Jessica Brown, Psy. D. Licensed Psychologist
Parkdale Therapy Group
1000 Shelard Parkway #520
St. Louis Park, MN 55426-1053
952-224-0399 Ext. 104

Directions to my office:
From the East:
Take Highway I-94 to I-394 West. Exit at Hopkins Crossroads and turn right. Turn right on North Frontage Road. We are the driveway on the left after the La Quinta hotel. Turn into the Focus Financial ramp.

From the West:
Take Highway I-394 East. Exit on Hopkins Crossroads and turn right. Turn right on North Frontage Road. We are the driveway on the left after the La Quinta hotel. Turn into the Focus Financial ramp.

The session will be held at my private office at Parkdale Therapy Group at 1000 Shelard Parkway, Suite 520, in St. Louis Park. This is a six story, black glass building that says Focus Financial on the side. Directions are as follows:

Please complete the enclosed forms and bring them to your first session. This will assist me in my understanding of you or your family members particular concerns and possible directions for problem solving. The insurance forms are fairly self-explanatory, please let me know if you have any questions about these. You will need to check with your insurance company to find out what, if any, deductible and co-pay fees will be. Payment, beginning with the first session, is due at the beginning of the hour.

If you need to change or cancel your appointment, or have further questions, please let me know, I can be reached at the above number. I look forward to meeting with you.

Fees and Phone Calls
My current fee for the initial intake session is $185.00, and then is $165.00 per session, unless otherwise agreed upon. Full payment or co-payment, if using insurance, is due at each session. Please check with your insurance carrier ***before*** your first session to find out the type and amount of coverage provided for mental health coverage. This information includes what your co-pay is and whether or not your deductible has been met. Phone calls up to 10 minutes are free of charge. If they go longer, they will be pro-rated at $165.00 per hour. If you become involved in legal proceedings that require my participation, you will be charged my hourly for all of my time, including preparation and transportation fees, and any legal fees I may incur, even if called to testify by another party.

Cancellations
The session fee is charged for appointments with less than 24-hour cancellation notice. Please note that cancellation fees will not be billed to insurance, and will need to be paid by the client directly. Such fees are standard practice (there are of course exceptions for things such as sudden illness, accident, or other emergencies), and are intended to preserve the time for those who may be needing it. Please feel free to direct any questions about this policy to me.

Overdue Payments
This policy requires payment for services at each session. You may be refused services if you miss more than one payment. In compliance with the Federal Consumer Credit Protection Act, I wish to notify you of my policy regarding payment of statements for services rendered on your behalf. I may choose to employ either a

collection agency or pursue legal action if accounts become seriously overdue and you have not made other arrangements with me. In such an event, you may also become liable for legal and other fees related to a collection on a past due account.

Crisis Situations

Depending on the nature of the crisis situation, you can call my voice mail at the above number and leave me a message regarding the crisis, or for police or medical emergencies you can call 911. If you are in Hennepin County, you can also call COPE for emergency mental health triage at 612-596-1223. If necessary, you and I will have discussed back-up systems for when I am unavailable.

Please feel free to ask if you have any questions.

Insurance Registration Form

CLIENT NAME:_____

BIRTHDATE:_____S.S.N.:_____

PHONE #1:_____PHONE #2:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

PARENT NAME (IF MINOR)_____

BIRTHDATE:_____S.S.N.:_____

PRIMARY INSURANCE COMPANY NAME:_____

INSURANCE COMPANY ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

INS. CO. PHONE#:_____EMPLOYEE I.D.:_____

SUBSCRIBER/POLICY HOLDER NAME: _____

GROUP NAME (INSURED'S EMPLOYER):_____

AUTHORIZATION TO PAY BENEFITS TO PROVIDER OF SERVICE

I authorize and request payment of medical benefits to the provider or supplier of services by insurance or myself. I understand charges include appointments I fail to cancel 24 hours in advance (full fee), sessions that my insurance fails to authorize (full fee), or phone calls that are longer than 10 minutes (prorated). I understand that I am responsible for all non-covered charges.

SIGNATURE:_____DATE:_____

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release of any medical information of other information necessary to process insurance claims. I agree that a reproduced copy of this authorization is valid as well.

SIGNATURE:_____DATE:_____

Provider Use Only: Date of Intake:_____DX_____

CLIENT'S RIGHTS AND CONSENT TO TREATMENT

As a client, you have the right to know and inquire about the following:

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 manner in which the therapist conducts sessions concerning intake, treatment, and termination. Clients may 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 procedure followed in the event of the therapist's death/illness.

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

_____ _____
Client Signature Date

_____ _____
Client Signature or Parent/Guardian for Minor Date

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 particular 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, Psy D, LP; Heather Klein, Ph D, LP; Tyra Hughes, MA, LMFT; Randi Born, Psy D, LP, MA, LMFT; Annie Will, MA, LMFT; Jake Voelker MA, LMFT; Tiffany Leuthold, MS, LMFT; Michelle Hunt-Graham, MA, LMFT, CDWF; Aysem Senyurekli, PhD, LMFT; Libby Marx, MA, LMFT; Jessee Daley, MA, LPCC; Megan A. Jankord, MA; Kate Schmidt, 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 collegial consultation we will make every effort to provide only those details necessary to gain adequate feedback.

My signature indicates I understand the above limits of confidentiality and the possible participation of interns.

_____ _____
Client Signature Date

_____ _____
Client Signature or Parent/Guardian for minor Date

CONFIDENTIAL QUESTIONNAIRE

PLEASE ANSWER THE FOLLOWING QUESTIONS FROM YOUR OWN PERSPECTIVE.

NAME_____DATE_____

D.O.B._____OCCUPATION_____

1. Who referred you to Jessica Brown?

2. What would you name the problem or issue that brought you to see Dr. Brown?

3. Who or what is the person/issue you are most concerned about and why?

LISTED BELOW ARE POSSIBLE PROBLEMS YOU OR YOUR FAMILY MAY BE STRUGGLING WITH.
PLEASE CIRCLE AND RATE EACH ISSUE ACCORDING TO YOUR DEGREE OF CONCERN AND STATE WHY.

1. Suicide Potential (Low) 1 2 3 4 5 6 7 8 9 10 (High)
   Why?

2. Depression (Low) 1 2 3 4 5 6 7 8 9 10 (High)
   Why?

3. Anxiety/Worrying (Low) 1 2 3 4 5 6 7 8 9 10 (High)
   Why?

4. Legal Problems (Low) 1 2 3 4 5 6 7 8 9 10 (High)
   Why?

5. Family/Relationship Conflict (Low) 1 2 3 4 5 6 7 8 9 10 (High)
   Why?

6. Alcohol/Drug Use (Low) 1 2 3 4 5 6 7 8 9 10 (High)
   Why?

7. Verbal Abuse/Behavior (Low) 1 2 3 4 5 6 7 8 9 10 (High)
   Why?

8. Sexual Abuse/Behavior (Low) 1 2 3 4 5 6 7 8 9 10 (High)
Why?

9. Physical Abuse/Behavior (Low) 1 2 3 4 5 6 7 8 9 10 (High)
Why?

10. Job/School Conflicts (Low) 1 2 3 4 5 6 7 8 9 10 (High)
Why?

11. Internet Use/Concern (Low) 1 2 3 4 5 6 7 8 9 10 (High)
Why?

12. Gambling Concerns (Low) 1 2 3 4 5 6 7 8 9 10 (High)
Why?

13. Spiritual/Faith Concerns (Low) 1 2 3 4 5 6 7 8 9 10 (High)
Why?

14. Other Problem/Issue (Low) 1 2 3 4 5 6 7 8 9 10 (High)
Name and Why?

Years of Education: Currently Enrolled: Yes ○ No ○

Completed High School/GED?

Vocational? College? Graduate School? Degree?

Military Service: Yes ○ No ○ Combat Service? Yes ○ No ○

Branch? Where Served? Length of Service?

Previous Therapy/Medical History:
Have you previously worked with a therapist? Yes ○ No ○

If so, where and with whom?

Approximate dates of prior therapy?

For what reasons did you seek therapy?

Were you given a diagnosis?

Have you utilized psychiatric services? Yes ○ No ○

Have you taken medication for any mental health concerns? Yes ○ No ○

Name of Medication: Dosage Dates Taken Helpful (Y/N)
1.

2.

3.

Other health or medical concerns:

Chemical Health Concerns:

Please describe past and current use of alcohol/mood altering substances:

Have you ever felt the need to cut down on your drinking or substance use? Yes ○ No ○

Have you ever felt annoyed by people criticizing your drinking or substance use? Yes ○ No ○

Have you ever felt guilty about drinking or substance use? Yes ○ No ○

Have you sought treatment for alcohol or substance use? If so briefly describe:

Religious Affiliation/Spirituality:

Ethnic/Cultural Heritage:

ASSESSMENT
Why do you think there are these problems for you or your family?

PROBLEM SOLVING
What is the main goal or need you have for today's session?

What goals do you wish to accomplish through therapy?

What are your thoughts on how that can be accomplished?

With respect to the concerns that brought you in, what are your hopes for the future?

QUESTIONS/COMMENTS

Please list **below** any questions or particular concerns you may have for Dr. Brown or any other comments you would like to add or things you believe it is important for her to know.

Name_____ Date: _____ Date of Birth:_____

Please ask for clarification if you are unclear about what the question is asking. Some questions are repeated.
To what extent do you consider each of the following a problem for yourself?

0 Not At All 1 Somewhat 2 Moderate 3 Often 4 Extremely

Decreased or irritable mood		History of Trauma	
Weight loss or gain		Nightmares (about: _____)	
Appetite disturbance		Intrusive memories	
Fatigue, low energy level		Flashbacks	
Low self esteem		Body memories	
Feeling of hopelessness		Intense distress when reminded of trauma	
Feelings of worthlessness		Avoidance of reminders of trauma	
Poor concentration		Partial amnesia about trauma	
Indecisiveness		Developmental regressions	
Loss of interest/pleasure		Loss of sense of future	
Observable agitation		Feeling estranged from others	
Slowing down of physical and/or emotional response		Difficulty falling asleep	
Excessive guilt		Anger outbursts	
Suicide threats, wishes, plans		Hypervigilance	
Self-harming urges, behaviors: _____ _____		Exaggerated startle response	
		Unexpected panic attack, not triggered by social focus	
Excessive worrying about 2 or more life circumstances		Frequency	
Examples: school, job, finances, marriage, kids etc.		Persistent fear of having another attack	
Content of worries: _____		Shortness of breath or smothering sensations	
Trembling, twitching, or feeling shaky		Dizziness, unsteady feelings, or faintness	
Muscle tension, aches, or soreness		Trembling or shaking	
Restlessness		Sweating	
Easy fatigability		Choking	
Shortness of breath or smothering sensations		Nausea or abdominal distress	
Palpitations or accelerated heart rate		Depersonalization or derealization (feeling of being outside your body, surreal)	
Sweating, or cold clammy hands		Numbness or tingling sensations	
Dry mouth		Flushes (hot flashes) or chills	
Dizziness or lightheadedness		Chest pain or discomfort	
Nausea, diarrhea, or other abdominal distress		Fear of dying	
Flushes (hot flashes) or chills		Fear of going crazy or doing something uncontrolled	
Frequent urination		Fear of or severe difficulty leaving your house	
Trouble swallowing or "lump in throat"			
Feeling keyed up or on edge		Unusually high mood, expansive	
Exaggerated startle response		Unusually irritable mood	
Difficulty concentrating or "mind going blank"		Feeling unusually good about self	
Trouble falling or staying asleep		Decreased need for sleep	
Irritability		Hypertalkative, feel pressured to keep talking	
		Feel like thoughts are racing	
Any unusual stressors within the past 3 months		Easily distracted	
List: _____		Observable agitation	
Impairment in school, work, or social performance		Unusually high activity level	
Symptoms in excess of expected reaction to stressor		Out-of-character behavior	
		Examples: buying sprees, sexual indiscretion, etc.	
		Occupational functioning impaired by high mood	
Any concerns about your use of prescription drugs		Persistent fear of scrutiny by others	
Any concerns about your use of street drugs		Fear of doing publically doing something humiliating/embarrassing	
Any concerns about your use of alcohol		Feared situation is avoided, or endured with intense anxiety	
Have you tried to quit/cut down		Avoidant behavior interferes with normal functioning	

0 Not At All 1 Somewhat 2 Moderate 3 Often 4 Extremely

Frequency of intoxication		Persistent fears of other specific objects or situations	
Any withdrawal symptoms		List: _____	
Any losses due to use (license, jobs, money, etc.)		Listed fear is avoided, or endured with intense anxiety	
Developed any tolerance symptoms		Avoidant behavior interferes with normal functioning	
Repetitive intrusive thoughts or impulses		Difficulty adhering to medication regiment	
Efforts to suppress them		Side effects from medication	
Content: _____			
Feel driven to repeat behavior to avoid something bad		Low sexual desire	
Behavior feels excessive, unreasonable		Impairment in sexual functioning	
		Orgasm difficulty	
Delusions- firmly holding beliefs that others typically do not and in spite of contradictory information		Preoccupation with sex	
Hallucinations- sensory experiences that others in the same environment are not experiencing		Sexual compulsivity	
Difficulty communicating in a way that makes sense to other people		Hormonal fluctuations	
Difficulty making sense of your own thoughts		Premenstrual symptoms: _____ _____	
		Post-partum symptoms:	
Spirituality concerns:			
Concerns about connecting with faith community		Financial concerns	
Concerns centered around the meaning of life		Legal concerns	
Difficulty with sense of purpose, passion			
Major life transition: (birth, death, job change, retirement, graduation, medical diagnosis, move) _____		Other concerns not covered:	

MINNESOTA NOTICE FORM

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 a greater degree of 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 Psychology 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 **Dr. Jessica Brown, Psy. D. @ 952-224-0399 Ext 104.**

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:

Jessica Brown
1000 Shelard Parkway #520
St. Louis Park, MN 55426-1053
Phone 952-224-0399 Ext. 104
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. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on 4/14/03

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.

Your signature below indicates you have read this notice form and have been offered a copy of the HIPPA Notice Form described above, and had the opportunity to clarify any questions.

_____ _____

Signature of Client **Date**

_____ _____

Signature of Client or Parent/Guardian for a Minor **Date**