Stable Living
Your Path to Personal Growth & Healthy Relationships

Therapist: _____ Diagnosis Code: _____

INDIVIDUAL INTAKE FORM

Please provide the following information for our records. Please know that the information you provide here is held to the same standards of confidentiality as our therapy.

Name: _____ Date: _____
Gender: ❑ Male ❑ Female Birth Date: _____ /_____ /_____ Age: _____
Address: _____

_____

_____

Home Phone: _____ May we leave a message: ❑ Yes ❑ No
Work Phone: _____ May we leave a message: ❑ Yes ❑ No
Cell Phone: _____ May we leave a message: ❑ Yes ❑ No
E-mail: _____

Significant Other : _____ Age: _____ ❑ Married ❑ Living Together ❑ Ex
Child's Name: _____ Age: _____ ❑ Biological ❑ Step ❑ Adopted
Child's Name: _____ Age: _____ ❑ Biological ❑ Step ❑ Adopted
Child's Name: _____ Age: _____ ❑ Biological ❑ Step ❑ Adopted
Child's Name: _____ Age: _____ ❑ Biological ❑ Step ❑ Adopted
Child's Name: _____ Age: _____ ❑ Biological ❑ Step ❑ Adopted
Child's Name: _____ Age: _____ ❑ Biological ❑ Step ❑ Adopted

Are you currently receiving psychiatric service: ❑ Yes ❑ No
Are you currently taking prescribed psychiatric medication (antidepressants or others): ❑ Yes ❑ No
If Yes, please list: _____
If no, have you been previously prescribed psychiatric medication: ❑ Yes ❑ No
If Yes, please list: _____

Have you had previous psychotherapy: ❑ Yes ❑ No
Therapist's Name: _____ From: _____ To: _____
Therapist's Name: _____ From: _____ To: _____
Therapist's Name: _____ From: _____ To: _____

How did you hear about Stable Living: _____
Referred by: _____

OCCUPATIONAL INFORMATION

Are you currently employed: ❑ Yes ❑ No

If yes, who is your current employer/position: _____

If yes, are you happy at your current position: _____

List any work-related stressors, if any: _____

HEALTH AND SOCIAL INFORMATION

How is your physical health at present: ❑ Poor ❑ Unsatisfactory ❑ Satisfactory ❑ Good ❑ Very good

List any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc):

_____

Are you having trouble sleeping: ❑ Yes ❑ No

If yes, check where applicable:

❑ Sleep too little ❑ Sleep too much ❑ Poor quality sleep ❑ Disturbing dreams ❑ Other _____

How many times per week do you exercise: _____ Approximately how long each time: _____

Are you having any difficulty with appetite or eating habits: ❑ Yes ❑ No

If yes, check where applicable: ❑ Eating less ❑ Eating more ❑ Binging ❑ Restricting

Have you experienced significant weight changes in the last 2 months: ❑ Yes ❑ No

Do you regularly use alcohol: ❑ Yes ❑ No

In a typical month, how often do you have 4 or more drinks in a 24-hour period: _____

How often do you engage in recreational drug use: ❑ Daily ❑ Weekly ❑ Monthly ❑ Rarely ❑ Never

Has anyone told you they were concerned about your alcohol/drug use: ❑ Yes ❑ No

Have you had suicidal thoughts recently: ❑ Frequently ❑ Sometimes ❑ Rarely ❑ Never

Have you had them in the past: ❑ Yes ❑ No If yes, have you attempted: ❑ Yes ❑ No

Are you currently in a romantic relationship: ❑ Yes ❑ No If yes, how long: _____

On a scale of 1-10 (with 10 high), how would you rate the quality of your current relationship: _____

YOUR MENTAL HEALTH HISTORY

In the last year, what significant life changes or stressors have you experienced: _____

_____

_____

HAVE YOU EVER EXPERIENCED:

❑ Yes ❑ No Extreme Depressed Mood
❑ Yes ❑ No Wild Mood Swings
❑ Yes ❑ No Rapid Speech
❑ Yes ❑ No Extreme Anxiety
❑ Yes ❑ No Panic Attacks
❑ Yes ❑ No Phobias
❑ Yes ❑ No Sleep Disturbances
❑ Yes ❑ No Hallucinations
❑ Yes ❑ No Unexplained Losses of Time/Memory Lapses
❑ Yes ❑ No Chronic, Unexplained Pain
❑ Yes ❑ No Alcohol/Substance Abuse
❑ Yes ❑ No Frequent Body Complaints
❑ Yes ❑ No Eating Disorder
❑ Yes ❑ No Body Image Problems
❑ Yes ❑ No Repetitive Thoughts (e.g. obsessions)
❑ Yes ❑ No Repetitive Behaviors(e.g., frequent checking, hand washing, etc.)
❑ Yes ❑ No Homicidal Thoughts
❑ Yes ❑ No Suicide Attempt

YOUR FAMILY'S MENTAL HEALTH HISTORY

Have immediate family members or relatives experienced difficulties with the following: If yes, please list relationship:

❑ Yes ❑ No Difficult Family Member _____
❑ Yes ❑ No Depression _____
❑ Yes ❑ No Bipolar Disorder _____
❑ Yes ❑ No Anxiety Disorders _____
❑ Yes ❑ No Panic Attacks _____
❑ Yes ❑ No Schizophrenia _____
❑ Yes ❑ No Alcohol/Substance Abuse _____
❑ Yes ❑ No Eating Disorders _____
❑ Yes ❑ No Learning Disabilities _____
❑ Yes ❑ No Trauma History _____
❑ Yes ❑ No Suicide Attempts _____

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious: ❑ Yes ❑ No If yes, what is your faith: _____
If no, do you consider yourself to be spiritual: ❑ Yes ❑ No

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OTHER INFORMATION

What are effective coping strategies that you've learned: _____

What are your strengths: _____

Brief description of your experience growing up (relationship with parents/siblings, sexual or physical abuse, etc):

Is there anything else you'd like me to know: _____

I have received, read and understand the Counseling Agreement and the Notice of Privacy Rights. I authorize the release of the minimum amount necessary of my personal health information to the above referenced insurance company, and Stable Living, LLC's billing company in order to obtain payment for services received.

Client Signature: _____ Date: _____

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Therapist: _____ Diagnosis Code: _____

TREATMENT PLAN

Please complete form as best you can. If you are unsure of your answers, bring your questions in and your therapist will help you form goals and estimate timeline.

Issues (Why I'm here): _____

Goals (What I want): _____

Indicators (How do I know that I'm making progress): _____

Estimate – Time to achieve goals: _____ (You and your therapist will determine this together)

Likelihood (0-100%) of achieving goals: _____ (You and your therapist will determine this together)

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

Review Dates: _____

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FEE POLICY

Client: _____ Date: _____

Fee Scedule: A fee of $_____ per 55 minute session (or applicable copay if utilizing health insurance) is payable at the beginning of each session. Missed appointments or late cancellation fee of $_____ will be charged for each missed appointment or appointments cancelled with less than a 24-hour notice.

- ***The client is fully and directly responsible to check with their insurance company to determine their benefits for mental health coverage and verify that this therapist, Kristin A. Palesch, MA, LPCC, is an in-network provider under their policy. The client agrees that they are fully and directly responsible to Stable Living, LLC, for the payment of services rendered with or without insurance coverage.***
- ***The client is fully and directly responsible for additional fees which may be charged for psychological testing or phone consultation as discussed prior to testing or consulting.***
- ***The client is fully and directly responsible to pay for missed appointments or appointments cancelled with less than a 24-hour notice (except in cases of illness, emergency or severe weather).***
- ***The client is fully and directly responsible for overdue payments which will be assessed at a 5% monthly interest fee.***
- ***If fees change during the course of treatment, client will be given adequate notice of these changes.***

Please initial:

_____ ***All Clients:*** I understand agree to the current fee schedule above and my responsibility for payment of fees according to the above bullet points.

_____ ***Fee-for-Service Clients:*** I will be paying for services out-of-pocket and will not be utilizing my insurance company or be given a diagnosis at this time. I would like a receipt of payment and understand that payment is due at time of service.

_____ ***Out-of-Network Clients:*** I will be utilizing my out-of-network benefits with my insurance company and will be given a dianosis. I would like a receipt to send to my insurance company for reimbursement. I understand that payment is due at time of service and that I will file my own claims for reimbursement with my insurance company.

_____ ***In-Network Clients:*** I have verified that my therapist is an in- network provider with my insurance company and understand that I will be given a dianosis. I also understand that benefits do not guarantee payment and that I will be responsible for payment if the insurance company doe. I give my permission for my therapist and their business office, Professional Services Consultants, LLC to contact my insurance company. It is my responsibility to supply and keep up-to-date the current and accurate information for insurance and patient billing purposes, which may include, but not limited to: my legal name, correct postal mailing address, phone number(s), and insurance policy/identification number, group or policy number for insurance(s). . Stable Living, LLC cannot guarantee the outcome of payment by the insurance company. Insurance companies determine eligibility for behavioral health treatment based on medical necessity. Initial and ongoing authorization of treatment. Even under stress or time constraints, it is extremely important to understand benefit limitations and any other insurance company requirements.

Insurance Company: _____ Employer: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____ /_____ /_____ Relationship to Client: _____

ID #: _____ Group #: _____

I hereby authorize Stable Living, LLC to furnish the above named Insurance Company all information that said insurance company, may request concerning my present condition/illness. I hereby assign to Stable Living LLC insurance proceeds to be credited against total fee for service due on my account with Stable Living, LLC and will pay my portion of charges incurred as indicated by my insurance company. I hereby verify that all information supplied above is current and accurate. I have been given a copy of the current fee policy and Ia understand that I will be responsible for all fees as indicated on the current fee schedule and as outlined on this payment contract. I am also aware that I may be charged a late cancel/no show charge.

Client Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

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RELEASE OF LIABILITY AND HOLD HARMLESS AGREEMENT

• GAME FARM LLC & STABLE LIVING LLC •

THIS FORM MUST BE COMPLETED BY ALL CLIENTS BEFORE SESSIONS BEGIN

As of the date signed below, this RELEASE OF LIABILITY AND HOLD HARMLESS AGREEMENT (the "Agreement") is entered into by GAME FARM, LLC & STABLE LIVING, LLC, collectively defined throughout this document as Kristin "Kippie" Palesch, her immediate family, heirs and representatives, other principals, trainers, therapists, employees, contractors, volunteers, members, agents and assigns ("Company") at 680 Game Farm Road North, Minnetrista, MN 55359 and:

_____ ("Participant").

Participant and Participant's legal guardian (if under 18 years of age) must review and sign to confirm their understanding and agreement (collectively also referred to as "Participant"):

Participant's Name _____

Participant's Legal Guardian (if minor) _____

Street Address _____

City/State/Zip Code _____

Emergency Contact Name _____

Emergency Phone _____

Other EmergencyPhone _____

By signing below, Participant agrees to assume the risk associated with horses, handling and riding horses both to Participant and their horse, and Participant also agrees that they are *giving up certain legal rights, including the right to recover damages in case of injury, death, or property damage arising out of your presence and/or participation in equine activities at the Company, including injury, death, or property damage arising out of the negligence of the Company*. If you have any questions about the meaning of the legally binding contract, please feel free to ask your attorney.

In consideration for and in favor of GAME FARM, LLC & STABLE LIVING, LLC for allowing Participant to be on the premise of the Company and participate in activities, Participant voluntarily agrees to the terms of this RELEASE OF LIABILITY AND HOLD HARMLESS AGREEMENT and hereby agrees to personally assume the risks associated with horses.

Participant is participating voluntarily in handling and/or riding horses. Participant understands and is fully aware that being around horses involves inherently dangerous risks of serious injury or loss to Participant, or Participant's personal property.

Such inherent risks include but are not limited to inherent risks and dangers of accidents, rescue operations, emergency treatment, property loss or damage, serious personal and bodily injury, death, and severe personal and economic losses.

Participant hereby releases, waives, and forever discharges (i.e. Participant waives the right to sue and possibly receive monetary damages) the Company for all actions of whatever kind or nature either in law or in equity arising from or by reason of any bodily injury or personal injuries known or unknown, death, or property damage - including damage to Participant's physical body or personal property - resulting during Participant's presence on the Company's premises and any activity involving the Company's services so long as such injury, property damage, or death is not caused by an intentional, willful, or wanton act or omission of Company or any of the other parties listed above.

Participant assumes full responsibility for the risk of bodily injury, death, or property damage from such activities, and shall hold the Company and all of the other parties listed above harmless for any liability thereof as set forth herein.

Participant is participating voluntarily in activities which take place on a horse farm and understands that there are risks inherent with being on a farm.

Such inherent risks include but are not limited to: interaction with livestock either currently present on the farm or later acquired; interaction with pets such as dogs and cats, either currently present on the farm or later acquired; farm employee operation of machinery such as, but not limited to, snowplows, tractors, rakes, ATVs, or construction equipment; uneven or unstable ground; icy conditions and other effects of nature; and other risks incident to being on or around farm property.

Participant hereby releases, waives, and forever discharges (i.e. Participant waives the right to sue and possibly receive monetary damages for) the Company for all actions of whatever kind or nature either in law or in equity arising from or by reason of any bodily injury or personal injuries known or unknown, death, or property damage - including damage to Participant's physical body or personal property - resulting during Participant's presence on farm so long as such injury, property damage, or death is not caused by an intentional, willful, or wanton act or omission of the Company or any of the other parties listed above.

Participant assumes full responsibility for the risk of bodily injury, death, or property damage from such activities, and shall hold Company and all other parties listed above harmless for any liability.

Participant understands that horses and livestock are dangerous, and may bite, kick, spook, trample, causing Participant to be injured. Equine activities are considered inherently high risk and such risks include serious injury and death. Such risk may be increased should Participant participate in mounted equestrian activities but are not solely limited to mounted dangers.

Participant agrees to remain in authorized areas, which are limited to the main barn, tack room and arena. Participant agrees to avoid any work areas, including but not limited to equipment storage areas, tillable land, or any other areas designated verbally or in writing by the Company.

The Company and Participant recognize that being around horses inherently carries risk. To minimize that risk, safety is first and foremost. The use of helmets is mandatory for all Participants while riding horses whether owned or leased by the Company, Participant, or any other party.

Please read and initial each of the following sections.

a. **Helmets and Safety Gear**. I understand that it is at my own risk that I choose to wear or not to wear a riding helmet and to utilize other safety gear appropriate to my level of experience while on a horse. I accept full responsibility for accident or injury to myself if I choose to wear or not wear a riding helmet or other appropriate safety gear. If Participant is under 18 years of age, the Participant is required to wear a helmet when riding, the parent and the Participant must also sign this agreement.

Participant Initial: _____ ***Legal Guardian Initials:*** _____

b. **Attire**. I hereby agree to wear long pants when riding horses; wear shoes with a hard sole, closed toe, and heel; and to remove any dangling jewelry or any other loose items that may put me at risk. I accept full responsibility for accident or injury to myself if I choose to wear or not wear the above attire.

Participant Initial: _____ ***Legal Guardian Initials:*** _____

c. **Horses are Inherently Dangerous**. I also understand that engaging in equine activities is an inherently dangerous activity, and that, by so doing, I expose myself to dangers both known and unknown, whether I am or am not wearing a helmet, safelty gear or recommended attire. Horses are large, unpredictable animals which may be dangerous no matter how much training they have, no matter what level of experience I or my therapist have, and no matter what the situation. I agree and understand the Company cannot control the horses that it owns or boards, and that I shall release and hold harmless the Company from any injury arising out of or related to equine activities at the Company's facilities.

Participant Initial: _____ ***Legal Guardian Initials:*** _____

d. **Inclusive Facility.** I understand that Stable Living, LLC provides services for people of all ages and levels of physical, mental, emotional ability. I will be respectful of persons with physical disabilities, special needs and/or behaviors that are different from my own.

Participant Initial: _____ ***Legal Guardian Initials:*** _____

e. **Behavior or Special Accommodations**. I will notify my therapist of any medical conditions, behaviors specific to me, or special accommodations that I may need that may impact my participation in activities or therapy.

Participant Initial: _____ ***Legal Guardian Initials:*** _____

f. **I am Responsible for My Own Conduct**. I understand that I will ride and/or handle the horse, and will conduct myself at my own risk and with proper courtesies while I am on the Company's property.

Participant Initial: _____ ***Legal Guardian Initials:*** _____

g. **Death or Injury to Horse**. The Company will not be held responsible for injury or death of Horse absent gross negligence on their part.

Participant Initial: _____ ***Legal Guardian Initials:*** _____

h. **Death or Injury to Person(s)**. The Company will not be held responsible for injury or death of participant, client or contractor, or their assigns, affiliates, agents, parents, family, guests or friends absent gross negligence on their part.

Participant Initial: _____ ***Legal Guardian Initials:*** _____

i. **Social Media & Photographs**. I understand that posts to any/all social media including photos, comments or other references to any animal or person at the facility is prohibited without express permission of the Company or written permission from the person or horse's owner referenced.

Participant Initial: _____ ***Legal Guardian Initials:*** _____

j. **Guests, Release and Waiver of Liability, and Assumption of Risk**. I take full responsibility for any guest that I may bring onto the property and will not hold the Company responsible for accident or injury to my guests, including parents or other family members.

Participant Initial: _____ ***Legal Guardian Initials:*** _____

k. **Hold Harmless, Defend and Indemnify**. Participant agrees to defend, indemnify, save and hold harmless the Company and its principals, agents, and affiliates from and against any loss, liability, damage, attorneys' fees, or costs that they may incur arising out of or in any way connected with Participant's use of the Company, presence at the Company's facilities, Horse's conduct, Participant's use or access to Horse, or Participant's or their agents' actions, breaches, failures, or omissions in performing or furthering this Agreement or any related agreement, obligation or conduct, or as they may relate to or arise out of the subject matter of this Agreement.

Participant Initial: _____ ***Legal Guardian Initials:*** _____

l. **Consent to Emergency Treatment**. Participant recognizes that Participant is participating in an activity where there are inherent risks that may render emergency treatment necessary. In the event of an emergency where Participant is incapacitated or otherwise unable to give consent, Participant hereby consents to and agrees to bear the costs of administration of emergency services by paramedics or other medical professionals. Participant additionally consents to administration of emergency treatment by the professionals at the Company until such a time as paramedics or other medical professionals become available.

Participant Initial: _____ ***Legal Guardian Initials:*** _____

STATUTORY NOTICE:

Minnesota Stat. 604A.12: Inherent risk of livestock activities means the dangers or risks arising from the propensity of livestock to behave in unpredictable ways, including, but not limited to, kicking, biting, spooking, and rearing in response to sound, sudden movement, unfamiliar objects, persons, and other animals.

This release is given on behalf of Participant, Participant's spouse, Participant's legal representatives, administrators, executors, heirs, and assigns. **This release is an ongoing release and remains in effect until Participant has revoked it in writing.**

Read this agreement carefully before signing it. Your signature below indicates your understanding of and your agreement to its terms. Participant hereby acknowledges and affirms that he/she has carefully read the contents of this document, understands its meaning, and has voluntarily executed the same.

1. **Notice.**
   a. **Notice to Company**. All notices must be in writing and delivered to Company at the following address, in a manner which provides proof of delivery: Stable Living, LLC, Kristin "Kippie" Palesch, 680 Game Farm Road North, Minnetrista, MN 55359.
   b. **Notice to Participant**. All notices must be in writing and delivered to Participant at Participant's address listed above in this agreement, in a manner which provides proof of delivery.

2. **Assignment or Transfer**. No party may assign or transfer this Agreement without the prior written consent of the other parties.

3. **Entire Agreement**. This 4 page Agreement contains the entire agreement among the parties. Any modifications or additions must be in writing and signed by all parties to the Agreement. No oral modifications will be considered part of the Agreement unless reduced to writing and signed by all parties.

Participant's Printed Name _____

Participant's Signature _____

Dated _____

Participant's Legal Guardian's Signature _____

Dated _____

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CREDIT CARD AUTHORIZATION

THIS FORM MUST BE COMPLETED BY ALL CLIENTS BEFORE SESSIONS BEGIN

This form certifies that I, _____,
request Professional Services Consultants, LLC (PSC) and/or Stable Living, LLC to bill the below listed credit card of mine for all co-insurance for visits that have processed through insurance and appear on the statement for the current month. It also gives permission to charge my credit card for the $125 Missed Appointments/Late Cancel Fee on the day of Missed Appointment/Late Cancel session.

I further understand that I retain the right to revoke this authorization, if done so in writing and sent certified/receipt requested mail to PSC at the address below:

Professional Services Consultans, LLC
7650 Currell Boulevard, Suite 110
Woodbury, MN 55125
Phone: 651-738-8561
Fax: 651-730-6657

Type of Credit Card ❍ Visa ❍ Mastercard ❍ American Express ❍ Discover

Credit Card Number: _____

Expiration Date: _____

CSC Code: _____

Billing Zip Code: _____

Name on Card: _____

Phone Number: _____

Card Holder Signature: _____

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COUNSELING AGREEMENT

This agreement is designed to help build a positive working relationship between you and your therapist. It also informs you of your rights and responsibilities in the therapy relationship. If you have any questions or concerns, please feel free to discuss them with your therapist.

1. Therapeutic Relationship

The relationship between you and your therapist is very important and is different from other relationships in your life. You are able to talk freely and openly about yourself, more than you might do in social relationships. Your therapist's responsibility is to listen, select, sort, make observations, and reflect back to you behaviors, thoughts, feelings, and values or beliefs that will enable you to understand and see yourself more clearly. The goal of this process is to gain more insight and understanding and increase adaptive thoughts, feelings, and behaviors that increase your wellbeing. This does not predict, nor guarantee, a successful outcome in therapy. While your therapist may suggest changes, only you can choose if those changes are valuable and pertinent, and only you are able to make those changes.

You and your therapist will work together to establish treatment goals for therapy that are meaningful to you. As you work towards your goals, some people can experience therapy as an intense or, at times, painful experience. This anxiety begins to reduce as the relationship between you and your therapist develops, trust builds and understanding is gained. This is not unusual in the healing process. Fortunately, most people find therapy to be a very rewarding and positive experience with life changing outcomes.

2. Appointments

Appointments are typically 55 minutes in length. You and your therapist will work together to personalize a schedule to fit your needs.

3. Cancellation Policy

If you need to cancel an appointment for any reason, it is necessary to notify your therapist via phone or email at least 24 hours in advance. 48 hour notice is required for a 2+ hour session. You will be charged $125/hour if session(s) are not canceled within 24 or 48 hours of session start.

4. Confidentiality

Client information is kept strictly confidential and the release of information about you to anyone can only be done with your written consent. Because therapists are all mandated reporters, state law, however, places certain limitations on the right of confidentiality (see also Notice of Privacy Rights):

- *Threats of suicide*
- *Threats of harming another person*
- *Any incidence or knowledge of suspected neglect, physical, or sexual abuse of children and/or vulnerable adults*

During professional consultation, the therapist may discuss facts in a case, but the identity of the client will remain confidential.

When meeting as couples and/or families, it may be helpful to meet with your therapist individually. If individual sessions are scheduled, no confidences will be held by the therapist. Your therapist reserves the right to use his/her best judgment to share pertinent information, or will ask the individual to share the information, in the best interest of the marriage or family.

For couples and families, in order for information to be shared between a therapist at Stable Living and another individual, we require a signed release of information from both or all parties.

When children are being seen by a therapist, the custodial parent(s) will be informed of their child's progress for children under 18 years of age.

Confidentiality can not be guaranteed by Stable Living LLC if client chooses to correspond using unsecure internet email.

5. Fees

Payment of fees is expected at the time of each session. You may use cash, check, credit card or money order. Insurance coverages differ, so please check with your insurance company to determine the requirements for mental health coverage. A receipt will be provided which can be submitted by the client. Your fee per 55-minute session will be billed to health insurance at the rate of $225 for Intake and followup sessions at the rate of $180. Overdue payments will be assessed a $5.00 fee for each month the payment is overdue. Additional fees will be charged for psychological testing and there is a charge for written reports of files based on an hourly fee structure. We will give you a 30-day notice if fees change. In court cases, we encourage information to be passed on to lawyers and the court through written reports at our hourly fee rate. If we are asked to do a deposition or appear in court, our fees are $350 per hour plus a mileage fee of $.75 per mile.

6. Hours & Emergencies

After normal business hours, you will receive our voicemail system where you can leave confidential messages. This voicemail system is available 24 hours a day and messages are retrieved regularly throughout the weekdays. If you need immediate assistance, please call:

- *Call 211 (or 1-800-543-7709; 24-hour help to connect you to resources)*
- *Hennepin County Mobile Crisis Team (COPE) at 612-348-2233 (under 18 yrs) or 612-596-1223 (18 yrs+)*
- *Acute Psychiatric Service at 612-873-3161*
- *National Suicide Hotline at 1-800-273-TALK (8255)*
- *Call 911, or go to the nearest hospital emergency room.*

7. Stable Living, LLC

Stable Living, LLC is a limited liability corporation. Therapists working under the name are contracted therapists who are covered individually with their own private liability insurance. If you have questions about Stable Living, LLC, please contact Kippie Palesch, LPC, President at 952.240.1621 or kippie@stableliving.us or contact your therapist directly with questions or concerns.

8. Complaints

You are urged to discuss with your therapist any questions, concerns, or problems you may have about the therapy you receive. Often times, part of the therapeutic relationship involves working through misunderstandings or misconceptions. You also have the right to file a complaint with: Kippie Palesch, MA, President, 680 Game Farm Road, Minnetrista, MN 55359, 952.240.1621 and Minnesota Department of Health, 121 East 7th Street, St. Paul, MN 55101, 612.623.5522.

9. Therapy Session

An important aspect of therapy is the relationship that develops between you and your therapist. As with any new relationship, it takes some time to trust and feel safe. If the relationship does not develop after a reasonable amount of time (three to four sessions), you may want to talk with your therapist about it and a referral can be made. Your therapist will be happy to help with this.

The therapeutic relationship is unique in that you will be focusing on aspects of yourself that may not ordinarily receive attention. The therapeutic approach used by the therapist comes from a variety of psychological theories. As each client is different, each session varies depending on the needs of the client and the goals set by the client and therapist.

The therapist will work with the client towards healthy development, meaningful and satisfying relationships, and address conflict between mind, body, and spirit. The intention is to address relationship issues, behavioral problems, family-of-origin concerns, destructive thought patterns, trauma and/or spiritual issues. Core values and beliefs are identified and based on the issues of concern your therapist will help with insight and observations where needed. Your therapist will strive towards a safe environment in which clients can talk freely and openly about their concerns.

Therapy is a process. Initially you may feel uncomfortable, even anxious, talking about sensitive issues. Again, this anxiety begins to reduce as the relationship between you and your therapist develops and trust builds. As you learn new ways to interact with yourself and others, these new ways to interact may feel uncomfortable. Sometimes things seem to get worse before they get better. This is expected and typical of everyone making life adjustments.

One of the most growth-producing times for the client can be when he/she expresses anger with the therapist. This expression of "owning" one's feelings and having the therapist respect them often results in a very affirming experience for the client. Your therapist is open to hearing about your concerns and feelings.

It is critical to stay with the therapy even during these uncomfortable times. Once you get through this phase, and as we discuss the emotions around these issues, you should begin to feel more comfortable. During this stage, you will continue to apply the new skills and you will feel more courageous in meeting problems directly. As you near the end of therapy, you and your therapist will discuss discontinuing the therapy, with the understanding that you can choose to return any time if you feel the need.

10. Therapy Techniques

Each therapist at Stable Living, LLC uses a combination of psychotherapy techniques. If you have questions, please ask your therapist directly and he/she can explain things more thoroughly.

Several therapists are trained in Eye Movement Desensitization and Reprocessing (EMDR) and Equine-Assisted Psychotherapy (EAP). Also, Cognitive Behavioral Therapy (CBT) is a type of therapy frequently used at Stable Living to address negative thoughts, feelings and behavior. These approaches are helpful when addressing trauma, abuse, post-traumatic stress disorder, anxiety and depression, to name a few. When using either EMDR, EAP or CBT, your therapist will outline how the therapy helps, if you are a good candidate for it, and you will be given the option to participate. For a thorough explanation of EMDR, visit the EMDR.com website. For a more thorough explanation of EAP, visit naturallifemanship.com to better understand Trauma-Focused Equine-Assisted Psychotherapy (TF-EAP).

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Stable Living, LLC • www.StableLiving.us • Phone 952.240.1621 • kpalesch@me.com

PRIVACY POLICY

The privacy of your medical information is important to us, with the understanding that this information is personal. Therefore, we are committed to protecting it. To comply with certain legal requirements, Stable Living, LLC creates a record of the care and services each individual receives to better provide you with quality care. This notice details the ways we may use and share medical information about you. Furthermore, we describe your rights and certain duties we have regarding the use and disclosure of medical information. This notice is effective January 1, 2017.

1. *Uses of Information Obtained From You: The information we obtain from you is used to establish diagnosis, determine your treatment plans and goals, provide the services you request, and establish your ability to pay for these services.*
2. *Our Legal Responsibility: The law requires us to keep your medical information private, give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information, and to follow the terms of the notice that is now in effect.*
3. *Patient Rights: Effective April 14, 2003, the 45 CFR Health Insurance Portability and Accountability Act (HIPAA) went into effect with rules on not only disclosure but also on the use of patient information. Under this Act clients, must be given a Notice of Privacy Practices upon the arrival of their first service. The following list of rights now apply to any patient of a health care provider:*
   a) *Right to Request Medical Records: The patient has a right to access their medical records.*
   b) *Right to Request Additional Restrictions: You may request restrictions on our use and disclosure of protected health information for treatment, payment, and health care operations. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction. If you wish to request a restriction, please make a request in writing and submit it to your therapist. We will send you a written response.*
   c) *Right to Receive Confidential Communications: You may request, and we will accommodate, any reasonable (written) request for you to receive protected health information by alternative means of communication or at alternative locations.*
   d) *Right to Inspect and Copy Your Health Information: If you desire access to your records, please make a written request to your therapist. If you request copies, there will be a $2.00 charge per page. Please note, under limited circumstances we may deny you access to a portion of your records.*
   e) *Right to Amend Your Records: You have the right to request that we amend protected health information maintained in your clinical file or billing records. If you desire to amend your records, please request in writing the amendment and submit it to your therapist. Under certain circumstances, we have the right to request to amend your records and notify you of this denial as provided by the HIPAA regulations. If your requested amendment to your records is accepted, a copy of your amendment will become a permanent part of the medical record. By "amend," your therapist is permitted to append information to the original record, as opposed to physically remove or change the original record.*
   f) *Right to Receive an Accounting of Disclosures: Upon request, you may obtain an accounting of disclosures of your protected health information other than those for which you gave written authorization or those related to your treatment, payment for services, or health care operations. The accounting will apply only to covered disclosures prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, a charge may apply. You will be informed of the cost prior to the request being filled.*
   g) *Right to Receive a Paper Copy of this Notice: Upon request, you may obtain a paper copy of this privacy notice.*
4. *Use and Disclosure of Your Medical Information With Written Consent: We are permitted to use and disclose information about you for treatment and/or services to doctors, nurses, psychiatrists, psychologists, other mental health professionals. Also included are other people in charge of your care or health care professionals assisting in your treatment. We may also use and disclose your medical information for payment purposes to insurance companies for disability payments, etc. Furthermore, we may also use information for healthcare operations that may include information disclosed to business associates such as billing software providers or transcriptionists.*
5. *Use and Disclosures Without Neither Consent Nor Authorization: According to state and federal requirements, we are mandated to report information we maintain about you to other agencies or individuals without your written consent under the following circumstances:*
   a) *If we have reason to believe there has been:*
   • abuse of a child or vulnerable adult. • victimization due to violence. • victimization due to other crimes. • potential or intention to seriously harm another person, we may have a legal obligation to warn the intended victim and/or the police. • the possibility a pregnant woman has used a controlled substance (e.g., cocaine, heroin) for a non-medical purpose during the pregnancy.
   b) *If it is court-ordered.*
   c) *If a non-custodial parent requests information, they may receive information about our services for their child, but not about services to the other parent.*
   d) *If there is an emergency, we may communicate your condition to a family member or other appropriate persons.*
   e) *If your account is delinquent, we may attempt to obtain reimbursement through small claims court or to collection agency. We may also report delinquent accounts to credit bureaus.*
   f) *Examination of records for an audit or accreditation.*
   g) *To meet federal, state, and local statistical requirements.*
   h) *If a new statute, federal law, or State Commissioner of Administration authorizes a new use of the information after you had been given this notice.*
6. *Regarding Minors: Minnesota State Law authorizes that a minor has the right to request the private data about them be kept from their parents. This request will be honored if we believe it will protect the child from physical or psychological harm.*
7. *Providing Information About You: You are not required to provide information about yourself; however, without some information we may not be able to provide the most appropriate services. If you are here because of a court order, and you refuse to provide information, that refusal may be communicated to the court.*
8. *Right to Change Terms of this Notice: We may change the terms of this notice at any time. If we change this notice, we may make the new notice terms effective for all protected health information that we maintain, including any information created or received prior to issuing the new notice. If we change this notice, we will post it in public access areas, or give you a copy of the updated notice.*
9. *Complaints: If you desire further information about your privacy and confidentiality rights, or are concerned that we have violated these rights, or disagree with a decision that we made about access to your protected health information, you may contact your therapist or Kippie Palesch, LPCC, Stable Living LLC, President at 952.240.1621. You may also file a written letter of complaint with the Secretary of the Department of Health and Human Services. We will not retaliate against you if you file a complaint.*