BIRCHWOOD

THERAPEUTIC SERVICES

Registration Packet

Professional Contract for Services

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating that you have fully read and understand the information contained in this document.

Client/Provider Relationship

You and your provider have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your provider can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship.

Available Services

Birchwood Therapeutic Services offers counseling services, including individual, family, couples, and group services. Effective psychotherapy is founded on mutual understanding and good rapport between client and provider. It is our intent to convey the policies and procedures used in our practice and we will be pleased to discuss any questions or concerns you may have.

Risks and Benefits

Counseling and psychotherapy are beneficial, but as with any treatment there are inherent risks. During counseling, you will have discussions about personal issues, which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, of course. It is our desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

Counseling Process

Your first visit will be an assessment session in which you and your provider will determine your concerns. If both agree that your provider can meet your therapeutic needs, a plan of treatment will be developed.

The goal of your provider is to offer the most effective therapeutic experience available to you. If at any time you feel that you and your current provider are not a good fit, please discuss this matter with your provider to determine if transferring to a more suitable provider is right for you. If you and your provider decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs.

Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. Our services are designed to provide our clients in an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

Appointments

Appointment frequency will vary by client. Your first appointment will be approximately 50 minutes – 1 hour long. Subsequent appointments will be approximately 50 minutes long. Frequency of appointments will be as determined is appropriate by your provider. If you must cancel or reschedule your appointment, we ask that you call our office at 218-643-9330 (Breckenridge Office) or 701-532-1353 (Fargo Office) at least 24 hours in advance. This will free your appointment time for another client.

Appointments that are missed without 24-hour notice will be recorded in the client's chart as "no show" and will be charge the standard missed appointment fee of $40. These fees are not covered by insurance and will be billed to the patient directly.

**Cancellations due to inclement weather will not be charged a no-show fee.*

Telehealth/Telemedicine

Telemedicine involves the use of electronic communications to enable mental health care providers at one site, to provide services to patients who are physically located at another site for the purpose of improving patient care.

Birchwood Therapeutic Services utilizes Telemedicine as an option for clients to access services using a secure Internet connection in a room provided for them, or, if available, through a secure format in their own homes.

Electronic systems used will incorporate network and software security protocols to adhere to HIPAA and protect the confidentiality of patient identification and to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

A telemedicine service facilitates videoconferencing and is not responsible for the delivery of, nor does it provide, any healthcare, medical advice, or care, including but not limited to, emergency or urgent medical services. Birchwood Therapeutic Services utilizes a HIPPA compliant platform to provide telemedicine.

The laws that protect privacy and the confidentiality of medical and mental health information also apply to telemedicine, and no information obtained in the use of telemedicine which identifies any client will be disclosed to researchers or other entities without the client's written consent.

To maintain confidentiality, clients should not share their telemedicine appointment link with anyone unauthorized to attend the appointment.

Clients have the right to withhold or withdraw consent to the use of telemedicine in the course of care at any time and seek services elsewhere.

Telemedicine may involve electronic communication of personal information to other practitioners who may be located in other areas, in order to ensure that clients receive the best care possible.

Expected Benefits:

- Improved access to treatment by enabling a client to receive treatment at their locations.
- More efficient evaluation, treatment and management.
- Obtaining expertise of a distant specialist.

Possible Risks:

As with any mental health treatment, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment;
- Lack of a face to face interaction may limit the therapists ability to interact in an emergency situation
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;

Emergencies

You may encounter a personal emergency which requires prompt attention. In this event, please contact our office about the nature and urgency of the circumstances. We will make every effort to schedule you with your counselor as soon as possible or to offer alternative care options.

Outside of office hours, you can leave a message on our voice mail and we will return it the next day we are in the office. You can also call the 24-hour Mental Health Crisis Response Team at 800-223-4512.

If it is a life-threatening emergency at any time of day, please call 911 or have someone take you to the emergency room for help.

Fee Schedule

Evaluations	**$ 250.00**	**per hour**
Psychotherapy	**$ 210.00**	**per hour***
**Court ordered evaluations must be paid by client in advance, these are not covered by insurance*		
Group Therapy	**$ 65.00**	**per session**
Court Testimony	**$ 150.00**	**per hour for preparation, three hour minimum.**
	$ 250.00	**per hour for court appearance**
Appointment No Show	**$ 40.00**	**per missed appointment (without 24 hour notice)**
Consultations	**$ 100.00**	**per hour plus mileage**
Couple's Counseling	**$ 150.00**	**per hour at time of service if no insurance coverage**

Phone calls in excess of 15 minutes will be billed at a rate of $3 per minute.

Payment/Insurance

Payment of fees, including any copays designated by your insurance company, are due at time of service. Any amounts not covered by your copayment or by insurance will be billed on a monthly basis. Clients who fail to pay or make payment arrangements will not be allowed to schedule appointments until payment arrangements are made. Payment arrangements must be made in writing and can be completed by any office staff member.

A credit or debit card will need to be kept on file in order to process any unpaid financial responsibilities. Birchwood Therapeutic Services maintains PCI compliance to protect client information. Your card will only be

charged for copayment, coinsurance, and deductible payments if payment is not made within two weeks of your monthly statement.

Birchwood Therapeutic Services participates with and are in-network with, most of the common insurance companies in our local area and are also listed as an EAP (Employee Assistance Program) provider. We will file insurance and EAP claims for you. It is your responsibility to keep us informed of any changes to insurance coverage.

Confidentiality

Birchwood Therapeutic Services, along with your individual counselor, follow all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a provider and a client are confidential. To ensure your confidentiality, recording audio or video in our session without written consent is prohibited. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include, but are not limited to, the following situations: child abuse, abuse of vulnerable adults, sexual exploitation, AIDS/HIV infection and possible transmission, criminal prosecutions, child custody cases, suits in which the mental health of a party is in issue, situations where the provider has a duty to disclose, or where, in the provider's judgement, it is necessary to warn or disclose due to threat of harm to self or others, fee disputes between provider and client, a negligence suit brought by client against the provider, or the filing of a complaint with the licensing or certifying board.

If you have any questions regarding confidentiality, you should bring them to the attention of your provider to discuss further.

By signing this Information and Consent form, you are giving consent to the provider to share confidential information with all persons mandated by law and the insurance carrier responsible for providing your mental health care services and payment for those services. You are also releasing and holding harmless the provider from any departure from your right of confidentiality that may result.

Duty to Warn/Duty to Protect

If your provider believes that a client is a physical or emotional danger to themselves or another human being, the provider has a duty to contact the person who is in a position to prevent harm to themselves or another, including but not limited to, the person in danger.

Record Requests

Birchwood Therapeutic Services believes that collaborative care results in the best patient outcomes, and will share records at patient request. Record requests up to 50 pages will be provided free of charge, with a charge of $0.25 per page applied after this. This charge is not covered by insurance.

Consent to Treatment

X_____
Client Name (Please Print)

By signing this Client information and Consent as the Client or Guardian of said client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for myself (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. I understand that I am responsible, however for any balance for services rendered.

x_____
Client/Guardian Signature *Date:*

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

X_____
Client/Guardian Signature *Date:*

I authorize the payment of medical benefits to the provider of services.

X_____
Client/Guardian Signature *Date*

I authorize the release of information to my emergency contacts listed on the Client Intake Form in the case of an emergency. I understand that this information may include diagnosis, records, or other information necessary to obtain emergency care.

X_____
Client/Guardian Signature *Date:*

I have read and understand the information provided regarding telemedicine, and all of my questions have been answered to my satisfaction. I hereby give my informed consent and authorization for the use of telemedicine by Birchwood Therapeutic Services in the course of my diagnosis and treatment as deemed appropriate.

X_____
Client/Guardian Signature *Date:*

I understand that in emergency situations, my therapist may need to break confidentiality as part of their Duty To Warn.

X_____
Client/Guardian Signature *Date:*

Notice of Privacy Practices Acknowledgement

I acknowledge that I have received a written copy of the Birchwood Therapeutic Services Notice of Privacy Practices. I understand that this form will be part of my permanent record and I acknowledge that I have been allowed to ask questions concerning this notice. I understand this does not affect the care I receive at Birchwood Therapeutic Services.

In accordance with the federal government HIPAA rules, please sign this form.

X_____

Client Name (Please Print)

X_____

Client Signature *Date:*

X_____

Parent/Guardian Signature *Date:*

Credit Card Authorization

By signing below, I agree to have my credit card information stored securely by Birchwood Therapeutic Services until my file is closed. I also authorize Birchwood Therapeutic Services to charge this card for any outstanding financial responsibilities as described above.

X_____

Client Name (Please Print)

Name as it appears on card: _____

Card Number: _____

Expiration Date: _____ **CVC**: _____

Signature: _____

** This authorization form will be destroyed per PCI security standards.*

BIRCHWOOD
THERAPEUTIC SERVICES

CLIENT INTAKE FORM

(Please Print)

Today's Date: _____

CLIENT INFORMATION

Client's Last Name First Middle			Pronouns	Marital Status Single / Married / Other	
Is this your legal name? Yes_____ No _____	If not, what is your legal name?	(Former Name)		Birth Date:	Age: Sex:
Street Address or P.O. Box City State Zip Code				Social Security:	
Home Phone No. ( )	Cell Phone No. ( )			Work Phone No. ( )	
On what phone number may we leave a message? Home____ Cell_____ Work_____					
Occupation:			Employer:		
Referred to Provider by: Doctor_____ Insurance Plan_____ Website_____ Family_____ Friend_____ Close to Home/Work_____ Other_____					
Email Address:					

INSURANCE INFORMATION

Person Responsible for Bill:			Birth Date:	Home Phone:	
Address:			Social Security #:	Cell Phone:	
Email Address:				Work Phone:	
Is this client covered by insurance? _____Yes _____No			Is this an EAP visit: _____Yes _____No Authorization # (if known) _____		
Name of Primary Insurance:					
Insured's Name:	Insured's Date of Birth:		Insured's Social Security #:		
Policy Number:	Group Number:		Insured's Relationship to Client: _____Self _____Spouse ____Child ____Other		
Secondary Insurance (if any):			Policy Number:		
Client's Relationship to Insured: _____Self _____Spouse _____Child _____Other					

IN CASE OF EMERGENCY I authorize the release of information to the following individuals in the case of an emergency.

Name:	Relationship	Phone:
Name:	Relationship	Phone:

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

PHQ-9	**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
Add the score for each column				

Total Score (add your column scores): _____

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

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

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	☐ 0	☐ 1	☐ 2	☐ 3
2. Not being able to stop or control worrying.	☐ 0	☐ 1	☐ 2	☐ 3
3. Worrying too much about different things.	☐ 0	☐ 1	☐ 2	☐ 3
4. Trouble relaxing.	☐ 0	☐ 1	☐ 2	☐ 3
5. Being so restless that it's hard to sit still.	☐ 0	☐ 1	☐ 2	☐ 3
6. Becoming easily annoyed or irritable.	☐ 0	☐ 1	☐ 2	☐ 3
7. Feeling afraid as if something awful might happen.	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column				

Total Score (add your column scores): _____

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

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

UHS Rev 4/2020

CAGE-AID Questionnaire

Patient Name: _____ Date of Visit: _____

When thinking about drug use, include illegal drug use and the use of prescription drugs other than prescribed.

Questions:	**Yes**	**No**
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

WHODAS 2.0

WORLD **H**EALTH **O**RGANIZATION
DISABILITY **A**SSESSMENT **S**CHEDULE 2.0

36-item version, self-administered

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

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

In the past 30 days, how much difficulty did you have in:						
Understanding and communicating						
D1.1	Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.2	Remembering to do important things?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.3	Analysing and finding solutions to problems in day-to-day life?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.4	Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.5	Generally understanding what people say?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.6	Starting and maintaining a conversation?	None	Mild	Moderate	Severe	Extreme or cannot do
Getting around						
D2.1	Standing for long periods such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.2	Standing up from sitting down?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.3	Moving around inside your home?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.4	Getting out of your home?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.5	Walking a long distance such as a kilometre [or equivalent]?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page …

In the past 30 days, how much difficulty did you have in:						
Self-care						
D3.1	Washing your whole body?	None	Mild	Moderate	Severe	Extreme or cannot do
D3.2	Getting dressed?	None	Mild	Moderate	Severe	Extreme or cannot do
D3.3	Eating?	None	Mild	Moderate	Severe	Extreme or cannot do
D3.4	Staying by yourself for a few days?	None	Mild	Moderate	Severe	Extreme or cannot do
Getting along with people						
D4.1	Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.2	Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.3	Getting along with people who are close to you?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.4	Making new friends?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.5	Sexual activities?	None	Mild	Moderate	Severe	Extreme or cannot do
Life activities						
D5.1	Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.2	Doing most important household tasks well?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.3	Getting all the household work done that you needed to do?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.4	Getting your household work done as quickly as needed?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page …

If you work (paid, non-paid, self-employed) or go to school, complete questions D5.5–D5.8, below. Otherwise, skip to D6.1.

Because of your health condition, in the past 30 days, how much difficulty did you have in:						
D5.5	Your day-to-day work/school?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.6	Doing your most important work/school tasks well?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.7	Getting all the work done that you need to do?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.8	Getting your work done as quickly as needed?	None	Mild	Moderate	Severe	Extreme or cannot do

Participation in society						
In the past 30 days:						
D6.1	How much of a problem did you have in joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.2	How much of a problem did you have because of barriers or hindrances in the world around you?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.3	How much of a problem did you have living with dignity because of the attitudes and actions of others?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.4	How much time did you spend on your health condition, or its consequences?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.5	How much have you been emotionally affected by your health condition?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.6	How much has your health been a drain on the financial resources of you or your family?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.7	How much of a problem did your family have because of your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.8	How much of a problem did you have in doing things by yourself for relaxation or pleasure?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page …

H1	Overall, in the past 30 days, how many days were these difficulties present?	***Record number of days*** ____
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?	***Record number of days*** ____
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?	***Record number of days*** ____

This completes the questionnaire. Thank you.