Transformation Counseling Twin Cities, LLC
Personal Data Form – If Client Is A Minor

Date _____ Who referred you to Transformation Counseling Twin Cities or Joseph (Joe) Sundeen, MA, LP? _____

Individual Counseling

Name (First, MI, Last) _____

DOB _____ Gender (circle one) Male Female SSN _____

Address _____ Email _____

City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____ Other _____

Mother (or Guardian) Name _____

Phone Home _____ Work/Other _____ Cell _____

Father (or Guardian) Name _____

Phone Home _____ Work/Other _____ Cell _____

May we identify ourselves by using the clinic name? (circle one) Yes No

If No, how should we identify ourselves? _____

May we leave a message? (circle one) Yes No

Parent's Marital Status (circle one)

Never Married	Married	Separated	Divorced	Widowed	Other

Siblings Names and Ages

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Non-Custodial Parent Information

Name _____

Address _____

City _____ State _____ Phone _____

Current School

Name		Grade	
City		State	

Transformation Counseling Twin Cities, LLC

Personal Data Form – If Client Is A Minor – Continued

Emergency Contact

Name _____ Phone _____

Relationship _____

Treatment

To best coordinate your care, may we contact your primary physician? (circle one)

Yes No

Do you have a psychiatrist? (circle one)

Yes No

To best coordinate your care, may we contact your primary psychiatrist? (circle one)

Yes No

Have you worked or are you working with any other mental health professionals? (circle one)

Yes No

Would you like us to contact this professional regarding your counseling sessions? (circle one)

Yes No

Transformation Counseling Twin Cities, LLC

Release of Information – Consent Form

If you answered YES to any of the above, please complete this **Release of Information Form below**

I, _____ , authorize Transformation Counseling Twin Cities, LLC and/or Joseph P. Sundeen, MA, LP to:

_____Send _____Receive the following information
_____To _____From the following agencies or people

Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

	Academic testing results		Psychological testing results
	Behavior Programs		Service plans
	Case notes		Summary reports
	Intelligence testing results		Vocational testing results
	Medical reports		Entire record
	Personality profiles		Other (specify below)
	Progress reports		
	Psychological reports		

The above information will be used for the following purposes:

	Planning appropriate treatment or program
	Continuing appropriate treatment or program
	Determining eligibility for benefits or program
	Case review
	Updating files
	Other (specify below)
Dates requested from_____ to current or _____	

Transformation Counseling Twin Cities, LLC

Release of Information – Consent Form – Continued

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

Client's name (please print)	_____	DOB	_____
Client's signature	_____	Date	_____
Spouse/Parent signature	_____	Date	_____
Witness (if client is unable to sign)	_____	Date	_____
Person informing client of rights	_____	Date	_____

Transformation Counseling Twin Cities, LLC

Consent for Treatment and Agreement to Terms

I. Consent for Treatment

By signing below, you are giving informed consent for treatment.
By signing below, you are also stating that you have received, read, and understood the Client Information and Office Policy Statement and agree to its terms, unless otherwise stated in writing.

I give my consent for treatment with Transformation Counseling Twin Cities, LLC and its associated professional staff to include evaluation, psychotherapy, and involvement in the treatment planning process. I understand that the client may decline at any time specific treatment recommendations.

II. Billing/Cancellations

I authorize Transformation Counseling Twin Cities, LLC to release the information necessary to Great Lakes Medical Billing, to process any applicable medical insurance claim for services provided by Transformation Counseling Twin Cities, LLC. I understand Transformation Counseling Twin Cities, LLC will release copies of my medical records and information as to the nature of my treatment as requested by the insurance company.

I understand that I will be charged for late cancellations or failed appointments (less than 24 hours). There will be a charge of $100.00, which is not covered by any insurance. You may leave a message or cancel 24 hours a day.

III. HIPAA/Notice of Privacy Practices/Limits of Confidentiality Statement

By signing below, you are stating that you have received, read, and understood the HIPAA/Limits of Confidentiality and agree to its terms, unless otherwise stated in writing.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Transformation Counseling Twin Cities, LLC's Notice of Privacy Practices. I understand that I can contact Transformation Counseling Twin Cities, LLC if I have any questions regarding the Notice of my privacy rights.

Client's Signature
(or parent/guardian if minor): _____ Date _____

Spouse's Signature
(for marital counseling): _____ Date _____

Name of minor being treated
(if applicable): _____

Transformation Counseling Twin Cities, LLC

Payment Contract for Services

Name(s) of client(s) receiving services _____
Person responsible for payment (if different) _____

Federal Truth in Lending Disclosure Statement

Clients With Insurance Coverage

Some Insurance companies have incorporated your Social Security number as a part of your ID number. Please check your card to see if this is required and fill in your full ID number here.

Insurance Carrier	
Full ID Number	
Group Number	

Deductible amount: $ _____

Co-payment: % or $ _____

We suggest you confirm your benefits and eligibility with your insurance company. Your insurance company
may not pay for services that they consider to be not effective, not medically or therapeutically necessary, or
ineligible. You are responsible for any amount not covered by insurance. It is your responsibility to know if
the desired therapist is accepted by your insurance.

Clients <u>Without</u> Insurance Coverage

I (we) agree to pay Transformation Counseling Twin Cities, LLC a rate of $ _____ per session (Defined as 45-60 minutes depending on the type of service rendered. Session could be for an assessment, individual, family, and/or relationship counseling).

All Clients: Please read and sign below

Payments and co-payments are due at the time of service. Any amount due on the client's account will be issued a statement showing the balance. Statement charges are due within 15 days. There may be an interest surcharge posted to overdue accounts which will be included on the statement.

I authorize Transformation Counseling Twin Cities, LLC to disclose case records (diagnosis, case notes, psychological reports, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment directly to Transformation Counseling Twin Cities, LLC. I understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I understand that I may revoke this consent at any time by providing written notice, and after one year this consent expires.

By signing below, I agree that I have received, read, and agree to the conditions of this form including the Federal Truth in Lending Disclosure Statement for Professional Services.

_____ _____

Signature of person responsible for payment Date