

**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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## Safe Harbor Agreement

In order to preserve the safety and confidentiality of your child's therapeutic environment, it is essential that he/she feels free to speak openly with their therapist without fear of their statements being disclosed. The therapist's office is to serve as an environmental "safe harbor" for your child(ren). Therefore, any information given by the mental health provider to other professionals will be maintained as confidential. Neither parent shall nor will either parent permit his or her attorney to subpoena the information contained in this specific file or to subpoena the child's therapist for purpose of litigation related to custody, separation or divorce. Any party (or his or her attorney who seeks to interrogate the child's therapist or subpoena the information in this separate file shall be liable for all attorney fees and costs incurred to resist answering discovery requests or to quash a subpoena. I understand that this agreement is being made because it is in the best interest of the child(ren) to have confidential counseling services through the legal family proceedings.

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Child's name

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Parent

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Date

---

Therapist

---

Date

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## CONSENT TO PROVIDE SERVICES TO A MINOR

Name of Client/child: \_\_\_\_\_ Date of birth: \_\_\_\_\_

I \_\_\_\_\_

(Print name of Responsible party or parties)

(Relationship to Minor)

Herby authorize Love the Journey to provide therapeutic and support services to the above named minor\* child. I/we understand that treatment goals, frequency, and estimated length of treatment will be established on a case by case basis.

There is Limited Access to personal information to ensure a healthy therapeutic relationship. Information will be given based on the clinical/professional opinions for the child with the child's best interest in mind. Parents have a right to a copy of the DA, treatment plan(s), and progress notes upon written request.

I acknowledge receipt of the Notice of Privacy Practices and Client Bill of Rights.

\*If there is a report of sexual or physical abuse, thoughts or actions towards suicide (unable to safety plan), homicide or neglect will be reported.

\*It is the practice of Love the Journey to honor the consent of both custodial parents when applicable.

\* I understand that I may revoke this consent at any time in writing and that this consent expires upon completion of the goals listed in the individualized treatment plan.

\* A minor is any client age 17 and under.

\_\_\_\_\_

Signature of responsible party

\_\_\_\_\_

Signature of 2<sup>nd</sup> responsible party if app

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Staff

\_\_\_\_\_

Date

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**CONSENT TO PROVIDE THERAPY IN A SCHOOL**

Name of Client/child: \_\_\_\_\_ Date of birth: \_\_\_\_\_

I \_\_\_\_\_

(Print name of Responsible party or parties)

(Relationship to Minor)

Herby authorize Love the Journey to provide therapeutic and support services to the above named minor\* child in his or her school. I/we understand that treatment goals, frequency, and estimated length of treatment will be established on a case by case basis.

If the school is unable or unwilling to provide space for medical necessary therapy appointment, I give my permission to Lori Petersen at Love the Journey to transport my child back to her office at 23 Pine St N, Mora MN and drive him/her back to school. I will not hold Love the Journey or Lori Petersen liable for an automobile accident. In return she agrees to follow all traffic rules.

\* I understand that I may revoke this consent at any time in writing.

\* A minor is any client age 17 and under.

\_\_\_\_\_

Signature of responsible party

\_\_\_\_\_

Signature of 2<sup>nd</sup> responsible party if app

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Staff

\_\_\_\_\_

Date

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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 \_\_\_\_\_

# Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behavior over the last six months.

Your child's name .....

Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other youth, for example CD's, games, food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often loses temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Would rather be alone than with other youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally well behaved, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries or often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other youth or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, depressed or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often offers to help others (parents, teachers, children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets along better with adults than with other youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good attention span, sees chores or homework through to the end	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

**Please turn over - there are a few more questions on the other side**

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behavior or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes", please answer the following questions about these difficulties:

• How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties upset or distress your child?

Not at all	Only a little	A medium amount	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	A medium amount	A great deal
HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLASSROOM LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	A medium amount	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature .....

Date .....

Mother/Father/Other (please specify:)

**Thank you very much for your help**

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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)