Love the Journey
Phone: 320-679-6964
Fax: 320-679-8183

23 Pine St N
Mora, MN 55051
www.lovethejourneymn.com

Name: _____Client chart #_____

Sex _____ Co-pay: _____

Birth Date: _____ Primary Provider: _____

Address: _____

Phone:_____ Work #_____

Insurance(s)

Insurance/Subscriber Eff Date/Rel Policy # Group #

_____

_____

Reason for intake:

I verify that the above information, as printed or as modified by me this date, is true and correct to the best of my knowledge.

_____Date:_____

Signature of Client or Guardian

RECORDS RELEASE: I hereby authorize the release of any information, including medical and billing information, by Love the Journey to my insurance company, and or designated payer on behalf of myself and or dependents.

_____Date:_____

Signature of Client or Guardian

Assignment of benefits: I hereby authorize payment of Medical Benefits to Love the Journey for services rendered to myself and/or dependents.

_____Date:_____

Signature of Client or Guardian

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Release of Information

I authorize Love the Journey to use or disclose the protected health information of the individual named below as indicated. This information could be exchanged or leased via verbal, electronic, or written contact. Incomplete or invalid request will be returned to the proper individual.

Client Name: _____Chart #_____

Address:_____Date of birth:_____

City:_____State:_____Zip Code_____Phone #_____

This authorization is for the following information: I understand that sensitive information

__Case Notes/Treatment Plan

__Discharge Summary

__Diagnostic Assessment(s)

__Psychiatric/Medication Records

__Verbal

__Other_____

Dates of service to be used/disclosed:

__ ____/____/____ to ___/____/_____

___ Other:_____

I understand that sensitive information including information regarding HIV/AIDS, alcohol and drug abuse and or mental health treatment may be released as part of this disclosure unless I initial here and indicate what sensitive information I do not want disclosed. Initials:_____ Information not to be released_____.

I understand that signing this authorization is not required in order for me to receive treatment except as indicated in any privacy practices notices I received. I understand that I can revoke this authorization in writing by sending notice to the facility releasing the above information. I understand that once information is disclosed it may no longer be protected by federal or state privacy rules and therefore may be re-disclosed by the recipient of the information without permission. A photocopy or fax is equivalent to the original.

Unless otherwise indicated here, this authorization shall expire in one year. Other expiration date_____.

The Purpose for this request is for

__Medical Care __ Legal __Insurance __Communication Only __Coordination of Care __Emergency Contact
__Collateral Contact __Personal Record __Other:_____

Love the Journey is AUTHORIZED to send and receive the indicated information to the following person/group:

Person or Group_____

Address:_____Phone:_____

Signature_____Relationship:_____Date_____

Witness Signature:_____Date_____

PATIENT HEALTH QUESTIONAIRE (PHQ-9)

NAME: _____ **DATE:** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle a number to indicate your answer)	**Not at all**	**Sometimes**	**Several days**	**Often**	**Every day**
1. Little interest or pleasure in doing things	0	1	2	3	4
2. Feeling down, depressed, or hopeless	0	1	2	3	4
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3	4
4. Feeling tired or having little energy	0	1	2	3	4
5. Poor appetite or overeating	0	1	2	3	4
6. Feeling bad about yourself – or that you are a failure or have let yourself down or your family down	0	1	2	3	4
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3	4
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	4
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3	4

10. If you checked off any of the problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very Difficult _____ Extremely difficult _____

TOTAL

_____

Generalized Anxiety Disorder (GAD-7)

NAME: _____ **DATE:** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle a number to indicate your answer)	**Not at all**	**Sometimes**	**Several days**	**Often**	**Every day**
1. Feeling nervous, anxious, or on edge	0	1	2	3	4
2. Not being able to stop or control worrying	0	1	2	3	4
3. Worrying too much about different things	0	1	2	3	4
4. Trouble relaxing	0	1	2	3	4
5. Being so restless that it is hard to sit still	0	1	2	3	4
6. Becoming easily annoyed or irritable	0	1	2	3	4
7. Feeling afraid as if something awful might happen	0	1	2	3	4

8. If you checked off any of the problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very Difficult _____ Extremely difficult	TOTAL _____

CAGE-AID

*if you do not use drugs or alcohol, indicate so here ☐

	Yes	No
Have you ever felt you should cut down on your drinking/drug use?		
Have people annoyed you by criticizing your drinking/drug use?		
Have you ever felt bad or guilty about your drinking/drug use?		
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)?		

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Informed Consent **Initial**

Consent to Treatment: By signing this Client Information and Consent Form 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 and it has been offered to me in written 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 me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. I am consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, Love the Journey will not render services to your child until the Therapist has received and reviewed a copy of the most recent applicable court order. X____

Mandated Reporting: Each therapist is a mandated reporter, and as such is required by law to report if they have reason to believe that the abuse, neglect, or financial exploitation of a vulnerable adult or child has occurred. By initialing here, I indicate that I understand. X____

Social Media: To safeguard the professional relationship between client and therapist, clients should not reach out to their therapist via their therapist's private account on any form of social media. Therapists will not accept friend requests or any other form of connection through social media. By initialing here, I agree to this arrangement. X____

Cell Phone Use: Cell phones are very convenient, but may serve as a distraction during the therapy process. To help avoid distraction, Love the Journey requests that cell phones and other mobile devices are turned off during sessions and are not used, unless an individual arrangement is made between client and therapist. By initialing here, I agree to this arrangement. X____

Office Cell Phone: The office cell phone number is 763-227-7617. This phone is for making and confirming appointments, and confidential information should not be sent to this number. Therapists will not be giving out their personal cell phone numbers. If a patient's safety plan requires the use of a cell phone for check-ins, it will be done using this phone. This phone is not monitored on weekends or evenings. If you are in crisis or are in immediate danger, please dial 911. By initialing here, I indicate that I understand. X____

Printed Name of client_____

Preferred phone number_____

Is it ok to leave a message Y / N

Is it ok to text message Y / N

Who is your emergency contact:

_____phone_____

What is the relationship with your emergency contact? _____

By initialing here, I give Love the Journey permission to contact this person in the event of an emergency. X____

Signature _____ Date _____

(client's signature, or that of a legal guardian)