Northland Counseling Center, Inc.
Adult Registration Form

Client Name: _____ **Client Number:** _____

I. ADMISSION INFORMATION

Client Address: _____

City _____ State _____ Zip _____

Phone #: (home) _____ (work) _____ (cell) _____

I authorize Northland staff to contact me at the above address and phone number: Yes No

May we leave a message if you are not at home? Yes No

Birthdate: _____ **Social Security #:** _____ **Sex:** Male Female

Client's primary physician: _____

II. POWER OF ATTORNEY/GUARDIANSHIP INFORMATION *(Signature on reverse authorizes treatment of above client)*

Your Name _____ Phone #_____

Address _____

_____ I have Power of Attorney on behalf of client above and am attaching supporting documentation of said Power of Attorney.

_____ I have Guardianship of client above and am attaching supporting documentation from the Court giving me said guardianship.

III. INSURANCE INFORMATION *(check and complete all that apply)*

_____ Primary insurance ***(attach copy of card)*** ID# _____ Group#_____

Insurance Company Name _____

Address _____

Phone Number _____

Subscriber Name _____ DOB: _____

Address _____

Relationship _____

_____ Secondary Insurance ***(attach copy of card)*** ID# _____ Group#_____

Insurance Company Name _____

Address _____

Phone Number _____

Subscriber Name _____ DOB: _____

Address _____

Relationship _____

_____ No insurance Have you applied for Medical Assistance? Yes No Pending or denied?

****PLEASE READ AND SIGN REVERSE****

IV. RELEASE OF INFORMATION

I authorize Northland Counseling Center, Inc. to release information to my insurance company regarding my treatment and I permit a facsimile or photographic reproduction of this authorization in place of the original. This could include my Social Security number, diagnosis, prognosis, dates of treatment, narrative notes, and types of treatment. This is for the purpose of validating claims submitted to stated insurance carrier. I also authorize stated insurance carrier to make payments to Northland Counseling Center, Inc. for all insurance benefits to which I or my dependents are entitled for services received. I understand that this consent will terminate one year from signature date unless I choose to revoke it earlier.

V. STATEMENT OF UNDERSTANDING

I understand that I am responsible for the charges in full if I do not maintain coverage for which I am eligible or fail to provide insurance information and/or income verification (if interested in fee reduction).

I recognize that Northland Counseling Center, Inc. cannot guarantee payment of charges by any particular insurance carrier. **If I have questions regarding coverage, I will contact my insurance company.**

In the event Northland Counseling Center, Inc. has been unable to collect payment from me for services within a reasonable period of time, the Center then reserves the right to turn the account over for collection of my bill. A 15% processing fee will be added to any account sent to collections.

I affirm that the information on reverse is accurate. I am aware of my financial responsibilities and agree to the payment terms. I authorize the release of information to my insurance carrier(s). **If my address, phone number, financial status, or insurance coverage changes, I will notify Northland Counseling Center, Inc.,** and an update of this agreement may be renegotiated.

_____ _____

Client signature Date

_____ _____

Parent/Guardian signature Date

Northland
COUNSELING CENTER, INC

Telemedicine Client Consent/Refusal Form

CLIENT NAME: _____

PURPOSE: The purpose of this form is to obtain your consent to participate in telemedicine services in connection with the following services provided by Northland Counseling Center, Inc. and all satellite offices associated within.

Services <u>may</u> include: Individual Therapy, Diagnostic Assessments, Medication Management, Psychiatric Consultations, Adult Rehabilitative Mental Health Services (ARMHS), Peer Support Services (PSS), Housing Services, Employment Services through Northern Opportunities Works (NOW), Crisis Assessments, Crisis Interventions, Crisis Stabilization, Intakes, Clinical Care Consultation, Case Management, DBT Services, Substance Use Disorder (SUD) treatment (assessments, treatment planning, individual/group services), Behavioral Health Home (BHH) and Children's Therapeutic Supports and Services (CTSS).

Service(s) if not listed: _____

INTRODUCTION: Telemedicine involves the use of electronic communications to enable office visits from a site other than Northland Counseling Center, Inc. 'Telemedicine' means using electronic systems to allow communication between a client and a provider who are in different locations.

CONFIDENTIALITY: Northland Counseling Center, Inc. utilizes Zoom, which incorporates networking software security protocols to protect confidentiality of patient identification and will include measures to safeguard data and to ensure the integrity against intentional or unintentional corruption.

Reasonable and appropriate efforts have been made to illuminate any confidentiality risks associated with the telemedicine consultation and all existing confidentiality protections under Federal and Minnesota State Law applied information disclosed while utilizing telemedicine services.

RIGHTS: You may withhold or withdraw consent to telemedicine services at any time without affecting your right to future services with Northland Counseling Center, Inc. or risk the loss or withdrawal of any program benefits to which you would otherwise be entitled.

RISKS, CONSEQUENCES and BENEFITS: In rare cases, the information transmitted may be inadequate quality or, if the equipment is not working, there could be delays in evaluation and treatment. In these cases, the visit maybe rescheduled or your provider will discuss Face-to-Face visit needs. You or your mental health provider may discontinue the telehealth visit if the connections are not adequate for the situation. Very rarely, security protocols could fail, causing a breach of privacy of medical information. Northland Counseling Center, Inc. has implemented appropriate security measures to mitigate against this rare situation.

By signing below, I indicate that Northland Counseling Center, Inc. has my permission to use a web-based video-conferencing application to facilitate my care and treatment.

- I understand the expiration date of this authorization is 1 year from today's date:_____
- I understand that my Protected Health Information (PHI) will be transmitted by a third party web-based video conferencing vendor to my provider during my telehealth visits.
- I understand that I have the right to revoke my permission at any time. I understand I must make my request in writing to Northland Counseling Center, Inc.

Signature:_____ Date:_____

If signed by someone other than the client, indicate relationship:_____

If you **<u>REFUSE</u>** to participate in telemedicine services please check this box: ☐

NORTHLAND COUNSELING CENTER

ADULT HEALTH QUESTIONNAIRE

Name: _____ Date of Birth: _____ Age: _____

Height: _____ Weight: _____ Do you have a Health Care Directive (assumed no if blank)? _____

In an emergency notify: _____ relationship: _____ phone: _____

Primary care physician/clinic: _____ Pharmacy: _____

Brief reason for contacting NCC: _____

Referred by: _____ Current therapist: _____

MEDICAL

Date of last physical examination _____

Yes No Medication allergies -List if yes _____

Yes No Other allergies - List if yes _____

Yes No Medication side effects -Explain if yes _____

Yes No Supplemental medicinal treatment (St. John's Wort, herbs, vitamins)

Types if yes _____

Yes No Family history of thyroid problems - Explain if yes _____

Yes No Head/brain injuries, seizure, stroke, concussion or loss of consciousness

Explain if yes _____

Yes No Current treatment for medical condition/infection

Explain if yes _____

Yes No Past medical problems

List if yes _____

Yes No Pain which interferes with daily activities - Explain if yes _____

Yes No Recent significant weight gain/loss? (how much) _____

Yes No Caffeine consumption - Type & daily quantity _____

Yes No Tobacco (smoke/chew) - Daily quantity _____

Yes No Do you eat regular meals? Describe meal if yes _____

Yes No Exercise - List type & how often _____

WOMEN

Yes No Currently pregnant – Due date _____

Yes No Regular periods - Explain if no _____

MEDICATION			
Brand	**Dose**	**Brand**	**Dose**
1		6	
2		7	
3		8	
4		9	
5		10	

Yes No Mental Health Assessment within past year (date) _____

MENTAL HEALTH			
Type	**Facility**	**Date**	**Reason**
In-patient			
Out-patient			
Medication management			
Other (i.e., day treatment, partial hospitalization)			

CHEMICAL DEPENDENCY (CD) TREATMENT			
Type	**Facility**	**Date**	**Reason**
In-patient			
Out-patient			

Comments: _____

_____

_____

_____

_____ Date: _____

Client/Guardian signature

Global Appraisal of Individual Needs-Short Screener (GAIN-SS)

Version [GVER]: GSS 3.0.1

Name: _____ **Date:** _____

First/Middle/Last

The following questions are about common psychological, behavioral and personal problems. These problems are considered significant when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on.

After each of the following questions, please tell us the last time you had this problem, if ever, by answering (circling) whether it was in the past month (4), 2-3 months ago (3), 4-12 months ago (2), 1 or more years ago (1), or never (0). Be sure to choose only one response.	Past Month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
IDSscr					
When was the last time you had significant problems...					
• with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	4	3	2	1	0
• with sleep trouble, such as bad dreams, sleeping restlessly or falling asleep during the day?	4	3	2	1	0
• feeling very anxious, nervous, tense, scared, panicked or like something bad was going to happen?	4	3	2	1	0
• becoming very distressed and upset when something reminded you of the past?	4	3	2	1	0
• thinking about ending your life or committing suicide?	4	3	2	1	0
• seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?	4	3	2	1	0
EDSscr					
When was the last time that you did the following things two or more times?					
• Lied or conned to get things you wanted or to avoid having to do something?	4	3	2	1	0
• Had a hard time paying attention at school, work, or home?	4	3	2	1	0
• Had a hard time listening to instructions at school, work, or home?	4	3	2	1	0
• Had a hard time waiting for your turn?	4	3	2	1	0
• Were a bully or threatened other people?	4	3	2	1	0
• Started physical fights with other people?	4	3	2	1	0
• Tried to win back your gambling losses by going back another day?	4	3	2	1	0

(Continued) After each of the following questions, please tell us the last time you had this problem, if ever, by answering (circling) whether it was in the past month (4), 2-3 months ago (3), 4-12 months ago (2), 1 or more years ago (1), or never (0). Be sure to choose only one response.	Past Month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
SDSscr When was the last time that...					
• you used alcohol or other drugs weekly or more often?	4	3	2	1	0
• you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (feeling sick)?	4	3	2	1	0
• you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	4	3	2	1	0
• your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events?	4	3	2	1	0
• you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?	4	3	2	1	0
CVSscr When was the last time that you...					
• had a disagreement in which you pushed, grabbed, or shoved someone?	4	3	2	1	0
• took something from a store without paying for it?	4	3	2	1	0
• sold, distributed or helped to make illegal drugs?	4	3	2	1	0
• drove a vehicle while under the influence of alcohol or illegal drugs?	4	3	2	1	0
• purposely damaged or destroyed property that did not belong to you?	4	3	2	1	0

Do you have other significant psychological, behavioral or personal problems that you want treatment for or help with? If yes, please describe: _____ Yes _____ No

_____

_____

_____ _____

Client Signature Date

Staff Use Only

Number of 2's, 3's, and 4's: IDSscr: _____ EDSscr: _____ SDSscr: _____ CVSscr: _____ TDSscr: _____

Referral: _____ MH _____ SA _____ ANG _____ Other: _____

 GAIN-SS/dla/10/18

NAME: _____ DATE: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Circle to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.

WHODAS 2.0
World Health Organization
Disability Assessment Schedule 2.0

Name:_____ Date: _____

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

	Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please check only one response.	None (1)	Mild (2)	Moderate (3)	Severe (4)	Extreme or cannot do (5)
1	Standing for long periods such as 30 minutes?					
2	Taking care of your household responsibilities?					
3	Learning a new task, for example, learning how to get to a new place?					
4	How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?					
5	How much have you been emotionally affected by your health problems?					
6	Concentrating on doing something for ten minutes?					
7	Walking a long distance such as a mile (or equivalent)?					
8	Washing your whole body?					
9	Getting dressed?					
10	Dealing with people you do not know?					
11	Maintaining a friendship?					
12	Your day-to-day work?					

1	Overall, in the past 30 days, how many days were these difficulties present?	Record number of days ____
2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	Record number of days ____
3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	Record number of days ____

This completes the questionnaire. Thank you.

Northland Counseling Center, 215 SE Second Avenue, Grand Rapids, MN 55744
218-326-1274 1-800-450-1274 Fax: 218-326-9787

Authorization for the Release of Medical Information

I, _____ **authorize**
(Name) (DOB)

Northland Counseling Center to: (Check one or both)
__x__ **Give information to**
__x__ **Receive information from**

_____
(Outside Agency or Individual's Name)

Dates or Type of service to be released by mail, telephone, or facsimile as follows:

X	Diagnostic Assessment/Psychological Evaluation	X	Psychological Testing Results
X	Treatment Plan	X	Medical Report and Medication Regimen
X	Narratives/Progress Notes		
X	Educational Information	X	Discharge Summary
X	Labs		
____	Other (specify) _____		

Records related to chemical dependency, mental health, sickle cell anemia, tuberculosis, and/or HIV/AIDS will be released, unless otherwise indicated by initialing here: _____

Approximate Dates of information requested: Current or most recent episode of care

Purpose of Disclosure:

X	Coordination of Care and Services	____	Legal
X	Future Referrals/References	____	Disability Claims
____	Other (specify) __		

I understand that my authorization terminates one year from the date of my signature. I understand that I have the right to revoke this authorization in writing at any time prior to the termination date. I understand that NCC cannot release information disclosed by this authorization to anyone other than listed above, and that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient only upon my written consent. I further understand that the information disclosed as a result of this authorization may no longer be protected and could be rediscloseed by the recipient without my permission. NCC will not condition treatment on my signing this authorization. A copy of this authorization shall be considered as valid as the original.

_____ _____
Client/Guardian Signature **Date**

If signing as the authorized representative of the patient, I am: (please check one)
____ Court appointed guardian
____ Custodial parent of a minor
____ Other, explain_____

_____ _____
Witness **Date**

This information will be disclosed from your records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical, or other information, is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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I, _____ **authorize**
(Name) (DOB)

Northland Counseling Center to: (Check one or both)
__x__ **Give information to**
__x__ **Receive information from**

_____
(Outside Agency or Individual's Name)

Dates or Type of service to be released by mail, telephone, or facsimile as follows:

X	Diagnostic Assessment/Psychological Evaluation	X	Psychological Testing Results
X	Treatment Plan	X	Medical Report and Medication Regimen
X	Narratives/Progress Notes		
X	Educational Information	X	Discharge Summary
X	Labs		
_____	Other (specify) _ _____		

Records related to chemical dependency, mental health, sickle cell anemia, tuberculosis, and/or HIV/AIDS will be released, unless otherwise indicated by initialing here: _____

Approximate Dates of information requested: Current or most recent episode of care

Purpose of Disclosure:

X	Coordination of Care and Services	_____	Legal
X	Future Referrals/References	_____	Disability Claims
_____	Other (specify) __		

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I, _____ **authorize**
(Name) (DOB)

Northland Counseling Center to: (Check one or both)
__x__ **Give information to**
__x__ **Receive information from**

_____
(Outside Agency or Individual's Name)

Dates or Type of service to be released by mail, telephone, or facsimile as follows:

X	Diagnostic Assessment/Psychological Evaluation	X	Psychological Testing Results
X	Treatment Plan	X	Medical Report and Medication Regimen
X	Narratives/Progress Notes		
X	Educational Information	X	Discharge Summary
X	Labs		
	Other (specify) _ _____		

Records related to chemical dependency, mental health, sickle cell anemia, tuberculosis, and/or HIV/AIDS will be released, unless otherwise indicated by initialing here: _____

Approximate Dates of information requested: Current or most recent episode of care

Purpose of Disclosure:

X	Coordination of Care and Services		Legal
X	Future Referrals/References		Disability Claims
	Other (specify) __		

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____ Custodial parent of a minor
____ Other, explain_____

_____ _____
Witness **Date**

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