Tamara Mason MSW, LICSW
Psychotherapy, Life Coaching & Consulting

522 Beltrami Ave. Suite 108
Bemidji, MN 56601
tamaramason.com
(218) 444 - 0899

INTAKE FORM

Date __________

Name____ Date of Birth__________
First Middle Last

Age____________

Address____

Street City State Zip

Home, Work, Cell ________________Is it okay to leave a message at this number?__________

Home, Work, Cell ______________Is it okay to leave a message at this number?__________

Marital Status: Single, Domestic Partner, Married, Widowed, Separated, Divorced

Occupation___________________________Employer____________________________

Spouse/Parents Name:____

(children)

Spouse/Parents Occupation____

(children) Others living in household

Name DOB Relationship Gender

____

____

____

____

How much alcohol do you consume in a week?_____________________________________

Do you use marijuana, if so how much?____

Do you use other drugs, if so what and how much?_________________________________

Who suggested you contact me for services?___________________________________

What do you want to see happen as a result of coming here?_______________________

What have you tried on your own to solve your concerns?________________________

____

INSURANCE INFORMATION (We prefer front and back copy of card)

MA/MNCARE/MEDICARE#____

Other Insurance Company name____

Group #___________________________ Policy #_____________________________

Policy Holder/Subscriber____

Policy Holder Date of Birth & Address____

Name of personal physician or clinic____

Date of last physical_____________________________

Have you had any outpatient mental health services billed to your insurance company or medical assistance this calendar year?_____________ If yes, how many hours?________ Who provided these services?_________________________________

Medical Conditions/Problems____

Have you had mental health services prior to this calendar year? If so when and who provided these services?____

____

Have you had chemical dependency treatment? If so when and who provided these services?
____

Please list your current medications____

____

Allergies____

Race/Ethnic Group______________________________________

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PERMISSION TO TREAT

I have read the "Policies for Professional Services" updated 1/13 and my questions about them have been answered to my satisfaction.

I've received a copy of the Minnesota Data Practices "Tenneson Warning" and I received a copy of the federal "Notice of Privacy Practices" updated 1/09.

I consent to minimum necessary information about my diagnosis and treatment being furnished to third parties for the purpose of treatment, payments and health-care operations as defined by federal privacy roles. I understand that I have the right to request restrictions as to how my mental health information may be used for these purposes and that my mental-health provider is NOT required to agree to these restrictions.

I consent to have third-party payment sent directly to the provider, Tamara Mason. I understand that the practice of Tamara Mason is legally and professionally separate from other providers in this facility and that those providers are not responsible for my treatment.

I request and consent to treatment by Tamara Mason, MSW, LICSW for myself, my child or other family member.

______________________________ ______________________________

Client Date Parent/Guardian, if under 18 Date

________I give permission for Tamara Mason to exchange information with my primary care medical provider.

_______I DO NOT give Tamara Mason permission to exchange information with my primary care medical provider.

(Check one of the above statements)

____

Client or guardian signature Date

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POLICIES FOR PROFESSIONAL SERVICES

I welcome the opportunity to work with you. The two most difficult steps are to make the first appointment and secondly to come to the first appointment. You are well on your way to changing your life. Congratulations!

APPOINTMENTS

All office visits are by appointment only. If you need to be seen sooner than your next scheduled appointment please call and let me know and I will attempt to schedule an earlier appointment.

Your appointment time has been reserved for you. Please call at least 24 hours in advance if you will be unable to keep an appointment. We may bill you for appointments not kept or canceled less than 24 hours in advance.

Initial______

EMERGENCIES

If you are having an emergency (for example wanting to harm yourself) after office hours or at another time when you are unable to reach me, call 911 or go the nearest hospital emergency room. The telephone number for North Country Regional Hospital is (218) 333-5595. The crisis line number is: 1-800-422-0045.

INSURANCE AND PAYMENT GUIDELINES

Psychotherapy is covered by most medical insurance. Life coaching is not covered by most medical insurance. I ask that you pay for services not covered by insurance on the day that they are received (including deductible and co-payments). You may choose to bill your health insurance for professional services; however, it is your responsibility to determine the extent of the coverage. We will submit claims for you for companies where I am a participating provider. I request that you take responsibility for monitoring the amount of third-party benefits you have available during the course of your treatment. You will be responsible for portions of your bill not covered by your insurance. For billing purposes I need to get a complete history regarding prior mental health services, because your treatment coverage may have specified limitations. In the event your bill is not paid in a timely manner your account may be turned over to a collection agency. Initial_______

PRACTICE DESCRIPTION

This is a psychotherapy and life coaching practice. I do psychotherapy and life coaching. My approach is strength based, solution focused and system oriented. I am a clinical social worker. I received my MSW from the University of Denver in 1985. I have experience as a school social worker, clinical supervisor in a day treatment center, social worker supervisor and over 20 years of experience doing outpatient therapy.

CURRENT CHARGES

$220 for the initial session (diagnostic assessment) and $120 to $160 for ongoing psychotherapy and life coaching sessions. On going sessions are 37 to 60 minutes in length. I reserve the right to change my fee for sessions.

Initial______

CONFIDENTIALITY

Please read the attached Minnesota Data Privacy Rules and Federal (HIPAA) Notice of Privacy Practices.

For billing purposes, information about diagnosis and treatment may need to be furnished to insurance carriers and other third party payers. Care is taken to provide the minimum necessary information to these companies.

Please be aware that when you authorize release of health information to non-health care providers those receiving the information may not be required to abide by the state and federal confidentiality standards described in the attached privacy information.

There are a few situations where your confidentiality is not protected. These are the most common situations:

1. If you were referred by the court or an employer for evaluation or treatment, the court or employer expects a report form me. If this is your situation please talk with me before you tell me anything you do not want the court or your employer to know. You have a right to tell me only what you are comfortable with telling.

2. If you are suing someone or being sued or charged with a crime and you tell the court you are seeing me I may then be ordered to give the court a copy of my records. Your records may be brought into custody or adoption proceedings or any other legal case in which a judge decides that a client's mental or emotional condition is an important element. Disability cases, worker's compensation hearings, psychiatric hospitalization and criminal cases are some of the possibilities. Please consult your lawyer about these issues.

3. If you make a serious threat to harm yourself or another person, the law requires me to try to protect you or that other person. This usually means telling others about the threat. I cannot promise never to tell others about threats you make.

4. If I suspect a child has been or will be abused or neglected, I am legally required to report this to the authorities.

On occasion it may be necessary to consult with other mental health professionals as part of providing quality care. This is done in a confidential manner.

If I see you out in the community I may not greet you or talk to you very much. This is a way to maintain your confidentiality, not a personal reaction to you.

I share the waiting room with other therapists. These therapists maintain their own practices and have no business association with me other than renting space and sharing the waiting room. These therapists operate under the same confidentiality rules required by law as I do.

If you have any questions about these policies please talk them over with me.

Initial______

PRIVACY NOTICE

TENNESSEN WARNING

YOUR RIGHTS UNDER THE. MINNESOTA DATA PRACTICES ACT AND

FEDERAL DATA PRIVACY RULES

HEALTH INSURANCE PORTABILITY AND ACCOUNTABIILITY ACT (HIPPA)

There are various state and federal laws to protect your rights as a recipient of mental health services. This sheet seeks to inform you of your rights under these laws.

Data Privacy.

- We must provide you with access to a privacy notice that explains how we may use or disclose medical information.
- You will be asked to acknowledge that you received and understood the privacy notice when you first receive services from a clinician in this office.
- I will abide by the terms of the privacy notice.

The Minnesota Government Data Privacy Act requires that when we ask you to provide us with private or confidential information about yourself that you be told:

- The purpose for which the information will be used.
- The legal requirements, if any of supplying it
- The consequences to you of providing the information or refusing to supply it
- The identity of other persons or agencies authorized by statute to secure the information

Purposes-Information we ask from you will be used to establish diagnosis, prognosis, determine treatment plans, treatment goals and to provide the service request. Information will also be used to establish your ability to pay for those services or collect reimbursement for services from third-party payers including insurance companies or employee assistance programs.

Legal Requirements and Consequence -- you are not legally required to provide any of the information we request. In most cases, it is to your benefit to provide the information. Failure to provide the information means that we will be unable to provide the service requested. In special or unusual situations, the giving of those services may be communicated to the court. If you do not provide the information we request regarding financial responsibility, you may be responsible for all costs of the services we provide to you. If you feel that certain information, we request is an unwarranted invasion of your privacy, please ask for clarification.

Sharing -- Certain state laws protect patient's right to confidentiality of their health records. Information we maintain about, you may be shared with other agencies or individuals in the following circumstances:

- The court, upon receipt of a valid court order.
- Between staff members, whose work assignments require access to ensure quality service to you.
- Your insurance company
- In emergencies as necessary to protect the health and safety of you and others.
- When we are required by law to warn others of potential homicide or suicidal acts or report suspected abuse of children or vulnerable adults.
- To obtain reimbursement for services through the court or collection agencies

Unless otherwise authorized by statute or federal law, agencies with which we share private confidential information must also treat the information as confidential. A health care provider or a person who receives the patient's health records from a provider may not re-release these health records without a signed and dated consent of the patient. Sometimes the law makes exceptions.

Under Minnesota law, a patient may review any information in his or her health records, regarding any diagnosis, treatment and prognosis. If a patient asks in writing, a provider must give the patient copies of either records or a summary of the information in the records unless the provider has determined that the information is detrimental to the physical or mental health of the patient, or is likely to cause the patient to inflict self harm or harm to another. If such a determination has been made, then the information can be given to another provider or appropriate third party as a representative of the patient. Minnesota statute sets a minimum charge for finding and copying records.

Additional Disclosures:

- Appointment Reminders -- staff may at times contact you to provide appointment reminders.
- Others involved in your health care: unless you notify us in writing we may disclose certain billing information to a family member who calls on your behalf. The kind of information, we will disclose is the claim, amount paid and payment date. Disclosure of other information will require written authorization.
- Required by law: we may disclose certain health care information as required by state or federal law. Examples include the abuse or neglect reports, to prevent serious threat to safety of you and others, certain public health activities for government oversight activities; Court orders associated with legal proceedings, law enforcement activities of federal officials as necessary for reasons of national security. If you are an inmate of a correctional facility under our care we may disclosure health-care information to your correctional facility to help provide health care or to provide safety to you or others. We may also disclose health information as required by workers compensation laws.

Your Rights Regarding Your Medical Records

- The right to request an accounting of certain disclosures of your medical information in the six years prior to the date of request.
- The right to submit a written request to obtain a copy of medical information.
- The right to request confidential communication about medical information in the location of your choice.
- The right to submit a written request to amend your medical record.
- The right to submit a written complaint to your mental health care provider about how your medical information is used or disclosed.

Minors-- if you are a minor you have the right to request that private data about you be kept from your parents. You must make this request in writing and explain why you wish this data to be withheld from your parents. If it is in your best interest it will not be shown to your parents. If you're 16 years of age you may request mental-health services without knowledge or consent of your parents. You are also responsible for payment of those services.

Problems or complaints -- If for any reason you have questions about the service you're receiving from me or about my policies and procedures, please talk it over with me. If questions and or concerns remain after the discussion, please ask for clarification. If the handling of your concern is still not satisfactory to you, you have the right to appeal the decision by contacting the appropriate professional organization or state offices:

Data Privacy Office

State of the Minnesota Commissioner of Administrations

Administrative Building, Second Floor

50 Sherburne Ave.

St. Paul, MN 55155

Minnesota Board of Social Work

2700 University Ave. W, Suite 225

St. Paul, MN 55114

If you believe it is necessary to contact the Commissioner of Administration about accuracy of data, include your name address, telephone number, description of the data why you felt that it is inaccurate or incomplete, and what you want done about the claimed inaccuracies. You must file your appeal the Commissioner of administration, within 60 days of the date of any decision by us to not make the corrections requested.

If you have any questions about how we will use or disclose medical information, please ask your mental-health provider. If you have more specific questions about your privacy rights please asked the provider for additional information.

We reserve the right to change your privacy practice to comply with federal law. We will post revised notice in the waiting room. A copy will be available on request. This privacy notice becomes effective on November 1, 2003.

If you believe your privacy rights have been violated you should submit a written complaint to your mental-health provider. You may also complain to the Secretary of the Department of Health and Human Services in Washington, DC. Please be assured we will not take retaliatory action against you, if you complain about the practice either with us or DHS.

Name______________________________ Date______________________

Problem Checklist

How long have you been experiencing the problem(s) which made you decide to get counseling?

Not a problem Mild Moderate Severe

Financial problem..................0.... ....1....................2.....................3

Job stress/employment ....0.. ....1....................2.......................3

Physical health or handicap .0............................1....................2.......................3

Use of drugs and or alcohol

Type of drug________________.0.... ....1....................2.....................3

Spiritual concerns....................0.... ....1....................2.....................3

Depression or sadness........... .0..... ....1....................2.....................3

Anxiety or nervousness...........0...........................1....................2......................3

Panic attacks...........................0...........................1...................2.......................3

Unusual fears.........................0.... ....1....................2.....................3

Example____

Feeling confused/overwhelmed........0... ....1....................2.....................3

Hearing, seeing or believing things not experienced by other People...0.....................1.....................2....................3

Problems btwn parents & children..........0..... ....1....................2.....................3

Threatened/actual abuse/violence.......0........................1....................2.....................3

Anger, problems with temper.... .0.......................1....................2.....................3

Problems with resentment...........0.......................1....................2.....................3

Sexual concerns...........................0..... ....1....................2.....................3

Pregnancy concerns....................0........................1....................2.....................3

Separation/divorce................ .0..... ....1....................2......................3

Trouble relating to others........0.... ....1....................2......................3

Problems with spouse/partner...0.... ....1....................2......................3

Lack of self-confidence..........0..... ....1....................2.....................3

Sexual abuse......................... .0..... ....1....................2.....................3

Eating problems.....................0.... ....1....................2.....................3

School/education problems.... .0..... ....1....................2....................3

Problems with appetite........... .0..... ....1....................2....................3

Problems with sleep...............0.... ....1....................2.....................3

Problems with energy level.....0..... ....1....................2.....................3

Decrease in enjoyment or pleasure ...0......................1....................2.....................3

Suicidal feelings..................0.... ....1.....................2......................3

Problems with memory...........0... ....1....................2....................3

Gambling............................... .0..... ....1....................2......................3

Other specify____

.0...........................1....................2.....................3

31. How would you rate your total problem? 0............1.....................2..................3

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems? *(Use "✔" 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 <u>any</u> problems, how <u>difficult</u> 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**
☐	☐	☐	☐

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