TRUE NORTH THERAPY

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: _____
(First, Last)

Name of parent/guardian (if under 18 years): _____
(First, Last)

Birth Date: _____ /_____ /_____
Age: _____
Gender: □ Male □ Female

Marital Status:
□ Single □ Relationship □ Married □ Divorced □ Widowed
Please list any children/age:
_____

Address: _____

Cell: _____
May we leave a message? □Yes □No

Work Phone: _____
May we leave a message? □Yes □No

E-mail: _____
May we email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?
□ Yes
□ No
Please list:
_____

_____

TRUE NORTH THERAPY

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (Please circle) Poor Average Good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (Please circle) Poor Average Good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

4. Please list any difficulties you experience with your appetite or eating patterns.

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes
If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes
If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
□ No
□ Yes
If yes, please describe? _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Please list any addictive behaviors: (ex: social media, gambling, gaming, sexual activity, drug use, eating, etc.)

_____

12. What significant life changes or stressful events have you experienced recently?

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. Please circle:

Alcohol/Substance Abuse	yes / no
Anxiety	yes / no
Depression	yes / no
Domestic Violence	yes / no
Eating Disorders	yes / no
Obesity	yes / no
Obsessive Compulsive Behavior	yes / no
Schizophrenia	yes / no
Suicide Attempts	yes / no

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, name and address of your employer:

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

TRUE NORTH THERAPY

MEDICAL HISTORY

Please complete: This is very important information. Please feel free to add any additional information that you feel is needed.

Name_____

Current Physician and/or Primary Care Physician_____

Address:_____City_____Zip_____

Phone:_____

Medications prescribed by this M.D. (Name and dosage)

_____

_____

Are you are under the care of a psychiatrist? Yes_____ No_____
Name: _____ Phone: _____

Medication and dosage prescribed by Psychiatrist:

_____

Have you been hospitalized for emotional problems? Yes___ No___
If so: When_____Where_____

Have you had previous individual therapy? Yes____ No_____ Last date:_____

Name of Therapist:_____ Phone:_____

Have you been treated for substance abuse? Yes ___ No___ Date: _____

Are you being treated now for substance abuse? Yes ___ No___

Please list any and all physical illnesses that are now being treated by M.D.

_____

_____

_____

_____

What would you want your therapist to know about your physical or emotional health?

_____

_____

_____

_____

RELEASE OF INFORMATION

I authorize Jaime McNatt to contact by telephone or mail the following medical professionals for the purpose of consulting and coordinating care for my therapy and treatment.

Name_____Address:_____

City:_____State_____Zip_____

Phone: ( )_____Fax: ( ) _____

Name_____Address:_____

City:_____State_____Zip_____

Phone: ( )_____Fax: ( )_____

_____Date_____
Your Signature

TRUE NORTH THERAPY

HEALTH INSURANCE INFORMATION

If you are using or may use in the future, health insurance, the following information is necessary in order to bill the insurance company.

PATIENT INFORMATION:

1. PATIENT'S FULL NAME _____

2. STREET ADDRESS _____

3. CITY _____

4. STATE & ZIP CODE _____

5. PATIENT'S DATE OF BIRTH _____

6. TELEPHONE _____

7. PATIENT'S GENDER M_____ F_____

8. PATIENTS' RELATIONSHIP TO INSURED:
SELF___ SPOUSE___ CHILD___ OTHER___

9. PATIENTS' STATUS:
SINGLE___ MARRIED___ OTHER___ EMPLOYED___ STUDENT___ OTHER__

10. SOCIAL SECURITY # _____

INSURED'S INFORMATION (If Someone Other Than Patient)
Definition: the "insured" is the person who owns the policy or is the employee to whom a group policy is applicable.

1. NAME OF INSURED _____

2. STREET ADDRESS OF INSURED _____

3. CITY _____

4. STATE & ZIP CODE _____

5. INSURED'S DATE OF BIRTH _____

6. SOCIAL SECURITY # _____

7. TELEPHONE _____

8. INSURED'S PLACE OF EMPLOYMENT: _____

9. INSURANCE PLAN NAME OR PROGRAM NAME. _____

TRUE NORTH THERAPY

1. INSURED'S INSURANCE ID NUMBER_____

2. POLICY GROUP NUMBER _____

I authorize the release of any medical or other information necessary to process insurance claims. I further authorize the payment of medical or insurance benefits to Jaime McNatt, LICSW, and authorize Jaime McNatt, LICSW to obtain or release therapy records and treatment plans to my insurance company for the purpose of evaluation, treatment and payment.

_____ _____

Signature of Insured Date

IF YOU HAVE AN INSURANCE CARD PLEASE BRING IT WITH YOU TO FIRST APPOINTMENT

EMPLOYEE ASSISTANT PROGRAMS

If you are using your Employee Assistant Program (EAP) to pay for your counseling sessions, you must contact them to obtain a referral to me (Jaime McNatt). I cannot do this for you.

- You will be given a limited number of sessions.
- You should be clear on the number of sessions authorized.
- This therapy is provided at no cost to you; however, if you need continued counseling beyond the number of sessions authorized by your EAP or if you need mental health treatment beyond the scope of the type of counseling provided through the EAP, it will be your responsibility to determine whether or not those outside services are covered under your medical benefit plan and to pay any charges for services not covered by your medical benefit plan.

TRUE NORTH THERAPY

Credit Card Intake form:

Credit Card intake form purpose: This form enables Jaime McNatt and True North Therapy to make service payment and/or co-pay payment to True North Therapy by using a credit card. This information is confidential and will not be used without patient knowledge.

Date: _____

Name (printed legibly): _____

Address (street or PO): _____

City, State, and Zip Code: _____

Phone number: _____

Description of sale: _____

Type of credit card: Mastercard/VISA/Discover _____

Credit card number: _____

Expiration date: _____

CVV code: _____

Amount of charge: $_____

TRUE NORTH THERAPY

STATEMENT OF FEE

It is important that you understand the Fee Policy. Please read-complete the section which states you insurance and your co-pay-Sign and Date. If you are a cash pay, you and your therapist will complete the section relative to fee.

True North Therapy/Jaime McNatt provides therapy, educational and consultation services. I am requesting that you read and sign this statement to acknowledge your understanding of my policy. Your signature does not bind you to therapy. It does make you responsible for charges incurred.

Insurance Billing: You are asked to contact your insurance company relative to your benefits. True North Therapy has made every effort to be a provider for a variety of managed care companies. As a service to you, True North Therapy/Jaime McNatt, may bill your insurance company on your behalf. If for any reason a claim is denied, it is your responsibility to contact the insurance company and clear up any reasons for its denial. You are responsible for verifying insurance coverage, obtaining any necessary pre-authorization, and resolving any claim denials. If you fail to do so, you will pay the full customary fee for all services rendered.

Co-Pay:
If your managed care policy requires a co-pay, it is your responsibility to bring the co-pay to each session or make other arrangements. This office does NOT send out statements for co-pay.

Deductible:
Your health insurance may also have a deductible. You are responsible for these amounts also. You should check with your insurance to see if a deductible applies.

Auxiliary Service:
Occasionally requests are made for mental health evaluations and other reports. A fee will be charged for these reports.

- Progress Report/Court Report writing - $140/hour
- Requested or Subpoenaed Court Appearances/Testimony - $185/hour including travel time.

Telephone Calls:
There is no charge for telephone calls that take less than 5 minutes. If a phone call takes longer than 30 minutes they will be billed accordingly.

Cancellations:
The time of your scheduled appointment is reserved for you. It is my policy to charge $50 when the appointment is canceled within three hours of the appointed time. It is my policy to charge for the entire session for a no show. I understand that circumstances arise that makes it difficult to keep an appointment. I will work with you relative to these charges. Please call (952) 373-1021 to cancel your appointment.

Length of Session:
A session is generally 45-50 minutes.

Fees:
Please speak openly to me about my fees. It is my desire to work with you as much as possible when it comes to payment. Fees are payable to True North Therapy, LLC. Insurance will be billed when requested.

I give my consent and authorization to True North Therapy, LLC and Jaime McNatt to bill my insurance noted above and I further acknowledge that I am responsible for my co-pay at the time of the session. My signature also represents my understanding of the above fee policies.

Signed:_____ Date:_____

TRUE NORTH THERAPY

CLIENT RIGHTS AND INFORMATION

1. You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy, and my fee. Please ask if you would like to receive this information.
2. You can seek a second opinion from another therapist or terminate therapy at any time.
3. In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate.
4. Generally speaking, information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and the therapist cannot disclose the information without the client's consent. There are several exceptions to confidentiality, which include: (1) I am required to report any suspected incident of child abuse or neglect to law enforcement; (2) I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (3) I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental disorder; (4) I am required to report any suspected threat to national security to federal officials; (5) I am required to report abuse of a senior, who is 70 years of age or older, which I believe has probably occurred, including institutional neglect, physical injury, financial exploitation, or unreasonable restraint; and (6) I may be required by Court Order to disclose treatment information.
5. When I am concerned about a client's safety, it is my policy to request a Welfare Check through local law enforcement. In doing so, I may disclose to law enforcement officers information concerning my concerns. By signing this Disclosure Statement and agreeing to treat with me, you consent to this practice, if it should become necessary.
6. I agree not to record our sessions without your written consent; and you agree not to tape record a session or a conversation with me without my written consent.
7. There may be times when I need to consult with a colleague or another professional about issues raised by clients in therapy. Client confidentiality is still protected during consultation. Signing this disclosure statement gives me permission to consult as needed to provide professional services to you as a client.

Children and Adolescents:

1. A child (14 or younger) is seen in this office, I must have the signature of a parent.

TRUE NORTH THERAPY

DISCLOSURE REGARDING DIVORCE & CUSTODY LITIGATION

If you are involved in divorce or custody litigation, my role as a therapist is not to make recommendations to the court concerning custody or parenting issues. By signing this Disclosure Statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that I write any reports to the court or to your attorney, making recommendations concerning custody. The court can appoint professionals, who have no prior relationship with family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interests of the family's children.

I understand and consent to agree to the disclosure regarding divorce and custody litigation

_____ _____

Signature Date

TRUE NORTH THERAPY

COURT APPEARANCE POLICY

I am a Licensed Independent Clinical Social Worker, who provides clinical services to individuals, parents, families and children. This clinical work takes the form of individual counseling, marital counseling, and services to children. In my clinical role, I cannot assist my clients in divorce or custody litigation, and I disclose this fact to each client and client family who come to me for services. As a LICSW, I cannot disclose any marital therapy, couples counseling or family therapy information without the consent of all my clients.

Please do not ask me to write any reports for the court, as I cannot do so. Do not ask me to testify in court, because this will destroy my professional relationship with my clients. I am not a custody evaluator and do not do Child and Family Investigation work or Parental Responsibility/Parenting Time evaluations. If the court has appointed a CFI or a PR/PT evaluator, those are the individuals that can make recommendations to the court. I cannot make recommendations to the court concerning parental responsibility or parental time issues. That would exceed my role as a therapist, and would adversely affect my ability to help families, parents and children.

If you have any questions or would like additional information, please feel free to ask during the initial session or anytime during the therapy process.

I have read the preceding information and I understand my rights as a client or as the client's responsible party.

_____
Print Client's Name

_____ _____
Client's or Responsible Party's Signature **Date**

TRUE NORTH THERAPY

SAFE HARBOR AGREEMENT

Parties: The parties to this Agreement are
_____ and
_____ (together "the parents"); and
_____ ("the therapist").

Goal: The therapeutic goal is to permit the children to have a place that they deem safe to be able to speak to a mental health provider about any apprehensions, concerns, or issues without fear that what they say will be used to interfere with, or create problems in their relationship with either parent.

Safe harbor. In order to effectuate the stated goal, the parties acknowledge the importance of the therapist's office being a safe harbor—a place where the children can be truthfully assured that what they say will not be disclosed to third parties without their consent.

AGREEMENT: Therefore, to create the safe harbor for the children, the parties agree as follows:
a. No court/no depositions. Neither parent shall, nor will either parent permit his or her attorney to, subpoena the therapist or her notes to a trial, hearing, deposition, or arbitration.
b. No interrogations. Neither parent shall, nor will either parent permit his or her attorney to, demand answers from either the therapist or the children to questions about the content of the therapy.
c. No disclosure. The therapist agrees that she shall not divulge to either parent, to either attorney, to the Judge, or to any other third party, any matter relating to the content of the therapy with the children (except required disclosures under the Child Abuse Reporting Act, or other safety concerns) without the children's explicit consent. d. Enforcement. Any party, or his or her attorney, who seeks to interrogate or subpoena the therapist shall be liable for all attorney fees and costs incurred to resist answering discovery requests or to quash a subpoena.

Signatures Signed:

Parent(s):_____ Date:_____

Therapist: _____ Date:_____

THERAPY SERVICES

I provide non-emergency therapeutic services by scheduled appointment. If I believe your therapeutic issues are above my level of competence, or outside of my scope of practice, I am legally required to refer, terminate or consult. If, for any reason, you are unable to contact me by telephone (952) 373-1021, and you are having a true emergency, please call 911 or go to the nearest hospital emergency room.

You may make appointments and contact me in the following ways:
For appointments: Office Phone (952) 373-1021; Email: Truenorththerapy@yahoo.com