INTAKE /ASSESSMENT FORM

Welcome! These forms will give you the chance to describe your situation and history. Please fill them out as completely as possible and have them ready before your first counseling session.

CLIENT INFORMATION

Name:_____

Date of Birth:_____ Age: _____ ❒ Female ❒ Male ❒ Non-binary

Address:_____

Occupation: _____ Employer: _____

School (if student):_____

Phone (h): _____ Messages ok at home? ❒ Yes ❒ No

Phone (cell): _____ Messages ok on cell? ❒ Yes ❒ No
(Note: I cannot guarantee the confidentiality of cell conversations.)

Phone (w):_____ Messages ok at work? ❒ Yes ❒ No

Email: _____ Emails ok? ❒ Yes ❒ No
(Note: I cannot guarantee the confidentiality of email.)

Website: _____
May I have your permission to look at your website? ❒ Yes ❒ No

How did you find out about my services? _____
If referred by a person, may I have your permission to thank him/her? ❒ Yes ❒ No

Religious Affiliation: _____

Ethnic/Cultural Heritage: _____
_____

MARITAL STATUS

❒ Single ❒ Married (legally) ❒ Divorced Total # of marriages:_____

❒ Cohabitating ❒ Divorce in process ❒ Separated ❒ Widowed Other:_____

Assessment of current relationship (if applicable): ❒ Good ❒ Fair ❒Poor

FAMILY INFORMATION

Relationship	Name	Age	Sex	Type(bio, step, etc.)	Living with you?
Mother	_____	_____	_____	_____	❒ Yes ❒ No
Father	_____	_____	_____	_____	❒ Yes ❒ No
Spouse/SO	_____	_____	_____	_____	❒ Yes ❒ No
Children/	_____	_____	_____	_____	❒ Yes ❒ No

Siblings _____ _____ _____ _____ ❒ Yes ❒ No
_____ _____ _____ _____ ❒ Yes ❒ No
_____ _____ _____ _____ ❒ Yes ❒ No

(Continue on back or extra page if needed)

EDUCATION

Fill in all that apply: Years of education: _____ Currently enrolled: ❒ Yes ❒ No

_____High School grad/GED _____College
_____Vocational: _____Graduate School
Other training:_____
Special circumstances:_____

MILITARY

Military experience? ❒ Yes ❒ No Combat experience? ❒ Yes ❒ No
Where: _____ Branch: _____
Type of discharge: _____ Length of service: _____
Rank at discharge: _____

PERSONAL STRENGTHS

What do you do well and what activities do you enjoy? _____
_____
_____

What personal qualities would others say you have? _____
_____
_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe) _____
_____
_____

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? ❒ Yes ❒ No

Approximate Dates of Counseling: _____

For what reason? _____

What did you find **most helpful** in therapy? _____
_____

What did you find **least helpful** in therapy? _____
_____

Have you used psychiatric services? Yes No Was it helpful? Yes No
Please describe. _____
_____

Have you taken medication for a mental health concern? Yes No

Name of medication	Dates Taken	Helpful?(Y/N)

Do you have other medical concerns or previous hospitalizations? Please describe. _____

_____

_____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past._____

_____

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you/your adolescent desire to have counseling? _____

_____

_____

What would you like to see happen as a result of counseling? _____

_____

_____

What is most concerning right now? _____

_____

_____

CURRENT FAMILY AND SIGNIFICANT RELATIONSHIPS

Strengths/supports (relationships, support groups, etc.)_____

_____

_____

Stressors/problems_____

_____

_____

Recent changes_____

_____

_____

Changes desired_____

_____

_____

FAMILY CONCERNS

Please check any family concerns that you are having

- ❒ Fighting
- ❒ Feeling Distant
- ❒ Loss of fun
- ❒ Lack of honesty
- ❒ Physical fights
- ❒ Education problems
- ❒ Money
- ❒ Disagreeing about Relatives
- ❒ Disagreeing about Friends
- ❒ Alcohol Use
- ❒ Drug Use
- ❒ Infidelity
- ❒ Other
- ❒

SUBSTANCE USE
Please check substances you use on a weekly/monthly (circle) basis:

Alcohol	_____ x per week / month	Meth	_____ x per week / month
Marijuana	_____ x per week / month	Ecstasy	_____ x per week / month
Cocaine	_____ x per week / month	Other_____	_____ x per week / month
Heroine	_____ x per week / month		

Check all that apply:
_____ I believe that my substance use may be a problem.
_____ I believe that my partner's substance use may be a problem.

INDIVIDUAL CONCERNS
Please check any personal concerns that you are having:

❒ Sadness _____	❒ Grief/loss _____
❒ Crying _____	❒ Work issues _____
❒ Irritability _____	❒ Spirituality issues _____
❒ Loss of pleasure _____	❒ Alcohol Use _____
❒ Sleep problems _____	❒ Another's Alcohol Use _____
❒ Eating problems _____	❒ Drug Use _____
❒ Hopelessness _____	❒ Another's Drug Use _____
❒ Guilt _____	❒ Hurting Self _____
❒ Mood swings _____	❒ Hurting others _____
❒ Fear _____	❒ Anger/Rage _____
❒ Nightmares _____	❒ Abuse (childhood) _____
❒ Flashbacks _____	❒ Abuse (adult) _____
❒ Obsessions _____	❒ Distractible _____
❒ Anxiety _____	❒ Hearing things _____
❒ Panic _____	❒ Seeing things _____
❒ Suicidal thoughts _____	❒ Loneliness _____
❒ Suicidal acts _____	❒ Other_____

Comments: _____
_____
_____
_____
_____
_____
_____

Is there anything else you would like to share:
_____
_____

I understand that by signing below, I am stating the above information is true.

_____ _____
Client Signature Date

_____ _____
Parent (or guardian) Signature Date

CONFIDENTIALITY STATEMENT

Susan Lessley, MA, LMFT
Licensed Marriage and Family Therapist

Under the rules governing Marriage and Family Therapists in the state of Minnesota, a therapist, and employees and professional associates of the therapist, must not disclose any private information that the therapist, employee, or associate may have acquired in rendering services except as follows.

- When the Board of Marriage and Family Therapy is reviewing a therapist. The Board shall be allowed access to records of a client treated by a therapist under review if the client signs a written consent permitting access. If no consent form has been signed, the hospital, clinic, or licensee shall first delete data in the record that identifies the client before providing it to the board.

- When disclosure is required by state law like prenatal exposure to drugs and alcohol, reports of child abuse and neglect and vulnerable adults abuse and neglect.

- When failure to disclose the information presents a clear and present danger to the health or safety of an individual.

- When the person, employee, or associate is a defendant in a civil, criminal, or disciplinary action arising from the therapy.

- When the patient is a defendant in a criminal proceeding and the use of the privilege would violate the defendant's right to a compulsory process or the right to present testimony and witnesses in that person's behalf.

- When a patient agrees to a waiver of the privilege accorded by this section, and in circumstances where more than one person in a family is receiving therapy, each such family member agrees to the waiver. Absent a waiver from each family member, a marital and family therapist cannot disclose information received by a family member.

- Communication via cellular telephone or electronic mail is not guaranteed to be confidential. I understand this and discuss my personal information at my own risk.

All other private information must be disclosed only with the informed consent of the client.

My signature below means I have reviewed and understand the points above, as well as received a copy of this form.

Client Signature _____ Date _____

Client Signature _____ Date _____

MINNESOTA MENTAL HEALTH BILL OF RIGHTS

Susan Lessley, MA
Licensed Marriage and Family Therapist
600 Twelve Oaks Center Drive, Suite 642G
Wayzata, MN 55391
612.581.7381

Practitioner: Susan Lessley, M.A., LMFT

THE STATE OF MINNESOTA HAS NOT ADOPTED UNIFORM EDUCATIONAL AND TRAINING STANDARDS FOR ALL MENTAL HEALTH PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATION PURPOSES ONLY.

The Mental Health Bill of Rights provides that:

- You have the right to file a complaint in writing or through a phone call with the practitioner's supervisor. The supervisor is Steven McManus, LMFT, 763-442-4434, 7575 Golden Valley Road, Suite 305, Golden Valley, MN 55427.
- You may file a complaint with the Office of Mental Health Practice, 2829 University Avenue SE, Suite 340, Minneapolis, MN 55414-3239. Their phone numbers are (612) 617-2105; TTY: (800) 627-3529; and fax: (612) 617-2103.
- You, the client, are billed directly for services, or your insurance coverage may be billed with your permission.
- You have a right to reasonable notice of changes in services or charges.
- You have the right to receive a summary, in plain language, of the theoretical approach used by the practitioner in working with clients.
- You have the right to complete and current information concerning our assessment and recommended course of treatment, including the expected duration of treatment.
- You have the right to expect courteous treatment and to be free from verbal, physical, or sexual abuse by the Practitioner working with you;
- Your records and transactions with the Practitioner are confidential, unless release of these records is authorized in writing by the client, or otherwise provided by law.
- You have the right to be allowed access to records and written information from records in accordance with Minnesota statutes.
- You should know that other services may be available in the community. To find out about such services, you may call First Call for Help at 651-291-0211.
- You have the right to choose freely among available practitioners, and to change practitioners after services have begun, within the limits of health insurance, medical assistance, or other health programs.
- You have a right to coordinated transfer when there is a change in the provider of services.
- You may refuse services or treatment, unless otherwise provided by law.
- You may assert these and other rights without retaliation.

Client Signature _____ Date _____

COUNSELING FEES

	Cash, Check, or Credit Card
50 Minute Session	$150.00
30 Minute Session	$75.00

Fees are effective January 1, 2022 and are adjusted periodically. The above fees apply to new clients or clients returning after a four month (or more) absence.

By signing below you are agreeing to the above fee schedule and understand payment (cash, check, or credit card) is due in full at the beginning of each counseling session.

Comments or notes about fees or fee arrangements:_____

_____

Client: _____ Date: _____

Client: _____ Date: _____

Parent/guardian: _____ Date: _____

Counselor: _____ Date: _____

Susan Lessley, MA, Licensed Associate Marriage and Family Therapist
600 Twelve Oaks Center Drive #642E, Wayzata, MN 55391 612.581.7381

AGREEMENT FOR THERAPY SERVICES

Susan Lessley Counseling
600 Twelve Oaks Center Drive, Suite 642E
Wayzata, MN 55391
612.581.7381

Welcome to the therapeutic practice of **Susan Lessley, MA, LMFT**. This document contains important information about my professional services and business policies. It also contains information about my policies and practices to protect the privacy of your health information. Please read this document carefully and let me know if you have any questions or concerns. By signing this document, you will be stating that you were provided with this information and it will represent a binding agreement between us.

Psychotherapy Services: Psychotherapy varies depending on the therapist, the client and the client's particular situation and goals. There are many different methods which may be used to deal with a particular situation, goals, and objectives. For the best outcome, each client must choose to invest energy in the process and work actively on relevant topics both during and between sessions.

Psychotherapy can have benefits and risks. The risks may include experiencing uncomfortable feelings like sadness, guilt, anger, anxiety or frustration when discussing aspects of life. Psychotherapy has been shown to have benefits that can include better relationships, solutions to specific problems, increased life satisfaction, improved physical health, and significant reductions in feelings of distress. However, there are no guarantees as to what each client will experience.

What to Expect: The first few sessions will involve an evaluation of your situation including needs, goals, and objectives to work toward. Psychotherapy can involve a significant investment of time, energy, and money. It is important to select a therapist with whom you are comfortable working. If at any time you have questions about therapy, please discuss them with me as they arise. If you decide to discontinue therapy, I will provide referrals to other therapists or other appropriate resources if requested.

Sessions: I schedule 50-minute sessions. If you would like longer sessions, the price will be pro-rated according to the length of appointment we agree upon. If you arrive late for an appointment, the remaining time of our scheduled session is available to you if you have called to state you will be late. If you have not called, I may not be available after 15 minutes from the scheduled start time. At times, it may be appropriate to meet more or less than once per week if that is consistent with the agreed upon treatment plan.

If you need to cancel a scheduled therapy session, you must do so at least 24-hours in advance. If you do not cancel a scheduled appointment with at least 24-hours notice, or if you fail to attend a scheduled session, you agree to pay the full fee for that session, unless it is agreed upon that the absence was due to uncontrollable circumstances.

Professional Fees: Fees are listed on the Counseling Fees document. Package rates are available which can be found on my website (www.SusanLessleyCounseling.com). In addition to regular sessions, it is policy to charge the therapy rate on a pro-rated basis for other professional services required. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings or consultations with other professionals which have been authorized, preparation of records or treatment summaries, and time spent performing any other professional service. Often, it is not helpful to participate in a legal process concerning any therapy that may have been given. Therefore, I will decline if asked to participate in any legal or court hearings. If it becomes necessary to participate, the rate for my preparation and participation in a court hearing or other legal proceeding will be $350 per hour. You will also be charged this rate for travel time, waiting time and agree to pay any additional necessary fees (for example, parking fees). Pre-payment of expected fees will be required one week (7 days) in advance of legal proceedings. You understand you will be billed for any remaining amount.

Billing and Payments: You will be expected to pay the full agreed upon fee at the time of each session unless other arrangements have been made. Payments may be made by check, cash, or credit card via PayPal, Square, or IvyPay. Payment schedules for other professional services will be agreed upon when/if they are requested. If a payment by check does not clear due to insufficient funds or any other reason, you will be expected to reimburse Susan Lessley Counseling in full for any related bank fees.

Insurance Reimbursement: To provide you with the most personal and confidential therapy services, I do not submit billing to insurance organizations. Your insurance provider may pay for out-of-network therapy services, depending on your plan. Alternatively, you may use your FSA or HSA to cover services. Please check your coverage carefully.

Contacting Me: Because I do not take calls during sessions, I may not be immediately available by telephone. A **confidential voicemail may be left at 612-581-7381**. Every effort will be made to return calls within 24 hours, more promptly if possible.

If you are in an emergency situation, you may either call your therapist and follow the instructions for emergencies, or immediately call the **Crisis Connection at (612) 379-6363**, the **St. Paul Ramsey Crisis Intervention Center at (651) 221-8922**, your local emergency services at 911, or call or go to the nearest hospital emergency room, telling them of your emergency. You understand that you are NOT to wait for me to return your call in an emergency situation.

Social Media Policy: I do not interact or accept "friend" requests via social media sites (Facebook, LinkedIn, etc) because it has the potential to compromise privacy and complicate our therapeutic relationship.

Emails, cell phones, computers and faxes: Computer, email, text, and cell phone communications can be relatively easy to access by unauthorized people and hence, can compromise the privacy and confidentiality of such communication. Emails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through them. Additionally, emails are not encrypted, and faxes can be sent erroneously to the wrong address. Our computers are equipped with a firewall, a virus protection and a password, and we also back up all confidential information from computers on to CDs on a regular basis. The CDs are stored securely. If you communicate confidential or highly private information via email, text, or cell phone, I will assume you have made an informed decision and will view it as your agreement to take the risk that such communication may be intercepted, and will honor your desire to communicate on such matters via electronic means. You agree that electronic communications are part of your medical record. You agree to not use electronic communication for emergencies. Due to computer or network problems, electronic communications may not be deliverable or in a timely manner.

Professional Records: The laws and standards of the therapy profession require that treatment records are retained and kept for a period of 7 years after the last point of contact.. You are entitled to examine and/or receive a copy of your record if requested in writing, unless it is believed that seeing them information would be emotionally damaging, in which case they will be sent to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to people who are not mental health professionals. Susan Lessley Counseling reserves the right to charge $.75 per page for the cost of copying and $25.00 for administration costs.

Confidentiality: In general, the law protects the privacy of all communication between a client and a mental health provider. I may only release information about your treatment to others if you sign a written authorization form. You may revoke any such authorizations at any time, which must be in writing. However, in the following situations, your authorization is not required to release your personal information:

- Therapist's duty to warn another in the case of potential suicide, homicide or threat of imminent, serious harm to another individual.
- Therapist's duty to report suspicion of abuse or neglect of children or vulnerable adults.
- Therapist's duty to report prenatal exposure to cocaine, heroin, phencyclidine, methamphetamine, amphetamine or their derivatives, THC, and excesses and habitual use of alcohol.
- Therapist's duty to report the misconduct of mental health or health care professionals.
- Therapist's duty to provide a spouse or parent of a deceased client access to their child or spouse's records.

- Therapist's duty to provide parents of minor children access to their child's records. Minor clients can request, in writing, that particular information not be disclosed to parents. Such a request should be discussed with the therapist.
- Therapist's duty to release records if subpoenaed by the courts.
- Therapist's obligations to contracts (e.g. to employer of client, to an insurance carrier or health plan.)

If an emergency happens to my therapist causing my therapist to be unable to provide services, my protected health information may be shared with a colleague, Lynn Harris Luetgers, MA, LMFT, for both clinical and administrative purposes, such as billing, scheduling, and quality assurance. She is bound by the same rules of confidentiality as your therapist. By signing this document, I am agreeing with the release of my health information to Ms. Harris Luetgers if the need arises.

While I am not an attorney, please discuss any questions or concerns you have about confidentiality with me at any time. If you have specific legal questions about the laws regarding confidentiality, the exceptions, and how it may relate to your situation, please seek formal legal advice from an attorney.

Other Client Rights: You agree that you understand the following:

- I have the right to request and receive confidential communication of my protected health information by alternate means or at alternative locations. For example, clients may request the therapist send any correspondences to an address other than the clients' home address if not wanting family members to know about therapy.
- I have the right to request that the therapist change information in my record. I understand I am required to make such requests in writing along with reasons for the requested changes. The client's request will be noted.
- I understand I generally have the right to receive an accounting of any disclosures the therapist has made of protected health information, which did not require client authorization.
- I understand my therapist may use or disclose my health information for treatment purposes including presentation of my case in consultation with other professionals or consultants who are bound by the legal framework of privacy and confidentiality for professional development and guidance purposes. This case consultation may include case consultation with other therapists at Susan Lessley Counseling or with therapists and supervisors outside of Susan Lessley Counseling. In most cases, outside consultation will be undertaken without the use of any identifying information.
- I understand my therapist may use or disclose my health information for the purposes of payment and health care operations including internal administration, participating in periodic file review, and normal business accounting procedures.

Changes in Services or Fees: Susan Lessley Counseling reserves the right to change the policies, practices, procedures and fees described in this document. You will be notified within 30 days of any such changes.

Minors: If you are under 18 years of age, please be aware that the law may provide your parents with the right to examine your treatment records. It is my policy to request an agreement from your parents that they consent to give up access to your records. If they agree, I will provide them only with general information on how your treatment is proceeding as well as a summary of your treatment when it is complete. However, if I feel that there is a high risk that you will seriously harm yourself or another, I will notify them of my concern. Before giving your parents any information, I will discuss the matter with you.

Safety: I strive to provide a safe environment for all. Please let me know immediately if you have concerns for your safety while at my office. You agree that if you engage in verbal, written or physical behavior that is threatening to a therapist or a therapist's family, or any other person at Susan Lessley Counseling, any therapist at Susan Lessley Counseling may identify you to the police, explain that you are a client at Susan Lessley Counseling, and report the threatening behavior using your personally identifying information. Further, if needed, you agree that any therapist or other at Susan Lessley Counseling may take other legal action to ensure safety for any therapist and any therapist's family or other people at Susan Lessley Counseling using your personally identifying information.

Information Received & Services Requested: The following materials pertaining to therapy (please check each) have been reviewed. Copies of these materials are available on my website.

____ Confidentiality Statement
____ Privacy Information (HIPAA)
____ Fee Information
____ MN Bill of Rights

I understand the basic goals, ideas, and methods of this therapy. I have no important questions or concerns that the therapist has not discussed with me. I understand that reaching the agreed upon therapy goal is not guaranteed. I understand that therapy is successful for some people, moderately successful for others, and for some not successful at all. I further understand that the initial symptoms or problems that were presented to the therapist may initially become more intense.

I am agreeing to participate in the following types of services, while acknowledging that the course of therapy may change, and the participants may change, by agreement of all parties.

_____ Individual Therapy
_____ Couples Therapy (partner name) _____
_____ Family Therapy (family names) _____
_____ Group Therapy

If I am participating in couple or family therapy I understand that:

- I do not have an individual file. Instead we share a couple or family file that holds all of the sessions regardless of who participates in any particular session.
- All people participating in therapy need to consent for information to be released from a couple or family file.
- When I am a participant in couple or family therapy and come to a session without all of the other participants listed above, I am giving my consent for my therapist to verbally share information from that session that the therapist deems pertinent to our work together with the other people participating with me in therapy.

Conclusion and Signatures: By signing below I am indicating I have received and read the information in this document, have discussed the contents with my therapist to my satisfaction, and agree to abide by its terms during the course of therapy. I understand I may request a copy of this document.

Client 1 - Print Name	Signature	Date
Client 2 - Print Name	Signature	Date
Susan Lessley, LMFT	Signature	Date