FINDING PEACE COUNSELING, LLC

MINDY FALKNER-WANN, LMFT

307.939.2620

PO BOX 4102

CHEYENNE, WY 82003

FAX NUMBER: 307.316.0773

Welcome to Finding Peace Counseling! I am excited you are taking this important step in your mental health care. I hope you find your time with me worthwhile and productive. The following information is provided to answer any questions you might have regarding what to expect from me, and how I intend to work together with you. **Please read the following information carefully and thoroughly.** Feel free to ask any questions you might have during your initial intake.

We are all human, therefore we all have problems from time to time. It's in those times of trouble that we sometimes need help. I would be honored to be that person to help in your time of need.

"We don't have to do all of it alone. We were never meant to." By Brene Brown.

I am a Licensed Marriage and Family Therapist in Wyoming. I hold a bachelor's degree in Psychology and a master's degree in Marriage and Family Counseling. Getting to apply my skills with such a broad variety of people and problems is really where I find purpose. Couples, families, adults, and children are all populations I care deeply about.

I use a variety of modalities in my work, such as cognitive behavioral therapy, family systems, play therapy, and even use my therapy dog, Lilly, in my work. She is a Certified Therapy Dog through the Alliance of Therapy Dogs and is also a Good Canine Citizen through AKC. She loves working with other as much as I do, and she helps alleviate anxiety, brightens emotional outlook, provides comfort, increases mental stimulation, and much more!

Please let me know if I can help you or your family in your time of need. I look forward to working with you

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.

OUR COMMITMENT TO YOUR PRIVACY:
We understand how important maintaining privacy of your personal health information is, and we are dedicated to doing just that. We are also required by law to maintain current privacy practices. Disclosure law is complicated, but important information will be provided. We cannot cover all possible situations, so please seek legal advice about any questions or problems concerning your legal rights as it relates to your treatment.

We will use information obtained about your health, obtained by you or others, primarily for the purpose of providing you with the best treatment possible. This information will be used to arrange for payment of services, including the use of collections agencies; or for some other business activities, considered health care operations. After you have read this notice, please sign the Consent for Treatment Form. This will allow us to use and share your information, as required; without this, we cannot provide treatment.

If we (or you) desire to use or disclose (send, share, release) your information for any purpose, other than ongoing treatment, we will discuss this and ask you to sign an authorization form regarding that disclosure.

Health information will be kept private, but there are times when we are required to release information, per the law:

1. A serious threat to your health and safety, or the health and safety or another individual or the public.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For workers compensation and other similar benefit programs.

There are other situations, but those do not happen regularly.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. You can ask for us to communicate with you about your health and related information in a particular way, or certain place. For example, to call you at your home and not a work to schedule or cancel and appointment. Once agreed upon, the agreement cannot change without your authorization.
2. You have the right to ask for limited information to be shared with individuals involved in your care or the payment of your care such as family or friends.
3. You have the right to request the health information we have, such as your medical and billing records notes. You also have the right to:
    a. Ask for and receive information about a therapist's qualifications including licensure, education, training, experience, special areas of practice and limits on practice,
    b. Written information, before therapy, about fees, method of payment, insurance coverage, and number of sessions likely needed, substitute therapists (vacations and emergencies), and appointment cancelations.
    c. Refuse video or audio recording of sessions.
    d. Refuse to answer any questions, or not provide information you do not wish to disclose.
    e. Know if you therapist will discuss your case with supervisors, other consultants or students.
    f. Ask the therapist to inform you of any progress.
4. You have the right to request to amend your records
5. You have the right to request an accounting of disclosures
6. You have the right to file a complaint.

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While we do not have to agree to any requests, if we do agree, we will keep our agreement to you, with the exception of an emergency, it is against the law, or if the information is necessary to treat you.

REPORT PROBELMS OR VIOLATIONS

If you have any issues regrading your treatment, please speak with me as your counselor. You may also contact the Wyoming Mental Health Professionals Licensing Board at: 2001 Capitol Avenue, Suite 104, Cheyenne, Wyoming 82001; Telephone 307.777.7788.

Name of Client: _____

Signature of Client: _____ Date: _____

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date: _____

Relationship to Client: Self ☐ Parent ☐ Guardian ☐

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INFORMED CONSENT FOR TREATMENT/FEE SCHEDULE

INFORMED CONSENT

The client hereby seeks and consents to take part in treatment by Finding Peace Counseling. Client understands that developing a treatment plan with the therapist and regularly reviewing the work toward meeting treatment goals is in client's best interest. Client agrees to play an active role toward meeting treatment goals as agreed upon. Client understands that no promises have been made regarding treatment results or outcomes, or of any procedures provided by the therapist.

Client is aware that he/she may terminate services at any time. The client will remain responsible for paying for services already received. Client must call to cancel an appointment at least 24 hours in advance. If client does not show up, or does not cancel, client may be charged a late cancel fee that cannot be billed to the insurance.

Client is aware that an agent of their insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), diagnose(s), and providers or any services or treatment client receives. Client understands that if payment for services is not made treatment may be stopped. Client also understands that any information needed to collect unpaid fees will be released to collections agencies, attorneys, or others necessary for the collection of fees for services that have been provided.

Client understands and agrees to pay for all services provided, and that is the responsibility of the client, and that phone consultation may be billed at the same rate as office visits. The undersigned requests payment of authorized benefits for services rendered by Finding Peace Counseling, is made directly to Finding Peace Counseling. In the event that the undersigned is paid directly by an insurance company, the undersigned agrees to promptly pay Finding Peace Counseling. Insurance payments sent to the client for services can and should be directly signed over to Finding Peace Counseling or Mindy Falkner. It is your responsibility to know your insurance coverage and receive any appropriate pre-authorizations. Finding Peace Counseling provides insurance billing only as a courtesy to clients.

FEE SCHEDULE

Initial intake billed in insurance includes treatment plan and insurance authorization (CPT 90791): $200
Full session billed to insurance, approximately 60 minutes (CPT 90837): $180
Abbreviated session billed to insurance, approximately 45 minutes (CPT 90834): $135
Brief session billed to insurance, approximately 30 minutes (CPT 90832): $90
Non-insurance sessions, "cash rate", only if paid in full at time of session, approx. 60 minutes: $100
Non-insurance sessions, "cash rate", only if paid in full at time of session, approx. 45 minutes: $75
Non-insurance sessions, "cash rate", only if paid in full at time of session, approx. 30 minutes: $50
Medicaid billed in 15 minute increments of $45
No show/take cancel fees (not billed to insurance): $50
We are currently unable to bill Medicare

COST: The charge for each session is listed above. Payments are expected at the end of each session unless previous billing arrangements have been made. Your health insurance MAY help pay these charges. Please contact your insurance company as soon as possible to inquire about benefits for mental health services. You are responsible for paying your fees. We will provide your insurance company with a statement (HCFA-1500 claim form) for insurance reimbursement. We currently employ a client accounts manager. The basic identifying information for service dates, type of service, diagnosis and fees will be shared with that person for billing purposes. We will make every effort to work with you regarding a payment plan if one is needed. If you ignore your responsibility to pay for services rendered, a collection agency will be utilized. Your signature below acknowledges that you have received notice that your information will be given in effort to bill and collect fees for services rendered. If a late cancel fee is assessed it cannot be billed to your insurance.

_____Bill my insurance company, and then balance bill the client/guardian of the client.

_____Collect reduced "cash rate" at the time of service.

EMERGENCY: We do NOT provide 24 hour, on call coverage and cannot always be reached. If you do have an emergency and we are not immediately available, contract 911 or go to your nearest emergency room.

In the event of an extended illness or death, another clinician at Finding Peace Counseling will work with you to coordinate services with another provider.

Client and/or parent/guardian signature below indicates that designated parties agree with all statement in the contract/informed consent for treatment/fee schedule.

Name of Client: _____

Signature of Client: _____ Date: _____

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date: _____

Relationship to Client: Self ☐ Parent ☐ Guardian ☐

I, the counselor at Finding Peace Counseling, have discussed the issues above the client and/or parent/guardian. Counselor observations of this person's behavior and responses give no reason to believe this person(s) is not fully competent to give informed and willing consent to receive treatment services from Finding Peace Counseling.

Counselor:_____ Date:_____

Copy accepted by client: ☐ Client requested copy to be kept by therapist: ☐

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CLIENT INFORMATION SHEET

CLIENT INFORMATION

Client Name: _____
Last First Middle

Home Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____

May we leave a voice message? Yes ☐ No ☐ May we send a reminder text message? Yes ☐ No ☐

Email: _____

SSN: _____ Birthdate: _____

Employer / School & Grade: _____

PARENT/GUARDIAN 1 INFORMATION:

Parent/Guardian Name:_____
Last First Middle

Home Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____

May we leave a voice message? Yes ☐ No ☐ May we send a reminder text message? Yes ☐ No ☐

Email: _____

SSN: _____ Birthdate: _____

Employer / School & Grade: _____

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PARENT/GUARDIAN 2 INFORMATION:

Parent/Guardian Name:_____
Last First Middle

Home Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____

May we leave a voice message? Yes ☐ No ☐ May we send a reminder text message? Yes ☐ No ☐

Email: _____

SSN: _____ Birthdate: _____

Employer / School & Grade: _____

EMERGENCY CONTACT:

Name:_____
Last First Middle

Relationship to Client:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

May we contact in the event of an emergency? (please initial) Yes _____ No _____

What information may we share with your emergency contact? (please initial all that apply)

_____ Scheduling Information _____ Billing Information _____ Diagnosis

_____ Session Notes _____ Other: _____

REFERRAL SOURCE

How did you hear about us?_____

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INSURANCE COVERAGE

It is very important that you provide us with ALL of your insurance coverage plans. We cannot provide an accurate, and complete billing of your insurance without it. Please bring with you to your first appointment all insurance cards.

PRIMARY INSURANCE COVERAGE

Insurance Name: _____

Policy Number: _____ Group Number: _____

Policy Subscriber Name: _____ Relationship to Client: _____

Company Address: _____

Company Phone Number: _____

Effective Date: _____ Deductible: $ _____ Co-Pay: $ _____

SECONDARY INSURANCE COVERAGE

Insurance Name: _____

Policy Number: _____ Group Number: _____

Policy Subscriber Name: _____ Relationship to Client: _____

Company Address: _____

Company Phone Number: _____

Effective Date: _____ Deductible: $ _____ Co-Pay: $ _____

TERTIARY INSURANCE COVERAGE

Insurance Name: _____

Policy Number: _____ Group Number: _____

Policy Subscriber Name: _____ Relationship to Client: _____

Company Address: _____

Company Phone Number: _____

Effective Date: _____ Deductible: $ _____ Co-Pay: $ _____

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INTAKE INFORMATION

PRESENTING CONCERNS

Describe your reasons for coming to counseling:

How long has this been happening?

How is it affecting you?

SELF-HARM & SUICIDE HISTORY

Are you currently experiencing self-harm or suicidal behaviors? Please describe.

Do you have a history of self-harm or suicidal behaviors? Please describe.

MENTAL HEALTH HISTORY

Have you seen a counselor/therapist? Please describe.

HEALTH HISTORY

How would you describe your overall health?

Are you currently taking any medications?

Any significant past surgeries/medical problems? Please describe.

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SUBSTANCE USE INFORMATION

In the past 12 months, have you had any alcoholic beverages? Please describe.

Have you ever used substances, legal or illegal, for the intent of altering your state of mind?

LIFESTYLE INFORMATION

Are you religious/spiritual?_____ Is spiritual important to you?_____

Do you participate in religious activities?_____ What church do you attend?_____

Do you date?_____ Are you currently in a relationship?_____

How satisfied are you in this relationship?_____

Do you have someone to talk to when you are struggling?_____

Any current legal problems? Please describe._____

How long have you been at your current job?_____ Are you satisfied with your job?_____

Any issues related to your job/school? Please describe:

FAMILY BACKGROUND

Does anyone in your family have a mental health issue? Please describe?

Who were you primarily raised by?

FINAL QUESTIONS

Any other concerns we should be aware of?

What would you like to accomplish in therapy?

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PRESENTING SYMPTOMS

Please check YES or No for situations currently occurring, and Past if you have a history of that symptom.

Yes	No	Past	Symptom
☐	☐	☐	Depression
☐	☐	☐	Mood Swings
☐	☐	☐	Low Energy
☐	☐	☐	Poor concentration
☐	☐	☐	Difficulty focusing
☐	☐	☐	Trouble with decisions
☐	☐	☐	Irritability
☐	☐	☐	Problems with anger
☐	☐	☐	Verbal abusiveness
☐	☐	☐	Physical abusiveness
☐	☐	☐	Seeing things that are not there
☐	☐	☐	Thoughts of death
☐	☐	☐	Cry frequently
☐	☐	☐	Poor appetite
☐	☐	☐	Weight loss
☐	☐	☐	Weight gain
☐	☐	☐	Excessive energy periods
☐	☐	☐	Frequent high anxiety
☐	☐	☐	Obsessing thoughts
☐	☐	☐	Panic attacks
☐	☐	☐	Fear of going crazy
☐	☐	☐	Other intense fears
☐	☐	☐	Anxiety in social settings
☐	☐	☐	Feeling shaky frequently
☐	☐	☐	Intrusive throughs/images
☐	☐	☐	Difficulty getting along with others?
☐	☐	☐	Concerns about your drug or alcohol use?
☐	☐	☐	Tingling or numbness
☐	☐	☐	Repetitive behaviors
☐	☐	☐	Worry a lot
☐	☐	☐	Nightmares
☐	☐	☐	Frequent spacing out
☐	☐	☐	Significant time loss
☐	☐	☐	Memory problems
☐	☐	☐	Frequently take sleeping pills

Yes	No	Past	Symptom
☐	☐	☐	Hearing voices
☐	☐	☐	Prior suicide attempts
☐	☐	☐	Hallucinations
☐	☐	☐	Binge Eating
☐	☐	☐	Self-induced vomiting
☐	☐	☐	Periods of self-starving
☐	☐	☐	Excessive exercise
☐	☐	☐	Laxative overuse
☐	☐	☐	Overuse of alcohol
☐	☐	☐	Alcohol induced blackouts
☐	☐	☐	Overuse of prescription drugs
☐	☐	☐	Compulsive behaviors
☐	☐	☐	Spending too much money
☐	☐	☐	Intentional self-injury
☐	☐	☐	Victim of abuse
☐	☐	☐	Flashbacks
☐	☐	☐	Difficulty coping
☐	☐	☐	Hard to function
☐	☐	☐	Sexual problems
☐	☐	☐	Relationship problems
☐	☐	☐	Low self-esteem
☐	☐	☐	Spirituality concerns
☐	☐	☐	Too much stress
☐	☐	☐	Headaches
☐	☐	☐	Stomach trouble
☐	☐	☐	Rituals (i.e. Hand washing/checking)?
☐	☐	☐	Others concerned about your drug/alcohol use?
☐	☐	☐	Bowel problems
☐	☐	☐	Physical pain
☐	☐	☐	Take pain pills often
☐	☐	☐	Frequent fatigue
☐	☐	☐	Other health problems
☐	☐	☐	Change in sleep
☐	☐	☐	Too much sleep

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