Bear Creek Therapy, PLLC

Jessica Ihns, Psy.D., L.P. - owner
229 S. Main Street, Ste. 1, Maquoketa, IA 52060

Welcome to Bear Creek Therapy!

Within this ***INTAKE PACKET***, you will find information that is both meant to inform you of the therapy process and the office policies, as well as information that will be needed at the time of the first session. Please take the time to complete the forms below. If you misplace the intake packet, please plan to arrive 20 to 30 minutes in advance of the first session in order to complete all of the necessary paperwork. This paperwork is needed prior to beginning the first session with Dr. Ihns.

Please note that the office is located in downtown Maquoketa at 229 S. Main Street. Parking is available on the street in front of the building or in the parking lot (formerly Fareway grocery store, now Goodwill) across the street.

You are also responsible for contacting your insurance provider to obtain benefit information prior to the first appointment. If *pre-certification* is required by your insurance, you must obtain this prior to the session.

Due to federal "Red Flag" regulations, you will also be asked to provide a photo ID. Please be sure to have one with you.

I look forward to meeting with you –

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Office Policy Statement

Psychological Services:

Psychotherapy involves the use of skilled interventions to resolve emotional, mental, and behavioral problems in individual, family, or group sessions. Psychotherapy has both benefits and risks. Benefits include reduced stress, better relationships, and resolution of specific problems. However, therapy might also lead you to experience stressful emotions or changes in your values or relationships. I will explain the purpose for therapeutic interventions and any potential stress I can foresee. You have a right to ask for a referral to a different therapist or agency if you are dissatisfied at any time. If you desire to change to a different therapist, you must first pay any outstanding bills. I ask that you also inform me of any concerns that you have about your therapy, as it would be optimal if we could resolve these together.

Confidentiality:

The laws of the State of Iowa require that most issues discussed during the course of therapy with a psychologist, social worker, or counselor be held confidential. Children have some of the same rights. However, parents of minor children also have a right to know the general content of therapy sessions with their children. The client (or parent of a minor child) may waive this privilege of confidentiality by signing an Authorization to Release Information form. Releases are frequently signed in order for a therapist to communicate with a physician, spouse, parent, attorney, or a previous counselor. If you learn at any time during the therapy process that information may be requested by a third party, please let me know as soon as possible.

Authorization to Release Information is *NOT* required in some circumstances:

I am legally obligated to release your Protected Health Information in several circumstances noted on the Notice of Privacy Practices Form (e.g., reports of or suspected cases of abuse, risk to self or others, for judicial or administrative proceedings, for health oversight activities, etc.)

Appointments:

It is a good idea to schedule appointments well in advance to be able to get the date and time that works best for your schedule. It is very important that you keep your appointment with me in order for counseling to be most effective. An appointment is like a contract between you and I. Once you make an appointment, please give it high priority. I understand that unforeseen circumstances or illnesses arise. However, if at all possible, **call or email at least 24 hours prior to an appointment** if you must cancel or change the time. Messages can be left by phone or email 24 hours a day.

Unless restricted from doing so by a third party payer, I may bill you for missed appointments or those canceled without 24 hours notice. The charge for a missed appointment begins at **$50.00** and may be **$100.00** for subsequently missed appointments. If there are extenuating circumstances, you may not be billed for the session. Repeatedly missing appointments will result in a charge and may result in no longer being able to be seen for therapy or psychological services. If you are charged for a missed appointment, I ask that you pay for that session before scheduling or being seen for another session.

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Charges, Fees, and Insurance

* If you have health insurance, part of your therapy expense may be covered. If applicable, please inform me of both primary and secondary insurances. **Remember, you are responsible for all charges and no guarantee of insurance coverage is implied by the fact that I submit your insurance claims.** This office and provider does not accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim.

* **Co-payment is to be paid at the time of service.**

* The person who seeks therapy, either for himself/herself or for a minor, is responsible for payment. Parents are responsible for account payments for their minor child. Accounts unpaid after 90 days may be released for collection. Clients will be billed for additional costs involved and a service charge of $20 will be added to their account if their account is released to collection. If no session has been scheduled for 60 days, I will understand that our therapeutic relationship has ended, unless otherwise agreed upon. If you want to continue counseling after that time, all outstanding bills will need to be paid before your file may be re-opened.

* If you or your child damages any office fixtures or furnishings, you will be responsible for the reimbursement cost of cleaning, repairing, or replacing the damaged fixture or furnishing prior to the next appointment.

*Fees:

Intake Interview	**$176**
Psychotherapy (45-50 minutes)	
Individual Therapy	**$115**
Family Therapy	**$135**
Psychological Testing	**$135 per hour of testing services**
Return Check Charge	**$25 per incident**
Court-related Activities	**$200 per hour for depositions**
	$115 per hour for travel time
Consultation Fees	**$25 per 15 minute increments**

**you may be charged for email or phone call consultations, as well as completion of paperwork (such as disability, FMLA, etc.) if it requires more than 15 minutes of clinical time

I, the undersigned, have read this Office Policy Statement and agree to abide by its terms.

_____ _____
(Client name or Parent/Legal Guardian) (Date)

_____
(Printed name)

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Informed Consent Form for Treatment

Acknowledgment and Authorization Form (#1): I hereby acknowledge that I was given the opportunity to read and to receive a copy of the Notice of Privacy Practices for Bear Creek Therapy, PLLC.

Authorization to Release Information to Insurance Carrier (#2): I hereby authorize Bear Creek Therapy, PLLC to furnish my insurance carrier all information required for processing claims. Such information typically includes identifying information (client's name, date of birth, insured's name and address, etc.), diagnosis, prognosis, progress, and treatment plan. I understand that I have the right to inspect any materials released to the insurance carrier.

I also authorize my insurance carrier to release any pertinent information regarding coverage, deductible, payments made, or any other information requested to clarify claims to Bear Creek Therapy, PLLC.

I further authorize photocopies to be made of this release and for the insurance company to accept the photocopies.

This authorization shall continue in force and effect until revoked in writing by me.

Authorization to Pay Supplier (#3): I hereby authorize payment of Medical Benefits and/or Mental Health Benefits to Bear Creek Therapy, PLLC for services rendered.

Authorization for Treatment(#4): I give Bear Creek Therapy, PLLC and Jessica Ihns, Psy.D., L.P. consent to treat myself or my minor child.

Authorization for Collection (#5): I understand that if I fail to pay, the account can be turned over for collection and that I will be responsible for all costs involved.

I acknowledge and agree to the authorizations listed above (#1, 2, 3, 4, & 5).

_____ _____

Client / Insured Signature / Biological Parent or Legal Guardian — Date

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Client
Name: Last _____ First _____ M.I.____
Address: _____ City:_____ Zip:_____
Home Phone: (_____) _____ Cell: (_____) _____
SSN: _____ Gender: M or F Birth Date: _____
Employer: _____ Address: _____
Work Phone: (_____) _____

Spouse
Name: Last _____ First _____ M.I.____
Address: _____ City:_____ Zip:_____
Home Phone: (_____) _____ Cell: (_____) _____
SSN: _____ Gender: M or F Birth Date: _____
Employer: _____ Address: _____
Work Phone: (_____) _____

When the client is a minor, please fill in the Mother's & Father's information.

Mother
Name: Last _____ First _____ M.I.____
Address: _____ City:_____ Zip:_____
Home Phone: (_____) _____ Cell: (_____) _____
SSN: _____ Birth Date: _____
Employer: _____ Address: _____
Work Phone: (_____) _____

Father
Name: Last _____ First _____ M.I.____
Address: _____ City:_____ Zip:_____
Home Phone: (_____) _____ Cell: (_____) _____
SSN: _____ Birth Date: _____
Employer: _____ Address: _____
Work Phone: (_____) _____

Emergency Contact (not spouse or parent)
Name: _____ Relationship: _____
Address: _____ Phone: _____

Send Statement to and Responsible Party for Payment:
Name: _____ Relationship: _____
Address: _____ City: _____
Phone: _____ Zip: _____

Insurance:
Company: _____ Policy ID#: _____
Insured's name: _____ Group #: _____
Authorization #: _____ Number of Sessions: _____
Dates of Authorization: From _____ to _____ Deductible: _____ Co-Pays: _____

I affirm that the above information is true: *Signed* _____ *date:* ___

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What to Expect from Counseling or Therapy

What is counseling or therapy?

Counseling or therapy is focused conversation about things you want to change in your life. Counseling is most effective when it occurs in a relationship in which trust and care are established. Friends and relatives provide a type of counseling, as do clergy, teachers, and many others. Therapists and psychologists are different from others who may offer counseling or therapy because of our capacity to maintain objectivity and privacy, as well as our extensive training in psychology and human behavior.

If I go to counseling or therapy, does it mean that there is something wrong with me?

You have sought counseling because you feel uncomfortable with some aspect of your life. You are demonstrating courage and wisdom by seeking help to gain new skills or perspectives. Some people struggle because of events in their lives. Others may struggle because of biological and situational reasons. We will work together to identify the sources of your distress and address them with the appropriate resources, including referrals to other professionals or agencies, if necessary.

What can I expect from Dr. Ihns?

You can expect someone who:

* will maintain the highest ethical and legal standards of confidentiality,
* is interested in listening to your concerns,
* is interested in helping you develop a better understanding of these concerns so that you may deal more easily and effectively with them,
* will take you seriously,
* will be open to discuss concerns,
* will be willing to answer questions about the therapeutic relationship and my approach to counseling,
* will help you explore options and discover strategies toward change,
* will help, but will not do for you what you are capable of doing for yourself.

What sort of time commitments do I need to make for counseling?

I strive to offer therapeutic treatment as efficiently as possible. The number of sessions you need will depend on the severity and nature of your presenting concerns. I can give you an estimate of how many sessions it may take to address your goals.

What can I do to benefit most from counseling?

* *Be ready to focus on a specific problem or issue*
* *Set clear and specific goals*
* *Attend your sessions regularly and take an active part in them*
* *Let me know if you will be late or are unable to attend a session*
* *Talk about what is bothering you as openly and honestly as you can*
* *Complete any tasks or homework assignments which you may be asked to do*
* *Be open to trying new or different approaches for dealing with your concerns*
* *Talk openly with me about your progress in counseling. I am most interested in you benefiting from counseling. There are may ways to provide counseling and I can modify my methods to be most effective for you.*
* *Apply your new insights and growth in your daily activities*

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Medical & Social History Form for Child/Adolescent

Minor's Name: _____ Date: _____
Address: _____
Date of Birth: _____ Age: _____ Race: _____
Name of Person completing this form:_____
Relationship to child: _____

SCHOOL INFORMATION:
Where does this child attend school:_____
Present grade: _____
Does this child receive Special Education Services (e.g., Chapter I, Resource Room, Tutoring)_____
_____
Does this child have an IEP?_____ Has this child ever repeated a grade? _____
School activities (e.g., sports, clubs): _____
Other community involvements (e.g., sports, Scouts, volunteering): _____
_____
In general, describe this child's performance during elementary school. List strengths or problems. _____
_____
_____
Describe this child's performance during middle school and high school. List strengths or problems. _____
_____
_____
Describe any problems with learning for this child. _____
_____
_____
Describe any social problems at school for this child. _____
_____
_____

FAMILY INFORMATION:
Child's father's name: _____
Father's address: _____
Home ph.no:_____ Cell ph.no: _____
Father's employer: _____
Work ph.no: _____

Child's mother's name: _____
Mother's address: _____
Home ph.no: _____ Cell ph.no: _____
Mother's employer: _____
Work ph.no: _____
With whom does this child live? _____
Who has legal custody of this child? _____
Has this child ever had any placements outside of the home (e.g., DHS, foster care)? _____
Names and ages of siblings to this child: _____
_____
_____
Any recent stressors for the family (e.g., job loss, school change, relocation, death in family)? _____
_____
_____

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What does the child think about coming to therapy? _____
_____

HEALTH INFORMATION:
Physician: _____
Clinic location: _____
Has this child previously been in counseling? If so, when, where, and what were the issues?_____
_____
_____
Was that counseling satisfactory? Why or why not? _____
_____
What is the current reason for seeking counseling? _____
_____
Does this child have any major medical problems? If so, please describe: _____
_____
_____
Any history of a major head injury, concussion, or loss of consciousness? _____
_____
Is this child currently taking any medications? If so, please state which ones, dosage, and how long they have been on them: _____
_____
_____
Previous medications prescribed for ADHD, mood, anxiety, or behavior? _____
_____
Have this child or a family member ever been hospitalized for emotional problems? If so, please explain when, where, and why: _____
_____
Any known allergies for this child? _____
_____

BEHAVIOR CHARACTERISTICS: (check all that CURRENTLY apply to your child)

___ Overactive / Fidgety	___ Inattentive	___ Under-active	___ Moody	___ Plays well
___ Accident prone	___ Stubborn	___ Destructive	___ Temper tantrums	___ Leader
___ Rebellious	___ Easily afraid	___ Sensitive	___ Shy	___C ooperative
___ Excitable	___ Impulsive	___ Cries easily	___ Easily angered	___Loner
___ Sad/Unhappy	___ Nervous/Worried	___ Follower	___ Mean to children	___Stealing
___ Happy/Cheerful	___ Mean to animals	___ Lying	___ Cheating	___Moody
___ Fire setting	___ Nail biting	___ Thumb sucking	___ Tics/Nervous habits	

ALCOHOL AND DRUG USE:
Do you have any concerns that this child may be using alcohol or drugs? If so, what are your concerns: _____
_____
_____

LEGAL INVOLVEMENT:
Has this child had any legal involvements (e.g., DHS, probation, juvenile placements)? _____
_____
_____