



INFORMED CONSENT FOR ADULT MENTAL HEALTH TREATMENT

Welcome. Compass Rose Counseling and Wellness, LLC provides outpatient mental health counseling in a respectful, collaborative setting. Please review this document before beginning services. We encourage you to ask your clinician about anything you do not understand.

1 Your participation in treatment

By signing this form, you request and consent to outpatient mental health assessment and psychotherapy with a clinician at Compass Rose Counseling and Wellness, LLC. Treatment may include discussion of thoughts, emotions, relationships, behaviors, and life experiences; development of goals; and use of clinically appropriate therapeutic approaches. You and your clinician will discuss recommendations, progress, and any changes in your care. You may ask questions, decline a particular intervention, seek a second opinion, or end treatment at any time, subject to applicable responsibilities and arrangements for safe transitions of care.

2 Potential benefits, risks, and alternatives

Therapy may improve insight, coping, functioning, relationships, and emotional well-being, but specific outcomes cannot be guaranteed. Discussing painful experiences or changing established patterns may temporarily increase distress, conflict, or discomfort. Your clinician will work with you to monitor these effects. Alternatives may include other providers, medication evaluation, group or family services, community supports, or a different level of care when appropriate.

3 Confidentiality and its limits

Your health information is protected by applicable federal and Minnesota privacy laws. Information may be used or shared for treatment, payment, and healthcare operations as permitted by law, and in other circumstances described in the practice Notice of Privacy Practices. Certain disclosures require your written authorization. Confidentiality is not absolute: disclosures may be required or permitted in situations involving suspected abuse or neglect, serious safety concerns, certain court or legal processes, oversight, or other circumstances established by law. Your clinician will discuss relevant limits with you when possible. Special protections may apply to certain records, including psychotherapy notes and qualifying substance use disorder records.

4 Records and coordination of care

Your clinician maintains a clinical record documenting assessment, treatment, progress, and related services. Information may be shared with other members of the practice workforce or service partners when permitted and necessary for care or operations. Coordination with outside providers, family members, schools, employers, or other third parties may require a separate release of information or other legal authority. You may request access to your records and exercise privacy rights as explained in the Notice of Privacy Practices.



ADULT INFORMED CONSENT | CONTINUED

5 Communication between appointments

The practice communicates by telephone and email and offers secure messaging through SimplePractice. These channels are intended for scheduling, administrative matters, and limited nonurgent clinical communication; they are not substitutes for therapy appointments or crisis services. Email, ordinary telephone messages, and voicemail can involve privacy risks, and response times may vary. Secure messaging provides additional protections but is not monitored continuously. Please discuss preferred contact methods and any confidentiality concerns with your clinician. Do not use email, voicemail, or SimplePractice messaging for emergencies.

6 Emergencies and crisis care

Compass Rose does not provide 24-hour crisis counseling or continuous message monitoring. If you are in immediate danger or cannot maintain your safety, call **911** or go to the nearest emergency department. You may also call or text **988** for the Suicide & Crisis Lifeline. Additional local crisis resources may be provided in your individualized safety plan. If safety needs exceed the services available in routine outpatient treatment, your clinician may recommend emergency evaluation, additional supports, or a higher level of care.

7 In-person and telehealth appointments

Compass Rose offers both in-person and telehealth appointments. Telehealth involves electronic communication and may present risks such as technical interruptions, reduced ability to observe nonverbal cues, or unauthorized access despite reasonable safeguards. For telehealth sessions, you agree to participate from a private, safe location, tell your clinician your physical location and a callback number when requested, and avoid driving or other activities that interfere with safe participation. Your clinician may determine that an in-person appointment or other service is more appropriate for your needs. If technology fails, your clinician will attempt to reconnect or use an agreed alternative method.

8 Scheduling, fees, and insurance

Appointment attendance, cancellations, payment obligations, insurance billing, and other financial matters are addressed in the practice's separate Cancellation/Missed Appointment Policy and Financial Responsibility Agreement. Please review those documents carefully and ask questions before signing them. Signing this treatment consent does not replace those separate agreements.

9 Privacy notice and client rights

You are entitled to receive or request a copy of the practice Notice of Privacy Practices, which explains uses and disclosures of health information, your rights, and how to raise privacy concerns. It is available through the practice website, in the waiting room, and on request. You may raise concerns about your care, request clarification of treatment recommendations, and ask how to contact the practice Privacy Officer without retaliation for exercising your rights.



ADULT INFORMED CONSENT | ACKNOWLEDGMENT

Please read the statements below and check each box to indicate your understanding. You are welcome to discuss any questions with your clinician before signing.

- ☐ I understand the general nature of outpatient mental health assessment and psychotherapy, including potential benefits, risks, and alternatives.
- ☐ I understand that my participation is voluntary and that treatment outcomes cannot be guaranteed.
- ☐ I understand that confidentiality has legal limits and that certain disclosures may be required or permitted by law.
- ☐ I understand the practice's communication methods and that phone messages, email, and SimplePractice messaging are not continuously monitored.
- ☐ I understand that Compass Rose does not provide 24-hour crisis counseling and that I should use emergency or crisis resources when immediate help is needed.
- ☐ I understand the additional considerations for telehealth appointments, when applicable.
- ☐ I understand that cancellation and financial policies are addressed in separate documents.
- ☐ I acknowledge that the Notice of Privacy Practices has been made available to me and that I have had an opportunity to request a copy and ask questions.

Consent: I have had an opportunity to ask questions, and I voluntarily consent to outpatient mental health treatment at Compass Rose Counseling and Wellness, LLC.

Client printed name: _____

Client signature: _____ Date: _____

Clinician name (optional): _____

Privacy Officer: Casey Wyman | casey@compassrose-cw.com

Draft for practice review. Final language should be checked against current Minnesota law, payer requirements, and the practice's actual procedures before use.



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

CANCELLATION & MISSED APPOINTMENT POLICY

At Compass Rose Counseling and Wellness, LLC, appointment times are reserved for individual clients. Providing advance notice allows us to offer available appointments to others seeking care.

Cancellation deadlines

Please contact your clinician **at least 48 hours before your appointment** to cancel or reschedule. **Monday appointments must be cancelled by 12:00 p.m. (noon) the preceding Friday.** Notice received after the applicable deadline is considered a late cancellation.

How to notify us

Call **(218) 878-9352** or email your clinician directly (contact information is available on our website). If leaving voicemail, include your name, callback number, and cancellation request. Please do not include sensitive clinical information in regular voicemail or email. Messages are not monitored continuously.

Missed appointments and late cancellations

A **\$100 fee** applies to missed appointments (no-shows) and late cancellations. **Insurance does not cover this fee;** the client is responsible for payment. If you expect to arrive late, notify your clinician promptly. Sessions may still end at the scheduled time.

Card payments and processing fee

The missed-appointment fee may be charged to an authorized card on file. **When Compass Rose processes an eligible credit-card payment, an additional 3.5% card processing fee is charged to the client, where permitted by applicable law and payer agreements.** For example, a \$100 missed-appointment charge paid by eligible credit card would total **\$103.50**. If payment is not collected by card, the outstanding missed-appointment fee is due before the next visit. Other card charges require prior cardholder authorization.

First appointments and repeated absences

New clients who miss or late-cancel their first appointment may be asked to provide a valid card on file or a refundable deposit before scheduling another intake. After **three missed or late-cancelled appointments within 12 months**, the practice may consider discontinuing services, with appropriate attention to clinical needs and continuity of care.

Unexpected circumstances

We understand emergencies and unforeseen circumstances occur. Contact your clinician as soon as possible; exceptions or fee adjustments are considered by the practice on a case-by-case basis.

ACKNOWLEDGMENT

I have read and understand the cancellation deadlines, missed-appointment fee, applicable credit-card processing fee, and policy concerning repeated absences. I have had an opportunity to ask questions.

Client name: _____

Client / parent or guardian signature: _____ Date: _____

Relationship to client (if applicable): _____



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FINANCIAL RESPONSIBILITY & PAYMENT POLICY

Thank you for choosing Compass Rose Counseling and Wellness, LLC. This policy explains payment expectations and financial responsibilities for services provided by our practice.

Payment at time of service

Payment is due at the time of service. We accept cash, checks, and major payment cards. Clients are responsible for applicable copayments, coinsurance, deductibles, noncovered services, and other amounts permitted by law and their insurance agreements. Payment plans may be available with prior approval and a signed agreement.

Insurance and assignment of benefits

Clients must provide accurate, current insurance and billing information and notify us promptly of changes. We may accept assignment of insurance benefits after the second visit, as applicable to payer requirements. Insurance verification is an estimate, not a guarantee of payment. We submit claims as appropriate, but coverage and payment depend on plan terms, medical necessity, and payer rules.

Clients are responsible only for balances legally payable by them under applicable law and payer contracts. When required, insurance or other benefit payments may be assigned directly to Compass Rose.

Card processing charges

When Compass Rose processes an eligible credit-card payment, a 3.5% processing charge is added to the client's payment, only where permitted by applicable law, card-network rules, and payer agreements. This may include an authorized card-on-file charge for a missed appointment or late cancellation. For example, a \$100 eligible credit-card charge would total \$103.50. This charge is **not applied to debit or prepaid cards**, or where prohibited. Any required advance disclosure will be provided before payment is processed.

Missed appointments and late cancellations

Missed appointments and late cancellations are subject to our separately acknowledged Cancellation & Missed Appointment Policy, including its \$100 fee, when applicable and permitted. Such fees are generally not covered by insurance. No card-on-file charge will be made without appropriate authorization.

Past-due balances

Balances unpaid more than 60 days after the date of service may be assessed a finance charge of **1.5% per month (18% annually)**, only to the extent permitted by law and applicable payer agreements. Accounts 90 days past due may be referred for collection. Where lawful and expressly authorized by the applicable agreement, collection expenses may be assessed up to 33% of the outstanding balance, plus reasonable attorney fees and court costs. We encourage clients to contact us promptly if payment is difficult.

Medicare, Medicaid, and other payer protections

Government-program and contracted-insurance rules take precedence over conflicting terms of this policy. Compass Rose will not charge amounts or impose fees prohibited by applicable program requirements or contracts. Clients may request information about expected costs and, when applicable, a Good Faith Estimate.

ACKNOWLEDGMENT

I have read and understand this policy, including payment responsibilities, potential eligible credit-card processing charges, and past-due account terms. I have had an opportunity to ask questions.

Client name: _____

Client / parent or guardian signature: _____ Date: _____

Relationship to client (if applicable): _____



CLIENT HEALTH HISTORY QUESTIONNAIRE

Welcome to Compass Rose Counseling and Wellness. Please share what you feel comfortable providing today. Brief answers are fine; you may leave a question blank and discuss it with your therapist. This form supports—not replaces—your first conversation.

1 | ABOUT YOU

Full name: _____ Date of birth: _____ Age: _____
Preferred name: _____ Pronouns (optional): _____
Phone: _____ Preferred contact method: ☐ Phone ☐ Email ☐ Portal
Who lives with you / important people in your household? _____
Current situation: ☐ Employed ☐ Student ☐ Retired ☐ Not working ☐ Other
School/grade or work (optional): _____
Relationship status (optional): ☐ Single ☐ Partnered ☐ Married ☐ Separated/divorced ☐ Widowed ☐ Other
Referred by (optional): _____

2 | WHAT BRINGS YOU HERE?

What would you most like help with right now?

How long has this been a concern? ☐ Recently ☐ Months ☐ Years ☐ Unsure

What would you hope might be different as a result of counseling?

3 | YOUR EXPERIENCE WITH COUNSELING

Have you received counseling or mental health treatment before? ☐ Yes ☐ No ☐ Prefer to discuss

If yes, what was helpful or unhelpful? _____

Have you ever had a psychiatric hospitalization or higher level of care? ☐ Yes ☐ No ☐ Prefer to discuss

If yes, approximate date/reason (optional): _____

Have you ever taken medication for mood, attention, sleep, or another mental health concern? ☐ Yes ☐ No ☐ Unsure

If yes, which medication(s) and how did they work for you? _____

4 | WHAT WOULD HELP YOU FEEL COMFORTABLE?

Is there anything that would help you feel more comfortable at your first appointment?

Are there any concerns or questions you would like us to address early in treatment?



CLIENT HEALTH HISTORY QUESTIONNAIRE | CONTINUED

5 | HEALTH AND MEDICATIONS

Primary care provider / clinic: _____

Current health conditions, significant injuries, allergies, or health concerns:

Current medications and supplements (name / dose if known):

Do physical health concerns affect your mood, sleep, energy, or daily life? ☐ Yes ☐ No ☐ Unsure

If yes, briefly: _____

6 | CURRENT WELL-BEING

Check any areas you would like to discuss (you can explain more during your appointment):

- ☐ Low mood ☐ Anxiety/worry ☐ Stress/overwhelm
☐ Panic ☐ Irritability/mood shifts ☐ Grief/loss
☐ Sleep ☐ Energy/fatigue ☐ Concentration
☐ Relationships ☐ School/work ☐ Trauma-related concerns
☐ Food/eating/body image ☐ Alcohol/substances ☐ Other

How are these concerns affecting daily life? ☐ Not much ☐ Somewhat ☐ A lot ☐ Unsure

Anything important about your sleep, appetite, or activity level? _____

7 | ALCOHOL, SUBSTANCES, AND CAFFEINE

Check any you currently use (no judgment—this helps us provide safe, informed care):

- ☐ Alcohol ☐ Cannabis/THC ☐ Nicotine/vaping
☐ Prescription medication outside directions ☐ Other drugs ☐ None

Would you like support with any substance use? ☐ Yes ☐ No ☐ Unsure ☐ Prefer to discuss

Caffeine / energy drinks (typical daily amount, if known): _____

8 | FAMILY AND PERSONAL HISTORY

Relevant family history of mental health, substance use, or major medical concerns? ☐ Yes ☐ No ☐ Unsure

If you wish to share: _____

Have you experienced trauma, abuse, or events that still affect you? ☐ Yes ☐ No ☐ Unsure ☐ Prefer to discuss

You do not need to describe traumatic experiences here. Your therapist can discuss them with you at your pace.



CLIENT HEALTH HISTORY QUESTIONNAIRE | CONTINUED

9 | SAFETY AND SUPPORT

These questions help us understand how to support you. You may discuss details privately with your therapist.

Have you ever intentionally hurt yourself (such as cutting or burning)? ☐ Yes ☐ No ☐ Prefer to discuss

Have you ever attempted suicide? ☐ Yes ☐ No ☐ Prefer to discuss

Recently, have you had thoughts of suicide or not wanting to be alive? ☐ Yes ☐ No ☐ Prefer to discuss

Are you currently concerned you might hurt yourself or someone else? ☐ Yes ☐ No ☐ Prefer to discuss

If you are in immediate danger, call 911 or go to the nearest emergency department. This questionnaire is not monitored for emergencies.

If you checked "Yes" or "Prefer to discuss," your therapist will follow up with you directly.

10 | SUPPORTS, STRENGTHS, AND COPING

Who or what helps you feel supported (people, pets, community, activities)?

What has helped you cope with difficult times in the past?

What personal strengths or qualities would you like your therapist to know about?

11 | ANYTHING ELSE?

Is there anything you would like your therapist to know before your first appointment?

Thank you for taking the time to complete this form. You do not need to have everything figured out before we meet.

Client name (print): _____ Date: _____



PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered
by any of the following problems?
(Use "✓" to indicate your answer)

	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 so 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 in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____
=Total Score: _____

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
☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from
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GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than 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 is 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

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they 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: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety



CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

When thinking about drug use, include illegal drug use and the use of prescription drug other than prescribed.

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

Scoring

Regard one or more positive responses to the CAGE-AID as a positive screen.

Psychometric Properties

The CAGE-AID exhibited:	Sensitivity	Specificity
One or more Yes responses	0.79	0.77
Two or more Yes responses	0.70	0.85

(Brown 1995)



WHODAS 2.0

WORLD HEALTH ORGANIZATION
DISABILITY ASSESSMENT SCHEDULE 2.0

12-item version, self-administered

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

In the past 30 days, how much difficulty did you have in:						
S1	<u>Standing</u> for <u>long periods</u> such as <u>30 minutes</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
S2	Taking care of your <u>household responsibilities</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
S3	<u>Learning</u> a <u>new task</u> , for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do
S4	How much of a problem did you have <u>joining in community activities</u> (for example, festivities, religious or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do
S5	How much have <u>you</u> been <u>emotionally affected</u> by your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page...



WHODAS 2.0

WORLD HEALTH ORGANIZATION
DISABILITY ASSESSMENT SCHEDULE 2.0

In the past 30 days, how much difficulty did you have in:						
S6	<u>Concentrating</u> on doing something for <u>ten minutes</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
S7	<u>Walking a long distance</u> such as a <u>kilometre</u> [or equivalent]?	None	Mild	Moderate	Severe	Extreme or cannot do
S8	<u>Washing</u> your <u>whole body</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
S9	Getting <u>dressed</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
S10	<u>Dealing</u> with people <u>you do not know</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
S11	<u>Maintaining a friendship</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
S12	Your day-to-day <u>work</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do

H1	Overall, in the past 30 days, <u>how many days</u> were these difficulties present?	Record number of days ____
H2	In the past 30 days, for how many days were you <u>totally unable</u> to carry out your usual activities or work because of any health condition?	Record number of days ____
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you <u>cut back</u> or <u>reduce</u> your usual activities or work because of any health condition?	Record number of days ____

This completes the questionnaire. Thank you.