jail or prison
- You lived with a household member who was depressed, mentally ill or attempted suicide
- You saw or heard household members hurt or threaten to hurt each other
- A household member swore at, insulted, humiliated, or put you down in a way that scared you OR a household member acted in a way that made you afraid that you might be physically hurt
- Someone touched your private parts or asked you to touch their private parts in a sexual way that was unwanted, against your will, or made you feel uncomfortable
- More than once, you went without food, clothing, a place to live, or had no one to protect you
- Someone pushed, grabbed, slapped or threw something at you OR you were hit so hard that you were injured or had marks
- You lived with someone who had a problem with drinking or using drugs
- You often felt unsupported, unloved and/or unprotected

2) Of the statements in section 2, HOW MANY apply to you? Write the total number in the box. ☐

Section 2. *At any point since you were born...*

- You have been in foster care
- You have experienced harassment or bullying at school
- You have lived with a parent or guardian who died
- You have been separated from your primary caregiver through deportation or immigration
- You have had a serious medical procedure or life threatening illness
- You have often seen or heard violence in the neighborhood or in your school neighborhood
- You have been detained, arrested or incarcerated
- You have often been treated badly because of race, sexual orientation, place of birth, disability or religion
- You have experienced verbal or physical abuse or threats from a romantic partner (i.e. boyfriend or girlfriend)

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