Melia McCubbin, MSW, LICSW, CST
Licensed Independent Clinical Social Worker, #19778
Open Insight Therapy, LLC
612-567-2909

melia@openinsighttherapy.com
2375 University Ave. W., Ste. 160
St. Paul, MN 55114

Client Intake Packet

Thank you for completing this form. It enables me to better assist you on your path of growth or healing. This form will be stored securely in your confidential file.

It would be helpful if you print and complete this form prior to our first appointment.

I look forward to meeting you!

Chosen name_____ Date_____

Full legal name_____ Your pronouns_____

Date of birth_____ Age_____ Gender_____ Sex, as indicated on insurance: _____

Name as indicated on insurance:_____

Relationship Status _____

Complete home address_____

At least one phone number where I may contact you:
_____ (circle:) home/work/cell Okay to leave message? ❑ yes ❑ no
_____ (circle:) home/work/cell Okay to leave message? ❑yes ❑ no

Education_____ Occupation_____

Employer_____

Emergency contact: Name_____ Phone_____ Relationship:_____

Name and address of person responsible for payment: _____
_____

How did you find me?
❑ Referred by someone (name & relationship:) ❑ online directory (which one, if known:)
_____ _____
❑ My website (www.openinsighttherapy.com) ❑ attended one of my workshops/presentations
❑ other_____

Current Concerns

What brings you to seek counseling, and why now? _____
_____
_____

Health & Counseling History *(use back of page if you need more room)*

Other health care professionals with whom you are currently working _____
_____
Current medical issues: _____
_____
History of any major illnesses, surgeries, or injuries:_____
_____
Do you have an Advance Directive? _____
When was your last physical exam _____
Please list any medications you are currently taking _____
_____

Current and past mental and/or chemical health treatment

Date	Where	Problem	Treatment

Family Information

List current partner/spouse, children, and roommates or others in your current household:

Name	Relationship to you	Gender	Current Age

(use back of page if you need more room)

Any concerns about your current living situation or environment? _____
_____

List your family of origin; also list significant members in your household while growing up:

Name	Relationship to you	Gender	Still living?	Current age (or age at death)
			Yes / No	
			Yes / No	
			Yes / No	
			Yes / No	
			Yes / No	

(use back of page if you need more room)
Significant deaths of other family members (not shown above) or of other important relationships: _____
_____

Have you or your family members experienced the following (check where applicable):

You		Household, Partner, or Family Member		
Past	*Present*	*Past*	*Present*	
				Alcohol/drug abuse or dependency, or Other compulsive behaviors or addictions
				Abuse or assault: *(Circle which apply)* physical / sexual / emotional / verbal
				Other trauma (car accident, major injury, major life event, etc.)
				Mental health issues
				Chronic or significant physical illness
				Any family history of suicide attempts or completed suicide

Personal Strengths & Background

What are some positive personal qualities or strengths that you or others would say you have?_____

What are some things you appreciate, or are proud of, about yourself? _____
_____

What are your top three challenges you manage? _____
_____

Describe your current support system: (i.e., where you obtain support for your physical, emotional and spiritual health). Examples would be: *physical exercise & relaxation; involvement with family & friends, support group, spiritual community, experiences with nature, recreational activities, etc.* _____
_____

Please fill out as much or as little of the questions on this page as you like:

How do you identify in terms of:	**How important is this area to:** (0 = unimportant, 4 = very important)	
	Your personal identity?	Your reason for seeking therapy?
Age and generational influences:	0 1 2 3 4	0 1 2 3 4
Disability status (born with, or developmental disability):	0 1 2 3 4	0 1 2 3 4
Disability status (acquired physical/ cognitive/ psychological disabilities):	0 1 2 3 4	0 1 2 3 4
Religion and spiritual orientation:	0 1 2 3 4	0 1 2 3 4
Ethnicity:	0 1 2 3 4	0 1 2 3 4
Socioeconomic status:	0 1 2 3 4	0 1 2 3 4
Sexual orientation:	0 1 2 3 4	0 1 2 3 4
Indigenous heritage:	0 1 2 3 4	0 1 2 3 4
National origin:	0 1 2 3 4	0 1 2 3 4
Gender:	0 1 2 3 4	0 1 2 3 4

Symptoms and Daily Functioning

Have you experienced in the last month (circle where applies in left column):

None - - - - - -	Moderate - - - - -			Severe	
0	1	2	3	4	Depression
0	1	2	3	4	Anxiety or Agitation
0	1	2	3	4	Sadness
0	1	2	3	4	Irritability or Anger
0	1	2	3	4	Loss or Grief
0	1	2	3	4	Guilt
0	1	2	3	4	Feelings of emptiness or apathy
0	1	2	3	4	Mood swings
0	1	2	3	4	Confusion or Indecision
0	1	2	3	4	Low energy or fatigue
0	1	2	3	4	Poor Memory or Concentration
0	1	2	3	4	Loneliness
0	1	2	3	4	Low self-esteem or self-neglect
0	1	2	3	4	Obsessive thoughts
0	1	2	3	4	Panic, Fears or Phobias
0	1	2	3	4	Problems related to trauma
0	1	2	3	4	Sleeping more or less than usual
0	1	2	3	4	Eating more or less than usual
0	1	2	3	4	Weight loss or gain
0	1	2	3	4	Concerns about body image
0	1	2	3	4	Concerns about sexuality or sex life
0	1	2	3	4	Gambling or compulsive spending
0	1	2	3	4	Concerns by you/others about alcohol/drug use
0	1	2	3	4	Concerns by you/others about other compulsive behaviors
0	1	2	3	4	Problems related to abuse (circle which apply): physical / sexual / emotional / verbal
0	1	2	3	4	Thoughts or actions of hurting yourself
0	1	2	3	4	Thoughts or actions of hurting others

Rate your satisfaction with (or the quality of) these areas of your life:

Very good	Good	Neither good nor poor	Poor	Very poor	
					Relationship with yourself
					Romantic/partner relationship(s)
					Family relationships
					Friendships
					Community (being a part of - sharing/giving to others)
					Spirituality
					Job/Career or School
					Finances
					Physical health
					Your sex life
					Your living environment
					Recreation (fun and play, leisure activities)

Anything else that is important for me to know? _____
_____

Client Signature_____ Date_____

This form will be stored securely in your confidential file.

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Consent for Professional Services

This document contains my policies and approach to counseling, along with some important disclosures intended to protect your interests as a consumer of counseling and psychotherapy. If you have any questions or would like additional information, please ask.

About Therapy

When people begin therapy, it is common to feel both eager and uncomfortable. I encourage you to bring up any uncomfortable feelings or questions you may have about the process. Typically, our first few sessions are a period of evaluation and building of rapport. I will spend some time getting to know you and your current situation and how that relates to your life history. We will discuss the issues you want to address and, together, create a treatment plan designed to meet your goals for growth and change. We will both start to get a sense of whether we are establishing a good working relationship, which studies show is a significant predictor of a successful therapy experience. If we come to believe that you could benefit from something I cannot provide, I will be happy to provide you with referrals to other counseling professionals.

Risks and Benefits: Many people experience intense or uncomfortable emotions during therapy, such as sadness, anger, or anxiety. It is possible to recall unpleasant life events or experience changes in thoughts, feelings and beliefs about situations or experiences in one's life. Therapy also presents a unique opportunity to make positive changes and increase self-awareness and understanding. Studies have shown that therapy provides many benefits, including helping people to: find solutions to specific problems, identify patterns that lead to unhappiness, improve relationship satisfaction, reduce symptoms of depression and anxiety, and increase awareness of emotions in order to cope more effectively with life circumstances.

An important part of the process is to periodically review how therapy is going for you and to regularly evaluate the accomplishment of treatment goals.

Ending Therapy: Typically, we will end therapy when your goals have been met. Therapy may also end if you choose to stop meeting with me or if we come to believe you are not benefiting from the services provided.

Confidentiality and Privacy

Client records are treated as private and confidential information according to ethical practice and federal and state law. Upon your written permission, I can disclose information to a third

party. You have a right to access to the information in your file except when its release might be harmful to you. For professional development and guidance purposes, I may present your situation in consultation with other professionals (who are also bound by the legal and ethical framework of confidentiality), and when doing so, will change or withhold certain details in order to further protect your confidentiality.

If you or I would like me to release information to or discuss clinical information about you with someone else I will ask you to sign a "release of information" form. You have the right to refuse to sign this form. Please remember that your refusal to sign an authorization form may limit my ability to treat you to my fullest capability.

If you are using health insurance to pay for my services, the insurance company or HMO will request certain specific information such as diagnosis, date of services, and sometimes a treatment plan. After you have read this letter, I will ask you to sign this form that authorizes me to release this information to the insurance company or HMO. You may refuse to authorize my release of information to the insurance company but in that case, you will need to pay for my services out of pocket.

There are several exceptions to confidentiality that are legally mandated. They are as follows:

- If you disclose or imply a plan for suicide, I am required to take steps to protect your safety and notify legal authorities. If you make a specific threat to harm someone else, and the risk of danger is deemed imminent, I am required to warn the intended victim and report this information to legal authorities.

- If a client states or suggests that they are abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, I am required to report this information to the appropriate social service and/or legal authorities.

- If you are pregnant and using a controlled substance, I am required to report admitted prenatal exposure to controlled substances that are potentially harmful.

- If you are involved in a court case, the court may order the release of client records.

Electronic media: E-mail and text messages are fine to use for scheduling. Please do not use these avenues to share personal information with me as they are not secure forms of communication. Similarly, social networking sites are not a secure form of communication. As part of maintaining your privacy and my own, my policy is that I do not connect with clients via social media.

Appointments

Therapy sessions are 45 or 53 minutes long, unless otherwise arranged. Please make every effort to be on time for your appointment and I will do the same. If you are 20 or more minutes late for session, your appointment will be cancelled. If I am late, you will receive your full time.

Appointments cancelled with less than 24-hour notice will be charged the full fee. *Please note: insurance companies will not pay the fee for a missed appointment, nor are you able to use HSA/HRA funds to cover missed session fees.* To cancel or reschedule an appointment call: 612-567-2909 or email: melia@openinsighttherapy.com.

On very rare occasions I am forced to reschedule an appointment due to an emergency or crisis situation. When I must do this, I will make every effort to reschedule your appointment at a time that is convenient to you.

Contacting Me

Feel free to call or email at any time. If you get my voicemail, please leave a message. I respond within one day during Monday through Friday. My policy is to keep phone conversations and email conversations brief due to not engaging in therapy processing over the phone or email. Also, please keep in mind that e-mail is not a secure/confidential form of communication.

Crisis Situations: If your call is of an emergency nature and you are not able to reach me immediately, or your emergency occurs at a time outside of my business hours, please call one of the following, or 911:

Crisis Connection.....612-379-6363
Suicide Hotline.....612-873-2222
Trans Lifeline…… 877-565-8860
Acute Psychiatric Services.....612-873-3161
Walk-In Counseling Center.....612-870-0565

Professional Fees

My rates are as follows:

Individuals: 30 minutes = $130
45 minutes = $135
53+ minutes = $160
Couples/relationships: 50 minutes = $160
Initial intake, including diagnostic assessment = $180
Group therapy: $75/session

Payments, including co-pays or co-insurance, are due at the beginning of each session. I accept cash, check, or credit card. I will provide you with a receipt you can submit for reimbursement if I am out of network with your health insurance provider.

Under most circumstances, it is inappropriate for a psychotherapist to become involved in a therapy client's legal case. However, should this become necessary, the fee for any time spent on activities related to any legal action (preparation, writing reports, copying notes, making phone calls, travel time, etc.) is charged in 15 minute increments at the rate of $185 per hour.

Cancellations

My services are by appointment only. Your appointment time is reserved for you, and without enough notice I cannot make that time available to another client who may be in need. Cancellations with less than 24 hours notice, and no-show appointments, are charged the full session fee. The only exception is when the absence is due to circumstances we would both define as an emergency, sudden illness, or accident. Charges for cancellations and no-shows are not covered by your health insurance.

Issues or Complaints

You may register a complaint about me or my services to my licensing board. Before doing so, I encourage you to bring to me directly any concerns you may have about me or our work together. Following is the address and phone number of my licensing board: Minnesota Board of Social Work, (612) 617-2100, 2829 University Ave. SE, Suite 340, Minneapolis, MN 55414-3239

CLIENT'S BILL OF RIGHTS

As a consumer of professional counseling services, you have the right to:

A. expect that I have met the minimal qualifications of training and experience required by state law;
B. ask about my training, professional competencies, experience, education, biases or attitudes, and any other relevant information that may be important to you in the provision of services;
C. examine public records maintained by the Board of Social Work that contain my credentials;
D. report complaints to the Board of Social Work (address & phone number on previous page);
E. be informed of the cost of professional services before receiving the services;
F. privacy as defined and limited by rule and law;
G. be free from being the object of unlawful discrimination while receiving counseling services;
H. be free from exploitation for the purpose of my benefit or advantage;
I. have access to your records as provided in part 2150.7520, subpart 1, and Minnesota Statutes, section 144.292, except as otherwise provided by law;
J. terminate services at any time, except as otherwise provided by law or court order;
K. know the intended recipients of assessment results;
L. withdraw consent to release assessment results, unless this right is prohibited by law or court order or is waived by prior written agreement;
M. a nontechnical description of assessment procedures; and
N. a nontechnical explanation and interpretation of assessment results, unless this right is prohibited by law or court order or this right was waived by prior written agreement.

CLIENT'S RESPONSIBILITIES

As a client, you can help yourself by being responsible following ways:

To be honest: You are responsible for being honest and direct about everything that relates to you as a client. Please tell me exactly how you feel about the things that are happening to you in your life.

To understand your treatment plan: You are responsible for understanding your treatment plan to your own satisfaction. If you do not understand, ask me. Be sure you do understand since this is important for the success of the treatment plan.

To follow the treatment plan: It is your responsibility to discuss with me whether or not you think you can and/or want to follow a certain treatment plan.

To keep appointments: You are responsible for keeping appointments. An appointment for your care is reserved solely for your care and treatment. If you cannot keep an appointment, notify me as soon as possible so that another client can be seen. In any case, you will be charged for appointments when canceled with less than 24 hours notice. This charge is not covered by your insurance company.

To keep me informed: So that I may contact you whenever necessary, I will rely upon you to notify me of any changes in your name, address, home, cell, or work phone numbers.

YOUR THERAPIST'S RIGHTS AND RESPONSIBILITIES

I have the responsibility to provide care appropriate to your situation, as determined by prevailing community standards. To accomplish this, I also have certain rights, including:
1. The right to information needed to provide appropriate care.
2. The right to be reimbursed, as agreed, for services provided.
3. The right to provide services in an atmosphere free of verbal, physical, or sexual harassment.
4. The right and ethical obligation to refuse to provide services that are not clinically indicated.

Your signature below indicates that you have read and understand the information in this document and have had your questions answered. You agree to abide by the terms of the policies as set forth. You have received a copy of this document.

_____ _____

Client Signature ***Date***

****Please complete and sign this page if you will be using your health insurance benefits to pay for therapy services.*

I hereby request that _____(name of third-party payer/insurance company) reimburse Melia McCubbin directly for services covered by _____(name of third-party payer/insurance company).

I hereby authorize Melia McCubbin to release information about diagnosis, dates of treatment, and services provided, acquired in the course of my evaluation and/or treatment as may be necessary to process claims for insurance reimbursement. This release will expire one year from the date below, or sooner if requested in writing by client. I understand that my therapist will discuss my diagnosis and treatment plan with me prior to releasing this information to the insurance company. I agree to promptly pay for charges incurred if for any reason my insurance carrier does not pay any portion of it.

_____ _____

Client Signature ***Date***

HIPAA NOTICE OF PRIVACY PRACTICES

The privacy of your health information is important to me. I will maintain the privacy of your health information and I will not disclose your information to others unless you sign a release of information, or unless the law authorizes or requires me to do so.

A federal law commonly known as “HIPAA” requires that I take additional steps to keep you informed about how I may use information that is gathered in order to provide health care services to you. As part of this process, I am required to provide you with the attached Notice of Privacy Practices and to request that you sign the attached written acknowledgement that you received a copy of this Notice.

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

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). I must follow the privacy practices that are described in this Notice (which may be amended from time to time).

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Permissible Uses and Disclosures without Your Written Authorization

I may use and disclose PHI without your written authorization, excluding Psychotherapy Notes as described in Section II, for certain purposes as described below.

1. **Treatment**: I may use and disclose PHI in order to provide treatment to you. For example, I may use PHI to diagnose and provide counseling service to you. In addition, I may disclose PHI to other health care providers involved in your treatment with your consent.

2. **Payment**: I may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from, your health plan. By way of example, I may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services.

3. **Required or Permitted by Law**: I may use or disclose PHI when I am required or permitted to do so by law. For example, I may disclose PHI to appropriate authorities if I reasonably believe that you are a current victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition I may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law.

B. Uses and Disclosures Requiring Your Written Authorization

1. **Psychotherapy Notes**: Notes recorded by me documenting the contents of a counseling session with you ("Psychotherapy Notes') will be used only by me and will not otherwise be used or disclosed without your written authorization.

2. **Marketing Communications:** I will not use your health information for marketing communications without your written authorization.

3. **Other Uses and Disclosures:** Uses and disclosures other than those described in Section I.A. above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

II. YOUR INDIVIDUAL RIGHTS

A. Right to Inspect and Copy. You may request access to your medical record and billing records maintained by me in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. I may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record will not be accessible to you.

B. Right to Alternative Communications. You may request, and I will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

C. Right to Request Restrictions. You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction in writing addressed to the Privacy Officer as indicated below. I am not required to agree to any such restriction you may request.

D. Right to Accounting of Disclosures. Upon written request, you may obtain an accounting of certain disclosures of PHI made by me after April 14, 2003. This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

E. Right to Request Amendment: You have the right to request that I amend your health information. Your request must be in wilting, and it must explain why the information should be amended. I may deny your request under certain circumstances.

F. Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by submitting a request to the Privacy Officer at any time.

G. Questions and Complaints. If you desire further information about your privacy rights, want additional copies of this Notice, or are concerned that Melia McCubbin, MSW, LICSW, CST has violated your privacy rights, you may contact the Privacy Officer, Melia McCubbin, at 612-567-2909. Upon request, I will provide you with the address of the Director, Office for Civil Rights of the U.S. Department of Health and Human Services, where you may file written requests. I support your right to the privacy of your health information. I will not retaliate against you if you file a complaint with the Director or myself.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date. This Notice is effective on January 31, 2014.

B. Changes to this Notice. I may change the terms of this Notice at any time in accordance with applicable law. Prior to making significant changes to my privacy practices, I will alter the Notice to reflect the changes and make the revised Notice available to you upon request. Any changes I make to privacy practices and/or this Notice may be applicable to health information created or received by me prior to the date of the changes.

By signing below, you acknowledge receiving a copy of this Notice of Privacy Practices.

_____ _____

Client Signature Date

Printed name: _____