**Maureen McNeal, LMFT, LICSW**
18300 Minnetonka Blvd, Suite 112
Wayzata, MN 55391
(952) 500-1957
www.awakecounseling.com

## Intake Form

Name ______________________________ Date ______________

Address ______________________________ Age ______________

______________________________ Birthdate ______________

OK to leave messages: Y or N

Home Phone (____) ____________ Y N

Cell Phone (____) ____________ Y N

Work Phone (____) ____________ Y N

Employment ______________________________

Education ______________________________

Health Insurance ______________________________

Subscriber ______________________________

ID/Group Number ______________________________

## Psychological History

Therapy Experience: Current ______________________________

Past ______________________________

______________________________

Mental Health Hospitalizations (year and diagnosis) ______________________________

______________________________

Psychological Diagnosis: Current ______________________________

Past ______________________________

Medications: Current ______________________________

Past ______________________________

Sexual Abuse: Current ______________________________

Past ______________________________

Suicidal Ideation: Current ______________________________

Past ______________________________

Physical or Verbal/Emotional Abuse: Current ______________________________

Past ______________________________

Drug and Alcohol Abuse History: Current ______________________________

Past ______________________________

## Social History

Marital History ______________________________

______________________________

______________________________

Significant Relationship History ______________________________

______________________________

______________________________

Significant Trauma/Issues from Childhood ______________________________

______________________________

______________________________

______________________________

## Medical History

Physical Conditions: Current ______________________________

Past ______________________________

## Family History

| Relationship - indicate if alive or deceased | Age | Mental Health/ Significant Issues | Current status of relationship (1-10, 10 being ideal) |
|---|---|---|---|
| Father | | | |
| Stepfather | | | |
| Mother | | | |
| Stepmother | | | |
| Siblings | | | |
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| Children | | | |
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Symptoms for which you would like help in therapy:

Therapeutic Goals:

Additional Comments:

Please check the symptoms below which you have experienced within the last THREE months; put a double check mark if you have experienced the symptom WITHIN THE LAST WEEK.

_____ Tension
_____ Anxiety
_____ Feeling restless or jittery
_____ Panicky feelings
_____ Excessive worrying
_____ Feeling numb
_____ Feeling dissociated
_____ Feelling unreal
_____ Difficulty concentrating
_____ Irritalbiity
_____ Agitation
_____ Mind going blank
_____ Nightmares
_____ Flashbacks
_____ Avoid situations reminiscent of trauma
_____ Intrusive thoughts or images
_____ Hypervigilance
_____ Excessive anger or rage

_____ Sleep difficulties
_____ Change in appetite
_____ Depressed mood
____ always ____more than 1/2 the time
____ less than 1/2 the time ____ rarely
_____ Lack of interest in activities
_____ Fatigue
_____ Crying more than usual
_____ Mood swings
_____ Obsessive thoughts
_____ Compulsions
_____ Withdrawal
_____ Low self-image
_____ Feelings of worthlessness
_____ Feelings of hopelessness
_____ Excessive fear(s)
_____ Phobia(s)
_____ Excessive guilt

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## Client Responsibilities and Information

- **Communicating with me between sessions:** I have a voice messaging service that will take your messages 24 hours a day. Messages will be checked several times a day and I will attempt to return your call the as promptly as reasonably possible. I attempt to return all calls the same business day as received. Messages should be brief, excessive details are not necessary. I do not return calls after 7:OO pm or on holidays or weekends. Weekends are defined as Thursday's from 5:00 pm until Monday's at 8:00 am. The voicemail is not checked on weekends and **if you have an emergency you should call the crisis center at 612 873 3161 or the suicide hotline at 612 873 2222 or 911.**

- **Payment/Fees:** Sessions are **$140**; a session is 50 minutes in length. Longer sessions are available in half session increments. Payment is due in full at the time of each session. I accept credit cards, checks or cash. I will provide a receipt with your diagnosis at the time of the session that you may submit to your insurance company for reimbursement. Out of network coverage is variable and determined by your insurance company.

- **Cancellations must be called in by 4:00 p.m. on the business day prior to your session or the full fee will be charged.** Insurance companies typically will not pay for failed appointments. Inclement weather will be taken into consideration avoiding unreasonable fees.

- **Insurance:** It is your responsibility to contact your insurance company to determine in advance what mental health services your insurance policy covers and how much of my fee your specific policy will cover. **You are financially responsible for any services not covered by your health insurance.**

- **Consultation:** I may occasionally find it helpful to consult other health and mental health professional about a case. During a consultation, I make ever effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential. Your signature below grants permission for such consultation.

- **Client's rights are posted in the waiting room.**

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our profession relationship. You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy or if you have not satisfied any financial obligations you have incurred.

Client signature______________________________________ Date_____________________

## Notice of Privacy Practices for Maureen McNeal, LICSW, LMFT

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

### I. Uses and disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI) for **treatment, payment, and health care operations** purposes with your consent. To help clarify these terms here are some definitions:

- **PHI** refers to information in your health record that could identify you.
- **"Treatment, Payment, and Health Care Operations"**
  - **"Treatment"** is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would e when I consult with another health care provider, such as your family physician or another psychotherapist.
  - **"Payment"** is when I obtain reimbursement for your health care. Examples of payment are when I disclose your **PHI** to your insurer to obtain reimbursement for your health care or determine eligibility or coverage.
  - **"Health Care Operations"** are activities related to the performance and operations of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.
  - **"DISCLOSURE"** applies to activities outside of my office, such as releasing, transferring or providing access to information to other parties.

### II. Uses and Disclosures Requiring Authorization

I may disclose PHI for purposes outside of treatment, payment or health care operations when your appropriate authorization is obtained. An "**authorization"** is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also obtain and authorization before releasing your psychotherapy notes. "**Psychotherapy notes"** are notes made about our conversation during a private, group, joint, or family counseling, which I have kept separate from the rest of your medical record. These notes are give a greater degree of protection than **PHI**.

You may revoke all such authorizations of (**PHI** or psychotherapy notes at any time, provided each revocation is in writing. You may not revoke an authorization to the

extent that I have (1.) I have relied on that authorization; (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose **PHI** without your consent or authorization in the following circumstances:

- **Child Abuse:** If I know or have reason to believe a child is being neglected or physically or sexually abused, or has been neglected or physically or sexually abused within the proceeding three years, I must immediately report the information to the local welfare agency, police or sheriff's agency.
- **Adult and Domestic Abuse:** If I have reason to believe that a vulnerable adult has sustained a physical injury which is not reasonably explained, I must immediately report the information to the appropriate agency in this county. I may also report the information to a law enforcement agency. **Vulnerable adult** means a person who regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical mental, or emotional dysfunction:
  - (i.) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and
  - (ii.) because of the dysfunction or infirmity and need for assistance, the individual has an impaired ability to protect the individual from maltreatment.

- **Health Oversight Activities:** The Board of Social Work or Marriage and Family Therapy may subpoena records from me if they are relevant to an investigation it is conducting.

- **Judicial and Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law and I must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case. In addition, I may disclose information pertinent to my defense in the case of a formal complaint or lawsuit filed by a client.

- **Serious Threat to Health or Safety:** If you communicate a specific, serious threat of physical violence against a specific. Clearly identified or identifiable

potential victim, I must make reasonable efforts to communicate this threat to the potential victim or to law enforcement agency. I must also do so if a member of your family who knows you well has reason to believe you are capable of and will carry out a threat. I also may disclose information about you necessary to protect you from a threat to commit suicide.

- **Worker's Compensation:** If you file a worker's compensation claim, a release of information from me to your employer, insurer, the Department if Labor and Industry or you will not need your prior approval.

IV. Patient's Rights and Therapist's Duties

- **Right to request Restrictions-** You have the right to request restrictions on certain uses and disclosures of protected health information. I am not required by law to agree to a restriction you request; however, it is my policy to agree to reasonable restrictions and I will notify you if I am unable to agree to a requested restriction.

- **Right to Receive Confidential Communications by Alternative Means at Alternative Locations-** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills or any other mailings to another address)

- **Right To Inspect and Copy-** You have the right to inspect or obtain a copy(or both) of PHI (and psychotherapy notes) in my mental health billing records used to make decisions about you as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have the decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- **Right to Amend-**You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- **Right to an Accounting-** You generally have the right to receive an accounting of disclosures of PHI for which neither provided consent nor authorization (as described in Section III. Of this Notice). On your request I will discuss with you the detail of the accounting process.

- **Right to a Paper Copy-** You have the right to obtain a paper copy of the notice from me upon request, even if you have received the notice electronically.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described int his notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedure, The Notice of Privacy Practices will be given to you indicating the revised date in the upper right hand corner. You will be given a copy of the revised Notice of Privacy Practices at your request.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you can file a complaint with me or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either me of the Office for Civil Rights, whose address is listed below.

Office for Civil Rights
Secretary of the U. S. Department of Health and Human Services
200 Independence Avenue, S. W.
Washington, D.C. 20201

VI. Effective Date Restrictions and Changes to Privacy Policy

I reserve the right to change the terms of this notice and to make new notice provisions effective for all PHI that I maintain. The notice of Privacy Practices will be given to you indicating the revised date in the upper right hand corner.

My signature below acknowledges that I have received a copy of this notice.

NAME ____________________________________________ DATE ______________________

ABOUT PSYCHOTHERAPY

The first two or three sessions will involve an evaluation of your needs. This involves understanding your history and current issues, formulating a diagnosis and treatment plan. Gathering information together is part of the therapeutic process and will be beneficial to the success of your therapy. Recalling events during the history and assessment process may be painful for you. We will use these potential reactions to your advantage and weave the insights they bring into your treatment.

Psychotherapy can bring up unpleasant feelings such as sadness, guilt, anger, frustration, loneliness and helplessness. These and other difficult thoughts and feelings may come up from time to time between sessions. I encourage you to keep track of these so that we might use them in our sessions. I will help you learn ways to manage and deal with unpleasant thoughts and emotions between sessions. We will discuss in session what to expect and when to call or schedule an additional appointment between regular sessions.

There are many benefits to psychotherapy. It often leads to better relationships, new tools for dealing with people, a greater sense of self worth and internal solidness, solutions to specific problems, significant reduction in distressing feelings, clearer thinking, more energy, and improved health. These benefits are common but not guaranteed.

Your therapy will be most beneficial if you are an active participant, follow through with homework and take responsibility for moving forward. I can assure you I will give you the highest standard of care I possibly can but for maximum benefit from your sessions, come prepared, do homework, and try the new skills we discuss.
I believe the name of my counseling practice AWAKE summarizes how I view our partnership. AWAKE is an acronym for:

| A | W | A | K | E |
|---|---|---|---|---|
| W | I | C | N | F |
| A | L | T | O | F |
| R | L | I | W | O |
| E | I | O | L | R |
| N | N | N | E | T |
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| S | N | | G | |
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Client Signature________________________________ Date____________________

# FORM FOR PARENTS OF ADOLESCENT CLIENTS

Psychotherapy with people of any age relies on the clients confidence that what is shared is private. While parents and guardians have the right to know general information about how their child is progressing frequent conversations between the therapist and parents can undermine the client therapist relationship. If your adolescent discloses anything to me that puts him or her or anyone else at risk of harm I will be contacting you promptly. I call parent child or family sessions to work through unresolved issues so difficulties your teen is having with you or other family members will become clear to you and have opportunity to be resolved. I typically inform your teen if I will be calling you. You may of course call me if a major concern arises and you fear your teen will not report it.

I am a family therapist and have a family systems perspective in working with your teen and the family. I use a variety of treatment modalities including EMDR therapy. I have found EMDR to be very effective. It is a rapid reprocessing technique that clears old triggers and allows for healthy new beliefs about self and life to be formed rapidly. I am happy to answer questions about this or any other treatment interventions I use.

I have given you two copies of this so you may keep one and return a signed copy for my file. Please sign this sheet as well as a Client Responsibility sheet and About Psychotherapy sheet and return for my file. The second copies are for you.

Thank you,

Maureen McNeal M.A., L.I.C.S.W, L.M.F.T.

Signature_________________________________ Date________________