Erin Mckeen, LMFT, ATR

Licensed Marriage and Family Therapist Registered Art Therapist
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Welcome. I'm pleased that you have chosen to take this step. I look forward to working with you.
Note: information you provide here is protected as confidential information. Please keep a copy of the 4 pages under office policies for your own reference.

Childs Name: _____**Birth Date:** ------/------/---------
Address: _____**City, Zip:**_____
Home Phone: _____May I leave a message? □ *Yes* □*No*
Cell/Phone: _____May I leave a **VM**? □ *Yes* □*No* **Text**? □ *Yes* □*No*
Email: _____May I **email** you? □ *Yes* □*No*
Mother:_____**Phone**_____
Father:_____**Phone**_____
Sibling(s) Name(s) and age(s)_____

Note: Email correspondence and texts are not guaranteed as a confidential method of communication. If you choose to use it please limit to details like scheduling and know that by checking the boxes you are allowing its use.* ****Please initial here: _____.*

Referred by/how did you find me?
_____

Has your child previously received any type of therapy or mental health services (psychotherapy, psychiatric help, counseling, self help, etc.)? □ *No* □ *Yes*, previous therapist/practitioner and timetable:
_____

Describe that process and if it was helpful:
_____
_____

Is your child currently in school? □ *No* □ *Yes*

Where?_____

Do they enjoy school? Please explain?
_____
_____

What currently describes your family structure:

□ Single □ Cohabitating/Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Who has Legal and Physical Custody of the child?_____

***If parents are divorced, please include a copy of the custody paperwork.

Are you a blended family? □ *No* □ *Yes* If *yes*, for how long_____

On a scale of 1-10, how would you rate your child's relationship with your partner? _____

Describe any issues that may impact your child:
_____
_____
_____
_____

Rate your child's current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good

Describe any health concerns:
_____
_____
_____

Describe current sleeping habits (please circle)

Poor Unsatisfactory Satisfactory Good

Describe any sleep problems your child is experiencing:
_____
_____

Describe any difficulties with your child's appetite or eating patterns:
_____
_____

What hobbies, interests, or exercise, if any, does your child participate in?
_____
_____
_____
_____

Is your your child currently experiencing anxiety, panic attacks, obsessions, compulsions, fears or phobias?

□ No □ Yes If yes, when did he/she begin experiencing this?_____

Describe:_____
_____
_____

Are they currently experiencing sadness, grief or depression? □ No □ Yes If yes, how long?
_____

Describe_____
_____

Does your child have a history or are they currently having thoughts of harming his/herself? □ No □ Yes if yes, describe circumstances/dates:

_____
_____
_____

Has your child had any suicide attempts? □ No □ Yes if yes, describe circumstances/dates:
_____
_____
_____

Is your child experiencing any acute or chronic pain? □ No □ Yes if yes, describe:
_____

Are they currently taking any medication including psychiatric meds? □ No □ Yes if yes, please list medication(s) & who's prescribing it:
_____
_____

Name of your Primary Care Physician_____

Last Doctors appointment_____

Would you like me to share your mental health information with your MD? □ No □ Yes if so, please fill out the Release of Information Form attached to this packet.

Has your child been known to use drugs or alcohol? □ No □ Yes if yes, describe:
_____
_____

How would you describe your child's use of technology or online time?
_____

What significant life changes or events have they experienced?
_____
_____
_____
_____ _____

In the section below identify if there is a current or past history of any of the following or if your child has been diagnosed as such. Explain if yes.

Alcohol/Substance abuse□ No □ Yes
_____ _____

Anxiety □ No □ Yes
_____

Depression □ No □ Yes
_____

Domestic Violence/Abuse in the home □ No □ Yes
_____

Eating Disorders □ No □ Yes
_____

ADHD □ No □ Yes

Suicide / Attempts □ No □ Yes

Obsessive Compulsive Behavior/OCD □ No □ Yes

Developmental Disorder/ASD □ No □ Yes

Learning Disability □ No □ Yes

Others?

Has anyone else in your family had these issues? □ No □ Yes
If so, please describe:

Has your child had any legal issues? □ No □ Yes
If yes, describe:

Do you consider your family to be spiritual or religious? □ No □ Yes if yes, describe your faith or belief:

What do you consider to be some of your child's strengths?

What do you consider to be some of the areas your child needs help with?

What do you wish your child to accomplish in therapy?

What may happen if you don't change/address the issues that brought them here?

How will you know therapy is working? Is there anything specific you want as an outcome?

Is there anything else I should know about your child's story, history, or situation?

OFFICE POLICIES/PRACTICES

Review carefully. Initial each box as you read/agree to it.

Informed Consent:
Participation in counseling can result in a number of benefits, including improving interpersonal relationships and resolution of the concerns that led you to seek therapy. Working toward these benefits requires effort on your part and your active involvement, honesty and openness in order to change. I will ask for your feedback and views on progress and other aspects of the therapy and expect you to respond openly and honestly.

Sometimes more than one approach can be helpful in dealing with a situation. Remembering or talking about unpleasant events, feelings or thoughts can result in you experiencing considerable discomfort or feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc. I may challenge some assumptions or perceptions or propose different ways of looking at; thinking about, or managing situations that may feel upsetting or you may feel challenged or disappointed. Attempting to resolve issues that brought you to therapy in the first place may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, work, substance use, school, or relationships. Sometimes another family member views a decision that is positive for one family member negatively.

Change will sometimes happen quickly, but more often takes time and patience on your part. There is no guarantee that counseling will yield positive or intended results. During the course of therapy, I may utilize therapeutic approaches according, in part, to the problem that is being treated, your choices, and feedback, and my assessment of what may benefit you. These may include but are not limited to supportive, cognitive-behavioral, psychodynamic, system/family, developmental, mindfulness, art therapy, play therapy (for children) or psycho-educational. _____ ***Initial here.***

Confidentiality:
All clients sign and agree to confidentiality/HIPAA guidelines that are available for your review indicating that I follow standards as a Licensed Marriage and Family Therapist to protect the privacy of your personal information. All info is kept private and confidential unless you provide written and specific authorization to share it such as if you need me to speak with your physician or another therapist.
_____ ***Initial here.***

Exceptions include:
Threat of imminent serious harm to self or others, suspected abuse of a minor, elder or disabled adult, a valid court order, in the event of a circumstance requiring immediate medical attention.

In couples and family therapy, or when members are seen individually, confidentiality does not apply between the couple or among family members. I will use my clinical judgment when revealing info. I will not release records to any party unless I am authorized in writing to do so by all adults who were part of treatment unless compelled to do so by law/valid court order.

If coming for family or couple therapy please sign below that you agree to the confidentiality limits and understand that I won't withhold info between parties involved in treatment.

***SIGN HERE** if coming as a couple/family and you agree:
_____

Confidentiality of email & text communication:
If you choose to email or text me, please limit the contents to issues such as cancellation or change in appointment time. Email and text messages are not guaranteed confidential. Occasionally I may send you an article or link that might be useful. If you choose to communicate with me this way, you do so

understanding that I cannot guarantee that these modes of communication are confidential. For this and other ethical reasons, I do not accept invitations from current or former clients via social networking sites such as LinkedIn, IG or FB.
_____ ***Initial here.***

Consultation:
On occasion, I may need to consult with licensed professionals regarding my clients when doing so might improve the outcome for the client. The client's name or other identifying information is never disclosed. The client's identity remains anonymous and confidentiality is maintained. If I am on vacation I may also need to share such info with the licensed therapist "covering" for me.
_____ ***Initial here.***

Insurance:
Most of my clients choose not to use their insurance for counseling as they prefer the choice, control, and confidentiality of a premium counseling service that is not under contract with managed care. If you choose to use your insurance, please note that a mental health diagnosis is necessary on the form for reimbursement.

For in-network plans I am able to bill your insurance directly. You are responsible for thoroughly checking your benefits and what percentage of the fee, if any, you may be reimbursed by your plan.

If I am an out of network provider with your insurance plan, I can provide you with a receipt that you can submit to your plan for out of network reimbursement. This is provided on a monthly basis for any sessions occurring over the month but can be requested more or less frequently.

If you are using a HRA, Health or Flex Saving Account type plan, I can often accept a CC. In addition to the tax savings, that process may not require a diagnosis. If I accept your insurance, you are responsible for the copay at the start of each session. If for whatever reason, the claim is denied, you will be responsible for payment of fees.
_____ ***Initial here.***

Fees:
I accept cash or check, (either is preferred) or VISA, Discovery, AE, or MC. Please fill out the Form for credit card use that all clients complete even if they intend to usually use cash or a Check. This allows use as a back up if you forget your payment or for a late fee.

Regular therapy sessions are about 50 min. which is considered a therapeutic hour. Session fees are $150 for individuals and for couples/family therapy. The initial assessment is $175 and is typically an hour. I also offer 85 min sessions/$200 if a longer session is indicated or requested. Double sessions are about 110 minutes and the fee is $300. These may work best for stuck couples; clients who want a jump-start on the process, or those who cannot attend on a weekly or regular basis. If requested, the initial session can be one of these longer versions if appropriate and agreed to ahead of scheduling. Sometimes a phone or video session using a free confidential platform, VSEE or Doxy Me, is appropriate as an option on a regular or occasional basis due to challenges such as work, travel, illness, or snow.
Please have payment ready so as not to use your session time writing checks, etc.
_____ ***Initial here.***

Late Cancellation:
If you need to reschedule, please call me as soon as possible. Unlike Doctors who can overbook and may spend 15 min. per patient, therapists need to block a full hour. I hold a spot for you making it unavailable to another client, if less than 24 hours is provided, you will be charged $95. If you do not show for a scheduled appointment without a cancellation call, you will be charged full fee for the missed session. All

reschedules or cancellations need to be done through confirmed communication. I may make an exception to the late fee based on the circumstances and/or if we are able to reschedule to another time that same week. If coming for couples counseling and one member is unable to attend, it may be appropriate for the other member to attend to continue progress or to work on individual issues. Check with me about this. _____ ***Initial here.***

Litigation Limitation:
Due to the nature of the therapeutic process and that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, you agree that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding. However, if the law requires my appearance at court and you signed a release form allowing this, my fee is $2,500 per day and must be paid in full 30 days prior to the expected court date. _____ ***Initial here.***

Duration and Termination:
Most clients come weekly. Committing to and prioritizing that time is ideal. Occasionally, people attend therapy more often. Others may reduce frequency once things improve. Longer sessions are an option for those looking to get a jump-start or if there's a need for more intensive work for a set period of time.
_____ ***Initial here.***

Extended sessions can be helpful for busy clients or couples who have trouble coming in weekly or who need or request more focused work. About half of my clients come for a few months until they get back on track. This is considered shorter-term counseling.
Some clients use therapy for a period of time, take a break, and return when they are ready or need to do more work. About half of my clients benefit from longer-term counseling. They may have long-standing issues, difficult childhood or recent experiences, on-going stressors in their career, relationships, health, recovery, or families, or multiple issues that require a lengthier counseling process.

Sometimes it becomes clear that a different approach or level of care is best or necessary. If I initiate terminating therapy with you, it will be because I feel that I am not able to be helpful or a higher level of care is indicated. My ethics and license requires that I have my clients' needs as primary in treatment planning. If I no longer feel that I am the right resource for you, I will offer referrals to other sources of care, but cannot guarantee that they will accept you or how they will approach your treatment needs. Once you have stopped attending you are no longer under my care and our therapeutic relationship will be ended unless you reinitiate treatment with me.

Ending therapy well is important. Length of counseling varies and is up to the client, however, please let me know if you feel ready to complete this course of counseling so that we can have 1-2 wrap up sessions to solidify gains you made and to discuss recommandations to maintain progress. Often when we approach ending clients choose to switch to monthly sessions for 3 months then reassess if they are ready to end or continue less frequently. I am open to working with you to find what is best.

Telephone & Emergency Procedures:
At times, phone contact is necessary between sessions. Clients are encouraged to keep phone contacts brief, if possible, and to address issues during your regular therapy session. If you need to speak with me between sessions, please call **612-351-2251**. Your call will be
returned as soon as possible. I am a solo-practitioner, so if an emergency requires immediate attention, you agree to call the National Suicide Hotline at **800-784-2433** or **911**, contact a crisis hotline, or go to a hospital emergency room.
_____ ***Initial here.***

***HIPPA**:*
I understand that Erin McKeen LMFT, ATR adheres to the privacy practices outlined in the HIPPA National Providers policy available for my review in the office. Typically State and license confidentiality regulations are far more stringent so the most restrictive standard is adhered to for counseling. _____ ***Initial here.***

Bill of Rights
I understand that Erin Mckeen LMFT, ATR adheres to the Client Bill of Rights which is available for my review in the office.

Payment Options

PLEASE CHECK ONE:

_____INSURANCE

BCBS, Aetna, Medica, Optum, PreferredOne, Ucare (If you check this box, please make copy of card both sides, thank you)

_____ PRIVATE FEE

Please indicate established fee amount $____

PLEASE INDICATE STRUCTURE OF TREATMENT:

_____Couples
_____Family
_____Individual _____Child/Minor _____Siblings
_____Other/To Be Determined

For Insurance Billing

PLEASE COMPLETE:

Insurance Plan Name/type
_____

Member ID #_____

Provider Phone Number on card_____

Do you want a monthly receipt to submit for out of network reimbursement? Yes_____ No____

I understand that I am ultimately responsible for any costs associated with receiving services from Erin McKeen LMFT, ATR that are not covered by my insurance.

****SIGNATURE**_____**DATE**_____

CREDIT CARD AUTHORIZATION

Please complete the following information:

I, the undersigned individual, authorize Erin Mckeen LMFT, ATR. To charge my credit card in the event that I (or the party for whom I am financially responsible) fail to show for a scheduled appointment, or do not notify Erin Mckeen LMFT, ATR. Of my inability to attend a scheduled appointment at least 24 hours in advance, as agreed to in the Office Policies Form. Furthermore, for outstanding payments of services rendered, I authorize Erin Mckeen LMFT, ATR. To charge my credit card for the full amount due. I will not dispute charges for sessions I have received or that I have not cancelled less than 24 hours in advance. I further authorize Erin Mckeen LMFT, ATR. To disclose information about my attendance and/or cancellation to my credit card company should there be a charge dispute (a deposit check in the amount of one full session can be left in lieu of credit card info).

•A missed session fee of $95 if the client has not cancelled or rescheduled with Confirmed 24 hrs. Notice, as outlined in the cancellation policy, or full fee if client does not show for an appointment and has not confirmed a cancellation.

•Telephone contact in excess of that usually associated with services, prorated at my regular Hourly rate, with prior notice given before any charges are incurred, this may include phone contact in excess of 20 minutes or completing forms such as medical/FMLA per your request.

•Checks that are returned will incur the check amount and an additional $14 bank fee.

Name on card_____
___ Visa ___ MasterCard ___ Debit Card ___ HRA ___HSA
Card #: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
Exp Date: _ _/ _ _
Verification Code (3-digit code on back by signature line): _ _ _
___ American Express
Card #: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
Exp Date: _ _/ _ _
Verification Code (4-digit code on front of card above card number): _ _ _ _

Billing Address:

Street:_____

City:_____State:_____Zip Code:_____

Signature_____ **Date:** _____

This form will be securely stored in your clinical file and may be updated upon request at any time. Please note, your credit card will only be charged with your approval unless the following conditions apply: no-show for a scheduled appointment, cancellation less than 24 hours in advance, or participation in treatment without payment rendered.

USING YOUR CARD FOR REGULAR BILLING OF APPOINTMENTS:
Please sign and date here if you would like us to bill your regularly scheduled sessions to the above card.

Signature: _____ **Date:** _____
(patient or responsible party)

Please indicate if you would like to receive email receipts for all transactions: Yes_____ No_____
E-mail address: _____