CROSSROADS COUNSELING CENTERS INC.

NEW CLIENT INTAKE REGISTRATION

Client Name: _____ Date of Birth: _____ Age: _____

Parent/Guardian Name(s) (if applicable): _____

Marital Status: _____ Gender: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (Please indicate if we may call/leave message at each number)

Cell: _____ ☐ Yes ☐ No Home: _____ ☐ Yes ☐ No

Work: _____ ☐ Yes ☐ No

Employment Status (Check all that apply): ☐ Employed full-time ☐ Employed part-time ☐ Self-employed
☐ Not employed ☐ Retired ☐ Active Duty Military ☐ Student ☐ Disabled

Employer: _____ Employer Address: _____

Spouse/Partner's Name: _____ Phone: _____

Other Emergency Contact: _____ Relationship: _____ Phone: _____

How did you learn of Crossroads/who referred you? _____

Would you like to receive text reminders sent to your cell phone for your appointments? ☐ Yes ☐ No

If I have checked "Yes" to the above, I hereby acknowledge that text messaging is not a "secure" form of communication and not HIPAA-compliant. _____ (Initials)

Methods of Payment (Check all that apply):

☐ Insurance - Proof of Insurance must be provided at the time of intake

☐ Private Pay - Exact cash, check or credit or debit card. Credit/debit information must be provided via Easy Pay Consent form.

☐ Church Payment Assistance - If your church is assisting with all or partial payments, our Counseling Referral Form must be completed prior to services being rendered. Name of church assisting with payments: _____

☐ Employee Assistance Program (EAP) – Case/Authorization number, if applicable: _____

☐ Health Savings Account (HSA)

☐ Employer Flex Plan

OFFICE USE ONLY

Intake Date: _____ Tenn. Given: ☐ Yes ☐ No Intake staff: _____ Counselor: _____ Client Number: _____ Date Entered: _____	
☐ 201 28th Ave SW, Willmar, MN 56201 | Phone: 320-214-8558 | Fax: 320-235-2733 ☐ 625 Broadway Suite 104, Alexandria, MN 56308 | Fax: 320-763-7500 ☐ 1120 Atlantic Ave, Benson, MN 56215 | Fax: 320-843-2621	

PAYMENT POLICY

Please note: Crossroads Counseling Centers, Inc. may also be referred as: Crossroads and/or CCC

1. **Insurance.** We accept a variety of insurances, which vary depending on the individual provider. If you have questions about the insurance you are enrolled in and whether or not your plan will cover mental/behavioral health services, please contact your health insurance company directly. We expect you to provide us with a copy of your insurance card prior to services being rendered in order to verify your health insurance coverage.
2. **Co-Payments, Deductibles, and/or Co-Insurance.** Co-payments may or may not be listed on your medical card and are due before services are rendered, *no exceptions*. Deductibles and/or co-insurance are the client's responsibility after your insurance company/companies have processed the claim(s). We will mail a statement with a due date after we've received the explanation of benefits from your health insurance company/companies. It is your responsibility to make your payment in full and on time.
3. **Non-payment.** If CCC does not receive your payment by the due date listed on the statement, you will incur the following late fees:
   a) 0-30 days: $15.00 fee **b)** 31-60 days: $30.00 fee **c)** 61-90 days: $45.00 fee
   d) 91 days and beyond: You will receive a final statement and letter stating you have 10 business days to make your payment in full. Partial payments will not be accepted unless otherwise negotiated. If your balance remains unpaid, your bill will be submitted to a debt collector.
4. **Non-covered services.** If your insurance does not cover the services provided, or is not considered medically necessary, you will be billed for these services and you must pay for these services in full at the time of visit.
5. **Proof of insurance.** Each client is required to complete our intake information upon their first visit. We require you to provide your insurance card at this time. Paper/electronic copies will not be accepted. If we do not receive this information, you will be billed for the balance.
6. **Claims Submission.** If you provided us with insurance coverage, we will submit the claims to your insurance company on your behalf. It is our intention to process your claims correctly and in accordance to your insurance company's policies. If we receive information that you need to contact your insurance company in order for them to process your claim, it is your obligation and duty to comply with their request. If you fail to follow up on the request, we will send you a bill for the balance. We are an outside party of your health insurance contract; and the contract is only between the insured and the insurance company.
7. **Coverage Changes.** If your insurance changes or there is a change how your services are being covered, notify us before your next visit. If your insurance coverage lapses, and there is no communication after 30 days, we will automatically bill you for the sessions you attended without coverage.
8. **Missed Appointments and Late Cancellation Policy.** It is our mission to serve you during your therapy sessions and we do our best to accommodate your schedule. With the exception of illness and inclement weather, **we require a 24-hour notice if you are unable to attend your scheduled appointment**. Insurance companies do not pay for "no-shows" or late cancellations. Our policy is to charge you for missed appointments and late cancellations. **You will be charged for no-shows and late cancellations.** These charges are your responsibility and you will be billed directly. After three no-shows or late cancellations, you will not be allowed to schedule another appointment. If you have arranged with your therapist to have standing appointments, all appointments will be removed from the schedule after the first no-show and you will need to arrange appointments on a week-by-week basis. Your therapy is important to us and providing adequate notice when you cannot attend is key to keeping your regularly scheduled appointments.

We are committed to providing you with the best treatment possible. Please contact our business office with any inquiries regarding the payment policy.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature: _____ **Date:** _____

Crossroads Counseling Centers, Inc. reserves the right to change and/or modify the information on this policy at any time.
Policy effective July 1, 2017

CLIENT RIGHTS & RESPONSIBILITIES

1. You have the right to impartial access to treatment regardless of race, religion, sex, age, ethnicity, or disability.
2. You have the right to considerate and respectful treatment and recognition of your personal dignity.
3. You have the right to be informed of your rights in a language you understand and to receive a copy of your rights.
4. You have the right to services provided in the least restrictive environment possible.
5. You have the right and responsibility to participate in treatment decisions.
6. You have the right to obtain information about your condition and prognosis from your clinician.
7. You have the right to obtain information about treatment recommendations and alternatives.
8. You have the right to periodic review of your treatment plan.
9. You have the right to review and correct information in your case file. There may be a charge if you would like copies.
10. You have the right to expect that case discussion and consultation will be conducted in a confidential manner.
11. You have the right to terminate services at any time.
12. You have the right and responsibility to be involved in planning for the termination of your treatment.
13. You have the right to be informed of alternatives available when you leave treatment, and to be given specific follow-up recommendations.
14. You have the right to report any incidences of mistreatment whether you are a victim or an observer.
15. You, your family, or your legal guardians have the right to present complaints concerning the quality of your care.
16. You, your family, or your legal guardians have the right to request a review of the practices and procedures for ensuring clients' rights and for addressing questions or complaints about your individual treatment plan.
17. You, your family, or your legal guardians have the right to file a formal grievance. You may request a copy of the grievance procedure or it may be found on the Crossroads website.
18. With the exceptions of illness or weather, you have the responsibility to inform your clinician at least 24 hours in advance if a scheduled appointment cannot be kept so that the appointment may be offered to another person in need.
19. You have the right to expect that if a clinician is unable to keep a scheduled appointment, you will be advised within a reasonable period of time.
20. You have the right to be informed in advance of all estimated charges being made, the costs of services provided, sources of the organization's reimbursement, and any known limitations on length of services.
21. You have the right to withdraw your permission at any time in matters to which you have previously consented.
20. You have the right to request the opinion of another clinician at your own expense.
21. You have the right to privacy regarding information contained in your case file. Your written permission is required to release information to a 3rd party. You have the right to be informed of what information will be released and why.
22. You have the right to expect that all communications and records pertaining to your treatment will be treated as confidential and in accordance with HIPPA, with the following exceptions to confidentiality:
when physical harm is threatened against one's self or another person,
when there has been physical abuse, sexual abuse, or neglect of a child or vulnerable adult,
when records are subpoenaed by a local, state, or federal court,
as otherwise required by law.
23. Crossroads Counseling Centers Inc. has a policy of legal neutrality. You agree to refrain from attempting to subpoena or require any clinician to appear in any legal proceeding related to any matters discussed during counseling; nor will you attempt to subpoena notes or records related to this counseling.
24. All counseling is values-based, and clinicians at Crossroads Counseling Center, Inc. represent the Christian perspective. While their counseling approach will reflect this values perspective, you have the right to expect Crossroads' clinicians to respect your personal values and religious perspective without judgment.

I have read and understand my rights and responsibilities as a client of Crossroads Counseling Centers, Inc.

_____	_____	_____	_____
Client Signature	Date	Clinician Signature	Date
_____	_____	_____	_____
Parent/Guardian Signature (if applicable)	Date	Parent/Guardian Signature (if applicable)	Date

EASY PAY CONSENT

I authorize Crossroads Counseling Centers, Inc. to charge my credit, debit, or Health Savings Account card at the time of service for copayments, deductibles, co-insurance, late cancellations and no-show appointments as they occur.

Please indicate if you would like Crossroads Counseling Centers to mail a monthly statement indicating charges incurred on your card.

☐ Yes ☐ No By marking "No" your card will still be debited for any applicable charges mentioned above; however a statement will ***not*** be mailed unless requested. A statement may be requested through our business office at any time during business hours.

Cardholder Information

Name: _____

Address:_____

City: _____ State: _____ Zip: _____

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Card Number: _____

Expiration Date (MO/YR): _____ CVV: _____

Cardholder Signature: _____ Date: _____

INSURANCE AUTHORIZATION

Primary Insurance

Insurance Company Name: _____

Subscriber ID: _____Group #: _____

Subscriber Name: _____ Subscriber Date of Birth:_____

Subscriber Mailing Address: _____

Subscriber SSN: _____Employer: _____

Secondary Insurance

Insurance Company Name: _____

Subscriber ID: _____Group #: _____

Subscriber Name: _____ Subscriber Date of Birth:_____

Subscriber Mailing Address: _____

Subscriber SSN: _____Employer: _____

Guarantor

Name: _____ SSN: _____

Relationship to Client: _____Date of Birth: _____

Mailing Address: _____

Home Phone:_____ Mobile: _____

Employer: _____ Work Phone: _____

I authorize direct payment of all insurance benefits, including Medicaid and Medicare, to CCC for all covered services provided to myself or my dependent during the course of counseling. I authorize CCC to release information from the medical record of the above mentioned client for the purpose of accessing insurance benefits. I understand insurance billing is a service provided as a courtesy and I am at all times financially responsible and will notify CCC of any changed in my health care coverage. In most cases, exact benefit coverage cannot be determined until after insurance has processed the claim. I am responsible for the entire balance of the bill as determined by CCC and/or my insurer if the submitted claims or any part of then are denied for payment. I authorize CCC to process my debit/credit/HSA card on file as sessions occur and have completed an Easy Pay Consent form. I understand that by signing below I am accepting financial responsibility as explained above for all payment of services/or treatment provided.

Responsible Party's Signature: _____ Date: _____

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PROBLEM CHECKLIST - ADULT

Name: _____ **Date:** _____

In an effort to be helpful to you, it is important that we get a good idea about the things that are happening in your life. Please be as honest as possible.

Please check the items that you have experienced <u>anytime</u> in your life, and/or have experienced in the <u>past six months.</u>

Anytime	6 Months	
☐	☐	Depressed Mood
☐	☐	Loss of Interest/Pleasure
☐	☐	A 2-Week Period of Time Where You Had Depressed Mood or Loss of Interest in Activities
☐	☐	Depressed Mood that is Worse in the Winter Months
☐	☐	Increased or Decreased Appetite or Unintended Weight Change
☐	☐	Difficulty Staying Awake
☐	☐	Sleeping Too Much
☐	☐	Fatigue/Low Energy Level
☐	☐	Low Self Esteem
☐	☐	Being Unable to Experience Pleasure/Positive Emotions
☐	☐	Difficulty Concentrating or Making Decisions
☐	☐	Difficulty Concentrating Because of Worry
☐	☐	Feelings of Hopelessness
☐	☐	Feelings of Guilt
☐	☐	Feelings of Worthlessness
☐	☐	Feeling Slowed Down
☐	☐	Recurrent Thoughts of Death or Dying
☐	☐	Suicidal Thoughts/Ideation
☐	☐	Suicidal Plan
☐	☐	Suicidal Actions
☐	☐	Urge to Cut Self
☐	☐	Cutting Self
☐	☐	Reduced Sexual Interest
☐	☐	Debilitating Shame
☐	☐	Waking up Too Early (At Least 2 Hours Before Usual Awakening)
☐	☐	Feeling "On Top of the World" Without a Special Reason
☐	☐	Inflated Self-Esteem (Feeling "Cocky")
☐	☐	Having a Lot More Energy than Usual
☐	☐	Being a Lot More Productive than Usual
☐	☐	Needing Less Sleep than Usual
☐	☐	Being More Talkative Than Usual (Pressure to Keep Talking)
☐	☐	Having Racing Thoughts or "Flight of Ideas"
☐	☐	Easily Distractible (By Unimportant/Irrelevant Things)
☐	☐	Being Hyperactive, Agitated, or "Speeded Up"
☐	☐	Being Impulsive
☐	☐	High-risk Behaviors (Overspending, Sex Sprees, Reckless driving)
☐	☐	Blackouts (With or Without Substance Use)
☐	☐	Hearing a Voice Even When No One Else is around
☐	☐	Knowing Special Secrets Which No One Else Believes
☐	☐	Having Someone Read My Mind/Tamper with My Thoughts

Anytime	6 Months	
☐	☐	Having an Outside Force Control My Brain or Thoughts
☐	☐	Using My Thought Waves to Control Thoughts of Others
☐	☐	Anxiety, Nervousness, or Worry
☐	☐	Fear
☐	☐	Needing Everything to Be Perfect
☐	☐	Having Thoughts that Repeat Themselves Over and Over
☐	☐	Feeling the Need to Repeat Certain Behaviors Over and Over
☐	☐	Feeling Like You Might Lose Control of Yourself
☐	☐	Agitation (Pacing, Inability to Sit Still, etc.)
☐	☐	Feeling Shaky or Trembling
☐	☐	Restlessness
☐	☐	Irritability
☐	☐	Difficulty Falling or Staying Asleep
☐	☐	Unintended Weight Loss
☐	☐	Smothering Sensation
☐	☐	Feeling "Keyed Up," Tense, or "On Edge"
☐	☐	Exaggerated Startle Response (Feeling "Jumpy")
☐	☐	Difficulty Concentrating ("Blanking Out") When Nervous
☐	☐	Palpitations or Accelerated Heart Rate
☐	☐	Shortness of Breath (Without Physical Exertion)
☐	☐	Sweating or Cold Clammy Hands
☐	☐	Panic Attacks with Shortness of Breath/Smothering
☐	☐	Panic Attacks with Dizziness or Fainting
☐	☐	Panic Attacks with Palpitations or Rapid Heart Beat
☐	☐	Panic Attacks with Trembling or Shaking
☐	☐	Panic Attacks with Sweating
☐	☐	Panic Attacks with Choking
☐	☐	Panic Attacks with Nausea or Abdominal Distress
☐	☐	Panic Attacks with Feelings of Unreality
☐	☐	Panic Attacks with Hot Flashes or Chills
☐	☐	Panic Attacks with Chest Pain or Discomfort
☐	☐	Panic Attacks with a Fear of Dying
☐	☐	Panic Attacks with a Fear of Losing Control/"Going Crazy"
☐	☐	Remembering Painful Things That Happened in the Past
☐	☐	Upset About Something That Happened in the Past 6 Months
☐	☐	Trying Hard Not to Think about Something that Happened, or
☐	☐	Going Out Of Your Way to Avoid Situations That Remind You of It
☐	☐	Nightmares
☐	☐	Intrusive Thoughts
☐	☐	Constantly Feeling on Guard, Watchful, or Being Easily Startled
☐	☐	Feeling Numb or Detached from Others, Activities, or Surroundings

Anytime / 6 Months

- ☐ ☐ Difficulty Swallowing or a "Lump in the Throat"
- ☐ ☐ Dry Mouth
- ☐ ☐ Hot Flashes or Chills
- ☐ ☐ Loss of Voice
- ☐ ☐ Heartburn or Acid Reflux
- ☐ ☐ Pain in Extremities
- ☐ ☐ Numbness in Extremities
- ☐ ☐ Back Pain
- ☐ ☐ Deafness
- ☐ ☐ Dizziness or Lightheadedness
- ☐ ☐ Headaches
- ☐ ☐ Amnesia
- ☐ ☐ Fainting or Loss of Consciousness
- ☐ ☐ Seizure or Convulsion
- ☐ ☐ Blurred or Double Vision
- ☐ ☐ Abdominal Pain (Other than When Menstruating)
- ☐ ☐ Vomiting (Other than Motion Sickness or During Pregnancy)
- ☐ ☐ Nausea (Other than Motion Sickness or During Pregnancy)
- ☐ ☐ Diarrhea
- ☐ ☐ Chronic Pain
- ☐ ☐ Muscle Tension
- ☐ ☐ Physical Health Problems
- ☐ ☐ Painful Menstruation
- ☐ ☐ Pain or Burning Sensation in Sexual Organs (Not During Intercourse)
- ☐ ☐ Painful Intercourse
- ☐ ☐ Difficulty Achieving Orgasm
- ☐ ☐ Erectile Dysfunction
- ☐ ☐ Other Sexual Problems
- ☐ ☐ Legal Problems
- ☐ ☐ Concerns About Children
- ☐ ☐ Avoidance

Anytime / 6 Months

- ☐ ☐ Poor Self Care
- ☐ ☐ Poor Interpersonal Skills
- ☐ ☐ Interpersonal Conflict
- ☐ ☐ Poor Judgement
- ☐ ☐ Job/Occupational Difficulties
- ☐ ☐ Difficulty Keeping Relationships/Friendships
- ☐ ☐ Recurrent Episodes of Binge Eating
- ☐ ☐ Feeling a Lack of Control During Episodes of Binge Eating
- ☐ ☐ Self-Induced Vomiting to Prevent Weight Gain
- ☐ ☐ Dieting or Use of Laxatives to Prevent Weight Gain
- ☐ ☐ Average of Two Eating Binges a Week for at Least 3 Months
- ☐ ☐ Persistent Concern with Body Shape or Weight
- ☐ ☐ Significant Weight Loss during the Past Year
- ☐ ☐ Intense Fear of Gaining Weight or Becoming Fat
- ☐ ☐ Feeling "Fat" Regardless of Actual Body Weight
- ☐ ☐ Missing at Least Three Consecutive Menstrual Cycles
- ☐ ☐ Drinking Alcohol in Larger Amounts or Longer Than Intended
- ☐ ☐ Unsuccessfully Trying to Cut Down or Control Drinking
- ☐ ☐ Spending a Lot of Time Drinking/Recovering from Being Drunk
- ☐ ☐ Drinking When You Should Have Been Doing Other Things
- ☐ ☐ Giving Up Social or Recreational Activities Because of Drinking
- ☐ ☐ Drinking Despite Arguments from Family or Friends
- ☐ ☐ Drinking Larger Amounts of Alcohol to Get the Same Effect
- ☐ ☐ Using a Drug in Larger Amounts or Longer Than Intended
- ☐ ☐ Unsuccessfully Trying to Cut Down or Control Drug Use
- ☐ ☐ Spending a Lot of Time Using/Recovering from Drug Use
- ☐ ☐ Using a Drug When You Should Have Been Doing Other Things
- ☐ ☐ Giving Up Social or Recreational Activities Because of Drug Use
- ☐ ☐ Using a Drug Despite Arguments from Family or Friends
- ☐ ☐ Using Larger Amounts of a Drug to Get the Same Effect

In your own words, describe the problem(s) you are currently experiencing:

_____
_____
_____
_____
_____
_____
_____

Following therapy/counseling, what would you like to see changed about your life and situation?

_____
_____
_____
_____
_____
_____
_____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Please Circle)	Not At All	Several Days	More Than Half The Days	Nearly Every Day
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 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

(Healthcare professional; For interpretation of TOTAL, Please refer to accompanying scoring card.

Add Columns ☐ + ☐ + ☐

Total: ☐

10.	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not Difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all or not sure	Several days	Over half the days	Nearly every day
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's 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
Add the score for each column	+	+	+	

Total Score *(add your column scores)* =

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____

Somewhat difficult _____

Very difficult _____

Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.