Valentine Counseling Services, LLC
1818 Wooddale drive suite 201 Woodbury, MN 55125
Phone: 651 440-6669
Valentinecounseling.com

Intake Packet

Client Registration

Client Name (First, MI, Last): DOB:

Address:

Preferred phone #:

Gender & Preferred pronouns:

Partner Status & Sexual Identity:

Race/Ethnicity:

Religion/Spirituality:

Education:

Occupation/Employer:

Emergency Contact & Phone:

Preferred Emergency Room/Hospital:

Have you had previous psychological consultations/treatments? Y N

If yes, when:

How did you first hear of Valentine Counseling Services?

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Notice of Privacy Practice and Disclosure of Information:

I have received a copy of the Notice of Privacy Practices for Protected Health Information.

I understand that my health information (including mental health information) may be disclosed for the purposes of treatment, for obtaining payment from my insurance carriers, and/or to other qualified health care professionals, with my written authorization, within limits of the law.

I understand that according to Minnesota law, I may choose to pay for services if I do not wish my health information to be given to my insurance company. I agree to notify this office about my wishes regarding payment and I understand that if I fail to pay for the services, the information will be sent to my insurance carrier.

Cancellations:
For self-pay or non-state funded insurance, $75 charge for late cancellations (appointments canceled with less than 24 hours' notice) or no-shows, which must be paid before scheduling future appointments. For state-funded insurance, 2 no-shows may result in referrals to other providers.

Nondiscrimination Policy:
This facility will treat clients within its capabilities, regardless of race, national origin, religious belief, gender, sexual orientation, marital status, age, veteran's status, political beliefs, or disability.

Communications:
Check ALL items that apply to you. *Non-urgent* results, confirmation, and general information / instructions regarding your health care can be left on:
____A message at my preferred number
____Preferred phone voicemail / text message
____Email (circle: work / personal)
____***Do NOT leave any messages on my home, work or cell phone***
Information regarding non-urgent results confirmation and general information/instructions regarding my health care can be shared with and via the following:

Name	Relationship	Phone number

Client/Parent Signature(s) Date

Print Name(s)

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Consent for Treatment

Initial each section and sign at the end of this form.

_____**: Valentine Counseling Services team (VCS team) and services offered as such:**

- Offers sessions for individual, couple, and/or family therapy
- Makes appropriate referrals according to professional standards of practice if more in-depth psychotherapy or medications are needed
- Expects that you **call 911** or *go to the nearest hospital emergency room,* or dial **988** for the Suicide and Crisis Lifeline

_____**: VCS team will keep a confidential file about my/our appointments and proceedings. Release of confidential information requires my/our signature on a statement of release with the following notable exceptions:**

- Significant indicators that a minor/child or vulnerable adult is being abused or neglected
- Significant indicators that a pregnant female is abusing drugs
- Significant indicators of a clear and present danger to the health and safety of an identifiable individual (you or someone else)
- If a court of law issues a legitimate court order (signed by a judge), VCS team is required by law to provide the information specifically described in that order
- Results of treatment for court-ordered therapy must be revealed to the court
- If you choose to pay through insurance, your insurance can request your records at any time

Should VCS team find or have reasonable belief that any of these above conditions are present, I/we expect that they will break confidentiality in order to protect me/us and/or others.

_____**: Your situation may be reviewed during consultations with other mental health professionals / providers in order to provide you with the best possible ongoing services. *Identifying information will not be disclosed.***

_____**: VCS team will not participate in testifying for or against either one of you, nor will they voluntarily or involuntarily participate in any court proceedings you may be a party to in any court in this state or elsewhere.**

_____**: Fees: $160.00 for hour.** Full, deductible, or co-payment is to be made by cash, check, or card due at each session. Tele-therapy is billed at the full, private pay rate.
_____**: I understand these rates may change at any time and I am responsible for payment.**
_____**: I am electing to self-pay and not bill insurance for services at this time.**

_____**: Cancellations, no-shows, unpaid balances:**

- Cancellations or changes must be arranged 24 hours in advance
- Late Cancellation or No-show fee is $75.00, which must be paid before scheduling future appointments
- Running a balance is not permissible
- VCS team has the right to seek legal recourse to recover any unpaid balance which requires disclosing personal information

_____**: If utilizing insurance, I understand that I am responsible for knowing what my insurance covers, what charges I am responsible for, and when my insurance renews or changes**
_____**: I understand that I am responsible for all unpaid balances or costs not covered by insurance**

_____**: There is no guarantee that benefits will be received from individual, couple, and/or family therapy. In addition, while exploring personal issues and making life changes, you might experience emotional pain, discomfort, and anxiety. You have the right to decide what to talk about and work on in and out of therapy. *Nevertheless, your active participation will have the greatest positive effect on the outcome of therapy*.**

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This Consent is in effect until the end of treatment. Please sign this page to consent for treatment
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Your signature(s) and initials indicate that you have had the opportunity to ask questions, had questions answered to your satisfaction, understand and agree to these terms, and are aware that you are free to discontinue services at any time.

Client/Parent Signature(s)

Print Name(s) Date

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Telehealth Informed Consent

From time to time, it is convenient or necessary to conduct a therapy session or consultation via telehealth. Even if you do not intend to engage in regular telehealth appointments, we ask all clients to review and sight this form in case the need arises.

By signing this form, I consent to engage in telehealth with Valentine Counseling Services, LLC. As part of the therapy process. I understand that telehealth may include mental health evaluation, assessment, consultation, treatment planning, and therapy. Telehealth will occur primarily through secure interactive audio, video, telephone and/or audio/video communications as determined by my therapist.

I understand I have the following rights with respect to telehealth:

1. I have the right to withhold or remove consent at any time without affecting my right to future care or treatment or endangering the loss/withdrawal of any program benefits to which I would otherwise be eligible.
2. The laws that protect the confidentiality of my personal information also apply ot telehealth. As such, I understand that the information released by me during my sessions is generally confidential. Thera re both mandatory and permissive expectations to confidentiality including but not limited to reporting child and vulnerable adult abuse, expressed imminent haram to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
3. I understand there are risks and consequences from telehealth including but not limited to the possibility, despite reasonable efforts on the part of VCS, that the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons.
4. I understand that I may benefit from telehealth services but that results cannot be guaranteed or assured. In addition, I understand that telehealth-based services and care may not be as complete or as effective as in-person services. I understand that certain services cannot be conducted from a distance. I understand that if my therapist believes I would be better served by other interventions, I will be referred to a mental health professional who can provide those services. I also understand that there are potential risks and benefits associated with any form of mental health treatment and despite my efforts and efforts of my therapist, my condition may not improve or may have the potential to get worse.
5. I understand VCS has established a quality assurance process related to telemedicine services which includes all applicable Health Insurance Portability and Accountability Act (HIPAA) requirements. I also understand that despite the efforts of VCS attempts to keep information confidential while using these systems, 100% confidentiality cannot be absolutely guaranteed due to inherent issues with telecommunication systems. I acknowledge that it is my personal responsibility to ensure the integrity and security of my won computer, internet connection or phone line and privacy of space in which I choose to conduct my therapy. Signing this form shows an awareness of these issues and a decision by this client to use these systems for telehealth services. I will not hold VCS or its staff liable for gathering or use of client information by these service providers.
6. By signing this document, I agree that certain situations including emergencies and crises are inappropriate for telehealth services. If I am in aa crisis or an emergency, I should immediately call 911 or go to the nearest hospital or crisis facility. By signing this document, I understand that emergency situations may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if am in a life threatening or emergency situation and/or if I am abusing drugs or alcohol and are not safe, By signing this document, I acknowledge I have been told if I fee suicidal, I will call 911 and/or text HOME to 741741 in the United States.

Client/Parent Signature(s)

Print Name(s) Date