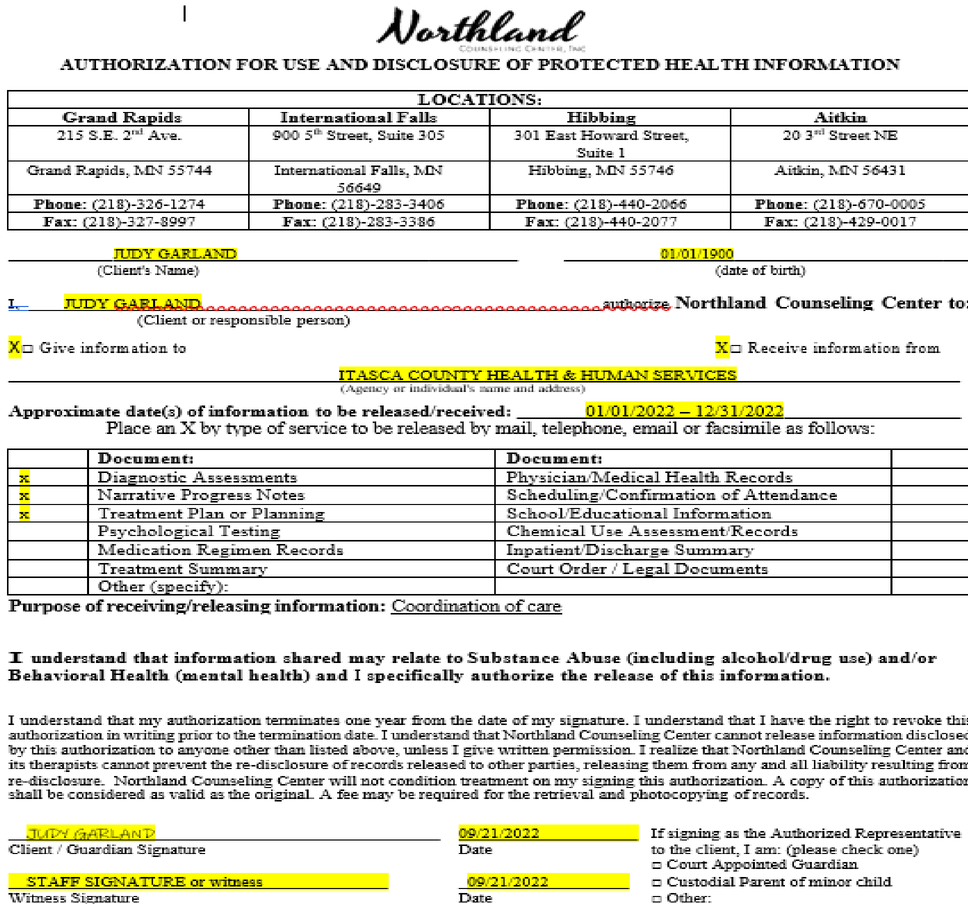
FORMS Needed for ADULT PACKET:

- Adult Pre-Intake Questionnaire – Signature pg 8
- Client Registration Form – Signature pg 10 and ALL boxes need to be checked!
- PHQ- 9
- GAIN-SS
- GAD-7
- WHODAS
- Provider Supervision Form – Signature 16
- Medicare Beneficiary Notice – Signature 17
- Release of Information (ROI) needs to be printed and filled out for each of these: *(SEE EXAMPLE BELOW)*
  - Primary Health Care Clinic(s)
  - Mental Health Agency (in the past year)
  - Medication Management (In the past 3 years)
    - You do NOT need to fill out a Release of Information for Northland Counseling Center, Inc.

ROI Example below:



Northland
Counseling Center, Inc

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

LOCATIONS:			
Grand Rapids	International Falls	Hibbing	Aitkin
215 S.E. 2nd Ave.	900 5th Street, Suite 305	301 East Howard Street, Suite 1	20 3rd Street NE
Grand Rapids, MN 55744	International Falls, MN 56649	Hibbing, MN 55746	Aitkin, MN 56431
Phone: (218)-326-1274 **Fax:** (218)-327-8997	**Phone:** (218)-283-3406 **Fax:** (218)-283-3386	**Phone:** (218)-440-2066 **Fax:** (218)-440-2077	**Phone:** (218)-670-0005 **Fax:** (218)-429-0017

JUDY GARLAND (Client's Name) 01/01/1900 (date of birth)

I, JUDY GARLAND (Client or responsible person) authorize **Northland Counseling Center to:**

X☐ Give information to X☐ Receive information from

ITASCA COUNTY HEALTH & HUMAN SERVICES
(Agency or individual's name and address)

Approximate date(s) of information to be released/received: 01/01/2022 – 12/31/2022

Place an X by type of service to be released by mail, telephone, email or facsimile as follows:

	Document:	**Document:**	
x	Diagnostic Assessments	Physician/Medical Health Records	
x	Narrative Progress Notes	Scheduling/Confirmation of Attendance	
x	Treatment Plan or Planning	School/Educational Information	
	Psychological Testing	Chemical Use Assessment/Records	
	Medication Regimen Records	Inpatient/Discharge Summary	
	Treatment Summary	Court Order / Legal Documents	
	Other (specify):		

Purpose of receiving/releasing information: Coordination of care

I understand that information shared may relate to Substance Abuse (including alcohol/drug use) and/or Behavioral Health (mental health) and I specifically authorize the release of this information.

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 prior to the termination date. I understand that Northland Counseling Center cannot release information disclosed by this authorization to anyone other than listed above, unless I give written permission. I realize that Northland Counseling Center and its therapists cannot prevent the re-disclosure of records released to other parties, releasing them from any and all liability resulting from re-disclosure. Northland Counseling Center will not condition treatment on my signing this authorization. A copy of this authorization shall be considered as valid as the original. A fee may be required for the retrieval and photocopying of records.

JUDY GARLAND
Client / Guardian Signature

09/21/2022
Date

STAFF SIGNATURE or witness
Witness Signature

09/21/2022
Date

If signing as the Authorized Representative to the client, I am: (please check one)
☐ Court Appointed Guardian
☐ Custodial Parent of minor child
☐ Other: ____________

NORTHLAND COUNSELING CENTER, INC.

ADULT PRE-INTAKE QUESTIONNAIRE

Name: ____ Date: ____________________________
(Last) (First) (M.I.)

Address:____
(Number & Street) (City) (State) (Zip)

Phone Number:_____________________________ May we leave a message? □ Yes □ No / May we text you? □ Yes □ No

Email Address: ____ May we email you? □ Yes □ No

Gender: □Male □Female □Non-Binary Birthdate: ____/_______/________ Age: ______________

Social Security Number: ____

Race: □ Asian □ Black/African American □ Native Hawaiian □ White □ Other: ___________________________

□ American Indian/Alaskan Native Tribe Enrolled: ____

Ethnicity: □ Hispanic/Latino (If yes, please answer next question):

□ Central American □ Cuban □ Dominican □ Puerto Rican □ South American □ Other: ___________

Hair Color: ______________________________ Length: □ Short □ Medium □ Long

Eye Color: _______________________________ Do you wear: □ Glasses □ Contacts

Height:__________________________________ Weight:____

Military Service: □ Non-Vet □ Vietnam Vet □ Other Vet □ Disabled Branch: _____________________

Emergency Contact

Emergency Contact Name: ____

Address: ____

Phone: ____ Relationship: ______________________________________

Guardian / Power of Attorney

If you have a Guardian and/or Power of Attorney please tell us their name

Contact Name: ____

Phone: ____Email: ____

Signature

____ _______________________

Signature Date

Please continue to fill out the additional pages.

Reason for your Visit

Tell us who referred you: ◻ Existing Client ◻ Self ◻ Healthcare Provider Mental Health Provider

◻ Court ◻ Probation ◻ Chemical Dependency/Drug Court

◻ Employment Requirement ◻ Other: ________________________

What services are you hoping to receive from Northland Counseling Center, Inc.? (*) Grand Rapids Only (**) I-falls Only

◻ Diagnostic Assessment Only ◻ Individual Therapy ◻ Family Counseling ◻ Adult Case Management**

◻ Testing (ex. ADHD) ◻ Kiesler Wellness Center* ◻ Hardwig House** ◻ ARMHS ◻ BHH ◻ PSS*

◻ Medication Management ◻ Northern Opportunity Works (NOW)

Current Life Situation

Marital Status: ◻ Single (never married) ◻ Married ◻ Divorced ◻ Re-Married ◻ Separated ◻ Widowed

◻ Living with significant other (boyfriend/girlfriend/fiancé)

Spouse/Significant Others Name: ____

Where do you live? ◻ Apartment ◻ House ◻ Residential Facility/Community Residential Setting

◻ Homeless ◻ Other: ____

Who do you reside with: ◻ Alone ◻ Spouse ◻ Parents ◻ Children ◻ Friends ◻ Other: ________________

How long have you resided in your current location:____

Name	Age	Relationship

Please use the back for additional people you reside with.

How would you describe your living situation: ◻ Excellent ◻ Good ◻ Okay ◻ Poor

Income / Employment Information

Current Source of Income: ◻ Wages ◻ Social Security ◻ Pension ◻ MFIP ◻ Child Support ◻ Other

Employment: ◻ Full-Time ◻ Part-Time ◻ Self-Employed ◻ Disabled ◻ Retired ◻ Homemaker ◻ Volunteer

◻ Unemployed ◻ Student

Employers Name: ____

Occupation: ____

Educational History

Education: □ GED □ High School Diploma □ Vocational Certificate □ Some College

□ College Graduate □ Post Graduate Degree: ____

□ Did not complete school Highest Grade Completed: ____

□ Currently Enrolled School Attending: ____

Special Education Services: □ No □ Yes, please tell us what services [for example, IEP, 504 Plan, Emotional Behavioral Disorder Services (EBD)]:____

Barriers to learning (reading/writing/math) or Past School Testing: _______________________________________

Additional Comments about educational history:

____

____

Mental Health History

Please let us know what symptoms you may be experiencing:

□ Anxiety □ Worry thoughts □ Racing heart □ Depressed mood □ Irritable mood □ Sleeping too much

□ Isolating □ Concentration □ Attention □ Inability to follow instructions □ Nightmares □ Vomiting

□ Restricting food intake □ Difficulties with relationships □ History of abuse (physical, mental, sexual)

□ Impulsivity □ Intense Anger □ Experienced a traumatic event □ Difficulty with authority figures

Have you received a Diagnostic Assessment and/or Psychological Testing in the past year?

□ No □ I do not know □ Yes (If yes, describe below):

Agency: ____

Date(s): ____

Have you received Mental Health Service (Therapy) in the Past? □ No □ I do not know □ Yes (If yes, describe below):

1. Agency: ____

   Date(s): ____

2. Agency: ____

   Date(s): ____

Do you currently have a MH Case Manager: □ No □ Yes, name and agency: ______________________________

Have you seen a Psychiatrist or a Nurse Practitioner for medication management? □ No □ Yes (If yes, describe below):

1. Agency: ____

   Date(s): ____

Do you have a Psychiatric Health Care Directive: □ Yes □ No

Early Childhood History

Early Childhood/Childhood Development - Any concerns with development, nutrition, and social concerns:

____

Normal Birth: □ Yes □ No (List any complications or birth defects, etc.):

____

Were early childhood milestones met on time? □ Yes □ No (Please list any delays):

____

List any special needs in childhood: ____

Substance or Alcohol Abuse History

Have you participated in a chemical dependency treatment program? □ No □ Yes

1) Agency: ____

   Date(s): ____

2) Agency: ____

   Date(s): ____

Do you feel you have a problem with substances or alcohol? □ No □ Yes

If yes, do you want help with this problem? □ No □ Yes

Any family history of substance or alcohol abuse/dependence? □ No □ Yes,
Describe____

Please describe use of the following: (Check box if using; note how often)

□ Alcohol: Uses _____ times per day/week; Amount per use_______

□ Tobacco: Uses _____ times per day/week; Amount per use _____

  □ Chewing Tobacco; How Much_____________________ □ Smoke Type:_________________________________

□ Caffeine: Uses _____ times per day/week; Amount per use _____

□ Marijuana: Uses _____ times per day/week; Amount per use _____

□ Other (ecstasy, meth, inhalants, cocaine, etc.): ____

  Uses _____ times per day/week; Amount per use _____

□ Non-medical use of prescribed or over-the-counter drugs (Vicodin, Percocet, Ritalin, etc.): ______________________

  Uses _____ times per day/week; Amount per use _____

Medical History

List significant current or past medical conditions:

____

____

____

Have you had your thyroid checked? □ No □ Unsure □ Yes, Approx Date: ______________________________

If yes, results: □ Normal □ Hypothyroidism □ Hyperthyroidism □ Unknown

Any family members with a thyroid condition? □ No □Yes If yes, who and what type if known:

____

Who is your Primary Care Physician / Clinic:

____

Most recent medical doctor appointment date, if known:

____

□ Within the past month □ Within six months □ Over one year □ Over 5 years

Previous Surgeries (type and dates):____

____

List of known Allergies:

Allergy To:	Severity:	Reaction:

Are you currently disabled: □ No □ Yes, please describe? ________________________________

Current and History of Head Trauma/Concussions/Seizures/Stroke or loss of consciousness: □ No □ Yes, please explain

____

____

Do you have pain which interferes with daily activities: □ No □ Yes, please explain

____

____

Do you exercise: □ No □ Yes, please explain

____

____

Have you gained / loss more than 10lbs in the past 6 months without trying: □ No □ Yes, please explain

____

____

Do you eat regular meals: □ No □ Yes, please explain

____

____

Significant medical problems of immediate family members and/or medical problems that run on your side of extended family?

____

____

____

Do you have a health care directive: □ No □ Yes

Dental

Who is your current dental provider, if known:____

When was your last dental visit:____

Medication

Preferred Pharmacy: ____

Current medications (Name and dosages if known, or please attach a list):

Medication Name	Dose	Medication Name	Dose

Do you have any medication allergies? □ No □ Yes, please list:

____

Do you experience any medication side effects? □ No □ Yes, please list:

____

Are you currently utilizing any supplemental treatment (St. John's Wort, Herbs, Vitamins) (Name and dosages if known, or please attach a list)?

Supplemental Treatment Name	Dose	Supplemental Treatment Name	Dose

Women

Are you currently pregnant: □ No □ Yes Due Date:_____________________________________

Do you experience regular periods: □ Yes □ No, please explain
____

Additional Information

FOR NORTHLAND COUNSELING CENTER, INC TO SERVE YOU BETTER:
Please list, to the best of your knowledge, any family members that currently work for Northland Counseling Center, Inc. to avoid a conflict of interest for your provider.

Name	Relationship	Name	Relationship

FOR NORTHLAND COUNSELING CENTER, INC TO SERVE YOU BETTER:
Please list, to the best of your knowledge, any people with whom you have had a significant relationship with that currently or previously attend/attended therapy at Northland Counseling Center, Inc. to avoid a conflict of interest for your provider.

Name	Relationship	Name	Relationship

Thank you for choosing Northland Counseling Center, Inc.

CLIENT REGISTRATION FORM

Client Name____ **Client Number**__________________________________

RIGHTS AND RESPONSIBILITIES:

1. I have been informed of my rights and if I feel like I have been discriminated against because of race, religion, national origin, sex or age, I may complain to this agency or to the State or Federal agencies listed in the "Notice of Privacy Practices".
2. I have been informed regarding my rights; have been read the Tennessen Warning; have had my initial questions answered regarding these issues; and have been given the handout "Client's Bill of Rights", "Notice of Privacy Practices." And a copy of the grievance procedure. I understand that I may request further information at any time.
3. I have been informed, and I understand that management personnel reserve the right to attend clinical staffing's where my case may be reviewed. This is to ensure that appropriate services are being offered and provided and ensure an effective interdisciplinary team approach.
4. By signing this form I am giving "Consent for Treatment."

INSURANCE / INCOME:

If you currently have insurance please fill out the following information:

Insurance Company: ____

Insurance Company Address: ____

Group #: ____ ID #: ____

Insurance Company Phone Number: ____

Employer Name: ____

Subscriber name: ____ Policy Holder DOB: ________________________

Policy Holder Address: ____

Relationship: ____

If you have a secondary insurance please fill out the following information:

Insurance Company: ____

Insurance Company Address: ____

Group #: ____ ID #: ____

Insurance Company Phone Number: ____

Employer Name: ____

Subscriber name: ____ Policy Holder DOB: ________________________

Policy Holder Address: ____

Relationship: ____

***If you have additional insurance please provide that information on the back of this form, thank you!**

If you do not have insurance and would like to fill out a sliding fee application check here: ☐

If you would like more information about our sliding fee scale please call:

- Aitkin, Grand Rapids, Hibbing: 218-326-1274 ask to speak with someone about the sliding fee application
- International Falls: 218-283-3406 ext 122 ask to speak about the sliding fee application

If you plan to use your employers EAP check here: ☐

It is YOUR responsible to contact your EAP provider AND provide the authorization number prior to your appointment. If the information is NOT received you may be responsible for the payment of services.

RELEASE OF INFORMATION:
I authorize Northland Counseling Center, Inc. (NCC) to release information to my insurance company regarding my treatment here. This could include my social security number, diagnosis, prognosis, dates of treatment, narrative notes and types of treatment and permit a facsimile or photographic reproduction of this authorization in place of the original. This is for the purpose of validating claims submitted to your insurance company. I also authorize my insurance to make payments to NCC for all insurance benefits to which I or my dependents are entitled for services received at NCC. I understand that my consent terminates one year from the date of signature, unless I choose to revoke it earlier. I affirm that the information reported above is accurate and that the fee, payment method and release of information have been discussed. If my financial status changes, an update of this agreement may be renegotiated. This release includes any insurance that you may have at the time of your, or your dependents, services.

PAYMENT PLAN:

- ☐ Each month I will pay a minimum of 25% of the total balance due until all charges are **paid.**
- ☐ Following each visit, I will pay the charges for that visit.
- ☐ Upon receipt of a monthly statement, I will remit the amount due.
- ☐ I will be responsible for payment for any services denied by my insurance company, including but not limited to deductibles,co-pays and exclusions.
- ☐ I understand that I am responsible for the charges in full, forfeiting my opportunity to be placed on the sliding fee scale, if I do not comply with the following (when applicable):

  a. Provide verification of income documentation
  b. Obtaining a physician referral when my insurance requires one.
  c. Applying for medical assistance and notifying Northland Counseling Center, Inc. (NCC) of disposition if referred.
  d. A fee may be charged for any missed appointments which are not canceled at least 24 hours in advance.

  I recognize that it is my responsibility to be aware of my insurance benefits and payment by insurance is not guaranteed.

  In the event NCC has been unable to collect payment from me for services within a reasonable period of time, NCC then reserves the right to turn the account over to an attorney or collection agency (this may include: address; phone/cell phone number; email, etc.). I understand that interest, finance charges and other costs as allowed by law, will be added to my account. A 15% processing fee will be added to any account sent to collections.

MISSING APPOINTMENT POLICY:
Time is a valuable commodity at Northland Counseling Center and we dedicate time to your treatment and expect that you do the same.
It is understandable that an appointment may need to be missed for planned or unplanned reasons. Please, notify us as soon as you are able when you realize you cannot attend a scheduled appointment. It is also important to be on time for an appointment as arriving late interferes with the therapeutic process and you may not be seen for your appointment. Most importantly, you are not able to benefit from therapy and/or medication management if tardiness or absences become frequent. We do our best to do reminder calls and texts and clients are ultimately responsible for remembering their appointments.

By signing below, I agree to try my best to provide a 24-hour notice if I am to miss a scheduled appointment. I will not schedule an appointment at a time when I know I am not able to attend. I understand that two consecutive no-shows or frequent late cancelations may result in me being placed on the waiting list for an appointment. I understand I may be charged a fee, if I do not provide notice and/or show for my appointment.

HEALTH RECORD:
A health record location service helps my mental health providers determine where I have received care and obtain information about my health to help treat me. NCC may access my information in a record locator service to help provide care to me. NCC may share my health record and information with a record locator services unless I CHECK the box below. If I check the box below, I understand NCC will exclude my information in any record locator service.

☐ I do **NOT** want my information shared in a record locator service for coordination of care reasons.

TELEHEALTH CONSENT
By signing below, I consent to the use of telehealth services for myself / child / dependent / person who I service as their guardianship of. You may obtain a copy of NCC's telehealth information.

CLIENT SIGNATURE____ DATE ____________________

RESPONSIBLE PARTY SIGNATURE ____

NORTHLAND STAFF SIGNATURE____DATE____________________

Patient Health Questionnaire (PHQ-9)

Name: ____ Date: ___________________

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use “X” to indicate your answer)	Not at All (0)	Several Days (1)	More than half the days (2)	Nearly every day (3)
Little Interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep or sleeping too much				
Feeling tired or having little energy				
Poor appetite or over eating				
Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that 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				
Thoughts that you would be better off dead, or of hurting yourself in some way				
Add Columns				
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: ____________ (0)
Somewhat difficult: ____________ (1)
Very difficult: ____________ (2)
Extremely difficult: ____________ (3)

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

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**.	Within the past month	2-3 Months ago	4-12 Months ago	1 or more years ago	Never
IDSacr					
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
• With 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
Tally the number of 2's, 3's and 4's for the sub-screener above:					
IDSscr:_____					
EDSscr					
When was the last time 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
Tally the number of 2's, 3's and 4's for the sub-screener above:					
EDSscr:_____					

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.**	Within the past month	2-3 Months ago	4-12 Months ago	1 or more 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
Tally the number of 2's, 3's and 4's for the sub-screener above: **SDSscr:_____**					
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
Tally the number of 2's, 3's and 4's for the sub-screener above: **CVSscr:_____**					

Do you have other significant psychological, behavioral or personal problems that you want treatment for or help with: No Yes

If yes, please describe:

____

____

____ __________________________

Client Signature Date

Tally the number of 2's, 3's and 4's from all of the sub-screeners above:
IDSscr___ EDScr___ SDScr___ CVSscr:___
Referral: MH SA AM Other:________________________________

Northland
Counseling Center, Inc

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

Name:___________________________________
Date:___________________________________

Over the **last 2 weeks**, how often have you been bothered by the following problems? Please check the box:

	Not at all	Several Days	More than Half the days	Nearly Everyday
1. Feeling nervous, anxious, or on edge	0 ☐	1 ☐	2 ☐	3 ☐
2. Not being able to stop or control worry	0 ☐	1 ☐	2 ☐	3 ☐
3. Worry 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 ☐

____

Staff Purpose Only *Add the score for each column* + + +

____

Staff Purpose Only Total Score (*add your column scores*) =

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

Please check the box next to the one that best describes the level of difficulty.

Not difficult at all: □ **Somewhat difficult**: □ **Very difficult**: □ **Extremely difficult**: □

Source: Spitzer RL, Kroenke K, William JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. Arch Inern 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 drug.

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 (0)	Mild (1)	Moderate (2)	Severe (3)	Extreme or Cannot do (4)
S1	Standing for long periods such as 30 minutes?					
S2	Taking care of your household responsibilities?					
S3	Learning a new task, for example, learning how to get to a new place?					
S4	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?					
S5	How much have you been emotionally affected by your health problems?					
S6	Concentrating on doing something for ten minutes?					
S7	Walking a long distance such as a mile (or equivalent)?					
SB	Washing your whole body?					
S9	Getting dressed?					
S10	Dealing with people you do not know?					
S11	Maintaining a friendship?					
S12	Your day-to-day work?					
	Add Columns					
	Total Score					

		Record # of Days
H1	Overall, in the past 30 days, how many days were these difficulties present?	
H2	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?	
H3	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?	

Supervision Waiver

CLIENT NAME: ____ DOB:___________________________

Dear Client,

Northland Counseling Center, Inc is a Rule 29 Licensed Mental Health Clinic. We employ a multidisciplinary mental health team with a broad spectrum of training and experience. Credentials for all of our staff are available at the front desk or online.

As part of our multidisciplinary team approach, we employ mental health professionals, mental health clinical trainees and interns. All of the staff participate in consultation with the team and their individual clinical supervisors. Some of our mental health staff are credentialed by certain health plans and not by others. The following may apply to the provider you will be working with.

- **Doctoral Intern, supervised by a Mental Health Professional**
- **Clinical Trainee, supervised by a Mental Health Professional**
- **Licensed Mental Health Professional, NOT credentialed by your health plan AND supervised by a credentialed provider**
- **Practicum Student, supervised by a Mental Health Professional**
- **Internship Student, supervised by a Mental Health Professional**

One of the following credentialed providers will be supervising your services•:

- Angie Baratto, MA, LPCC
- Amie Madl, MA, LMFT, RPT-S
- Laura Maxwell, MSW, LICSW
- Danielle Krasaway, MS, LPCC
- Brandi Worrath, MS, LPCC
- Dessa Bergan, MSW, LICSW
- Jennifer Alstad, MS, Ed., LMFT
- Allison O'Hara-Meyer, Psy.D., LP
- Brea Wallaker, MSW, LICSW

□ Other:____

I have read and understand the information and agree to services as indicated.

____ ___________________________________

Client and/or Parent Guardian Signature Date

Adverse Childhood Experience Questionnaire for Adults

California Surgeon General's Clinical Advisory Committee

Our relationships and experiences—even those in childhood—can affect our health and well-being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below, as they may be affecting your health today or may affect your health in the future. This information will help you and your provider better understand how to work together to support your health and well-being.

Instructions: Below is a list of 10 categories of Adverse Childhood Experiences (ACEs). From the list below, please place a checkmark next to each ACE category that you experienced prior to your 18th birthday. Then, please add up the number of categories of ACEs you experienced and put the *total number* at the bottom.	
1. Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	
2. Did you lose a parent through divorce, abandonment, death, or other reason?	
3. Did you live with anyone who was depressed, mentally ill, or attempted suicide?	
4. Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	
5. Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?	
6. Did you live with anyone who went to jail or prison?	
7. Did a parent or adult in your home ever swear at you, insult you, or put you down?	
8. Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	
9. Did you feel that no one in your family loved you or thought you were special?	
10. Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?	
Your ACE score is the total number of checked responses	

Do you believe these experiences have affected your health? ◯ Not Much ◯ Some ◯ Alot

Experiences in childhood are just one part of a person's life story.
There are many ways to heal throughout one's life.

Medicare Advanced Beneficiary Notice
Please fill out if you have Medicare for insurance

CLIENT NAME: ____ DOB:____________________________

Dear Client,

This form is to ensure you are aware of your Medicare Coverage and possible denial of payment. Medicare will not pay for services that it determines to be not reasonable and necessary under Section 1862 of the Medicare law. If Medicare determines that a particular service, although it would be otherwise covered, is not reasonable and necessary under the Medicare program Standards, Medicare will deny payment for that service. In your case, I believe Medicare will deny payment for the following services and reasons (not all maybe applicable):

Please circle one of the following:

1. Medicare does not pay for this many of visits of treatments.
2. Medicare does not pay for the services because the provider is a Non-Medicare Provider.
3. Medicare does not pay for this many of services within this time frame.
4. Medicare does not pay for educational materials/programs.
5. Medicare does not pay for the diagnosis associated with the treatment you are having.
6. Medicare does not usually pay for this service because:____

Beneficiary Agreement:

I have been notified by my provider that he or she believes that, in my case, Medicare is likely to deny payment for the service(s) identified above, for the reasons stated. My secondary/supplemental insurance will be billed if applicable. If Medicare/Secondary Supplemental denies payment, I agree to be personally and fully responsible for payment.

____ ___________________________________

Client and/or Parent / Guardian Signature Date

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

LOCATIONS:			
Grand Rapids	**International Falls**	**Hibbing**	**Aitkin**
215 S.E. 2nd Ave.	900 5th Street, Suite 305	301 East Howard Street, Suite 1	20 3rd Street NE
Grand Rapids, MN 55744	International Falls, MN 56649	Hibbing, MN 55746	Aitkin, MN 56431
Phone: (218)-326-1274	**Phone:** (218)-283-3406	**Phone:** (218)-440-2066	**Phone:** (218)-670-0005
Fax: (218)-327-8997	**Fax:** (218)-283-3386	**Fax:** (218)-440-2077	**Fax:** (218)-429-0017

____ ____
(Client's Name) (date of birth)

I,____authorize **Northland Counseling Center to:**
(Client or responsible person)

□ Give information to □ Receive information from

____
(Agency or individual's name and address)

Approximate date(s) of information to be released/received: ____

Place an X by type of service to be released by mail, telephone, email or facsimile as follows:

	Document:	Document:	
x	Diagnostic Assessments	Physician/Medical Health Records	x
x	Narrative Progress Notes	Scheduling/Confirmation of Attendance	x
x	Treatment Plan or Planning	School/Educational Information	x
x	Psychological Testing	Chemical Use Assessment/Records	x
x	Medication Regimen Records	Inpatient/Discharge Summary	x
x	Treatment Summary	Court Order / Legal Documents	x
	Other (specify):		

Purpose of receiving/releasing information: ____

I understand that information shared may relate to Substance Abuse (including alcohol/drug use) and/or Behavioral Health (mental health) and I specifically authorize the release of this information.

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 prior to the termination date. I understand that Northland Counseling Center cannot release information disclosed by this authorization to anyone other than listed above, unless I give written permission. I realize that Northland Counseling Center and its therapists cannot prevent the re-disclosure of records released to other parties, releasing them from any and all liability resulting from re-disclosure. Northland Counseling Center will not condition treatment on my signing this authorization. A copy of this authorization shall be considered as valid as the original. A fee may be required for the retrieval and photocopying of records.

____ ____________________
Client / Guardian Signature Date

____ ____________________
Witness Signature Date

If signing as the Authorized Representative to the client, I am: (please check one)
□ Court Appointed Guardian
□ Custodial Parent of minor child
□ Other: ______________________

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

LOCATIONS:			
Grand Rapids	**International Falls**	**Hibbing**	**Aitkin**
215 S.E. 2nd Ave.	900 5th Street, Suite 305	301 East Howard Street, Suite 1	20 3rd Street NE
Grand Rapids, MN 55744	International Falls, MN 56649	Hibbing, MN 55746	Aitkin, MN 56431
Phone: (218)-326-1274	**Phone:** (218)-283-3406	**Phone:** (218)-440-2066	**Phone:** (218)-670-0005
Fax: (218)-327-8997	**Fax:** (218)-283-3386	**Fax:** (218)-440-2077	**Fax:** (218)-429-0017

____ (Client's Name)

____ (date of birth)

I,____authorize **Northland Counseling Center to:**
(Client or responsible person)

☐ Give information to ☐ Receive information from

____
(Agency or individual's name and address)

Approximate date(s) of information to be released/received: ____

Place an X by type of service to be released by mail, telephone, email or facsimile as follows:

	Document:	**Document:**	
X	Diagnostic Assessments	Physician/Medical Health Records	X
X	Narrative Progress Notes	Scheduling/Confirmation of Attendance	X
X	Treatment Plan or Planning	School/Educational Information	X
X	Psychological Testing	Chemical Use Assessment/Records	X
X	Medication Regimen Records	Inpatient/Discharge Summary	X
X	Treatment Summary	Court Order / Legal Documents	X
	Other (specify):		

Purpose of receiving/releasing information: ____

I understand that information shared may relate to Substance Abuse (including alcohol/drug use) and/or Behavioral Health (mental health) and I specifically authorize the release of this information.

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 prior to the termination date. I understand that Northland Counseling Center cannot release information disclosed by this authorization to anyone other than listed above, unless I give written permission. I realize that Northland Counseling Center and its therapists cannot prevent the re-disclosure of records released to other parties, releasing them from any and all liability resulting from re-disclosure. Northland Counseling Center will not condition treatment on my signing this authorization. A copy of this authorization shall be considered as valid as the original. A fee may be required for the retrieval and photocopying of records.

____ ____________________
Client / Guardian Signature Date

____ ____________________
Witness Signature Date

If signing as the Authorized Representative to the client, I am: (please check one)
☐ Court Appointed Guardian
☐ Custodial Parent of minor child
☐ Other: ______________________

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

LOCATIONS:			
Grand Rapids	**International Falls**	**Hibbing**	**Aitkin**
215 S.E. 2nd Ave.	900 5th Street, Suite 305	301 East Howard Street, Suite 1	20 3rd Street NE
Grand Rapids, MN 55744	International Falls, MN 56649	Hibbing, MN 55746	Aitkin, MN 56431
Phone: (218)-326-1274	**Phone:** (218)-283-3406	**Phone:** (218)-440-2066	**Phone:** (218)-670-0005
Fax: (218)-327-8997	**Fax:** (218)-283-3386	**Fax:** (218)-440-2077	**Fax:** (218)-429-0017

____ (Client's Name)

____ (date of birth)

I,_______________________________________authorize **Northland Counseling Center to:**
(Client or responsible person)

☐ Give information to ☐ Receive information from

____
(Agency or individual's name and address)

Approximate date(s) of information to be released/received: _______________________________

Place an X by type of service to be released by mail, telephone, email or facsimile as follows:

	Document:	**Document:**	
X	Diagnostic Assessments	Physician/Medical Health Records	X
X	Narrative Progress Notes	Scheduling/Confirmation of Attendance	X
X	Treatment Plan or Planning	School/Educational Information	X
X	Psychological Testing	Chemical Use Assessment/Records	X
X	Medication Regimen Records	Inpatient/Discharge Summary	X
X	Treatment Summary	Court Order / Legal Documents	X
	Other (specify):		

Purpose of receiving/releasing information: _______________________________________

I understand that information shared may relate to Substance Abuse (including alcohol/drug use) and/or Behavioral Health (mental health) and I specifically authorize the release of this information.

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 prior to the termination date. I understand that Northland Counseling Center cannot release information disclosed by this authorization to anyone other than listed above, unless I give written permission. I realize that Northland Counseling Center and its therapists cannot prevent the re-disclosure of records released to other parties, releasing them from any and all liability resulting from re-disclosure. Northland Counseling Center will not condition treatment on my signing this authorization. A copy of this authorization shall be considered as valid as the original. A fee may be required for the retrieval and photocopying of records.

_______________________________________ ________________
Client / Guardian Signature Date

_______________________________________ ________________
Witness Signature Date

If signing as the Authorized Representative to the client, I am: (please check one)
☐ Court Appointed Guardian
☐ Custodial Parent of minor child
☐ Other: ___________________________