2550 University Ave. W., Suite 435-S
St. Paul, MN 55114
Phone: 651-647-1900
Fax: 651-342-8023

# Welcome to MidWest Center for Personal & Family Development!

We are honored that you have asked us to assist you in managing the mental health needs of you or your loved one. We plan to treat our time together as if the future of your health depends upon it.

***That is because it does.***

As one of our clients, the most valuable element of your mental health is the expertise, care, and personal touch that we provide.

That is why we do such a thorough evaluation and ask so many questions before making recommendations about your treatment plan. We encourage you to ask us questions along the way so we can better understand and address each of your concerns.

If questions arise before your appointment, please do not hesitate to call us at **651-647-1900**. We want to make this a smooth and comfortable process for you.

Because we know how much you depend upon your health, we want you to know how much your health can depend upon us.

We know you have dozens of mental health providers from which you could choose. This is our chance to show you why thousands of clients choose to trust us.

Thank you for giving us the opportunity to assist you in achieving a better quality of life – *a life you control.*

Sincerely,

*The MidWest Center Team*

**PS: If you know someone who could benefit from a mental health check-up, we invite them to visit our website to take a FREE Screening Tool at [http://www.mentalhealthinc.com/screening-tools/](http://www.mentalhealthinc.com/screening-tools/)**

**Saint Paul – Main Office**
Court International
2550 University Ave. W.
Suite 435S
St. Paul, MN 55114-1096
Ph: 651-647-1900
Fax: 651-342-8023

**Burnsville**
14300 Nicollet Court
Suite 130
Burnsville, MN 55306
Ph: 651-647-1900
Fax: 651-342-8023

**Lake Elmo**
Eagle Point Office Center
8530 Eagle Point Blvd
Suite 100
Lake Elmo, MN 55042
Ph: 651-647-1900
Fax: 651-342-8023

**Saint Louis Park**
Sunset Business Park
5821 Cedar Lake Road S.
St. Louis Park, MN 55416
Ph: 651-647-1900
Fax: 651-342-8023

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# Important Policies

# IMPORTANT INFORMATION

Following is some important information about your care at MidWest Center for Personal & Family Development (MWC).

***Your Insurance Company:***
When insurance is filed, please remember that your insurance company has access to all your records. Also be advised that, even if your insurance policy includes mental health benefits, most insurance companies do not provide reimbursement for mental health services rendered to persons who are not diagnosed as having a mental disorder. Thus, if insurance is to be filed, the report must contain a diagnosis of a mental disorder. Although most insurance companies do not pay for marriage and family therapy, they may pay if a mental disorder is significantly contributing to the dysfunction in the marriage.

***Confidentiality:***
Most of the information a therapist collects about you will be classified as confidential. However, when insurance is involved MWC does not have control over and cannot assure its clients of confidentiality. That means employees of MWC, employees of the insurer and employees of contracted organizations of the insurer all have access to your chart. This is provided for in the insurance policy between you and your insurance company.

The client record is legally the property of MWC. However, clients may have access to information contained in the file, except in those cases where the release of such information may be deemed harmful to the client's well-being. Information can be released to others only upon written informed consent of the client.

In a few cases, information is unavailable to a client. Certain confidential data may be available only to the therapist and particular government agencies. Classified material falling into this category might deal with adoption, civil or criminal investigations, some medical data and the names of persons who report suspected abuse of children or vulnerable adults.

***Exceptions to Privacy:***
All members of the staff of the Clinic will hold information confidential except under the following circumstances:

- If a client threatens to harm someone (including self), a staff person must, by law, take appropriate action to ensure safety.
- If a client engages in irresponsible sexual activity while HIV positive.
- If a client uses recreational drugs or alcohol irresponsibly while pregnant.
- If a therapist suspects that a client is physically or sexually abusing a child or vulnerable adult, the therapist is required by law to report concern to the proper authorities.
- If a client is under age 18 and the therapist judges it is in the best interest of the client to share information.
- Requests from your insurance company.

MWC Professionals meet in consultation with other mental health professionals within this clinic. During those meetings, your situation may be reviewed. Mental health professionals seeing members of the same family or significant others may discuss your situation. If you have questions or concerns about this, please speak to your clinician.

***Children Visiting our Facility:***
If children accompany a client, either because the child(ren) is/are going to be seen by one of the clinicians, or simply because they are with the parent, please be advised that our staff cannot assume responsibility for caring for them in the reception area. Children under age 10 cannot be left in the reception area unless accompanied by a person specifically responsible for their care.

***Emergencies:***
If you have a mental health crisis during business hours, try to contact your clinician at the number they provide to you. Listed below are some phone numbers you may want to keep with you in case of emergency and your clinician is not immediately available.

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**24 Hour Emergency Mental Health Response**

- If you live in Anoka County for adults and children call: 763-755-3801
- If you live in Carver or Scott County for adults and children call: 952-442-7601
- If you live in Dakota County for adults and children call: 952-891-7171
- If you live in Hennepin County for children call: 612-348-2233
- If you live in Hennepin County for adults call: 612-596-1223
- If you live in Ramsey County for children call: 651-774-7000
- If you live in Ramsey County for adults call 651-266-7900
- If you live in Washington County for adults and children call: 651-777-5222
- National Suicide Prevention Lifeline: 800-273-8255
- Behavioral Emergency Center, University of Minnesota Medical Center: 612-672-6600

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# CLIENT RIGHTS

***Bill of Rights:***
Consumers of professional mental health services have the right:
(a) to expect that the professional consulted has met minimal qualifications of training and experience commensurate with service requirements and in accordance with professional and/or disciplinary standards.
(b) to be informed of the credentials of those by whom they are served;
(c) to be informed of the cost of professional services prior to receiving those services;
(d) to privacy as defined by rule and law;
(e) to be free from being the subject of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services;
(f) to have access to their records as a provided in Minnesota Statutes, section 144.335 subdivision 2; and
(g) to be free from exploitation for the benefit or advantage of a clinician.

***Professional Boundaries:***
Clinicians must not, under any circumstances, be involved with their clients in a sexual way. They may not "date" or behave with their clients in a "dating" manner. They are not to be involved in social relationships/functions with their clients. This prohibits going to lunch/dinner with clients.

***Complaints:*** If you are dissatisfied with the services you are receiving, please immediately discuss your concerns with your clinicians. A clinicians needs honest feedback to be most effective. However, if you feel uncomfortable confronting your clinicians with your concerns or if you are not satisfied with the result when you express your concerns, please contact another clinicians on the staff.

In case you feel it is necessary to contact a professional group outside the clinic, it is your right to do so. Professional associations interested in promoting high quality services and professional ethics are:

Minnesota Psychological Association
Minnesota Board of Psychology
Minnesota Psychiatric Society
Minnesota Board of Medical Examiners
Minnesota Board of Marriage and Family Therapy
Minnesota Board of Social Workers
National Association of Social Workers
Minnesota Nurses Association
Minnesota Board of Nursing
American Association of Marriage and Family Therapists
Department of Human Services

***Other Rights:***
(a) A client has the right to refuse to give any information (however, by not providing necessary information the client will probably not fully benefit from the assistance being sought).

(b) A client has the right to challenge the accuracy of any of the information contained in the records; if a client wants to challenge any information, write to the Clinic Director, or talk with the responsible clinician. A challenge must be answered within 30 days.

(c) A client has the right to insert his/her own explanation of anything she/he objects to in his/her records.

***Client Services Committee***
Clients are invited to contact us with comments, questions, or concerns. Charges for emergency cancellations may be appealed to our Client Services Committee for consideration. Please send an e-mail via clientservices@midwestcenter4u.com or a letter attention: Client Services Committee, to the above address.

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# OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment. All clients must complete our registration forms before seeing a psychotherapist.

ALL CO-PAYS ARE DUE AT THE TIME OF YOUR SESSION UNLESS OTHERWISE AGREED UPON BY YOUR CLINICIAN. WE ACCEPT CASH, CHECKS OR CREDIT CARDS.

***Regarding Insurance:***
We may accept assignment of insurance benefits. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a 3rd party to that contract. In the event we do accept assignment of benefits and your insurance has not paid your account in full within 60 days, the balance will be automatically transferred to your responsibility. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance. Contact your employer or insurer if you have questions.

All co-pays are due at the time of your session when you use an insurance plan for which your clinician is a provider. In the event that your insurance coverage changes, it is your responsibility to notify us. If your new plan is one for which we are not participating providers, you are responsible for your account. Any follow up or reporting to 3rd parties that become necessary due to unpaid balances on your account, shall not be considered breach of confidentiality.

You must notify us in advance of your first appointment if you intend to use an Employee Assistance Program (EAP). Once services have been provided under insurance, we will not bill your EAP.

***Adult Patients***:
Adult patients are responsible for full payment of any co-pays at time of service.

***Minor Patients***:
Parents or guardians accompanying minors are responsible for payment of co-pays at the time of service. If a minor is accompanied by an adult other than a parent or guardian, payment is still expected at the time of service. For unaccompanied minors, your clinician may be willing to make arrangements for you to be billed and pay for co-pays by mail.

***Missed Appointments:***
For ALL appointments, unless canceled with at least 24 hours notice, a charge of $75.00 will be applied to your account. Charges for "emergency" cancellations will be considered. This charge is normally not payable by your insurance and will be billed as your responsibility. Please help us serve you better by keeping scheduled appointments. Clients with two or more unpaid missed appointment fees are subject to termination of care.

***Fee Schedule:***
Fees are based on length and type of psychotherapeutic session provided. Additional fees for reports/letters, psychological testing, phone consultations and therapy groups may apply. Some or all additional services may not be covered by your insurance and will be billed at an hourly rate. Please consult your clinician with questions.
***Service/Finance Charges***:
• A monthly finance charge of 1.5 % is charged for balances exceeding 30 days.
• Accounts exceeding 90 days may be reported to a collection agency.
• There is a $25.00 service charge for returned checks.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

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# NOTICE OF PRIVACY PRACTICES

**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.**

## Minnesota Patient Consent for Disclosures

For most disclosures of your health information, we are required by State of Minnesota Laws to obtain a written consent from you, unless the disclosure is authorized by Law, court ordered or subpoena, or for public health purposes through the Minnesota Department of Health Activities. This consent may be obtained at the beginning of your treatment, during the first delivery of health care service, or at a later point in your care, when the need arises to disclose your health information to others outside of our organization.

## Our Clinic's Responsibilities:

• We are required by law to maintain the privacy and security of your protected health information.
• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

## Our Clinic's Uses and Disclosures:

We typically use or share your health information in the following ways:
• **Treat you:** We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
• **Run our organization:** We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*
• **Bill for your services:** We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

We are allowed or required to share your information in some ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.
• **Help with public health and safety issues:** We can share health information about you for certain situations such as:
  - o Preventing disease
  - o Helping with product recalls
  - o Reporting adverse reactions to medications
  - o Reporting suspected abuse, neglect, or domestic violence
  - o Preventing or reducing a serious threat to anyone's health or safety
• **Do research:** We can use or share your information for health research.
• **Comply with the law:** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
• **Respond to organ and tissue donation requests:** We can share health information about you with organ procurement organizations.
• **Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

• **Address workers' compensation, law enforcement, and other government requests:** We can use or share health information about you:
  - o For workers' compensation claims
  - o For law enforcement purposes or with a law enforcement official
  - o With health oversight agencies for activities authorized by law
  - o For special government functions such as military, national security, and presidential protective services
• **Respond to lawsuits and legal actions:** We can share health information about you in response to a court or administrative order, or in response to a subpoena.

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**Your Rights Name:**

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

• **Get an electronic or paper copy of your medical record:** You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
• **Ask us to correct your medical record:** You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
• **Request confidential communications:** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
• **Ask us to limit what we use or share:** You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
• **Get a list of those with whom we've shared information:** You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
• **Get a copy of this privacy notice:** You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
• **Choose someone to act for you:** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
• **File a complaint if you feel your rights are violated:** You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

**Your Choices**

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

**In these cases, you have both the right and choice to tell us to:**
• Share information with your family, close friends, or others involved in your care
• Share information in a disaster relief situation
• Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

**In these cases we never share your information unless you give us written permission:**
• Marketing purposes
• Sale of your information
• Most sharing of psychotherapy notes

**In the case of fundraising:**
• We may contact you for fundraising efforts, but you can tell us not to contact you again.

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**Changes to the Terms of this Notice:** We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

**If you have questions or concerns regarding your privacy rights or the information in this notice,** please contact MidWest Center for Personal & Family Development.
**Privacy Official:** Molly Kehr, MA, LMFT
**Address:** 2550 University Ave. W., Suite 435-S
Saint Paul, MN 55114
**Phone Number:** 651-647-1900

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html Saint Paul, MN 55114

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# Client Registration Form

## Client Information

| Client Name: | | Gender: | Date of Birth: | |
|---|---|---|---|---|
| Address: | Home Phone No. | Work Phone No. | Cell Phone No. | Employment/Student Status: |
| | Employer/School Name: | Occupation: | Email Address: | |

Is it OK to call you at the #'s listed above about your account? ☐ Yes ☐ No

I would like to receive appointment reminders via: ☐ Text ☐ Email

Who is responsible for this account? (If different than "Self" as listed above, please list Name/Address/Phone)

| In case of an emergency, please call (Name and phone #): | Whom May We Thank For Referring You To Us? |
|---|---|

| Race: | Ethnicity: | Preferred Language: | Smoking Status: |
|---|---|---|---|

## Insurance Information

We cannot guarantee insurance coverage by your insurance carrier. The information below will assist us in determining if some of the expenses are reimbursable by your HMO or insurance carrier. **We will ask for a copy of your insurance card and a form of ID at your first appointment.**

| **Primary Insurance Carrier:** | ID#: | Group #: |
|---|---|---|
| Name of Insured: | Relationship to Insured: | Date of Birth: |
| Street Address: | Home Phone No. | Work Phone No. |
| City, State, Zip: | Employer: | |

| **Secondary Insurance Carrier:** | ID#: | Group #: |
|---|---|---|
| Name of Insured: | Relationship to Insured: | Date of Birth: |
| Street Address: | Home Phone No. | Work Phone No. |
| City, State, Zip: | Employer: | |

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Authorization and Release

## FINANCIAL POLICY / MISSED APPOINTMENT POLICY

My signature below indicates that I have been provided with a copy of the Financial Policy and Missed Appointment Policy. I understand that I am financially responsible for all appointments, unless cancelled with at least 24 hours' notice; a charge of $75 per scheduled hour will be applied to my account.

## IMPORTANT INFORMATION AND CLIENT RIGHTS

My signature below indicates that I have been provided with a copy of the Important Information and Clients Rights form.

## ASSIGNMENT OF BENEFITS

I hereby certify that I (or my dependent) have insurance coverage as noted and authorize direct payment to MidWest Center for Personal & Family Development of any medical benefits otherwise payable to me for services provided by a clinician affiliated with MidWest Center for Personal & Family Development. I understand that I am financially responsible for all charges whether or not paid by insurance.

## RECORDS RELEASE

I hereby authorize MidWest Center for Personal & Family Development to release all information necessary to my insurance company for the purpose of processing my insurance claims and to mail patient statements. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payer.

## NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been provided with a copy of the Notice of Privacy Practices.

## CONTACT INFORMATION

MidWest Center for Personal & Family Development considers your e-mail address and other contact information to be confidential and will not disclose it to outside entities. If indicated on the Client Registration form, I agree to receive appointment reminders via text or email.

## CONSENT FOR THERAPY/CERTIFICATE OF CUSTODY

☐ Parents are married to each other and are both legal parents of the child/children
☐ I am a single or remarried parent and have full legal custody of the child/children.
☐ The child/children's other parent and I share legal custody (Legal documentation may be requested.)
☐ The child is in the custody of the State of Minnesota.

County: _____

Name of person authorized to consent for services: _____

☐ I am an adult seeking assessment and therapy for myself.

By signing this form, I state the above is true, and I authorize Midwest Center for Personal & Family Development to carry out mental health assessment and treatment. I understand the purpose of these procedures will be explained to me upon my request, and that they are subject to my agreement. I also understand that while the course of my assessment and treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment.

If I am a parent or guardian of a client, I understand that I have a right to information concerning my minor child in therapy, except where otherwise stated by state and federal law and rule. I also understand that this clinician believes in providing a minor child with a private environment in which to disclose himself/herself to facilitate therapy. I therefore give permission to the clinician to use his/her discretion, in accordance with professional ethics and state and federal laws/rules, in deciding what information revealed by my child is to be shared with me. I understand that the clinician will inform me of any risk to my child with which I can help.

**I give consent to receive therapy at Midwest Center for Personal & Family Development and have been provided a copy of the Important Policies. (please sign and date)**

**CLIENT SIGNATURE: _____ DATE: _____**
(Signature of Parent, Guardian, or Authorized Representative if a Minor)

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# MidWest Center for Personal and Family Development (MidWest Center)
# Request for Services Information Form

Name: _____ Date of Birth: _____

**Referral Information:**

How did you learn about MidWest Center? _____

Who referred you to MidWest Center (ie: doctor, friend, self-referral, insurance)? _____

_____

Reasons for seeking services from MidWest Center? _____

_____

_____

_____

What do you hope to accomplish by obtaining services from MidWest Center? _____

_____

_____

_____

**Demographic Characteristics:**

Education: _____

Relational Status: _____

**Additional Information:**

Describe any additional background, demographic, or situational information that you feel is important to understanding you and your request for services. _____

_____

_____

_____

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**Concerns, Issues, Problems, and Symptoms:**
Have you been experiencing any of the following concerns, issues, problems, or symptoms? Check all that apply:

| Difficulty with: | Now | Past | | Difficulty with: | Now | Past | | Difficulty with: | Now | Past |
|---|---|---|---|---|---|---|---|---|---|---|
| Anxiety | ☐ Now | ☐ Past | | Motivation | ☐ Now | ☐ Past | | Academic/Educational issues | ☐ Now | ☐ Past |
| Depression | ☐ Now | ☐ Past | | Loss of interest | ☐ Now | ☐ Past | | Occupational/Vocation or work problems | ☐ Now | ☐ Past |
| Mood changes | ☐ Now | ☐ Past | | Memory | ☐ Now | ☐ Past | | Delusions, hallucinations (hearing/seeing things) | ☐ Now | ☐ Past |
| Fear | ☐ Now | ☐ Past | | Impulse control | ☐ Now | ☐ Past | | Beliefs that you have special powers | ☐ Now | ☐ Past |
| Panic Attacks | ☐ Now | ☐ Past | | Organization | ☐ Now | ☐ Past | | Bizarre/Unusual experiences | ☐ Now | ☐ Past |
| Irritability | ☐ Now | ☐ Past | | Completing tasks | ☐ Now | ☐ Past | | Grief/Loss | ☐ Now | ☐ Past |
| Excessive worry | ☐ Now | ☐ Past | | Obsessive thinking | ☐ Now | ☐ Past | | Marriage/Partner | ☐ Now | ☐ Past |
| Stress | ☐ Now | ☐ Past | | Compulsive behaviors | ☐ Now | ☐ Past | | Relationships (home, work, school) | ☐ Now | ☐ Past |
| Anger/Temper | ☐ Now | ☐ Past | | Hoarding/difficulty getting rid of things | ☐ Now | ☐ Past | | Parenting issues | ☐ Now | ☐ Past |
| Guilt | ☐ Now | ☐ Past | | Changes in appetite/ Weight loss or gain | ☐ Now | ☐ Past | | Employment | ☐ Now | ☐ Past |
| Worthless | ☐ Now | ☐ Past | | Body image | ☐ Now | ☐ Past | | Finances/Money | ☐ Now | ☐ Past |
| Hopeless | ☐ Now | ☐ Past | | Binging, purging, restricting, or overeating | ☐ Now | ☐ Past | | Gambling | ☐ Now | ☐ Past |
| Shame | ☐ Now | ☐ Past | | Low self esteem | ☐ Now | ☐ Past | | Legal problems | ☐ Now | ☐ Past |
| Intrusive thoughts | ☐ Now | ☐ Past | | Drugs | ☐ Now | ☐ Past | | Sexual problems | ☐ Now | ☐ Past |
| Sleeping too much/too little | ☐ Now | ☐ Past | | Alcohol | ☐ Now | ☐ Past | | Sexual orientation/ Gender identity | ☐ Now | ☐ Past |
| Difficulty staying asleep | ☐ Now | ☐ Past | | Feeling sick often | ☐ Now | ☐ Past | | Sexual/Physical/ Emotional abuse | ☐ Now | ☐ Past |
| High/low energy | ☐ Now | ☐ Past | | Physical pain (head, stomach, body) | ☐ Now | ☐ Past | | Domestic violence | ☐ Now | ☐ Past |
| Nightmares | ☐ Now | ☐ Past | | Shortness of breath | ☐ Now | ☐ Past | | Thoughts of hurting self | ☐ Now | ☐ Past |
| Hyperactivity | ☐ Now | ☐ Past | | Heart palpitations | ☐ Now | ☐ Past | | Thoughts of hurting others | ☐ Now | ☐ Past |
| Concentration/ Attention | ☐ Now | ☐ Past | | Isolation/Withdrawn | ☐ Now | ☐ Past | | Thoughts of suicide or suicide attempt | ☐ Now | ☐ Past |
| Careless mistakes | ☐ Now | ☐ Past | | Traumatic Experience | ☐ Now | ☐ Past | | Other: | ☐ Now | ☐ Past |
| | | | | | | | | Other: | ☐ Now | ☐ Past |

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# Patient Health Questionnaire 9 (PHQ-9) FOR TEENS

NAME:_____ DATE:_____

| 1. **Over the *last* 2 weeks, how often have you been bothered by any of the following problems?** (circle the best answer) | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
|---|---|---|---|---|
| a. Feeling down, depressed, or hopeless. | 0 | 1 | 2 | 3 |
| b. Little interest or pleasure in doing things. | 0 | 1 | 2 | 3 |
| c. Trouble falling or staying asleep, or sleeping too much. | 0 | 1 | 2 | 3 |
| d. Poor appetite, weight loss, or overeating. | 0 | 1 | 2 | 3 |
| e. Feeling tired or having little energy. | 0 | 1 | 2 | 3 |
| f. Feeling bad about yourself-or that you are a failure or have let yourself or your family down. | 0 | 1 | 2 | 3 |
| g. Trouble concentrating on things, such as school work, reading or watching television. | 0 | 1 | 2 | 3 |
| h. 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 |
| i. Thoughts that you would be better off dead or of hurting yourself in some way. | 0 | 1 | 2 | 3 |

2. **In the past year have you felt depressed or sad most days, even if you felt OK sometimes?** ☐YES ☐NO
3. **If you circled *any* problems on this questionnaire so far, 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
4. **Has there been a time in the past month that you have had serious thoughts about ending your life?**
   ☐YES ☐NO
5. **Have you <u>ever</u>, in your whole life, tried to kill yourself or made suicide attempts?**
   ☐YES ☐NO

MidWest Center For Personal & Family Development

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# Severity Measure for Generalized Anxiety Disorder – Child Age 11-17

NAME:_____ DATE:_____

Sex: ☐ Male ☐ Female

**Instructions:** The following questions ask about thoughts, feelings, and behaviors, often tied to concerns about family, health, finances, school, and work. Please respond to each item by selecting a response for each row.

| **During the PAST 7 DAYS, I have…** (circle the best answer) | **Never** | **Occasionally** | **Half the time** | **Most of the time** | **All the time** |
|---|---|---|---|---|---|
| 1) Felt moments of sudden terror, fear, or fright. | 0 | 1 | 2 | 3 | 4 |
| 2) Felt anxious, worried, or nervous. | 0 | 1 | 2 | 3 | 4 |
| 3) Had thoughts of bad things happening, such as family tragedy, ill health, loss of a job, or accidents. | 0 | 1 | 2 | 3 | 4 |
| 4) Felt a racing heart, sweaty, trouble breathing, faint, or shaky. | 0 | 1 | 2 | 3 | 4 |
| 5) Felt tense muscles, felt on edge or restless, or had trouble relaxing or trouble sleeping. | 0 | 1 | 2 | 3 | 4 |
| 6) Avoided, or did not approach or enter, situations about which I worry. | 0 | 1 | 2 | 3 | 4 |
| 7) Left situations early or participated only minimally due to worries. | 0 | 1 | 2 | 3 | 4 |
| 8) Spent lots of time making decisions, putting off making decisions, or preparing for situations, due to worries. | 0 | 1 | 2 | 3 | 4 |
| 9) Sought reassurance from others due to worries. | 0 | 1 | 2 | 3 | 4 |
| 10) Needed help to cope with anxiety (e.g., alcohol or medication, superstitious objects, or other people). | 0 | 1 | 2 | 3 | 4 |

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NAME: _____ DATE: _____

## Kiddie-CAGE

1. Have you used more than one chemical at the same time in order to get high? ☐ Yes ☐ No
2. Do you avoid family activities so you can use? ☐ Yes ☐ No
3. Do you have a group of friends who use? ☐ Yes ☐ No
4. Do you use to improve your emotions such as when you feel sad or depressed? ☐ Yes ☐ No

*When paraphrasing, it is important to keep the meaning of the bolded text intact.
Scoring: Each question is scored 1 point.
A score of 2 or more indicates the likelihood of a substance use disorder.

Ken Winters, Ph.D., Department of Psychiatry, University of Minnesota, Unpublished, 2001.

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# PRIMARY CARE PHYSICIAN: RELEASE OF INFORMATION

Client Name: _____ DOB: _____

**Do you currently have a Primary Care Physician (circle one)**: **YES** **NO**
****If you circled NO, please just sign/date below*
****If you circled YES, please complete the form and sign/date below*

**What is Coordination of Care?** A collaborative effort between MidWest Center and your Primary Care Physician to provide optimal treatment for your overall health.
**What is the Coordination of Care Letter?** A letter sent after your initial appointment and periodically throughout your treatment to your Primary Care Physician which includes the following information:

- ✓ MidWest Center Provider(s)
- ✓ Appointment History
- ✓ Diagnosis(es)
- ✓ PHQ-9 Score (if available)
- ✓ Diagnostic Assessment
- ✓ Brief summary of treatment

**Please check what protected health information you authorize MidWest Center to disclose to your Physician:**

☐ I do NOT want MidWest to coordinate care/disclose information to my Primary Care Physician
☐ I authorize ONLY the Coordination of Care Letter to be sent to my Primary Care Physician
☐ I authorize the Coordination of Care letter AND exchange of the information below by mail, fax, or verbally:

*Please check what type(s) of protected health information you authorize to be released:*
☐Complete Record ☐Initial Evaluation ☐Medical Record(s) ☐Testing ☐Discharge Summary
☐Other (please specify): _____

Primary Care Provider: _____

Clinic Affiliate: _____

Address: _____

Phone: _____ Fax: _____

**Consent is valid for ONE YEAR from Signature Date or revocation by client.**

Purpose of Disclosure: Coordination of Care

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in compliance of this consent. This authorization will be effective for medical/treatment records generated to the date of signature, and the release of medical records created after the date of signature until the expiration date or the release is revoked by myself in writing. If revocation is not received, authorization will be considered valid for a period of time not to exceed one year.

The facility, its employees, officers, and attending physician are released from legal responsibility or liability for the release of the above PHI to the extent indicated and authorized herein.

I understand that the PHI released could contain reference to Substance Abuse, Psychological and/or Psychiatric Impairment. The information disclosed is restricted to the minimum amount necessary to accomplish the intended purpose. The information used or disclosed may no longer be protected once it is used or disclosed in accordance with this authorization.

I understand that, except for research-related treatment, MidWest Center will not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. This authorization for disclosure of information has been fully explained to me and I understand it. I have been offered a copy of this form.

SIGNED: _____ DATE: _____
(Signature of Parent, Guardian, or Authorized Representative if a Minor)