Brian Ross, LMFT

Date_____

Accept Assignment:_____Yes_____No

Dx:_____

Patient Information

Patient Name (Print)_____Date of Birth_____

Cell Phone:_____

Street Address_____Home Phone_____

Okay to Leave Message?____Yes____No

City_____State_____ZIP_____Work Phone_____

Okay to Leave Message?____Yes____No

Soc Sec#:_____Emergency Contact_____Emergency Phone_____

Sex: ____M ____F Age_____ Marital Status: ____Single ____Married ____Widowed ____Divorced ____Partnered

Employer_____Occupation_____E-Mail:_____

Referred by_____May we acknowledge this referral?_____

Primary Insurance Company_____Phone_____

Ins Claims Address_____City_____State_____Zip_____

Policy/ID_____Group/Plan ID_____

Name of Policyholder_____Relationship_____

Address_____City_____State_____Zip_____

Soc Sec #_____Employer_____Policyholder's Date of Birth_____

Secondary Insurance Company_____Phone_____

Ins Claims Address_____City_____State_____Zip_____

Policy/ID_____Group/Plan ID_____

Name of Policyholder_____Relationship_____

Address_____City_____State_____Zip_____

Soc Sec #_____Employer_____Policyholder's Date of Birth_____

Responsible Party

Name_____Relationship_____

Address_____Phone_____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all necessary information to A.C.E. Billing, Inc, to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship Date

ADULT INTAKE FORM

Name: _____ Date of Birth: _____

Please answer these questions as completely as possible. You can discuss any topic more fully when you met with your therapist. It is your choice whether or not to answer any question. The purpose is to help your therapist understand you, your background, and your concerns.

Please describe the issue or concern that brings you to therapy, including specific symptoms or problems you most want to address:

Do you have any of the following symptoms regularly or severely enough to cause you concern?
Please complete by assigning a number to each problem listed, using the key below. Leave blank if you've never had the symptom. Use space next to an issue to provide more information, if you wish.

1 - In the past, but not now
2 - Some of the time
3 - Most of the time
4 - All of the time

____ ADD or ADHD concerns (even if undiagnosed)

____ Adoption issues

____ Alcohol or chemical abuse/dependency

____ Anger issues

____ Anorexia/bulimia/eating issues (binging, under/over-eating)

____ Anxiety/panic attacks

____ Attempting suicide

____ Avoidance of conflict

____ Bi-polar concerns

____ Body issues

____ Childcare/parenting

____ Child development/behavior problems

____ Cigarette addiction

____ Codependency

____ Communication problems

____ Compulsive/addictive behavior

____ Concern about another's alcohol or chemical use

____ Cyber/internet sex/pornography, computer gaming or online issues (i.e. over-use, compulsivity)

____ Depression

____ Dissociation

____ Divorce/separation

____ Elder parent issues

____ Fear/sense of not being safe

____ Feeling ashamed

____ Feeling guilty

____ Feeling sad

____ Feeling suicidal

____ Financial problems/concerns

____ Gender identity concerns

____ Isolation

____ Jealousy

____ Legal problems

____ Loneliness

____ Loss of concentration

____ Loss of energy

____ Loss/grief issues

____ Low self-esteem

____ Marital/couple conflict

____ Mood swings

____ Neglect

____ Occupational/job problems

____ Parent/child issues

____ Physical health issues

____ Physically/sexually abused as an adult

____ Physically/sexually abused as a child

____ School-related problems

____ Self-hate/self-loathing

____ Self-injury

____ Sexual identity/orientation

____ Sexual relationship issues

____ Sexuality concerns

____ Single parenting issues

____ Step-family issues

____ Verbal/emotional abuse

____ Other

Have your symptoms impacted your daily functioning or caused you any problems at school, work or home? Please describe:

How would you describe your emotional health at the present time?

____ Poor ____ Fair ____ Average ____ Good ____ Excellent

Have you sought therapy at other times in your life? ____ Yes ____ No

From when to when? _____

With whom? _____Was your experience helpful to you? _____

Please describe any current or significant past stressors in your life (school, work, relationships, financial, etc.)

Are you aware of any family history of alcoholism, addiction, depression, anxiety, bi-polar, schizophrenia, or other mental illness? ____ Yes ____ No Please describe:

Chemical Health History

Describe your current alcohol/drug use:

Amount? _____ Frequency? _____

Have others expressed concern about your alcohol or drug use? ____ Yes ____ No Who? _____

Have there been any negative consequences as a result of your alcohol or drug use? For example, DUIs, arrests, relationship difficulties, etc?

Previous treatment? ____ Yes ____ No If yes, where and when? _____

Are you worried about the drug or alcohol use of a significant person in your life - i.e. spouse, parent, child, sibling? ____ Yes ____ No If yes, please describe your concern:

Identity/Relationship Status

How do you identify your sexual orientation?

Are you: ____ Single ____ Married ____Divorced ____ Widowed ____ In a significant relationship

Pleases list the names and ages of the people you live with and their relationship to you:

_____
_____
_____

Please list the names and ages of any children you have who aren't living with you currently:

_____
_____
_____

Family History: Please provide the names and current ages of your parents or primary caregivers and your siblings. *If deceased, please indicate age and date of death.*

Patents/Caregivers: Siblings:

_____ _____

_____ _____

_____ _____

_____ _____

Pleases list any other significant adults who impacted your childhood:

Legal History:

Have you had any current or past problems with the legal system? Please describe:

Are you currently involved in any legal action/litigation?

Do the reasons you are seeking services at Lakewood have to do with legal issues? Please describe:

Occupation: _____ Employer: _____

How satisfied are you with your occupation?_____

Highest level of education achieved: _____

Interests/activities: *Please describe interests or hobbies and how you spend time during a typical day*.

Personal strengths/challenges: *Do you have any attributes that you consider to be strengths and are there areas you identify as being difficult for you?*

How would you describe your physical health at the present time?

____ Poor ____ Fair ____ Average ____ Good ____ Excellent ____ Not sure
Explain:

Date of your last physical exam and name of your physician and/or psychiatrist. Which clinic/office?

Current medications:

Name	For what condition	Date began	Dosage

Have you experienced any significant illnesses, accidents or surgeries? Please describe:

Describe the physical fitness program you follow, if any:

Spiritual/Religious Belief System:

Do you actively participate in a faith community? ____ Yes ____ No If yes, pleases identify that community:

How important is your faith to you?

What kind of a support system do you have?

Is there anything more that you want to share?

Emergency Contact: _____ Phone: _____ Relationship to you _____

Signature _____ Date _____

Adolescent Intake Form

Name:_____ Age:_____ Cell # :_____

Please answer these questions as completely as possible. You can discuss any topic more fully when you meet your therapist. It is your choice whether or not you answer any specific question(s). The purpose of this form is to help your therapist understand you, your background, and your concerns. This will not be shared with anyone else parents. THIS IS FOR YOUR THERAPIST ONLY.

***Please describe the issue or concern that brings you to therapy, including specific symptoms or problems you MOST want to address:**

Check any of the following statements that are true for you. *USE SPACE NEXT TO STATEMENT TO PROVIDE MORE INFORMATION, IF YOU WISH.*

___ I've been told or think I have ADD/ADHD

___ Others have expressed worry about my eating habits

___ I get angry a lot

___ I worry often

___ I think about hurting or killing myself

___ At times, my life or future seems hopeless

___ I'm comfortable with my eating habits

___ My parents think I sleep too much

___ Thoughts seem to race in my head a lot

___ I have a hard time concentrating when I need to

___My energy levels are lower than I'd like

___ I get frustrated easily

___ My mood seems to go up and down quickly and/or severely

___ I avoid conflict

___ I feel stressed a lot

___ I feel successful about school

___ I cry quite a lot

___ I get angry and I don't know why

___ I feel guilty about things often

Check any of the following statements that are true for you. ***USE SPACE NEXT TO STATEMENT TO PROVIDE MORE INFORMATION, IF YOU WISH.***

___ I get sad for no reason

___ I'm scared at home and/or school

___ I get all of my homework done on time

___ I'm bored with school

___ I have trouble falling and/or staying asleep

___ Myself or others have said they think I sleep too much

___ I have good friends

___ I feel supported by my family

___ My parents do not like my friends

___ I'm happy with my success in school

___ I feel people in my family do not care about me

___ My parents and I get along pretty well

___ My siblings and I get along fine

___ My friends have said that they worry about me

___ My parents put too much pressure on me

___ I worry about someone in my family

___ There is a lot of conflict in my house

___ My parents are too controlling

___ I have trouble making or keeping friends

___ I like myself

___ I know what I am good at

___ I feel my strengths outweigh my weaknesses

___ I feel comfortable at my school

___ I am comfortable with my looks

___ My weight is an issue for me

___ I wish I could change certain things about me or my life or family

___ I am sexually active

___ I have concerns about certain sexual things

___ My parents and/or friends express worry about my sexual activity

Check any of the following statements that are true for you. ***USE SPACE NEXT TO STATEMENT TO PROVIDE MORE INFORMATION, IF YOU WISH.***

___ I am often very jealous of certain people and it bothers me / others

___ I am NOT clear about my sexual orientation and/or gender (gay, straight, bisexual, transgender)

___ I like being in committed relationships

___ My culture, religion, and/or ethnicity is an issue for me

___ I have experience with drugs and alcohol

___ I currently use drugs and/or alcohol

___ Others have expressed worry or concern about my use of drugs and/or alcohol

___ I have been in trouble with the legal system before

___ I am concerned about someone else's use of drugs and/or alcohol

___ Sometimes I think I overuse the internet, videogames, etc.

___ Sometimes I think I overuse pornography or I may have a pornography addiction

___ My parents think I am addicted to screens/electronics

Are you currently having any other *specific* problems at work, school, home? Please describe:

Chemical Health History (Alcohol, Illegal Substances, Non-Prescribed Substances, Tobacco, other)

Substance	Age When 1st Tried	Date of most recent Use	Frequency of Use in Last Six Months (how often)	Amount Used Typically

Have there been any negative consequences as a result of your chemical use? i.e., DUI's, arrests, charges, relationship difficulties, etc. If yes, please describe.

Previous chemical abuse treatments? Describe (where, when, comments):

OVER →

My personal strengths:

My personal challenges/weaknesses:

Losses I have experienced (Who/What?... ..When?..... How/Why?.)

Something that I would change about my family:

What do you want to get out of therapy?

Would doing family therapy be helpful in addition to your individual therapy? How? What issues would YOU address in family therapy?

Is there anything else you want to share?:

THANK YOU!!

Brian T Ross LMFT

Welcome

6607 18th Ave. S. (Suite 101) Richfield, MN 55423
Telephone: 612-798-7373 x17

I am a highly skilled therapist dedicated to serving your special needs and concerns. In a setting that is caring, supportive and ethical, I work to empower individuals, couples and families to manage their own well-being.

Patient Satisfaction
Thank you for trusting my ability to provide you with appropriate, high quality care. I will make every effort to treat each client with respect and dignity regardless of race, beliefs, national origin, source of payment, age, religion, disability, or sexual preference.

If you experience a problem with any service, please discuss this with your therapist. If the situation is not resolved, or if the nature of the concern prohibits such discussion, please contact the professional licensing board.

Financial Responsibility
I request payment at the time of service. A.C.E. billing will submit your insurance claims. I am an out of network provider for most insurance companies, you will want to check with your insurance plan to find out what coverage you have for out-of-network benefits. Some insurance plans limit the number of sessions covered so you will want to understand the benefits available to you.

Initial Appointment
Your first appointment will take approximately one hour. During this appointment, you can discuss your situation and concerns with me. After this initial appointment, an assessment and recommendation for treatment will be made. We require a 24-hour notice to change or cancel an appointment Missed or cancelled appointments without the 24-hour notice will be charged at the regular rate.

Confidential Information
Information you furnish to me is confidential according to the Minnesota Access to Health Records Statute. This means that only you and restricted, authorized personnel have access to information in your medical chart. No treatment information will be released to persons, schools, or agencies without your consent, except by court order. If you choose to give your permission, be sure that you understand what information will be released and how it will be used.

If it appropriate to coordinate your care with your primary care physician, you will be asked for your written permission to do so. Your insurance company may require information about your care prior to providing payment of services.

There are some exceptions to confidentiality. For example:

- ❑ Health care providers are required by law to report cases of known or suspected abuse or neglect of children or vulnerable adults.
- ❑ In cases of threatened homicide or serious harm, the police and possible victim must be notified.
- ❑ In cases of threatened suicide, the police will be called.
- ❑ By law, information concerning dependent minors is accessible to the parents unless it is determined that such access would be harmful to the minor.

Clients under the age of 18:
All non-emancipated minor clients under the age of 18 years old must have the consent of their parents following an initial intake session to receive further services.

All minors have the right to request that their records be withheld from their parents. No information will be provided to parents of minors without the consent of the client.

As a client, you have the right to:
- ❑ Courteous and respectful treatment.
- ❑ A safe and comfortable environment
- ❑ Appropriate behavioral health care.
- ❑ A clear explanation of your diagnosis and treatment plan.
- ❑ Privacy and confidentiality.
- ❑ Participate in planning your care.
- ❑ Refuse behavioral health treatment.
- ❑ Be free from discrimination based on your religion, race, gender or culture.
- ❑ Register complaints.
- ❑ Access to your records as provided by law.

You are asked to:
- ❑ Treat staff with respect.
- ❑ Ask questions about your care.
- ❑ Tell your therapist everything you can about your condition, including all symptoms, medications, and past medical history.
- ❑ Pay your bills on time.
- ❑ Keep appointments, or give at least 24 hours notice if you need to cancel your appointment.
- ❑ Let the therapist know about any changes in your symptoms, medications or general condition.
- ❑ Treat clinic property with care.

Emergency Procedures:
For emergency situations you can call the Crisis Connection at 612-379-6363 or go to your nearest emergency room.

Business Services:
- ❑ Most therapeutic sessions will be 50 minutes in length. Longer sessions may be advisable based on the need and the therapeutic methods being used.
- ❑ Clients are asked to pay for each session at the time of service.
- ❑ For questions regarding scheduling, billing and payments, please talk with your therapist.
- ❑ Therapists will return calls within 24 hours with the exception of weekends. If an emergency arises and you are unable to reach your therapist, you can call the Crisis Connection or go to your nearest emergency room.
- ❑ Phone consultations with the therapist that exceed 10 minutes in length will be billed as a session and charge based on the time spent.
- ❑ You are expected to be here for each session that you schedule. The regular fee will be charged for sessions that are missed or cancelled without 24 hours notice.

Brian T Ross, LMFT

Informed Consent for Confidentiality

1. If anyone requests information about me, my therapist will not give it unless and until I have signed a separate written authorization for her to do so. My therapist will not discuss anything about me worth anyone without my written permission, except as noted here:

a. If I use insurance benefits, my therapist cannot guarantee confidentiality from the insurance company.
b. If my therapist learns that I have abused a child, a spouse or vulnerable adult (or if I am a child, spouse or vulnerable adult and report having been recently abused), she must report it to the proper authority.
c. If my therapist has good reason to believe that I intend to physically harm myself or someone else, she will discuss it with me and may be required to warn that person or persons (the Tarasoff duty), or to take steps to prevent such harm.
d. If my therapist has good reason to believe that I may be a danger to myself, she will contact at least one concerned person and/or take steps to prevent such harm.
e. If I give permission to release my records to a legal representative of my choice, these records could become discoverable by other legal representatives. If subpoenaed by the courts to release your records, we may have to do so.
f. My therapist may discuss my case with other clinicians. Identifying information (such as name) will not be shared without written permission.

2. All non-emancipated minor clients under the age of 18 years old must have the consent of their parents following an initial session to receive further treatment services. All minors have the right to request that their records be withheld from their parents. No information will be provided to parents of the minor without the knowledge of the client.

My signature indicates that I have read, discussed and understand this information.

_____ _____

Client/Parent/Legal Guardian Signature Date

Brian T Ross LMFT

Consent to use Disclosure of Healthcare Information for Treatment, Payment, or Healthcare Operations

This notice describes how Psychological and Medical information about you may be used and disclosed. Please review it carefully.

by signing this statement, I understand that as a part of my healthcare, Brian T Ross, LMFT originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. This information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that as a part of my treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I wish to have the following restrictions to the use or disclosure of my health information:

_____

(please list any restrictions)

I fully understand and accept the terms of this consent:

_____ _____

Client/ Parent/Legal Guardian Signature Date

I understand and have access to a *Notice of Information Practices* that provides a more complete description of all information uses and disclosures. I fully understand and accept the terms listed in that document including my rights and privileges as a client of Brian T Ross, LMFT:

_____ _____

Client/Parent/Legal Guardian Signature Date

Payment Agreement

I understand that I am responsible to pay for services received each time that I attend a session.

I further understand that cancelled appointments require at least 24 hour notice. In the case of a cancellation without 24 hour notice, a missed appointment or a late arrival, I may be charged for a full session. Insurance companies will not pay for appointments that are cancelled or missed.

The agreed upon fee for clinical services is as follows:

60 minute sessions: $165.00

75 minute sessions: $225.00

Group Sessions: $75.00

A service fee of $3.00/ transaction will be charged to all payments made by credit card.
A finance charge of 1.5% will accrue on accounts 90 days past due.
A $20.00 service charge will be added for returned checks.
A collections agency will be used for delinquent accounts.

I understand and agree to the above conditions:

_____

Client/Parent/Guardian Signature Date

PARENT INTAKE FORM

Date: _____ Therapist: _____

Adolescent's Name: _____ Age: ____ Date of Birth: _____

Main purpose for contacting Brian Ross (please give a brief summary):

_____
_____
_____
_____
_____

Parent's Name: _____ Occupation: _____
Address: _____ Home #: _____ Work#: _____
Cell#: _____ E-mail Address: _____

Parent's Name: _____ Occupation: _____
Address: _____ Home #: _____ Work#: _____
Cell#: _____ E-mail Address: _____

Parent's relationship: Married ____ Divorced ____ Never Married ____ Committed Partners ____
State of the relationship: _____

Adolescent lives with which parents: Both equally ____ Primarily with _____
Explain: _____

Siblings:

Name	Age	Check One: Biological	Adopted	Step	Foster

Who lives together in the home(s), include pets:

_____
_____

If adopted, significant aspects of the adoption:

_____
_____

What birth family information is available:

_____
_____
_____

Medical Information:

Name of Adolescent's Physician: _____Phone #: _____
Clinic Name: _____Address: _____
_____

Current medications (include dosages):

_____
_____

List any hospitalizations (include reason, age, length of time):

_____
_____
_____

Current medical problems:

_____
_____
_____

Any developmental concerns:

_____
_____
_____

Please check the items that are important to address with your child in therapy. Consider each in terms of your adolescent's experience:

___ Friendships
___ Anger
___ Eating habits
___ Behavior in school
___ Relationship with parents
___ School performance
___Drug/alcohol use
___ Sibling relationships
___ Anxiety/worry
___ Trouble concentrating/focus
___ Mood swings
___ Grief and loss
___ Independent living skills
___ Taking responsibility
___ Vocational issues
___ Cultural issues
___ Sexual orientation
___ Self-esteem
___ Depression
___ Sleep issues
___ Physical health
___ Legal issues
___ Sexual activity
___ Gender issues
___ Bullying

List the strengths of your adolescent:

_____
_____

What methods have you used to discipline your adolescent:

_____
_____

Which is most effective:

_____
_____

Has your adolescent been to therapy or counseling in the past? Yes ___ No ___
Was it helpful? Yes ___ No ___
What was the concern and how long did you attend counseling?
_____
_____
Therapist's Name:_____

Has your adolescent experienced physical abuse? No ___ Yes ___
Explain:_____
_____
Has your adolescent experienced neglect? No ___ Yes ___
Explain: _____
_____
Has your adolescent experienced sexual abuse? No ___ Yes ___
Explain: _____
_____
Has your adolescent experienced emotional abuse? No ___ Yes ___
Explain: _____
_____
Has your adolescent ever talked about suicide or made an attempt? No ___ Yes ___
Explain:_____
_____
Has your adolescent ever talked about or physically hurt an animal or another human being? No ___
Yes ___ Explain:_____
_____
Are there areas of concern about your adolescent's school experience?
_____
_____
_____
_____

What are the stressors on your adolescent (i.e. family death, illness, unemployment, divorce, change in school, friendships, etc.)?
_____
_____
_____
_____

Is there any other information you would like to share?
_____
_____
_____
_____

Signature: _____ Date: _____

Thank you