

# Parkdale Therapy Group, LLC

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## Client Information Packet

This booklet will help acquaint you with my office procedures, as well as provide information about your rights and responsibility with regard to therapy. You will also find updated information about your rights pursuant to the Health Insurance Portability and Accountability Act (HIPAA). If you have any questions about this information, please discuss them with me at any time.

### Directions

**From the North** take 169 south to Shelard Pkwy/ Betty Crocker Drive. Take Shelard Parkway to 1000 Shelard Parkway. Turn right into the parking lot, and if you park on ground level, use the main entrance to the elevators up to the fifth floor. Turn right and continue down the hall to suite 520.

**From the South** take 169 north to Shelard Pkwy/ Betty Crocker Drive. Take Shelard Parkway to 1000 Shelard Parkway. Turn right into the parking lot, and if you park on ground level, use the main entrance to the elevators up to the fifth floor. Turn right and continue down the hall to suite 520.

**From the East** take 394 west to 169 North and then exit on Shelard Pkwy/ Betty Crocker Drive. Take Shelard Parkway to 1000 Shelard Parkway. Turn right into the parking lot, and if you park on ground level, use the main entrance to the elevators up to the fifth floor. Turn right and continue down the hall to suite 520.

**From the West** take 394 east to Hopkins Crossroads exit and turn left to cross over 394, then take the first right (East) on N. Wayzata Blvd (frontage road) approximately six blocks to the six-story blue glass building with FOCUS FINANCIAL in white letters. Turn into the ramp and park, then take the walkway to the second floor elevators up to the fifth floor. Turn right and continue down the hall to suite 520.

Upon entering, please have a seat in the waiting room and I will come out to greet you at your appointment time. Help yourself to tea or water. If you'd prefer coffee, just let me know and I will be happy to grab you a cup and provide sugar and cream.

### Professional Relationship

The professional relationship is not easily described in general statements. It varies depending on the personalities of the consultant and client, and the concerns you are experiencing. There are many different methods we may employ to attend to the concerns that you hope to address. The relationship is not like a medical doctor and calls for a very active role on your part. It might even include other important people in your life.

Therapy can have benefits and some risks. Since consultation may involve discussing challenging experiences of your life, you may experience sadness, guilt, anger, frustration, loneliness, etc. On the other hand, therapy may have many benefits. Successful therapy can lead to increased satisfaction in relationships, new possibilities for addressing specific concerns, and/or reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will focus on understanding your needs, goals, and presenting concerns. After these first few sessions, we will be able to discuss your first impressions of what our work could include and then co-create a potential plan to follow if we decide to continue with therapy. It is important to evaluate this information along with your own opinions of whether you feel comfortable working together. Since therapy involves a commitment of time, money, and energy, it is important to be selective about the therapist you select. If you have questions about my procedures, we can discuss these whenever they arise. While we co-create possible solutions, you maintain the right to implement them, or decide against implementing any or all of them.

## **Meetings & Professional Fees**

I conduct an initial session of 53-55 minutes at a cost of \$250. Following the initial session is an evaluation period of 2 to 3 sessions, during which we both decide if I am the best person to provide the services you need to meet your goals. The fee for these 53-55 minute sessions is \$180. I usually suggest one 53-55 minute session per week at a time, but we work together to determine how often and for what length of time we meet. Once an appointment hour is scheduled, you will be financially responsible if you were to cancel with at least a 24-hour notice. If were unable to attend due to circumstances beyond your control, such as an unforeseen emergency, sudden illness, etc., the fee is waived. *It is important to note that insurance companies do not provide reimbursement for canceled session charges.* Periodically we are faced with the issue of raising our rates. While this is not an annual change, there have been times when our hourly rate increased. In the event of a change, we will make every effort to post these changes in our individual offices at least 30 days in advance.

## **Additional Professional Fees**

In addition to weekly appointments, I charge \$180 per 53-55 minutes for other professional services you may need, though I will break down the hourly cost if I work for periods of less than 53-55 minutes. Other services may include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and time spent performing other services you may request. These services may not be covered by insurance.

If you become involved in any legal proceedings that require my participation, you will be expected to pay for all my professional time, including preparation and transportation costs, and any legal fees that I might incur, even if I am called to testify for another party. I charge \$180 per hour for preparation and attendance, and in addition, mileage to and from any location.

Relational and Couple Therapy may not covered by the majority of insurance panels to which I belong. The fees for the session are due at the beginning of each session.

## **Contacting Me**

You may leave me a message on my confidential voicemail or e-mail me. Email or text is used to make or change appointments, or for general questions not requiring an immediate response. For more detailed and sensitive information, please leave a voicemail. I will make every effort to return your call or e-mail within 24 hours, except for weekends and holidays. If it might be difficult to reach you, please leave times when you might be available by phone.

## **Emergencies**

If you are experiencing an immediate crisis and are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call, Community Outreach for Psychiatric Emergencies (COPE): 612-596-1223, the St. Paul Ramsey Crisis Intervention Center at (651) 266-7900, or your local emergency services at 911. Please visit our website for additional resources. If I will be unavailable for an extended time, I will provide you the name of a colleague to contact.

## **Billing and Payments**

You will be expected to make co-pays or deductibles for each session *at the time of the session*. If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

## **Insurance Reimbursement**

Your health insurance company requires an assessment covering a broad range of topics, typically more than may be covered in our initial session, and we are required to provide your insurance provider with information relevant to therapeutic services, including a clinical diagnosis. I will make every effort to release the minimum information necessary for the purpose requested by your insurance company to process your claim. Upon request, you may have a copy of any report I submit. This information will become part of the insurance company files, and while your insurance company may endeavor to keep this information confidential, we have no control over what happens to the information once it is submitted. Your private information might become part of a national medical information databank, and could be used in determining future insurability.

To avoid the problems described above [unless prohibited by contract] you may opt to pay for these services yourself. Our health insurance company contracts do not reimburse couple or relational therapy. As such you are responsible for all fees related to your therapy.

Your insurance company require we coordinate care with your Primary Care Physician, so it is important that we have your written consent to do so. If you have any questions or concerns regarding this, we can talk more about those before I coordinate care with your physician.

**We process all insurance claims on your behalf. Please do not submit insurance claims unless we instruct you to do so, as this might reject our claim to your insurance provider.**

## **Concerns**

I urge you to discuss with me any questions or concerns you may have with the consultation you receive. If you are not satisfied with the results of that discussion, and additional measures are necessary, a formal concern or complaint may be made with Ms. Michelle A. Craveiro, MA, LMFT whose number is 952-224-0399 ext 102. If the results of that consultation are not satisfactory, you may call the Board of Marriage and Family Therapy at 612-617-2220.

# Insurance Registration Form

Today's Date \_\_\_\_\_

Client Name (Print) \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First Middle Initial

Street Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Sex: F M O Age \_\_\_\_\_ Partner Status: Sgl \_\_\_ Mar \_\_\_ Div \_\_\_ Sep \_\_\_ Other

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

May I Leave A Message? Yes No May I Leave A Message? Yes No May I Leave A Message? Yes No

Confidential Email Address: \_\_\_\_\_ May we send unencrypted confidential email? Yes No

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ May I contact: Yes No

## Insurance

Primary Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Claims Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policy/ID # \_\_\_\_\_ Group/Plan # \_\_\_\_\_

(This can be the Policy Holder's social security number)

Policy Holder Information: (if the client is not the employee/policy holder)

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Last First Middle Initial

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Date of Birth \_\_\_\_\_

Diagnosis \_\_\_\_\_ Therapist \_\_\_\_\_

(Required for Billing Insurance – Therapist will fill in)

Second Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Policy/ID # \_\_\_\_\_ Group/Plan # \_\_\_\_\_

(This can be the Policy Holder's social security number)

Policy Holder Information: (if the client is not the employee/policy holder)

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Last First Middle Initial

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Date of Birth \_\_\_\_\_

Diagnosis \_\_\_\_\_ Therapist \_\_\_\_\_

(Required for Billing Insurance – Therapist will fill in)

## Responsible Party

Where should the personal portion of the bill be sent, if not to the person named at the top of the page?)

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 (therapist) listed on this form all insurance benefits, if any, otherwise payable for services rendered. I understand that I am financially responsible for all charges not covered by insurance. I authorize the use of this signature on all insurance submissions. I hereby authorize the healthcare provider (therapist) to release all information necessary to secure the payment of benefits and to mail billing statements, and understand it is my (client) responsibility to alert the provider of any insurance changes.

Signature of Responsible Party

Relationship (self, parent, etc.)

Date

\_\_\_\_\_

## Payment Authorization Form

Keeping your account up to date is effortless and worry free, simply authorize your charges not covered by insurance, using your Health Savings account (HSA), credit card or debit card. We require one form of guaranteed payment on file for expenses not covered by your insurance company, and you will only be charged the amount specified on your monthly statement.

This form authorizes Megan A. Jankord, or administrative staff to charge your HSA, credit or debit card for your unpaid account balance. Your credit card will be charged any unpaid balance over 30 days. Your personal information will be kept secure and confidential. A paid receipt will be sent to the mail, email, or Fax you prefer. Complete and sign this form to get started.

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Please complete all the information below:

I, \_\_\_\_\_, authorize Parkdale Therapy Group to charge my credit card as follows:

For, \_\_\_\_\_ the client(s)

Billing Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### Credit Card Information

Visa            MasterCard            HSA  
Amex            Discover

Cardholder Name: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Exp. Date: \_\_\_\_ / \_\_\_\_

CVV (3-digit number on back of card) or (4 digit on the front of Am Ex) \_\_\_\_\_

Zip: \_\_\_\_\_ - \_\_\_\_\_

Receipt to be sent by (circle one):    Email    Mail    Fax

Signature \_\_\_\_\_

Date \_\_\_\_\_

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Parkdale Therapy Group in writing of any changes to my account information. I understand that if I fail to make payments owed for attended sessions, if I fail to show for a scheduled appointment without notification, or if I cancel a session less than 24 hours from the start time of the session, and do not make the required payment(s) at the end of the month, authorized personnel at Parkdale Therapy Group has my permission to charge the card listed above accordingly. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card Company; so long as the transactions correspond to the terms indicated in this authorization form.

## Other Contacts

I'm interested in others who know about the concern(s) you are facing. I've found some people may have knowledge or experience this could be useful when we discuss the impact these problems and their potential solutions. Concerned others may know of ways you have stood up to these or other challenges in the past. Feel free to list these people, so that if we both decide it would be helpful to contact them, we will have their information. Please note I will obtain your written permission *before* consulting with any of these people.

First Potential contact/resource \_\_\_\_\_ Relation to You? \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Email \_\_\_\_\_

Second Potential contact/resource \_\_\_\_\_ Relation to You? \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Email \_\_\_\_\_

Third Potential contact/resource \_\_\_\_\_ Relation to You? \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Email \_\_\_\_\_

## Emergency Contacts

My priority is maintaining the safety and privacy of those with whom I consult. If there comes a time when I am concerned with your safety or the safety of others in your life, I may need to contact them. I ask you provide two names of people I could call if I am concerned about your safety. If you are the parent of a client I am seeing, there may be times when I am unable to contact you immediately and need someone else to verify your child's safety. Please list these individuals below.

First Emergency contact \_\_\_\_\_ Relation to You? \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Email \_\_\_\_\_

Second Emergency contact \_\_\_\_\_ Relation to You? \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Email \_\_\_\_\_

# Confidentiality Agreement

Information about clients and their families is confidential with exception to the following:

1. Written authorization by the client and/or family (valid authorization form).
2. Therapist's duty to warn another in the case of potential suicide, homicide or threat of imminent, serious harm to another individual.
3. Therapist's duty to report suspicion of abuse or neglect of children or vulnerable adults.
4. Therapist's duty to report prenatal exposure to cocaine, heroin, phencyclidine, methamphetamine, and amphetamine or their derivatives, THC, or excessive & habitual alcohol use. (253b.02; 2007).
5. Therapist's duty to report the misconduct of mental health or health care professionals.
6. Therapist's duty to provide a spouse or parent of a deceased client access to their child or spouse's records.
7. Therapist's duty to provide parents of minor children access to their child's records. Minor clients can request, in writing, that specific information not be disclosed to parents. Such a request should be discussed with the therapist.
8. Therapist's duty to release records if subpoenaed by the courts.
9. Therapist's obligations to contracts (e.g. to employer of client, to an insurance carrier or health plan).

## Consultation Within The Parkdale Therapy Group

The Parkdale Therapy Group, LLC consists of a clinical team including: John L Jankord, MA, LMFT, LADC, LPCC, Michelle Craviero, MA, LMFT, Jessie Brown, PsyD, LP, Tyra Hughes, MA, LMFT, Randi Born, PsyD, LP, Jake Voelker, MA, LMFT, Michelle Hunt-Graham, MA, LMFT, CDWF, Aysem Senyurekli, PhD, LMFT, Libby Marx, MA, LMFT, Megan A. Jankord, MA, LMFT, Kate Schmidt, MSW, LICSW, Maureen Trefethren, MS, LPCC, Meredith Hyduke Dehn, MA, LAMFT, Samantha Waldron, MA, Megan O'Brien, MSW, LICSW.

The purpose of consulting with colleagues is to obtain additional insight, further therapeutic skills, and ensure the highest possible service to the people we serve. During consultation we will make every effort to provide only those details necessary to gain adequate feedback.

## Communication: Email, Text, & Other Non-Secure Means

It may become useful during our work to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Please know that these methods, in their typical form, are not confidential means of communication and may be susceptible to a third party may be able to intercept and eavesdrop on those messages, even though we offer encrypted email. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with Parkdale Therapy Group, LLC
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

If there are people in your life you don't want to access these communications, please talk to your Parkdale Therapy Group, LLC provider about ways to keep your communications safe and confidential.

I consent to Parkdale Therapy Group, LLC providers use of email and mobile phone text messaging when transmitting your protected health information, such as:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment
- Non-emergency related correspondence

My signature indicates I have been informed of the risks, including but not limited to my confidentiality in therapy, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement to receive therapy. I also understand that I may terminate this consent at any time.

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Client Signature

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Date

## **You Have the Right to Know and Inquire About:**

1. The cost of counseling, time frame for payment, access to billing statements, billing procedure for missed appointments, and any issues related to insurance coverage.
2. When the therapist is available and where to call during off hours in case of emergency.
3. The way the therapist conducts sessions concerning intake, treatment, and termination. Clients take an active role in the process by asking questions about relevant therapy issues, specifying therapeutic goals, and renegotiating goals when necessary.
4. The nature and perspective of the therapist's work, including techniques used, and alternative methods of treatment.
5. The purpose and potential negative outcomes of treatment. Clients may refuse any treatment intervention or strategy.
6. The anticipated length and frequency of treatment and limitations that may arise due to difficulties in financing.
7. The liberty of clients to discuss any aspect of their therapy with others outside the therapy situation, including consultation with another therapist.
8. The status of the therapist, including the therapist's training, credentials, and years of experience.
9. The maintenance of records, including security and length of time they are kept, client's rights to access personal records, and release policies.
10. The right to request a referral and the right to require the current therapist to send a written report regarding services to the qualified referred therapist or organization upon the client's written authorization.
11. The procedures followed in the event of the therapist's death/illness.

**I consent to this consultation, have read and understand my rights listed above, and have reviewed the Client Bill of Rights posted in our waiting room.**

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date



## **As a Client You Have a Responsibility to:**

1. Ask questions and get clarification regarding your diagnosis and suggested treatment plan.
2. Be willing to be an active and collaborative partner in the therapeutic relationship.
3. Inform your therapist of any changes in your behavior and/or physical or mental health status that could affect your care, including compliance with any prescribed medication.
4. If using insurance, inform your therapist of any changes in your health insurance plan.
5. Be on time for scheduled appointments. If running late, please inform me by leaving a voice message on the office line (952-224-0399, ext. 101). Please do not text or email and drive.
6. Cancel appointments if you are unable to keep them, so others may use the time slot. Please adhere to a minimum of a 24-hour notice to cancel your appointment. Thank you!
7. Limit email communications primarily to scheduling issues (making appointments, rescheduling or canceling appointments). Email is not monitored sufficiently for therapeutic or crisis correspondence
8. Understand that for your confidentiality and to minimize the possibility of dual relationships, your therapist will not accept invitations for any social media connections (i.e., Facebook, LinkedIn, etc.).
9. Inform your therapist if you would prefer to “opt out” of text message or email appointment reminders.
10. Understand that, depending on our financial agreements, co-pays, deductible amounts or full session fees are due at the time of service. Delays may occur with insurance reimbursement, or may accrue due to unmet deductible amounts, therefore, balances on your account will be reviewed monthly. Please understand, should a balance accumulate on your account, it will be limited to \$300.00, and must be paid within 45 days. If a balance remains unpaid without prior arrangement, additional fees and suspension or termination of services may result.

**I have read and understand my responsibilities as a client listed above.**

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

## **Collaborating in Therapy**

### **Tell Me What Works and Has Worked for You**

Each person, couple, and family is unique. You can help by sharing the style and questions I use that work best for you and your partner and your family. You are not expected to run the therapy. Therapists have expertise and good reasons for doing what they are doing, and a therapist should allow some room for flexibility. If you have been in counseling before and found some aspect or method particularly helpful, let me know more about those experiences.

### **Let Me Know When We Do Something That Was Useful/Helpful**

Therapy can be a difficult and challenging and rewarding process. We see people when they are feeling stressed, feeling hopeless and sometimes feeling impatient. We often aren't aware of the things we do that have been helpful if people don't return or when change takes some time. So, most therapists appreciate hearing when we've done something that worked or you've found helpful. This can also make your therapy experience more productive, since your therapist will have your feedback to guide him or her in future sessions.

### **Tell Me Your Expectations**

If you attend therapy hoping to go back to your childhood to find origins or contributions to the concerns that brought you into therapy and your therapist focuses on the present, someone is bound to be frustrated if that expectation isn't brought up and discussed before you proceed. Also, you might indicate how long you had anticipated you would attend therapy, and how often, to make sure you and the therapist are on the same track.

### **Let Me Know When We Do Something That Doesn't Work or Which You Do not Agree**

Like telling your therapist your expectations and letting him/her know what has worked or is helping, as well as letting him/her know when something isn't helping is important. This includes what is happening between as well as during your therapy sessions. This gives the opportunity for mid-course corrections in the therapy process.

### **Let Me Know Your Objections**

Some people think that they shouldn't speak up about their worries or objections to their therapist's suggestions, but a free and frank discussion about any misgiving helps your therapist attend to your concerns and make any adjustments to ensure a higher likelihood of success.

### **Ask Questions**

About the therapy process, fees, any suggestions or methods, the therapist's training and qualifications, etc. Anything you are curious about. If it gets too personal or the therapist considers the questions intrusive or inappropriate, he/she will let you know.

# Confidential Questionnaire

## Relational Status

Single \_\_\_ Partnered \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widow \_\_\_ Total # of marriages: \_\_\_\_\_

Length of current marriage/relationship: \_\_\_\_\_

Assessment of current relationship: Good \_\_\_ Fair \_\_\_ Poor \_\_\_

Race: \_\_\_\_\_

Gender Identity: \_\_\_\_\_

Sexual Orientation: \_\_\_\_\_

Religious Affiliation/Spirituality: \_\_\_\_\_

Ethnic/Cultural Identification: \_\_\_\_\_

## Information About You

What activities do you enjoy and feel successful when trying?

What activities do you find helpful (e.g. walking, hunting, yoga, painting), or beliefs (e.g. religion)?

What personal qualities would others say you possess?

Who would you say are the influential and supportive people in your life?

## Family History

Who lived in your home when you were a child?

Where are you in the birth order?

What words would you use to describe your family of origin?

Are you aware of any birth trauma your mother endured during her pregnancy with you, or any trauma you endured between birth and 3?

Did/do you have any significant concerns experiences with someone in your family? Please describe

Did you experience or witness any abuse as a child (physical, verbal, emotional, or sexual) or experience these outside your home? Please describe to the extent you feel comfortable

Have you experienced or witnessed any abuse in your adult life (physical, verbal, emotional, or sexual)? Please describe to the extent you feel comfortable

## Family Composition

| Relationship | Name  | Age   | Sex   | Type (Bio, Step, Etc) |
|--------------|-------|-------|-------|-----------------------|
| Mother       | _____ | _____ | _____ | _____                 |
| Father       | _____ | _____ | _____ | _____                 |

| Relationship | Name  | Age  | Sex  | Type (Bio, Step, Etc) |
|--------------|-------|------|------|-----------------------|
| Stepmother   | _____ | ____ | ____ | _____                 |
| Stepfather   | _____ | ____ | ____ | _____                 |
| Sibling      | _____ | ____ | ____ | _____                 |
| Sibling      | _____ | ____ | ____ | _____                 |
| Sibling      | _____ | ____ | ____ | _____                 |
| Sibling      | _____ | ____ | ____ | _____                 |
| Sibling      | _____ | ____ | ____ | _____                 |
| Spouse/SO    | _____ | ____ | ____ | _____                 |
| Children     | _____ | ____ | ____ | _____                 |
| Children     | _____ | ____ | ____ | _____                 |
| Children     | _____ | ____ | ____ | _____                 |
| Children     | _____ | ____ | ____ | _____                 |
| Children     | _____ | ____ | ____ | _____                 |

### Current Family Concerns

Please check any family concerns you may be experiencing:

- |            |                 |                             |                 |                             |
|------------|-----------------|-----------------------------|-----------------|-----------------------------|
| Fighting   | Feeling Distant | Loss of fun                 | Lack of honesty | Physical fights             |
| Drug Use   | Alcohol Use     | Disagreeing about relatives |                 | Infidelity (Couple)         |
| Divorce    | Separation      | Remarriage (self or parent) |                 | Disagreeing about friends   |
| Education  | Finances        | Birth of a sibling          |                 | Death of a family member    |
| Empty Nest | In-laws         | Blended family concerns     |                 | Leisure time                |
| Abuse      | Neglect         | Inadequate Housing          |                 | Inadequate health insurance |
| Gambling   | Internet Usage  | Employment/Underemployment  |                 | Other _____                 |

### Education (Fill in All That Apply)

Years of Education \_\_\_\_\_ Currently Enrolled: Yes \_\_\_ No \_\_\_

Completed: High School/GED \_\_\_ Vocational \_\_\_ College \_\_\_ Graduate School \_\_\_ Doctorate \_\_\_

Other Training \_\_\_\_\_

Special Circumstances \_\_\_\_\_

### Military

Do you have a history of serving in the military? Yes \_\_\_ No \_\_\_

Combat Experience? Yes \_\_\_ No \_\_\_

Where: \_\_\_\_\_ Branch: \_\_\_\_\_

Length of Service: \_\_\_\_\_ Type of Discharge: \_\_\_\_\_

Rank at Discharge: \_\_\_\_\_

## Legal Issues

Are there any legal issues that are affecting you or your family at present, or any which have had a significant effect upon you or others.

Any past legal issues that affect you or your family?

## Counseling & Medical History

Have you previously worked with a counselor or therapist? Yes \_\_\_ No \_\_\_

If so, where and with whom:

Approximate dates of prior counseling?

For what reason(s) did you seek counseling?

Were you given a diagnosis? If so, what?

What did you find **most helpful** in counseling?

What did you find **least helpful** in counseling?

Have you utilized psychiatric services? Yes \_\_\_ No \_\_\_ If so, was it helpful? Yes \_\_\_ No \_\_\_

Have you taken medication for any psychological health concerns? Yes \_\_\_ No \_\_\_ If so, please list below:

| Name of Medication | Dosage | Dates Taken | Is it helping? |    |
|--------------------|--------|-------------|----------------|----|
|                    |        |             | Yes            | No |
|                    |        |             | Yes            | No |
|                    |        |             | Yes            | No |
|                    |        |             | Yes            | No |
|                    |        |             | Yes            | No |
|                    |        |             | Yes            | No |
|                    |        |             | Yes            | No |
|                    |        |             | Yes            | No |

Other medical concerns requiring surgery, treatment, or hospitalization? Please describe:

## Symptom Checklist

Items that you currently or have been experiencing in the last 30 days.

| Symptom                  | None | Mild | Moderate | Severe | Symptom                           | None | Mild | Moderate | Severe |
|--------------------------|------|------|----------|--------|-----------------------------------|------|------|----------|--------|
| Sadness/Depression       |      |      |          |        | Increased or decreased appetite   |      |      |          |        |
| Crying                   |      |      |          |        | Unplanned weight gain             |      |      |          |        |
| Sleep disturbances       |      |      |          |        | Unplanned weight loss             |      |      |          |        |
| Dissociation             |      |      |          |        | Paranoid thoughts                 |      |      |          |        |
| Hyperactivity            |      |      |          |        | Poor concentration/indecisive     |      |      |          |        |
| Binging/Purging          |      |      |          |        | Low energy                        |      |      |          |        |
| Decreased sex drive      |      |      |          |        | Excessive worrying                |      |      |          |        |
| Unresolved guilt         |      |      |          |        | Low self-worth                    |      |      |          |        |
| Irritability             |      |      |          |        | Anger management problems         |      |      |          |        |
| Nausea/Acid indigestion  |      |      |          |        | Spiritual concerns                |      |      |          |        |
| Anxiety                  |      |      |          |        | Hallucinations                    |      |      |          |        |
| Self-mutilation/cutting  |      |      |          |        | Racing thoughts                   |      |      |          |        |
| Impulsivity              |      |      |          |        | Restlessness                      |      |      |          |        |
| Nightmares               |      |      |          |        | Drug Use                          |      |      |          |        |
| Hopelessness             |      |      |          |        | Alcohol Use                       |      |      |          |        |
| Elevated mood            |      |      |          |        | Decreased creativity/productivity |      |      |          |        |
| Mood swings              |      |      |          |        | Easily distracted                 |      |      |          |        |
| Disorganized             |      |      |          |        | Memories of trauma/flashbacks     |      |      |          |        |
| Anorexia                 |      |      |          |        | Work issues                       |      |      |          |        |
| Social isolation         |      |      |          |        | Problems at home                  |      |      |          |        |
| Phobia(s)                |      |      |          |        | Panic attacks                     |      |      |          |        |
| Obsessive thoughts       |      |      |          |        | Feel panicky/anxious              |      |      |          |        |
| Grief                    |      |      |          |        | Suicidal thoughts                 |      |      |          |        |
| Headaches                |      |      |          |        | Attempts of suicide in the past   |      |      |          |        |
| Physical Abuse or Threat |      |      |          |        | Internet or Social Media Usage    |      |      |          |        |
| Verbal Abuse or Threat   |      |      |          |        | Other                             |      |      |          |        |
| Sexual Harm/Threat       |      |      |          |        |                                   |      |      |          |        |
| Sexual Behaviors         |      |      |          |        |                                   |      |      |          |        |

## **Additional Information**

Is there anything else you would like to share that could be helpful in our work?

### **Your Reason for Seeking Therapy Today**

Who referred you to Megan A. Jankord, MA, LMFT? \_\_\_\_\_

May I acknowledge this referral? \_\_\_\_\_

Their email or phone number with which to acknowledge the referral \_\_\_\_\_

Briefly describe the problem or concern for which you, your child or adolescent would like addressed in counseling.

Who is the Person/Issue you are most concerned about and why?

Why do you think these challenges are present for you or your relationship? How long have they been present?

What are your main goal(s) for today's session?

- 1.
- 2.
- 3.

What are your mid-term and long-term goal(s) for our work together?

- 1.
- 2.
- 3.

What attempts have you made in the past to challenge these concerns?

- 1.
- 2.
- 3.



If the work that we did together was helpful or successful, how would you know? What would be different in your life?

If the work that we did together was helpful or successful, what might be different in the lives of others close to you?

**Your signature below indicates that you have read the entire Confidential Individual Questionnaire, understand the content, and agree to abide by its terms during our professional relationship. Your signature also indicates you have had an opportunity to ask questions about this material and how it applies to my situation, and that you have been offered the HIPAA MN Notice Form (see below)**

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

**Therapist Will Complete:**

Dx: \_\_\_\_\_; \_\_\_\_\_

ACE: \_\_\_\_\_

PHQ-9: \_\_\_\_\_

GAD 7: \_\_\_\_\_

CAGE: \_\_\_\_\_

| <b>Over the last 2 weeks, how often have you been bothered by any of the following problems?</b>  | <b>Not at all</b>   | <b>Several days</b> | <b>More than half of the days</b> | <b>Nearly every day</b> |
|---|---------------------|---------------------|-----------------------------------|-------------------------|
| 1. Little interest or pleasure in doing things  | 0                   | 1                   | 2                                 | 3                       |
| 2. Feeling down, depressed, or hopeless   | 0                   | 1                   | 2                                 | 3                       |
| 3. Trouble falling or staying asleep, or sleeping too much  | 0                   | 1                   | 2                                 | 3                       |
| 4. Feeling tired or having little energy  | 0                   | 1                   | 2                                 | 3                       |
| 5. Poor appetite or overeating  | 0                   | 1                   | 2                                 | 3                       |
| 6. Feeling bad about yourself or that you are a failure or have let yourself or your family down  | 0                   | 1                   | 2                                 | 3                       |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television  | 0                   | 1                   | 2                                 | 3                       |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual | 0                   | 1                   | 2                                 | 3                       |
| 9. Thoughts that you would be better off dead, or of hurting yourself   | 0                   | 1                   | 2                                 | 3                       |
| <b>Column Totals</b>  |                     | +                   | +                                 | =                       |
|   | Add Totals Together |                     |                                   |                         |
| 10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people         | Not difficult       | Some difficulty     | Very difficult                    | Extremely difficult     |
| <b>Over the last 2 weeks, how often have you been bothered by any of the following problems?</b>  | <b>Not at all</b>   | <b>Several days</b> | <b>More than half of the days</b> | <b>Nearly every day</b> |
| 1. Feeling nervous, anxious, or on edge   | 0                   | 1                   | 2                                 | 3                       |
| 2. Not being able to stop or control worrying   | 0                   | 1                   | 2                                 | 3                       |
| 3. Worrying too much about different things   | 0                   | 1                   | 2                                 | 3                       |
| 4. Trouble relaxing   | 0                   | 1                   | 2                                 | 3                       |
| 5. Being so restless that it is hard to sit still   | 0                   | 1                   | 2                                 | 3                       |
| 6. Becoming easily annoyed or irritable   | 0                   | 1                   | 2                                 | 3                       |
| 7. Feeling afraid as if something awful might happen  | 0                   | 1                   | 2                                 | 3                       |
| <b>Column Totals</b>  |                     | +                   | +                                 | =                       |
|   | Add Totals Together |                     |                                   |                         |
| 8. If you have checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people     | Not difficult       | Some difficulty     | Very difficult                    | Extremely difficult     |
| <b>When thinking about drug use, including illegal drug use and prescription drug use other than prescribed (in the last 12 months):</b>                                    |                     |                     | <b>Yes</b>                        | <b>No</b>               |
| 1. Have you ever felt that you ought to cut down on your drinking or drug use?  |                     |                     |                                   |                         |
| 2. Have people annoyed you by criticizing your drinking or drug use?  |                     |                     |                                   |                         |
| 3. Have you felt bad or guilty about your drinking or drug use?   |                     |                     |                                   |                         |
| 4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?  |                     |                     |                                   |                         |

**HIPAA Minnesota Notice Form**  
**Notice of Parkdale Therapy Group, LLC**  
**Policies and Practices to Protect the Privacy of Client Health Information**

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

**I. Uses and Disclosures for Treatment, Payment, and Health Care Operations**

I may use or disclose your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- “*PHI*” refers to information in your health record that could identify you.
- “*Treatment, Payment, and Health Care Operations*”
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or a psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.
- “*Use*” applies only to activities within my [office, clinic, practice group, etc.], such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “*Disclosure*” applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

**II. Uses and Disclosures Requiring Authorization**

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An “*authorization*” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. “*Psychotherapy notes*” are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given different protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

**III. Uses and Disclosures with Neither Consent nor Authorization**

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I know or have reason to believe a child is being neglected or physically or sexually abused or has been neglected or physically or sexually abused within the preceding three years, I must immediately report the information to the local welfare agency, police or sheriff’s department.
- **Adult and Domestic Abuse:** If I have reason to believe that a vulnerable adult is being or has been maltreated, or if I have knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, I must
- Immediately report the information to the appropriate agency in this county. I may also report the information to a law enforcement agency.

“*Vulnerable adult*” means a person who, regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:

- (i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and
- (ii) because of the dysfunction or infirmity and the need for assistance, the individual has an impaired ability to protect the individual from maltreatment.

- **Health Oversight Activities:** The Minnesota Board of Marriage and Family Therapy or Board of Behavioral Health may subpoena records from me if they are relevant to an investigation it is conducting.
- **Judicial and Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law and I must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case.
- **Serious Threat to Health or Safety:** If you communicate a specific, serious threat of physical violence against a specific, clearly identified or identifiable potential victim, I must make reasonable efforts to communicate this threat to the potential victim or to a law enforcement agency. I must also do so if a member of your family or someone who knows you well has reason to believe you are capable of and will carry out the threat. I also may disclose information about you necessary to protect you from a threat to commit suicide.
- **Worker’s Compensation:** If you file a worker’s compensation claim, a release of information from me to your employer, insurer, the Department of Labor and Industry or you will not need your prior approval.

#### IV. Client's Rights and Clinician's Duties

Client's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI (and psychotherapy notes) in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Clinician's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will send you a copy by mail or give you a copy in session.

**V. Questions and Complaints**

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact **Ms. Michelle A. Craveiro, MA @ 952-224-0399 ext 102.**

If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to:

**Parkdale Therapy Group, LLC  
1000 Shelard Parkway, Ste 520  
St. Louis Park, MN 55426**

**952-224-0399 ext 101 Fax 952-224-0396**

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint. **VI.**

**Changes to Privacy Policy**

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail or in session.