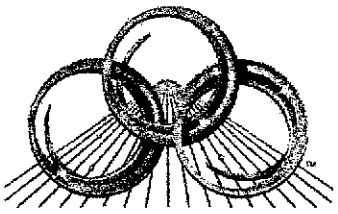
Beyond the Brain Therapies
Inc. / dba
Counseling & Mediation
Solutions LLC
651-307-4993



The Brick House
407 West Broadway Ave.
Forest Lake, MN 55025
Fax: 651-464-2289

Date of Intake

Client's Personal Information

Client Name	**Birthdate**
Address:	**Preferred Phone Number**
City **State** **Zip**	**School**
Email Address:	**Place of Employment**
Parent or Guardian Name (If Applicable)	**Work Phone**

Name of Insurance Company: **ID #** **Group ID**	**Policy Holder other than client?** **Birthdate of Policy Holder:**
EAP or Secondary Insurance (if applicable) **ID#** **Group ID**	**Provider Number to Contact Insurance?**
Counselor Name: _____ **Services Requested: (Circle)** **Counseling Biofeedback Ketamine**	**Physician:** _____ **Clinic:** _____ **Date Last Seen by MD:**

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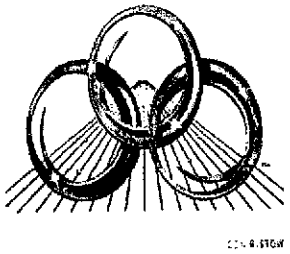

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Acknowledgement of Electronic Communication

I understand that while every effort will be made to hold your personal information at the highest level of privacy (Federal HIPPA Standards), electronic communication is not always secure. Counseling and Mediation Solutions, LLC / Beyond the Brain Therapies Inc. has taken every step to encrypt and secure our network to meet all medical standards of compliance. Telephone, email or text exchanges will be used only for information related to treatment (including telehealth) and billing between yourself, your therapist/staff, your insurance carrier and the billing company we outsource to (Bell MedEx).

I authorize my therapist and those hired above to process my information as needed to cover my services. I have provided the following information for therapist-client exchanges:

Email _____ Email Address _____

Text _____Cell Phone _____

Please initial one of the following 2 options:

_____ I authorize the release of information to my insurance or funding source. I authorize payment from my funding source for services rendered accordingly. I acknowledge and take full responsibility for amounts that are not payable by my funding source (i.e. unbillable services, deductibles and co-pays).

_____ I opt for a private pay agreement... and that insurance will NOT be billed. An agreed upon Self – Pay in the amount of $_____ per hour has been established. I also acknowledge full responsibility for payment at time of service.

I understand that I have the option to switch insurance billing to Self-Pay or vice versa anytime. If insurance has been billed for a specific date(s) and no payment is made, I acknowledge my responsibility to pay the remaining amount.

I have read and understand the information given regarding my rights and responsibilities and the confidential commitment of my therapist (Informed Consent and Confidential Information Form).

(Client Signature)_____ _____ (Date)

(Therapist)_____ _____ (Date)

Beyond the Brain Therapies, Inc./dba
Counseling and Mediation Solutions

The Brick House
407 West Broadway
Forest Lake, MN 55025

Direct: 651- 408-3174

debranelson@beyondthebraintherapies.com

Fax: 651- 464-2289

INFORMATION FOR NEW CLIENTS (2020 Informed Consent)

The following statements are presented to insure that you are aware of your rights and responsibilities. If you have any questions, please ask your Practitioner.

Please check each box to indicate that you have read and understood the information within each section:

☐ ***What You Can Expect During Therapy***

The therapeutic process cannot be easily described because it varies depending on the health practitioner, the client, resources and the presenting circumstances.

Therapy has both benefits and risks. It can lead to a significant reduction of distress, to better relationships, and can lead to resolutions of specific issues. We cannot, however, guarantee what will happen. During the healing process, the risks may include uncomfortable feelings of sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness. Therapy involves a commitment of your time, money, and energy, so it is important that you are comfortable working with your practitioner and are willing to provide accurate information about yourself so you can receive the most effective treatment.

We want you to be satisfied with the quality of service you receive. If you have any questions or concerns, please talk to your practitioner immediately. If the issue remains unresolved, you may talk to owner Debra Nelson, MA LMFT at 651-307-4993. If you need to consult further, you may contact the Minnesota Board of Marriage and Family Therapy (612) 617-2220 to discuss your concerns. We are here to listen and hope you will feel safe.

☐ ***Overview of Services Provided***

We are licensed health providers who work with individuals of all ages, couples, and families on a broad range of issues such as mental health, stress, trauma, anxiety, relationships, grief, PTSD, conflict, developmental goals, career, spirituality, academics, and other issues. We work as an integrated team; each practitioner has a variety of specializations and skills.

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Counseling sessions are generally 45 to 60 minutes in length. Biofeedback is usually 90 to 120 minutes. If you would like to secure a specific weekly time of the week, please advise your practitioner. Therapy will be based on treatment goals (weekly or bi-weekly).

☐ ***Privacy and Confidentiality***

All information disclosed within sessions and any written records are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law.

I (the client) understand that disclosure is required by law in the following instances:

- Therapists must report known or suspected cases of incest, abuse, or neglect of children or vulnerable adults.
- Therapists must report when any client makes a specific threat of violence against another person, or if the therapist believes the client presents a clear, imminent risk of serious physical harm to self or another person.
- Parents and in some cases, legal guardians, have a right by law to information in children's files. Minors also have a right, again by law, to request that data be kept from their parents. Minnesota law requires that this request be in writing, that the child explains any reasons for withholding data from his/her parents, and show an understanding of the consequence of doing so.
- Disclosure may be required in pursuance to a legal proceeding. I understand that information, records, or testimony about me may have to be produced if there is a court order or subpoena.

I understand that each individual involved in couple, family, or group therapy must provide written authorization before the therapist can disclose any information outside the treatment context. Within couple, family or group therapy, the therapist cannot share individual confidences with the rest of the members of the therapeutic unit without written permission from the individual. Your therapist will ask for your signature on releases of information for interoffice teaming when you both agree that it is appropriate.

☐ ***Client Records***

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Private pay or cash payments will be negotiated utilizing a sliding fee & Private Pay Agreement. Other payment methods include HSA accounts, Credit Cards, Debit Cards, Cash, Check and PayPal on our website. You go online to our website www.beyondthebraintherapies.com or submit a payment at the time of service directly to your health professional.

Appointments: We strongly request that you give a notice of 48 hours – 2 business days when changing appointment times. We understand that a waiver for an emergency may be needed and that can be negotiated with your Practitioner. Any cancellation for services without this notice will result in a fee: $75 for first one-hour session or $150 for 1.5 hour missed session. A $100 fee will be applied for each subsequent one-hour sessions missed or $150 for 1.5-hour sessions missed. We are diligently respectful of time and hope you will be also. With that said, we do our best but there are times when sessions run over the expected end time. We do ask for your patience and understanding.

***If at any time you have an emergency, you should call 911 or 24 hour crisis 866-379-6363 as we do not have emergency staffing.**

☐ ***Relationships***

It is unethical for health practitioners to have casual, sexual, social or financial relationships with a client or his/her family member outside of therapy. A copy of the "Bill of Rights of Clients" is visible in the lobby. Therefore, no outside time-outside of therapy is allowed.

Consent to Treatment

☐ I knowingly give my consent to therapy and/ or biofeedback/neurofeedback services.

☐ My signature below indicates that I understand and agree with the above statements in each section of this document. I also understand that the therapeutic process isn't guaranteed, and my health professional is here to educate me on possibilities.

☐ I have received a copy of "The Health Information Privacy" document and have had an opportunity to discuss any questions or concerns I have about how PHI is being managed.

X _____ _____

Signature of Client ***Date***

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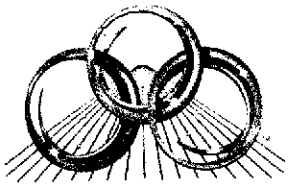
Counselingsolutionsmn.com



Beyond The Brain –
Therapies Inc.
The Brick House
407 West Broadway Ave.
Forest Lake, MN 55025

The following information is being requested for the therapeutic treatment of a child/teen. The more information and history we can obtain from you, the more effective our care can be. We appreciate you taking the time and energy to be as thorough as you are able to be.

Child/Adolescent Intake Information for _____

Person who is filling out this form _____

Date this Form was completed _____

Place of Birth	
Date of Birth	
Adoptive Parents Names	
Biological Parents	
Guardian	

Child Currently Lives at .... **Address:** _____ _____	**Child Currently Lives with** _____ _____
Siblings In Home	
Childcare Placement	
Child Foster Care Placement	
Child Abuse Case Worker (County)	

If you are not sure of the above information, please check the ROI box. CMS will send a Release of Information to the provider to request a copy of treatment records.

Relationships

Child/Adolescent Gets Along well with Mother	**Yes**	**No**
Child/Adolescent Gets Along well with Mother	**Yes**	**No**
Child/Adolescent Gets Along well with Siblings	**Yes**	**No**
Child/Adolescent Gets Along well with Grandparents	**Yes**	**No**
Child/Adolescent Gets Along well with Step Parent	**Yes**	**No**
Child/Adolescent Gets Along well with Teacher	**Yes**	**No**
Child/Adolescent Gets Along well with Friends	**Yes**	**No**

Helpful Information:

_____

_____

_____

If my Child had his/her own way, they would

_____.

I very much enjoy my child when we

_____.

The most difficult times we have are

_____

_____

Holidays are _____

This child is most like _____ **(who) in**

_____ **(ways).**

Sometimes I feel like I should have done better at

_____.

I blame _____ **for** _____.

I am most proud of my child/teen for

_____.

Physician / Clinic of Care	
Allergies	
Medical Health History/ Diagnosis	
Mental Health History/ Diagnosis	
Medications Currently Taking / How often	
Alternative Care Providers	
Current Supplementation/Vitamin	
Childhood /Teen Traumatic Experiences	
Domestic Abuse Child has Been Exposed to:	
Death / Loss Experienced	

Household Member Name	Relationship to Child	Age	Occupation/School	Highest level of Education	Quality of Relationship

Is there a Parenting Plan? YES NO Dated: _____

Custody Arrangements

- **Lives with Mother _____ % of the time**
- **Lives with Father _____% of the time**
- **Lives with Both Parents yes no**
- **Other _____**

Developmental Issues

Pregnancy Complications with mother?	
Use of Chemicals by Mother During Pregnancy	
Medical concerns or injuries of mother during pregnancy	
Family trauma and/or losses during pregnancy	
Weight loss during pregnancy?	
Smoking during pregnancy?	
Birthing Complications?	

Born Prematurely	**Yes**	**No**
Born with Chord around The Neck	**Yes**	**No**
Trouble Breathing	**Yes**	**No**
Incubated for longer than a couple of hours	**Yes**	**No**
Infections at Birth	**Yes**	**No**
Other Problems at Child's Birth?		
Medical Diagnosis at Birth		

Child Hood Development Details

	Check for Yes	Check for No
Constipation		
Stomach Aches		
Trouble Falling Asleep		
Trouble Staying Asleep		
Over-activity		
Head banging		
Rocking in Bed		
Temper Tantrums		
Self-Destructive Behavior		
Difficulty in being comforted or consoled		
Stiffness or rigidity		
Aloof		
Crying often and easily		
Shyness with Strangers		
Irritability		
Extreme reactions to noise or sudden movement		
Poor Eating Habits		
Only Eats a Few Items		
Opposes Directions		
Lashes Out		
Little Energy		

Attention and Focus

Focus and Attention	Check for Yes	Check for No
Can concentrate for short amounts of time (10 minutes)		
Can concentrate for a fair amount of time (20 to 30 minutes)		
Does what is asked and asks questions if needed		
Learns a skill one day and can't recall it the next day or so		
Attention and Focus Continued	Check if YES	Check if NO

Needs constant Attention Needs Supervision to Complete Tasks		
Very Independent/Calm		
Cannot Sit Still		
Inquisitive		
Easily Bored		
Daydreams		
Pleasant Conversationalist		
Enjoys Learning		
Often Makes Mistakes that are Unnecessary		
Rages at Others		
Often Confused		
Complains of Body Aches or Pain		
Struggles to have Relationships		
Competitive		
Blurts out Answers and Interrupts Often		
Trouble with the Law		
Hurts himself/herself		
Uses Chemicals		

Child's School History and Functioning Information

If Educational Services are Provided, who is overseeing the progress

_____

Check the following if they apply:

Early Childhood Special Education ___
Special Learning Disability ___
Visual Impairment ___
Physically Impaired ___
Cognitive Disorder ___
Autism Spectrum Disorder _____
Traumatic Brain Injury ___ _____

Developmental Delay Diagnosis ____
Hearing Impaired ____
Speech or Language Impairment ___
Emotional/Behavioral Disorder ___
Special Learning Disability ___

Current School Plans _____

My child has received mental health therapy at (clinic):

_____

Treating Therapist/Evaluator/Doctor: _____

Reason for Visit _____

Time of Treatment: _____ **ROI NEEDED**_____

Diagnosis Given: _____

Tests Completed: _____

Medications Prescribed _____

My child has received mental health therapy at (clinic):

_____

Treating Therapist/Evaluator/Doctor: _____

Reason for Visit _____

Time of Treatment: _____ **ROI NEEDED**_____

Diagnosis Given: _____

Tests Completed: _____

Medications Prescribed _____

My child has received mental health therapy at (clinic):

_____

Treating Therapist/Evaluator/Doctor: _____

Reason for Visit _____

Time of Treatment: _____ **ROI NEEDED**_____

Diagnosis Given: _____

Tests Completed: _____

Medications Prescribed _____

School Information

School Attending	
Grade	
Teacher Name (s)	
Gifted, Home-Schooled, Tutored, Outside Educational Programs, District Support Services	

ATHLETIC ACTIVITIES AND HOBBIES

Child's Legal History

Shoplifting/Damage to Property? Yes			NO?			
Running Away?	YES	NO	Juvenile Detention?	Yes	When?	NO
Charges	YES	When?	Where?		What for?	
Charges	YES	When?	Where?		What for?	
Youth Services Bureau Involvement		Yes	When?		No	
This Child has been incarcerated		Yes	When?		No	

Traumatic Experiences and Treatment

Trauma	When	By Whom
Physical Abuse		
Sexual Abuse		
Emotional Abuse		
Bullying		
Parental Abandonment		
Domestic Abuse Exposure		
Parental Abuse Exposure		
Community Violence		
Suicide		
Murder		

Medical and Mental Health Treatment History

Family History Information

Health Problems	CHECK Yes	No	(Grand) Parent	Sibling	Other
Disability					
Legal Issues					
Alcohol					
Street Drugs					
Prescription Pills					
Anxiety					
Depression					
ADHD/ADD					
Bipolar					
Schizophrenia					
Psychosis					
Violent Acting Out					
Learning Disabilities					
Sensory Disorder					
Autism Spectrum					
Developmental Disorders					

Military Involvement

Please describe military involvement in your family:

Parental Deployment Dates:

Changes and losses related to deployments:

Thank you very much for taking the time to share your personal information with me. I hope to help you improve your current circumstances that your family is facing. I will work diligently on your behalf to accurately evaluate, develop a plan, recommend resources and promptly initiate therapeutic services. If you have specific needs, cares or questions please don't hesitate to discuss it with me.

Parent/Guardian Signature **Date**

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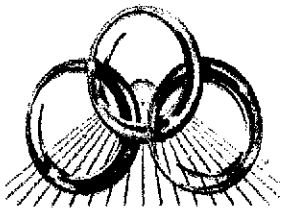

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"PERSONAL HEALTH INFORMATION"

The privacy of your health information is important to you and to me. Additionally, as a Licensed Marriage and Family Therapist, I am required by law to secure your "protected health information" (PHI). This information includes:

1. I must protect PHI that we have created or received about your past, present or future health condition, health care we provide to you or payments we receive;
2. I must notify you about how we protect PHI about you;
3. I must offer you explanation of how, when and why we use this information;
4. I may only use and/or disclose PHI if we have discussed it and you have agreed; and
5. I will and must abide by the terms of this notice.
6.

Minnesota Patient Consent for Disclosures

For most disclosures of your health information we are required by the State of Minnesota Laws to obtain a written consent from you, unless the disclosure is authorized by Law. This consent may be obtained at the beginning of your treatment, during the first delivery of health care services or at a later point in your care, when the need arises to disclose your health information to others.

Uses and Disclosures

A. For the purposes of treatment, payment and health care operations:
   1. Health Care Treatment: We may use and disclose PHI to provide, coordinate and/or manage your health care and related services. This may include communication with other health care providers regarding your treatment and coordinating and managing the delivery of health service with others.
   2. Payments: I may use and disclose your medical information to others to bill and collect payment for treatment and services provided to you. For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill ay include

information that identifies you, as well as your diagnosis. Before you receive scheduled services, we may share information about these services with your health plan to achieve authorization. Sharing information allows me to ask for coverage under your plan or policy and gain approval of payment before we meet. I may also share portions of your medical information with the following:

a. The billing service I utilize (Greater Lakes Medical Billing);
b. Collection agency;
c. Insurance companies, health plans and agents;
d. Personnel that review the care you receive and the costs associated; and
e. Consumer reporting agencies.

B. Requiring your Authorization: You may give us written authorization, different from the Minnesota Patient Consent, to use your health information for disclosure. If you give me an authorization, you may revoke it in writing at any time. Unless you give a written authorization, I cannot use or disclose your health information for any reason except those described in this notice.

C. Require your Opportunity to Agree or Object: I will provide you the opportunity to agree or object to a use or disclosure of your PHI in the following instances:

1. If I need to disclose information to notify a family member, personal representative, or another person responsible for your care, your location and general condition

2. Communication with family members: health professionals, using their best judgment may disclose to a family member, other relative, close personal friend or any other person who you identify, health information relevant to that person's involvement in your care or payment related to your care.

You have the right to object to my use or disclosure of PHI in the either of the above situations. I will take your wishes very seriously and do all I can under the law to work in your best interest.

D. Circumstances in which I am authorized by Law to release personal information that DO NOT require your Consent, Authorization or Opportunity to Agree or Object are:

1. When the use and/or disclosure is authorized or required by law;
2. When the use and/or disclosure is necessary for public health activities;[1]
3. When the use and/or disclosure relates to victims of abuse or neglect;
4. When the use and/or disclosure is for health oversight activities;
5. When the use and/or disclosure is for law enforcement purposes;

6. When the use is for disclosure related to decedents;
7. When the use is to avert a serious threat to health and safety;
8. When the use disclosure related to specialized government functions; and
9. When the use and/or disclosure relates to correctional institutions and in other law enforcement custodial situations.

Know Your RIGHTS!

A. You have the right to request restrictions on uses and disclosures of personal health information. I am not required, however, to agree to your request but at all times I am committed to work with you as long as it is within the ethical and legal parameters set by the State of Minnesota and the Minnesota Board of Marriage and Family Therapy.

For example, emergency care treatment; you may request a restriction be given related to the release of information to the Secretary of the Department of Health and Human Services by submitting it in writing to me. You will then be notified as to whether your request can be honored.

A. You have the right to request communications via alternative means or to alternative locations.
B. You have the right to see and retain a copy of the Personal Health Information outlined.
C. You have the right to see and receive a copy of your clinical, billing and other records used to make decisions about you. Your request must be in writing. You may incur a charge for this service. There are certain situations which we are not required to comply with your request. Under these circumstances, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of the denial.
D. You have the right to request an amendment to your personal health information.
E. You have the right to request an accounting of disclosures of personal health information.
F. You have the right to receive a copy of this notice.

This document has been created from legal guidelines and is intended for the purpose of educating you of your rights and my professional obligations. If at any time you have concerns or questions, please discuss them with me and/or submit your complaint in writing. This herein, serves to meet the State and Federal procedures for "Personal Information Disclosure".

Thank you!

Modified Mini Screen (MMS)

Patient Name: _____ **Date:** _____

Section A – Please circle "yes" or "no" for each question.

1. Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks? ..... Yes No
2. In the past two weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time? ..... Yes No
3. Have you felt sad, low, or depressed most of the time for the last two years? ..... Yes No
4. In the past month, did you think that you would be better off dead or wish you were dead? ..... Yes No
5. Have you ever had a period of time when you were feeling up, hyper, or so full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol.) ..... Yes No
6. Have you ever been so irritable, grouchy, or annoyed for several days, that you had arguments, had verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or overreacted, compared to other people, even when you thought you were right to act this way? ..... Yes No

Section B – Please circle "yes" or "no" for each question.

7. Have you had one or more occasions when you felt intensely anxious, frightened, uncomfortable, or uneasy, even when most people would not feel that way? Did these intense feelings get to be their worst within ten minutes? (If the answer to both questions is "yes," circle "yes"; otherwise circle "no.") ..... Yes No
8. Do you feel anxious or uneasy in places or situations where you might have the panic-like symptoms we just spoke about? Or do you feel anxious or uneasy in situations where help might not be available or escape might be difficult? Examples: ○ being in a crowd, ○ standing in a line, ○ being alone away from home or alone at home, ○ crossing a bridge, ○ traveling in a bus, train, or car? ..... Yes No
9. Have you worried excessively or been anxious about several things over the past six months? (If you answer "no" to this question, answer "no" to Question 10 and proceed to Question 11.) ... Yes No
10. Are these worries present most days? ..... Yes No
11. In the past month, were you afraid or embarrassed when others were watching you or when you were the focus of attention? Were you afraid of being humiliated? Examples: ○ speaking in public, ○ eating in public or with others, ○ writing while someone watches, ○ being in social situations. ..... Yes No

continued on other side

12. In the past month, have you been bothered by thoughts, impulses, or images that you couldn't get rid of that were unwanted, distasteful, inappropriate, intrusive, or distressing? Examples: ○ being afraid that you would act on some impulse that would be really shocking, ○ worrying a lot about being dirty, contaminated, or having germs, ○ worrying a lot about contaminating others, or that you would harm someone even though you didn't want to, ○ having fears or superstitions that you would be responsible for things going wrong, ○ being obsessed with sexual thoughts, images, or impulses, ○ hoarding or collecting lots of things, ○ having religious obsessions. ..... Yes No

13. In the past month, did you do something repeatedly without being able to resist doing it? Examples: ○ washing or cleaning excessively, ○ counting or checking things over and over, ○ repeating, collecting, or arranging things, ○ other superstitious rituals. ..... Yes No

14. Have you ever experienced, witnessed, or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? Examples: ○ serious accidents, ○ sexual or physical assault, ○ terrorist attack, ○ being held hostage, ○ kidnapping, ○ fire, ○ discovering a body, ○ sudden death of someone close to you, ○ war, ○ natural disaster. ..... Yes No

15. Have you re-experienced the awful event in a distressing way in the past month? Examples: ○ dreams, ○ intense recollections, ○ flashbacks, ○ physical reactions. ..... Yes No

Section C – Please circle "yes" or "no" for each question.

16. Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you? ..... Yes No

17. Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear what another person was thinking? ..... Yes No

18. Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Or, have you ever felt that you were possessed? ..... Yes No

19. Have you ever believed that you were being sent special messages through the TV, radio, or newspaper? Did you believe that someone you did not personally know was particularly interested in you? ..... Yes No

20. Have your relatives or friends ever considered any of your beliefs strange or unusual? ..... Yes No

21. Have you ever heard things other people couldn't hear, such as voices? ..... Yes No

22. Have you ever had visions when you were awake or have you ever seen things other people couldn't see? ..... Yes No