Cynthia White Meyer, LICSW

7260 University Avenue NE Suite 315
Fridley, Minnesota 55432
(651) 307-4899
CWMeyerLICSW@gmail.com

Client Identification Data

Client Name (Last) (First) (M)	Age	Birthdate	Sex

Address City/State/Zip

Cell phone: OK to call? _____	Home Phone: OK to call? _____	Work Phone: OK to call? _____

Marital Status
Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Email address:

Education (Highest degree/grade Completed)	Health Insurance Company Name	Health Insurance Member ID #
Health Insurance Group #	**Employer/ Occupation**	**Secondary Insurance Information**

Family History

Family Members	**Age**	**Emotional Problems**		**Living?**		**Occupation**
		Yes	**No**	**Yes**	**No**	
Spouse's Name						
Child's Name (if applicable)						
Child's Name (if applicable)						
Child's Name (if applicable)						
Child's Name (if applicable)						
Other significant person in your household						

Notify in case of emergency (Name, relationship, phone number for contact)

Address	Home Phone
Print Name of Client	Date
Signature of client or legal guardian	Date

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Health Data			
Your Physician (Full Name):			
Address (Clinic Name)	(Street)	(City)	(State/Zip)

Date of most recent physical: _____

Do you have any current medical problems (including any infectious diseases)? ___yes ___ no Please describe:

_____

_____

Are your medical problems being treated? _____ If yes, by whom? _____

Have you ever had a drug allergy or sensitivity? __yes __no If yes, to what drug:_____

Medications:

Current Meds: _____

_____

Prescribing MD:_____

Past trials of psychiatric meds:_____

_____

_____

Chemical Use History

Do you drink alcoholic beverages? __ Yes __No If yes, what do you drink __ Beer __ Wine __ Hard liquor

How often do you drink? ___Daily ___ 3-5 times weekly ___ 1-2 times weekly ___ Less frequently

Do you sometimes drink more than you had planned? ___Yes ___No

Have family and friends ever expressed concern about your drinking? ___Yes ___ No

Have you ever been arrested for alcohol related charges: DWI, public intoxication etc.? ___Yes ___ No

Have you ever been treated for drinking, chemical dependency or gone to AA? ___ Yes ____ No

Have you ever had periods where you were unable to remember what happened when you were drinking? __ Yes __No

Have you ever overdosed? ___yes ___no

Do you use nicotine? ___yes ___no If yes, how much and for how long: _____

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Counseling and psychiatric history: (dates of tx, hospitalization, provider/tx and outcome, etc)

__Outpatient tx __IOP __Partial hospitalization __Inpatient hospitalization __Residential tx

Name of Facility/Doctor/Address:

_____

_____

Additional info:_____

Any trauma history – accidents, injuries, illness, losses, death of loved one, other

_____

_____

Other factors that impact client's life (e.g. cultural issues, military, spiritual and/or legal issues)

Legal issues: __No __Yes (describe if yes)_____

Military: __No __Yes (describe if yes)_____

Cultural issues: __No __Yes (describe if yes_____

Spiritual beliefs/practices: _____

Abuse History

Hx of abuse: __no __yes If yes: __physical __sexual __verbal/emotional **Legal Action**: __no __yes

By: _____

When: _____

Family Mental Health History: (include family hx of suicide/homicide**)**

Maternal side: __depression __anxiety __bipolar __eating disorder __alcoholism __drugs __suicide

Paternal side: __depression __anxiety __bipolar __eating disorder __alcoholism __drugs __suicide

Additional information: (who, treatment, other diagnoses, etc)

_____

_____

Client's name: _____Date: _____

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Parent/Guardian _____

Presenting situation: (include reason for making appointment, precipitating events, onset, course of symptoms)

_____

_____

_____

_____

_____

_____

_____

_____

_____

Current Family and Significant Relationships: (Marital status, children, friendships, support people)

__Single ____Widow/widower ____Divorce __Married __Multiple Marriages (note details below) __Dating

If Female (ck if yes): miscarriages _____abortion (if yes, note # and when)_____

Spouse/Significant other described as:_____

_____

Mom described as: _____

Dad described as: _____

Any difficult relationships that you would like help with?

_____

_____

_____

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CLIENT NAME_____ **DATE**_____

Current Symptom Checklist: Rate the intensity of symptoms present in the last 4 weeks.

None: This symptom not present at this time
Mild: Impacts quality of daily life, but no significant impairment of day to day functioning
Moderate: Significant impact on quality of life and/or day-to-day functioning
Severe: Profound impact on quality of life and/or day to day functioning

Symptom	**None**	**Mild**	Moderate	**Severe**	**Symptom**	**None**	**Mild**	Moderate	**Severe**
Depressed Mood					Increased/decreased appetite				
Low Energy					Unplanned weight gain				
Sleep disturbance					Unplanned weight loss				
Dissociation					Paranoid thoughts				
Hyperactivity					Poor concentration or Indecisive				
Bingeing					Purging / Over-exercising				
Decreased Sex Drive					Excessive worrying				
Unresolved guilt					Impulsive actions/speech				
Irritability					Anger management problems				
Nausea/Acid indigestion					Daily Stress Level				
Social Anxiety					Hallucinations				
Self-mutilation/cutting					Racing thoughts				
Low self worth					Restlessness				
Nightmares					Loss of interest in normal activity				
negative voices inside					Decreased creativity/productivity				
Losing train of thought					Unresolved Anger				
Mood swings					Easily Distracted				
Disorganized					Memories of trauma				
Anorexia					Hopelessness				
Social Isolation					Marital problems				
Grief					Panic Attacks				
Phobia's					Suicidal thoughts				
Headaches					Feel panicky/anxious				
Loneliness					Work problems				
Viewing Pornography					Alcohol / drug Intake				
Problems at home					Attempted suicide in the past				

Briefly describe how the above symptoms impair your ability to function:

_____
_____
_____
_____
_____
_____
_____
_____

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Treatment Contract/Registration

WELCOME! The most important goal of therapy is to help you feel and do better in your life. As a client, you can help with your treatment by keeping the following information in mind throughout your therapy. This is a solution-focused, goal directed approach for a wide variety of problems, from crises in daily living to ongoing mental health issues. It is especially important that you keep in close contact with family or supportive friends during a crisis and that you assume responsibilities for helping yourself. Treatment will be provided in the least restrictive environment possible.

Standard therapy sessions are 45-50 minutes. While this can be somewhat flexible, the time frame will be maintained as much as possible to help all involved. Also this is a courtesy to others that may be waiting. If you are dissatisfied with your progress in therapy, please discuss this openly. Your input and concerns are very important and talking about them often leads to beneficial results for all involved.

Confidentiality: Please understand that what you say is CONFIDENTIAL and will be discussed with other people only with your written permission (except in medical emergencies, under a court order, or as required by law, i.e. mandatory child abuse reporting, and vulnerable adult abuse reporting or for the purpose of consultation or supervision). If there is a clear intention to do serious harm to self or to another person, information will be shared in an attempt to prevent that harm from occurring. Information regarding services provided to minor children can be given to parents on request as a matter of state law. If a minor child is seen, issues regarding confidentiality will be discussed with the parents. Insurance providers often require more detailed information of your situation prior to approval of continued treatment or payment for treatment. If you wish to know the informational requirements of your insurance company, please ask.

Office Hours and Cancellation Policy: Office hours vary. Therapy time is valuable to all involved. **Cancellations or changes of an appointment must be made at least 24 hours in advance or you will be charged for your session.** Please note that insurance companies do not pay for failed or canceled appointments. This is standard practice and is intended in part to preserve the time for those who may need it. See "Fees, Phone Calls and Reports" for specific fees. Please ask me about any questions you may have about this policy. You can make appointment changes by calling the office and leaving a message with your provider.

Consultation: To provide you with the best possible service, *Cynthia White Meyer, LICSW* engages in ongoing consultation with other mental health professionals. When discussing clients in these forums, confidentiality is protected.

Crisis Situations: Steps to take during a crisis will depend upon the nature of the crisis. You may call your individual therapist during normal business hours and then the Crisis Connection at 612-379-6363 after business hours, weekends and holidays. When immediate service is required for life threatening situations, please call 911 or go to the emergency department at the closest hospital.

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Fees, Phone Calls and Reports: Fees are as follows: $175 for the initial diagnostic session; $160 for individual and/or family follow-up sessions, training and/or consultation (whether in the office or by phone), $60 per session for group therapy.

Full payment (or co-payment if services are covered by insurance and any deductible has been satisfied) is due at the beginning of the therapy hour. There are not fees charged for phone calls, letters and reports to facilitate scheduling, information sharing, etc. and requiring up to 10 minutes of time. After 10 minutes, you are billed at a prorated $125 per hour rate. Scheduling paid telephone sessions is welcome when a situation is particularly urgent or because of travel or geographical difficulties. Failed individual/family appointments or cancellations made with less than 24 hour notice will be charged at $75. Failed or cancellations made with less than 24 hour notice for group therapy will be billed at the rate of $40 per missed session. Please note: **All payment, including copays/co-insurance, late cancel/failed appointment fees and unpaid claims from your insurance company is due prior to or at the time of service or your appointment will be rescheduled for a time after payment is received.**

Insurance and Bookkeeping: In many cases, insurance companies provide outpatient mental health benefits to their insured customers. **Please remember that services are provided for and charged to you, not to your insurance company. You are responsible for checking with your insurance company and/or your employer to be certain that they cover the services provided.** Because of the wide variety of insurance plans available guarantee cannot be made that any particular company will provide payment for services that you receive. If your insurance company does not cover the services you receive, you are fully responsible for the amount due. If you have any questions about obtaining coverage, please ask. However, your insurance carrier will make a decision about any reimbursement. With your permission, your insurance will be billed by this provider, unless you make other arrangements.

Collections: In case you do not pay your bill, Cynthia White Meyer, LICSW reserves the right to seek payment through the use of a collection agency or through other legal means. The cost of collection may be added to your bill. Return check fee is $35 and will be billed to you. Unpaid balances may incur reasonable and customary interest charges.

I understand and agree to abide by the policies stated above.

_____ _____
Client Signature Date

_____ _____
Parent Signature Date

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Registration: Crisis Coverage

Cynthia White Meyer, LICSW**,** understands that at times you may be in a psychological or life threatening crisis. Since therapists are frequently in sessions with other clients and thus may not be immediately available to assist you through your crisis we ask that you follow the crisis procedures outlined below. Please follow the crisis procedures outlined below.

In a crisis situation please do the following:

1. If you are in a life-threatening crisis please go the nearest emergency department or call 911 no matter what time of day it is.

2. If you are in urgent need to talk to your therapist, please call the therapist during normal business hours and listen closely to the voice mail directing you through steps for urgent calls. Include in any message you leave a phone number for a return call AND indicate that it is an urgent matter.

3. If you are in crisis after 5:00 pm Monday through Friday, on the week-ends or on holidays, you may call the Crisis Connection at (612) 379-6363. This is a free charge to you.

Signature indicates that you have read, understand and agree to the above.

_____ _____
Client Signature Date

_____ _____
Parent Signature Date

_____ _____
Therapist Signature Date

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NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES/Registration

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

Cynthia White Meyer, LICSW is committed to treating and using protected health information about you responsibly. This Notice of Health Information Privacy Practices describes the personal information I collect, and how and when I use or disclose that information. It also describes your rights as they relate to your protected health information.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Understanding Your Health Record/Information

Each time you visit Cynthia White Meyer, LICSW, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

4. Basis for planning your care and treatment,
5. Means of communication among the many health professionals who contribute to your care,
6. Legal document describing the care you received,
7. Means by which you or a third-party payer can verify that services billed were actually provided,
8. A tool in educating health professionals
9. A source of information for public health officials charged with improving the health of this state and the nation,
10. A source of data for our planning and marketing,
11. A tool with which I can assess and continually work to improve the services rendered and the outcomes achieved.

Your Health Information Rights

Although your health record is the physical property of Cynthia White Meyer, LICSW, the information belongs to you. You have the right to:

12. Obtain a paper copy of this notice of information practices upon request,
13. Inspect and copy your health record
14. Amend your health record
15. Obtain an accounting of disclosures of your health information
16. Request communications of your health information by alternative means or at alternative locations
17. Request a restriction on certain uses and disclosures of your information and revoke your authorization to use or disclose health information except to the extent that action has already been taken.

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NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES/Registration (2)

Responsibilities of My Practice

Cynthia White Meyer, LICSW is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to my legal duties and privacy practices with respect to information I collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if I am unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

I reserve the right to change my practices and to make the new provisions effective for all protected health information I maintain. Should my information practices change, I will give you in person, or mail a revised notice to the address you've supplied me.

I will not use or disclose your health information without your authorization, except as described in this notice. I will also discontinue using or disclosing your health information after I have received a written revocation of the authorization according to the procedures included in the authorization.

I have received the Health Information Privacy Practices notice and I have been provided an opportunity to review it.

Name_____ Birth Date_____

Signature_____Date_____

Office Copy

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Consent for Release of Information

This authorizes Cynthia White Meyer, LICSW to use and disclose the specific health information described below concerning:

Client:_____ Date of Birth:_____

This will authorize Cynthia White Meyer, LICSW to release to/obtain from :(Name)_____

(Address)_____City _____State _____ Zip _____

(Phone)_____ (Fax)_____
Information from the medical record maintained from _____

The information to be disclosed is (please check all info that you are willing to have exchanged):

	History and intake information		Social/ Psychological/ Medical reports
	Consultation notes/ progress reports		Chemical dependency abuse or diagnosis, history and treatment
	Treatment plan, goals, and results		Medications used in treatment
	Court or probation records		Other (specify)

The purpose of the information release is(please check all that apply):

	Diagnosis and evaluation		To facilitate treatment
	Treatment planning		Other (specify)

If I am requesting the Authorization from you for my use and disclosure or to allow another health care professional or entity to disclose information to me: (1) You have the right to inspect a copy of the protected information to be used or disclosed; (2) You may refuse to sign this authorization; and (3) I must provide you with a copy of the signed authorization at your request. You may revoke this consent at any time and that upon fulfillment of the above stated purposes(s) or within one year, this consent will automatically expire without express revocation.

By signing this authorization, you may be directing me to disclose your health information to a person or organization that does not have the same obligations to protect privacy required of health care practitioners under state and federal law. The disclosure of the information specified above may carry with it the potential for unauthorized disclosure of your protected health information and loss of protection under state and federal law.

You may request that I require the recipient of your protected health information to sign a Confidentiality Agreement in which the recipient agrees to limit its use and disclosure of your information as specified by the confidentiality agreement. If the intended recipient refuses to sign the confidentiality agreement you request, I will not release the information.

I have reviewed the Authorization and I understand it. I understand that the information used or disclosed under this Authorization may be subject to redisclosure by the recipient and may no longer be protected under federal privacy law.

_____ _____
Signature of Client Date

_____ _____
Signature of parent or guardian or witness Date

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Bill of Rights/Registration

Consumers of services offered by Independent Clinical Social Workers, licensed by the State of Minnesota have the right:

- to expect that the practitioner has met the minimal qualifications of training and experience required by state law.
- to examine the public records maintained by the Minnesota Board of Social Work which contain the credentials of the practitioner.
- to obtain a copy of the rules of conduct from the Minnesota Board of Social Work.
- to report complaints to the practitioner, and if not satisfactorily resolved, to file a complaint with the Minnesota Board of Social Work.
- to be informed of the cost of professional services before receiving the services.
- to privacy as defined by rule and law. This means that no information will be released from the facility in which the practitioner works without the client's informed, written consent, except for the following:

    a. The practitioner is required by law to report instances of abuse or neglect of a child or a vulnerable adult.
    b. The practitioner is required by law and professional codes of ethics to notify proper persons and/or authorities if the practitioner believes there is a danger to a client or another identified person.
    c. The practitioner is required to report admitted prenatal exposure to harmful controlled substances.
    d. In the event of a client's death, the spouse or parents of the deceased have a right to access the client's records.
    e. The practitioner must produce records or testimony in response to a Court Order and potentially to a subpoena.
    f. Parents or legal guardians of a non-emancipated minor client have the right to access their child's records.
    g. Case discussions with other staff through case management, consultation, testing, and treatment are confidential and are to be conducted as such by all staff.

1. to be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving psychological services.
2. to respectful, considerate, appropriate, and professional treatment.
3. to see information in his/her record upon request.
4. to be involved in the formulation of the treatment plan, the periodic review of plans and progress, and the formulation of the discharge plan.
5. to be informed of treatment options, expected outcome of treatment, expected length of treatment, and cost in language that he/she can understand.
6. to discuss needs, wants, concerns, and suggestions with the practitioner.
7. to be advised as quickly as possible if a scheduled appointment time cannot be kept due to illness or emergency.

Signature acknowledges receipt and understanding of these rights.

_____ _____

Signature of client **Date**

_____ _____

Signature of Parent/Guardian **Date**

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Client Responsibilities/Registration

Client Responsibilities

Each client has the responsibility to:

1. Refrain from physical (and other) abuse of self, others, and property. Clients are responsible for repair or replacement of any property they damage in the facility.

2. Devote reasonable energy and time to therapy work. Therapy is generally "hard (emotional) work." For progress to occur, we recommend making your therapy a high priority in your personal life. Your therapist may regularly assign homework that is intended to help you learn about yourself, and doing your homework is expected to expedite your therapy and decrease your costs.

3. Fulfill contracted behavior.

4. Be honest with your therapist concerning your thoughts and feelings about your therapy and treatment.

5. Keep appointments as made. Your appointment time is reserved for you. Therefore, you will be charged for the appointment unless you give at least 24 hours advance notice. Exceptions may be made for emergencies and other extenuating circumstances.

6. Keep current in paying your fees (deductibles, co-payments, fee-for-service payments). You are required to pay your fee at the beginning of each session. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that occurred prior to the first visit to my office), session fees credited toward the deductible will be collected at the time of the session until the deductible payment is verified by the insurance company or third-party provider. Verification can be made through my billing coordinator, who will contact your insurance company to check your benefit status upon request.

7. Inform those involved in the treatment plan about any changes to physical health, insurance plan, or ability to pay for contracted services.

8. Parents or caregivers are responsible to supervise the activities of children with respect to use of facilities, material, etc.

I have read and understand my rights and responsibilities as noted above.

_____ __ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian Date