Northern Prairie Community Clinic
501 North Columbia Road
Grand Forks, ND 58202-7132
701-777-3745

Confidentiality Policy and Consent for Therapy and Assessment Services Agreement
(put X in the box in front of each paragraph as appropriate)

☐ Your signature indicates that you have read, understood, and agree to the terms of this **Confidentiality Policy and Consent for Therapy and Assessment Services**. Your signature also indicates that you have received the Notice of Privacy Practices and have been given the opportunity to ask any questions about them.

☐ Notice for parents or legal guardians, by signing this Agreement, you are stating that you are a legal guardian of this child and can therefore seek medical service on behalf of this child. You agree to take full legal and financial responsibility for seeking mental health services of this child.

☐ Your signature indicates that you understand that Telemental Health counseling at NPCC will occur through synchronous interactive video conferencing and that Telemental Health counseling may include psychological health care delivery, diagnosis, consultation, and psychotherapeutic treatment. Further you understand the risks associated with Telemental Health counseling vs face-to-face counseling.

☐ Your signature indicates that you give permission for counseling sessions at Northern Prairie Community Clinic, a training clinic, to be audio or video recorded. Your signature also indicates that you understand these tape recordings will be used only for training and supervision purposes. No one will view or listen to these tapes except for your Student Therapist, Doctoral Student and Licensed Supervisor(s), and other masters or Doctoral Students in training in the Counseling program at UND. You understand that all of those individuals are bound by the same standards of confidentiality and professional ethics as the Student Therapist. You also understand the recordings will be destroyed after they are used for supervision purposes.

Client Name (Print): _____ Date signed: _____

Client or Legal Guardian Signature: _____Relationship to Client (Print):_____

_____ _____
Client Name (Child, Adol, Adult, Couple, Family) Client Name (Child, Adol, Adult, Couple, Family)

_____ _____
Client Name (Child, Adol, Adult, Couple, Family) Client Name (Child, Adol, Adult, Couple, Family)

_____ _____
Client Name (Child, Adol, Adult, Couple, Family) Client Name (Child, Adol, Adult, Couple, Family)

Witness Signature:_____ Date Witnessed: _____

NORTHERN PRAIRIE COMMUNITY CLINIC

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Adult Telemental Health Counseling Intake Form (NDUS)

Today's Date: _____

Name: _____
(Last) (First) (Middle)

Address: _____
(Street)

_____
(City) (State) (Zip)

May we send correspondence to this address? _____Yes ____ No

Date of Birth: _____ /_____ / _____ Age: _____

Preferred Email: _____

May we send correspondence to this email address? _____Yes ____ No
(Please note once your counselor has contacted you for your initial session you will be provided with instructions via email and you will receive a link for all subsequent sessions. No private or confidential information will be shared over email, it will only be used for scheduling and coordination)

Telephone Contact Information Check Yes or No below

Home: _____ **May we leave a message? ____ Yes ____ No**

Cell: _____ **May we leave a message? ____ Yes ____ No**

Work: _____ **May we leave a message? ____ Yes ____ No**

Person to contact in case of emergency:

Name: _____ Phone: _____

Relationship to the client: _____

Demographics

Racial Identification_____ Ethnic Identification _____

Gender Identification _____ Sexual Orientation _____

Family spiritual beliefs_____ Personal spiritual beliefs_____

Occupation: _____ Employer_____

Highest education completed: _____ Relationship Status: _____

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Partner/Spouse Name: _____ Partner/Spouse Occupation/Employer: _____

Physician Name: _____ Who referred you to the Center?_____

What brings you in for therapy at this time?

_____
_____
_____

When did this problem **begin**? Has it become better or worse over time?

_____
_____
_____

What **changes** do you want to happen as a result of counseling ?

_____
_____
_____

What are your biggest **stressors** at this time**?**

_____
_____
_____

What or who are your biggest sources of **social support** at this time?

_____
_____
_____

What kinds of things do you do for **pleasure or enjoyment** at this time?

_____
_____
_____

In general, how satisfied are you with

You relationship with family	Not at all	Somewhat Satisfied	Completely
You relationship with friends	Not at all	Somewhat Satisfied	Completely
Your work or school	Not at all	Somewhat Satisfied	Completely
Your sense of well-being	Not at all	Somewhat Satisfied	Completely

Medications

Current prescriptions and what purpose you take it for:

_____
_____
_____
_____

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Current over the counter (including vitamins and supplements):

_____

_____

_____

What, if any, important physical health conditions do you have at this time?

_____

_____

Family members and others in household

Last Name	First Name	Birth date	Age	Gender	Relationship

Have you ever been to counseling/therapy before?

When_____

_____

_____

Where_____

_____

_____

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What
Purpose_____

_____

_____

Have you ever received previous formal diagnosis for a Psychological Condition? (i.e. Major Depression, Generalized Anxiety Disorder, Schizophrenia, etc.)

Yes No

If Yes, what was the Diagnosis

_____

_____

Family history of concerns (please check all that apply)

	Self	Mother	Father	Brother	Sister	Step-parents	Aunts	Uncles	Grand-parents
Alcohol Abuse									
Other Drug Use									
Depression									
Anxiety									
Mental Illness									
Trouble with the law									
Major medical illness									
Abuse or Neglect									
Abusive or Neglectful									
Suicide									

Suicidality/Self Harm
Have you ever had thoughts of or attempted hurting yourself or hurting someone else?

Yes No If yes, please describe:

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Consent for Recording Telemental Health Sessions

I give permission for counseling sessions at Northern Prairie Community Clinic, a training clinic at the University of North Dakota, to be audio and video recorded. I understand these recordings will be used only for training and supervision purposes. No one will view or listen to these tapes except for my Student Counselor, Student and Licensed Supervisor(s), and other masters or doctoral students in training in the same program at UND. I also understand that all of those individuals are bound by the same standards of confidentiality and professional ethics as my Student Counselor.

I understand these tapes will be destroyed after they are used for supervision purposes.

_____ _____

Client Name Date

_____ _____

Therapist Date