Walk-in hours information

Hello! Thank you for your interest in the Mains'l walk-in clinic hours. The following information will tell you about our counseling services.

If you decide to come in for a session, you and your counselor will work together to meet your goal or desired outcome.

When you come in:

1. Please check in with the receptionist. You will be given brief forms to complete
2. Please fill out and return completed forms to the receptionist
3. You will be called (first come, first served) when the next counselor is available
4. Wait time will depend on how many people are waiting; most counseling sessions are 30-50 minutes long.
5. If paying with cash or electronic payment do so with the receptionist

What we provide:

We offer counseling sessions to help with many different personal or family concerns. Our counseling services are provided by professional counselors or advanced graduate students under the supervision of licensed professionals. We can provide on-going counseling sessions, if needed. You and your counselor can determine if on-going sessions are appropriate during your visit. Our goal is to provide high quality counseling to all, regardless of race, ethnic background, religion, sex, age, sexual or affectional orientation, or ability.

What we ask from you:

- Please be patient while you wait for your counseling session
- Please take any phone calls outside to respect the privacy of others waiting
- Participate fully in the conversation with your counselor
- If there is anything about Mains'l counseling or the work you are doing with your counselor that you do not understand, please ask your counselor to explain

Walk-in information

We respect your right to privacy.

Here are some **things you should know about confidentiality** at Mains'l:

You may refuse to give any information you do not feel comfortable revealing.

- When we do inquire or ask for information it is strictly for our use here at Mains'l walk-in to serve you as best we can. We will not share your information unless it is a life-threatening emergency or you have given your permission.
- Your counselor may take some notes during your session and enter this information in your confidential record. You have a right to look at and/or obtain copies of anything in your record. Records are secured and/or locked. Counseling sessions are typically discussed with a consultant, the clinic team, or a supervisor to ensure that you get the best service we can provide.

You and Mains'l staff are the only ones who can see your file. A release form will be signed by you if you want us to send any information to another counselor or agency. However, there are some exceptions to this. A counselor may have to release information:

- To prevent harm from occurring if you make a serious threat to harm someone, and we believe you are about to do it; or to prevent you from killing yourself.
- If you tell your counselor of abuse or neglect of a child or a vulnerable adult, a report must be made to appropriate authorities.
- If you tell us of misconduct by a Minnesota-licensed health professional and identify that professional to us, the counselor has a duty to report the misconduct to the board that licenses the professional. However, you may discuss complaints at length and you do not need to reveal the identity of the person until you are ready.

We are required by law to possibly break confidentiality when:

- Reporting abuse or neglect of minors;
- Reporting of abuse or neglect of vulnerable adults;
- Reporting of controlled substances for non-medical purposes by pregnant women;
- To prevent suicide by the client when the possibility seems imminent;
- To prevent the client from harming someone else when explicit and specific threats have been made (duty to warn or protect);
- When the client reports misconduct by a Minnesota- licensed health professional;
- In response to court orders or subpoenas (e.g. lawsuits, custody cases, probation).

Thank you for your trust in Mains'l.

Walk- in first visit questionnaire

(You can complete this and print it to bring for your visit)

Name: _____DOB: _____

Address: _____

What symptoms or events happened that caused you to decide to come in today?

_____

_____

What would you like to have addressed before you leave to feel that this was helpful?

_____

_____

Have you been seen for mental health symptoms before? Yes ☐ No ☐

Are you taking any medications for mental or physical health reasons? In general how long have you been taking them?

_____

_____

Would you like a counselor to contact you after your visit? Yes ☐ No ☐

If yes, provide a contact phone number_____

Is it ok to leave a message at the number provided? Yes ☐ No ☐

What else would you like us to know?

_____

_____

Walk- in first visit questionnaire

By signing I acknowledge that I have read and understand the "things you should know about confidentiality" located on the Walk-in information document. If I have questions about confidentiality or privacy I will ask my counselor.

Print Name **Signature** **Date**

Brief insurance form, (if using insurance):

To bill your insurance, information must be accurate and we need to take a photocopy of each medical insurance card if you have multiple policies.

Policyholder name: (First, Middle initial, Last) _____

Policyholder place of work, if insurance is through employer: _____

Person being seen: (First, Middle initial, Last) _____

Date of birth for person being seen: (mm/dd/yy) _____

Assignment and release statement: I the undersigned, indicate that I (or my dependent) may have insurance coverage and assign directly to the healthcare provider Mains'l Services, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges weather they are paid or not by my insurance. I hereby authorize the healthcare provider to release all information necessary to secure payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

_____

Print Name **Signature** **Date**

Payment (cash or electronic)

Payment type: HSA☐ Credit /Debit ☐ Check* ☐ Cash ☐ Amount of payment $_____

Full name on card _____

Card number _____ Expiration date_____

CSV number (on back of card) _____ *Returned checks will have an additional $35 fee.

Print Name **Signature** **Date**

Walk- in first visit questionnaire

Please circle your experience, in the past 30 days, with the below items by circling 0-10.

	Not at all					Last 2 weeks					Daily
Depressed Mood:	0	1	2	3	4	5	6	7	8	9	10
Hopelessness:	0	1	2	3	4	5	6	7	8	9	10
Low Self-Esteem:	0	1	2	3	4	5	6	7	8	9	10
Suicidal thoughts:	0	1	2	3	4	5	6	7	8	9	10
Self-injurious thoughts or acts:	0	1	2	3	4	5	6	7	8	9	10
Low Energy:	0	1	2	3	4	5	6	7	8	9	10
Sleep Disturbance:	0	1	2	3	4	5	6	7	8	9	10
Lack of Appetite:	0	1	2	3	4	5	6	7	8	9	10
Weight Gain or Loss:	0	1	2	3	4	5	6	7	8	9	10
Poor Concentration:	0	1	2	3	4	5	6	7	8	9	10
Anxiety:	0	1	2	3	4	5	6	7	8	9	10
Irritability:	0	1	2	3	4	5	6	7	8	9	10
Anger:	0	1	2	3	4	5	6	7	8	9	10
Relationship Conflicts:	0	1	2	3	4	5	6	7	8	9	10
Lack of interest:	0	1	2	3	4	5	6	7	8	9	10
Use of alcohol or drugs:	0	1	2	3	4	5	6	7	8	9	10
High Stress level:	0	1	2	3	4	5	6	7	8	9	10
Obsessive/Compulsive:	0	1	2	3	4	5	6	7	8	9	10
Difficulties at Work/Home:	0	1	2	3	4	5	6	7	8	9	10
Job loss:	0	1	2	3	4	5	6	7	8	9	10
Legal Issues:	0	1	2	3	4	5	6	7	8	9	10
Meaningful contact with support system:	0	1	2	3	4	5	6	7	8	9	10
Medication Concerns:	0	1	2	3	4	5	6	7	8	9	10