118 Avenue C Cloquet, MN 55720
Phone: (218) 878-9352
Fax: (218) 878-9342
www.compassrose-cw.com

Cancellation/Missed Appointment Policy

We recognize that in today's busy world, adhering to a schedule is important in order to maximize time and meet the demands of daily life. Our goal is to provide quality care in a timely manner. In order to do so, we have had to implement a missed appointment/cancellation policy. Missed appointments, late cancellations, and late arrivals are disruptive to our schedule and other clients. This policy enables us to better utilize available appointments for our clients.

In order to be respectful of the needs of other clients, please be courteous and call your therapist at Compass Rose Counseling and Wellness, LLC or email them promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in need of an appointment. ***If it is necessary to cancel your scheduled appointment, it is require that you call or email at least 48 hours prior to your appointment to avoid a "Late Cancellation" charge.*** Monday appointments must be cancelled by noon the Friday before your appointment to not be considered a Late Cancellation. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely care. Appointments not cancelled as directed above will be considered a "Late Cancellation." Late cancellations will be considered the same as a "no-show".

To cancel appointments, please call 218-878-9352 or email your therapist directly. Your therapist's email address can be found at www.compassrose-cw.com. If you do not reach someone by phone you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please be sure to leave your phone number and the best time and method to contact you.

A failure to be present at the time of a scheduled appointment will be recorded in your chart as a "no-show". ***A fee of $100.00 will be charged to the credit or debit card on file for missed appointments or late cancellations.*** This fee is not covered by your insurance and it will be your responsibility to pay before your next visit if it is not taken from your credit card. We reserve the right to dismiss clients from the practice after three missed/late cancelled appointments in a twelve month period. New clients that miss or late cancel appointments are also held to this policy and must provide valid credit card information or make a refundable deposit to secure a time for their first appointment. Credit cards will not be charged for other fees unless prior authorization is given by card holder.

By signing below I have read and understand the above policy.

_____
Print Client Name

_____ _____
Client/Guardian Signature Date

_____ _____
Staff Initials Date

Revised 12/5/24

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CONSENT and ACKNOWLEDGEMENT

Consent for Treatment I request treatment at the office of Compass Rose Counseling and Wellness, LLC that includes the provision, coordination or management of mental health services and related care for me or for a person whom I have the legal right to give such consent.

Consent for Disclosure of Protected Health Information As explained in the Notice of Privacy Practices, I consent to the disclosure of my information for the purposes of this office's Treatment, Payment and Healthcare Operations. I may revoke this consent at any future time upon written notice to the office of Compass Rose Counseling and Wellness, LLC.

Assignment of Benefits I authorize all insurance, Medicare or Medicaid benefits, or benefit payments from other sources for claims originating from this office to be paid directly to Compass Rose Counseling and Wellness, LLC.

Medicare/Medicaid If I am a participant in Medicaid or Medicare programs, I understand the laws, rules and regulations of such shall apply or I may contact the Medicare Coordination of Benefits Contractor at 1-800-999-1118.

ACKNOWLEDGEMENT of Receipt of Privacy and Rights Information
I have received the information packet including description of services, cost, Patient Rights and Grievance procedure.

__X__ I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES POLICY that explains how my health information will be handled in various situations. A copy of this policy can additionally be found at www.compassrose-cw.com.

I have been given the chance to discuss my concerns and questions about the privacy of my health information.

Signature_____ Date_____

Printed Name_____

Client Name (if different from above)_____

Relationship to client if signing as legal representative of client _____

Must have documentation of guardianship, conservatorship, Attorney-in-fact for healthcare, etc.
Staff must document any refusal to sign.

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Credit Policy and Patient Responsibility

Thank you for choosing Compass Rose Counseling and Wellness, LLC where we are committed to ensuring a successful treatment journey. Please understand that prompt payment of your bill is considered part of that process. Our Credit and Financial Policies are detailed below. We ask that you review the information carefully and sign when you are ready to move forward with your treatment.

All clients must complete our information and insurance forms.

FULL PAYMENT IS DUE AT TIME OF SERVICE

We accept cash, checks, and all major credit cards.

Credit Card payments will incur an additional 3.5% convenience fee on the amount paid.

We offer payment plans with prior credit approval and signed agreement.

A finance charge of 18% annually (1.5% per month) will begin accruing after 60 days from the date of service.

PATIENTS WITH INSURANCE COVERAGE

We may accept assignment of insurance benefits after your second visit. However, we do require your copayment be paid at the time of service. The balance incurred is your personal responsibility whether your insurance company pays or not. Coverage amounts vary from policy to policy and we cannot guarantee the amounts of coverage offered by your insurance carrier. It is your responsibility to seek coverage amounts and limits of liability on your insurance policy. You understand that your insurance policy is a contract between you and your insurance company. This office holds no party to that contract and will not be held responsible in the event your insurance company denies any claim.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our clients. We charge what is usual and customary for our area. You are responsible for any balance regardless of what your insurance company's arbitrary discrimination of usual and customary rates are, unless we are under contract with your insurance company for specified allowable charges.

Delinquency (90 days past due)

In the event your account becomes past due and is referred to an outside collection agency or attorney, you will be responsible for the collection costs (up to 33% of the balance due), along with reasonable attorney fees and court costs incurred by this office.

I have read and understand Compass Rose Counseling and Wellness, LLC's Credit and Financial policy with respect to payment on my account. I understand and agree to the terms of this agreement.

_____ _____

Print Client Name Date

_____ _____

Client/Guardian Signature Staff Initials

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Welcome! And, thank you for choosing Compass Rose Counseling and Wellness, LLC. To better understand your needs, please complete this brief history questionnaire and bring all intake paperwork, including consent forms and the testing packet, to your first appointment.

Name: _____ Age: _____ Date of Birth: _____ Gender: _____ Pronouns: _____

Address:_____ City: _____State: _____ Zip Code: _____ Phone #:_____

Relationship Status (Circle One): Single Married Separated Divorced Widowed Engaged Living with Partner

Names & Ages of Others Living in the Home: _____

_____

Are you currently in school? YES NO If yes, please list name of school and grade: _____

Employment Status (Circle One): Unemployed Retired Part time Full time Sabbatical Disability LOA

Are you currently involved in any legal matters? (Custody, criminal charges, divorce, etc.) YES NO If so, please explain:

_____

Who referred you to counseling? _____

What made you decide to seek services? _____

_____

_____

MENTAL HEALTH HISTORY

Have you ever been in counseling/therapy before? YES NO

Approximate Dates	**Location**	**Reason**	**Was it helpful?**

Have you ever been hospitalized for psychiatric reasons? YES NO

Approximate Dates	**Location**	**Reason**	**Was it helpful?**

Have you ever taken medication for psychiatric reasons? YES NO

Approximate Dates	**Prescribing Provider**	**Reason**	**Was it helpful?**

Do you have a history of suicide attempts? YES NO If yes, when was your most recent attempt?_____
Do you have a history as a child, teenager, or adult of physical, sexual, or emotional abuse? YES NO
Have you experienced other traumas in your life? YES NO

MEDICAL

Primary Care Physician: _____

Location & Phone Number: _____

Other Treating Providers: _____

Chronic medical conditions and date of onset: _____

_____

_____

Prescription and Over-the-Counter Medications:

Medication	**Dosage**	**Reason**	**Prescribing Provider**

FAMILY HISTORY

Please indicate any major mental or physical health issues for any close relatives (e.g., anxiety, depression, bipolar disorder, schizophrenia, diabetes, cancer, heart disease, substance abuse issues, etc.).

Relative	**YES**	**NO**	**If yes, please list conditions:**
Mother	_____	_____	_____
Father	_____	_____	_____
Sister(s)	_____	_____	_____
Brother(s)	_____	_____	_____
Maternal Grandmother	_____	_____	_____
Maternal Grandfather	_____	_____	_____
Maternal Aunt(s)	_____	_____	_____
Maternal Uncle(s)	_____	_____	_____
Maternal Cousin(s)	_____	_____	_____
Paternal Grandmother	_____	_____	_____
Paternal Grandfather	_____	_____	_____
Paternal Aunt(s)	_____	_____	_____
Paternal Uncle(s)	_____	_____	_____
Paternal Cousin(s)	_____	_____	_____

Please complete the following checklist of symptoms/concerns for us to discuss at your first visit. Indicate how many days each symptom was present in the past two weeks and how functioning has been impaired as a result.

Symptom	NO	YES	# of Days	Impact on Functioning
Sleeps too much				
Sleeps too little				
Lack of interest				
Guilt feelings				
Tired/fatigued				
Poor concentration				
Appetite disturbance				
Weight changes				
Physical inactivity				
Social withdrawal				
Depressed mood				
Irritability				
Upward mood swings				
Morbid thoughts				
Suicidal thoughts				
Suicide plans				
Self-injurious behavior				
Aggressive behavior				
Excessive worrying				
Panic Attacks				
Social discomfort				
Perfectionism				
Preoccupation				
Fear (phobia)				
Nightmares				
Flashback of trauma				
Excessive worrying				
Strict dieting				
Strict exercise regimen				
Binge or overeating				
Food purging				
Memory loss				
Disorientation/confusion				
Hallucinations				
Thoughts being controlled				
Gambling				
Sexual orientation concerns				
Gender identity concerns				
Violence or abuse in home				
Alcohol/drug abuse in home				

SUBSTANCE USE

QUESTION #1
Do you use alcohol? YES NO
If "NO", go to question #2 If "YES"", please answer questions below.
How often do you use alcohol? _____ times per day/ week/ month (circle one)
Have you ever been concerned about your own alcohol use?_____
Has a friend, spouse, or other loved one expressed concern about your alcohol use?_____
Do you ever experience blackouts or times that you couldn't remember what happened when drinking?_____
Does it take more alcohol now to become intoxicated than it used to?_____
Have you ever received a DUI/DWI?_____

QUESTION #2
Do you use any drugs? YES NO
If "NO", go to question # 3 If "YES", please answer questions below.
Have you ever been concerned about your drug use?_____
Has a friend, spouse, other loved one expressed concern about your drug use? _____

QUESTION #3
Do you use tobacco products? (cigarettes, chewing tobacco, cigars, etc) YES NO
If "NO", go to question #4. If "YES", please answer questions below.
How many cigarettes/cigars/cans per day? _____
Have you ever tried to quit?_____

QUESTION #4
Do you use any caffeine? YES NO
If "NO", go to question #5. If "YES", please answer questions below.

_____sodas per day _____cups of coffee per day _____other per day

QUESTION #5
Have you ever been in chemical dependency treatment for alcohol/drug use? YES NO

QUESTION #6
Is another person's substance use creating difficulty for you?

QUESTION #7
Do you gamble? YES NO