VOGT PROFESSIONAL COUNSELING SERVICES

"Finding Hope, Courage & Freedom"

INDIVIDUAL INTAKE FORM

Date:_____

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status:

□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Please list any children/age: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?
□ Yes
□ No

Please list: _____

_____

Have you ever been prescribed psychiatric medication?
□ Yes
□ No

Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns:

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression?
□ No
□ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
□ No
□ Yes

If yes, please describe: _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:
_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

In case of an Emergency, please provide the name of someone we have permission to contact:

Name:_____Phone_____Relationship_____

I, the undersigned, have read ALL portions of Vogt Professional Counseling Service's Confidentiality Agreement, Financial Agreement, Counseling Agreement and Privacy Policy and Consent for Treatment Agreement. I am aware of how my information will be used and protected, and I understand that there are instances that require Vogt Professional Counseling Services to release information without my consent. I am familiar with the risks of electronic communication, and my rights as they pertain to confidentiality, use of information, and my medical records.

I agree to release a minimum amount of personal health information to billing professionals in order to obtain payment for services received.

I am aware that I can ask for a copy of any of the above forms for my records.

I also understand the Vogt Professional Counseling Services LLC has hired Kasa Solutions as a person/s or third party for administrative purposes. They will maintain confidentiality in the same manner as stated above and would have access to my personal records for the purposes of: Contacting me to schedule, cancel and/or reschedule appointments. Contact me about my bill or other administrative information, sending bills, and receiving payment. Supporting my therapist and her EHR of mine within their protected system. thus providing support of my overall care i an administrative capacity.

Client Signature: _____Date: _____

Printed Name of Client Representative_____

Relationship to Client _____

Signature of Client's Representative _____Date: _____

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TREATMENT PLAN

Name_____

Date _____

Please complete this form as best you can. If you are unsure of your answers, bring your questions in and your therapist will help you complete the treatment plan.

Problems (Why I'm Here):

_____
_____
_____
_____
_____
_____
_____

Goals (What I Want):

_____
_____
_____
_____
_____
_____
_____

Indicators (How Do I Know That I'm Making Progress?):

_____
_____
_____
_____
_____

Estimate – How Long to Achieve Goals_____ (You and your therapist will figure this out.)

Likelihood (0-100%) of Achieving Goals? _____ (You and your therapist will figure this out.)

_____ _____

Client Signature and Date Therapist Signature and Date

Review Dates: _____

Maureen Vogt, M. A., LPCC
13911 Ridgedale Drive Suite 320 Minnetonka, MN
612-900-9721
vogtprocounseling@gmail.com

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FEE AGREEMENT

Name _____ Date _____

Out of Pocket Payments:

- Payable at the close of the session or pay over the phone to Kasa Solutions at 612-900-9721…You may use your HSA account, CC information, or pay by check when billing is due.
- The client is fully and directly responsible to Vogt Professional Counseling Services' for the payment of services rendered.
- You will be charged a fee for missed appointments or appointments canceled with less than a 24-hour notice (except in reasonable situations).
- Fees for telephone consults will be prorated, based on the standard hourly fee.
- A receipt can be provided which the client can submit to his/her insurance company, if requested.
- Additional fees will be charged for psychological testing and are not included in a typical session fee.

- If payment becomes a problem, you are encouraged to discuss this directly with your therapist to consider other alternatives.
- If fees change during the course of treatment, you will be given adequate notice of these changes.

~ ~

- Vogt Professional Counseling Services Counseling Center will bill my insurance company for my counseling sessions.

I understand and discussed the fees for services with my therapist, I give permission for my therapist and/or Kasa Solutions to contact if necessary my insurance company to determine insurance coverage and my responsibility of payment. I accept full responsibility for all charges and understand I will be responsible for all fees as outlined on this payment contract A am also aware that I may be charged a late cancel;/no show charge (out of pocket fee of $150 charge which insurance companies are not responsible for, the client is).

Signature of Client_____DATE_____

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COUNSELING AGREEMENT

This agreement is designed to help build a positive working relationship between you and your therapist. It also informs you of your rights and responsibilities in the therapy relationship. If you have any questions or concerns, please feel free to discuss them with your therapist.

1. **Therapeutic Relationship**

The relationship between you and your therapist is very important and is different from other relationships in your life. You are expected to talk freely and openly about yourself, much more so than you do in social relationships. Your therapist's responsibility is to listen, select, sort, make observations, and reflect back to you behaviors, thoughts, feelings, and values or beliefs that will enable you to understand and see yourself more clearly. The goal of this process is the reorganization of your thinking, feelings, and behavior in a manner more satisfying to you. This does not predict, nor guarantee a successful outcome in therapy. While your therapist may suggest changes, only you can choose if those changes are valuable and pertinent, and only you are able to make those changes.

You and your therapist will work together to establish goals for therapy and this will be the focus of your initial session which is something that will continue to be revisited. Therapy can be a very intense experience and sometimes painful. But therapy is also very supportive, reassuring, with very rewarding, life changing outcomes.

2. **Appointments**

Appointments are typically 50 to 80 minutes in length. You and your therapist will work together to personalize a schedule to fit your needs.

3. **Cancellation Policy**

If you need to cancel an appointment for any reason, please do so at least 24 hours in advance. You will be charged a full fee for appointments not canceled within 24 hours.

4. **Confidentiality**

Client information is kept strictly confidential and the release of information about you to anyone can only be done with your written consent. Emails are not confidential so be aware of this if you choose to communicate with your therapist by email. Because therapists are all mandated reporters, state law, however, places certain limitations on the right of confidentiality (see also Notice of Privacy Rights attached):

- Threats of suicide
- Threats of harming another person
- Any incidence or knowledge of suspected neglect, physical, or sexual abuse of children and/or vulnerable adults

During professional consultation, the therapist may discuss facts in a case, but the identity of the client will remain confidential.

When meeting as couples and/or families, it may be helpful to meet with your therapist individually. If individual sessions are scheduled, no confidences will be held by the therapist. Your therapist reserves the right to use his/her best judgment to share pertinent information, or will ask the individual to share the information, in the best interest of the marriage or family.

For couples and families, in order for information to be shared between a therapist at Vogt Professional Counseling and another individual, we require a signed release of information from both or all parties.

When children are being seen by a therapist, the custodial parent(s) will be informed of their child's progress for children under 18 years of age.

5. **Fees**

Payment of fees is expected at the time of each session. Insurance coverages differ, so please check with your insurance company to determine the requirements for mental health coverage. A receipt will be provided which can be submitted by the client. Overdue payments will be assessed a $5.00 fee for each month the payment is overdue. Additional fees will be charged for psychological testing and there is a charge for written reports of files based on an hourly fee structure. We will give you a 30-day notice if fees change. In court cases, we encourage information to be passed on to lawyers and the court through written reports at our hourly fee rate. If we are asked to do a deposition or appear in court, our fees are $350 per hour plus a mileage fee of $.75 per mile.

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6. **Hours & Emergencies**

After normal business hours, you will receive our voicemail system where you can leave messages. This voicemail system is available 24 hours a day and messages are retrieved regularly throughout the weekdays. If you need immediate assistance, please call 911, or Hennepin County Crisis Center at 612.347.3161, or call 911, or go to the nearest hospital emergency room.

7. **Vogt Professional Counseling Services, LLC**

If you have questions about Vogt Professional Counseling Services, LLC, please contact Maureen Vogt, LPCC, vogtprocounseling@gmail.com for any questions and or concerns.

8. **Complaints**

You are urged to discuss with your therapist any questions, concerns, or problems you may have about the therapy you receive. Often times, part of the therapeutic relationship involves working through misunderstandings or misconceptions. You also have the right to file a complaint with: Maureen Vogt, LPCC Vogt Professional Counseling Services, President, 13911 Ridgedale Drive, Suite 320, Minnetonka, MN 55305, 612-900-9721 and Minnesota Department of Health, 121 East 7th Street, St. Paul, MN 55101, 612.623.5522.

9. **Therapy Session**

An important aspect of therapy is the relationship that develops between you and your therapist. As with any new relationship, it takes some time to trust and feel safe. If the relationship does not develop after a reasonable amount of time (three to four sessions), you may want to talk with your therapist about it and a referral can be made. Your therapist will be happy to help with this.

The therapeutic relationship is unique in that you will be focusing on aspects of yourself that may not ordinarily receive attention. The therapeutic approach used by the therapist comes from a variety of psychological theories. For those clients wishing to address spiritual concerns, a Christian perspective will be utilized. As each client is different each session varies depending on the needs of the client and the goals set by the client and therapist.

The therapist will work with the client towards healthy development, meaningful and satisfying relationships, and address conflict between mind, body, and spirit. The intention is to address relationship issues, behavioral problems, family-of-origin concerns, destructive thought patterns, and spiritual issues. Core values and beliefs are identified and based on the issues of concern your therapist will help with insight and observations where needed. Your therapist will strive towards a safe environment in which clients can talk freely and openly about their concerns. Therapy is a process. Initially you may feel uncomfortable, even anxious, about talking about sensitive issues. This anxiety begins to reduce as the relationship between you and your therapist develops and trust builds. As you l earn new ways to interact with yourself and others, these new ways to interact may feel uncomfortable. Sometimes things seem to get worse before they get better. This is expected and typical of everyone making life adjustments. One of the most growth-producing times for the client can be when he/she expresses anger with the therapist. This expression of "owning" one's feelings and having the therapist respect them often results in a varying experience for the client. Your therapist is open to hearing about your concerns and feelings.

It is critical to stay with the therapy even during these uncomfortable times. Once you get through this phase, and as we discuss the emotions around these issues, you should begin to feel more comfortable. During this stage, you will continue to apply the new skills and you will feel more courageous in meeting problems directly. As you near the end of therapy, you and your therapist will discuss discontinuing the therapy, with the understanding that you can choose to return any time if you feel the need.

10. **Therapy Techniques**

Vogt Professional Counseling Services, therapist (Maureen Vogt, MA, LPCC) uses a combination of Psychotherapy techniques. If you have questions on treatment interventions, please ask Maureen and she can explain more thoroughly.

- Cognitive Behavioral Therapy is what many know as therapy addressing negative thoughts, feelings and behavior.
- Several therapists are trained and certified in EMDR (Eye Movement Desensitization and Reprocessing). This visit the EMDR.com website.

approach is very helpful when addressing trauma, abuse, post-traumatic stress disorder, anxiety and depression. When using EMDR, your therapist will outline how the therapy helps, if you are a good candidate for EMDR, and you will be given the option to participate. For a thorough explanation of EMDR,

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PRIVACY POLICY

The privacy of your medical information is important to us, with the understanding that this information is personal. Therefore, we are committed to protecting it. To comply with certain legal requirements, Vogt Professional Counseling Services creates a record of the care and services each individual receives to better provide you with quality care. This notice details the ways we may use and share medical information about you. Furthermore, we describe your rights and certain duties we have regarding the use and disclosure of medical information. This notice is effective April 14, 2003.

1. **Uses of Information Obtained From You:** The information we obtain from you is used to establish diagnosis, determine your treatment plans and goals, provide the services you request, and establish your ability to pay for these services.

2. **Our Legal Responsibility:** The law requires us to keep your medical information private, give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information, and to follow the terms of the notice that is now in effect.

3. **Patient Rights:** Effective April 14, 2003, the 45 CFR Health Insurance Portability and Accountability Act (HIPAA) went into effect with rules on not only disclosure but also on the **use** of patient information. Under this Act clients, must be given a Notice of Privacy Practices upon the arrival of their first service. The following list of rights now apply to any patient of a health care provider:
   a) Right to Request Medical Records: The patient has a right to access their medical records.
   b) Right to Request Additional Restrictions: You may request restrictions on our use and disclosure of protected health information for treatment, payment, and health care operations. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction. If you wish to request a restriction, please make a request in writing and submit it to your therapist. We will send you a written response.
   c) Right to Receive Confidential Communications: You may request, and we will accommodate, any reasonable (written) request for you to receive protected health information by alternative means of communication or at alternative locations.
   d) Right to Inspect and Copy Your Health Information: If you desire access to your records, please make a written request to your therapist. If you request copies, there will be a $2.00 charge per page. Please note, under limited circumstances we may deny you access to a portion of your records.
   e) Right to Amend Your Records: You have the right to request that we amend protected health information maintained in your clinical file or billing records. If you desire to amend your records, please request in writing the amendment and submit it to your therapist. Under certain circumstances, we have the right to request to amend your records and notify you of this denial as provided by the HIPAA regulations. If your requested amendment to your records is accepted, a copy of your amendment will become a permanent part of the medical record. By "amend," your therapist is permitted to append information to the original record, as opposed to physically remove or change the original record.
   f) Right to Receive an Accounting of Disclosures: Upon request, you may obtain an accounting of disclosures of your protected health information other than those for which you gave written authorization or those related to your treatment, payment for services, or health care operations. The accounting will apply only to covered disclosures prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, a charge may apply. You will be informed of the cost prior to the request being filled.
   g) Right to Receive a Paper Copy of this Notice: Upon request, you may obtain a paper copy of this privacy notice.

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4. **Use and Disclosure of Your Medical Information With Written Consent:** We are permitted to use and disclose information about you for treatment and/or services to doctors, nurses, psychiatrists, psychologists, other mental health professionals. Also included are other people in charge of your care or health care professionals assisting in your treatment. We may also use and disclose your medical information for payment purposes to insurance companies for disability payments, etc. Furthermore, we may also use information for healthcare operations that may include information disclosed to business associates such as billing software providers or transcriptionists.

5. **Use and Disclosures Without Neither Consent Nor Authorization:** According to state and federal requirements, we are mandated to report information we maintain about you to other agencies or individuals without your written consent under the following circumstances:
   a) If we have reason to believe there has been:
      - abuse of a child or vulnerable adult.
      - victimization due to violence.
      - victimization due to other crimes.
      - potential or intention to seriously harm another person, we may have a legal obligation to warn the intended victim and/or the police.
      - the possibility a pregnant woman has used a controlled substance (e.g., cocaine, heroin) for a non-medical purpose during the pregnancy.
   b) If it is court-ordered.
   c) If a non-custodial parent requests information, they may receive information about our services for their child, but not about services to the other parent.
   d) If there is an emergency, we may communicate your condition to a family member or other appropriate persons.
   e) If your account is delinquent, we may attempt to obtain reimbursement through small claims court or to collection agency. We may also report delinquent accounts to credit bureaus.
   f) Examination of records for an audit or accreditation.
   g) To meet federal, state, and local statistical requirements.
   h) If a new statute, federal law, or State Commissioner of Administration authorizes a new use of the information after you had been given this notice.

6. **Regarding Minors:** Minnesota State Law authorizes that a minor has the right to request the private data about them be kept from their parents. This request will be honored if we believe it will protect the child from physical or psychological harm.

7. **Providing Information About You:** You are not required to provide information about yourself; however, without some information we may not be able to provide the most appropriate services. If you are here because of a court order, and you refuse to provide information, that refusal may be communicated to the court.

8. **Right to Change Terms of this Notice:** We may change the terms of this notice at any time. If we change this notice, we may make the new notice terms effective for all protected health information that we maintain, including any information created or received prior to issuing the new notice. If we change this notice, we will post it in public access areas, or give you a copy of the updated notice.

9. **Complaints:** If you desire further information about your privacy and confidentiality rights, or are concerned that we have violated these rights, or disagree with a decision that we made about access to your protected health information, you may contact your therapist or Maureen Vogt,LPCC, Vogt Professional Counseling Services, vogtprocounseling@ gmail.com You may also file a written letter of complaint with the Secretary of the Department of Health and Human Services. We will not retaliate against you if you file a complaint.

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VOGT Professional
Counseling Services

13911 Ridgedale Drive, Suite 320
Minnetonka, MN 55305

Consent for Treatment Agreement

I, the undersigned, hereby consent to treatment at Vogt Professional Counseling Services and assert that:

- I have voluntarily entered into treatment at Vogt Professional Counseling Services.
- I agree to have treatment provided by a psychotherapist with licensure.
- I have discussed the risks and benefits of treatment with my individual therapist, and consent to continue therapy.
- I have read and understand the Confidentiality Agreement and the Financial Policy; and understand I can request a copy of these documents for my records.
- I, or my therapist, may discontinued therapy at any time. If I choose to end treatment, I understand that I am encouraged to discuss the decision with my individual therapist so the most appropriate discharge plan may be facilitated.
- I understand I can be discharged from treatment non-voluntarily for the reasons listed below, and that I will be notified of a non-voluntary discharge in writing.
    - I exhibit physical violence or verbal abuse, carry a weapon, or engage in illegal acts at the clinic.
    - I do not make payments or a payment arrangement in a timely manner.
- I understand that I can appeal Vogt Professional Counseling Services decision if I am discharged non-voluntarily.
- I may also request to reapply for services at a later date.
- *If the client is under the age of 18, I sign on behalf of the individual as their legal guardian and/or parent (client representative), and assert that I voluntarily enter this minor into treatment at Vogt Professional Counseling Services LLC, I agree to the above-stated consent for treatment on behalf of this minor.

_____

Printed Name of Client

_____

Client Signature Date Signed

_____

*Printed Name of Client Representative Relationship to Client

_____

*Signature of Client Representative Date Signed