**Client Information Form**

Client Name: Today’s Date:

Street: City: State:

Zip: Home Phone: Cell Phone:

Sex: *Male Female* Ethnicity: Date of Birth: Age:

Parent/Legal Guardian Name Phone:

Name of Spouse: Phone:

E-mail: Referred by:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Names of Other Children: | Age | Gender | Living w/ you? | Comments: |
|  |   |   | *M F* | *Yes No* |   |
|  |   |   | *M F* | *Yes No* |   |
|  |   |   | *M F* | *Yes No* |   |
|  |   |   | *M F* | *Yes No* |   |
|  |   |   | *M F* | *Yes No* |   |

|  |
| --- |
|  Have you ever been seen by a mental health professional before? *Yes No*  If yes, please indicate who, when and why:   |

|  |
| --- |
|  Who is your primary physician? Phone #: |
|  Please list any troublesome or significant medical conditions you may have. |
|  | Please list your current medications (Prescription & Non-Prescription): |
|  | Drug | Dose | Frequency | When Started | For what symptom(s) | Prescribing Doctor |
|  |   |   |   |   |   |   |
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|  Who should be notified in case of emergency? Name: Relationship:  Home Phone: Work Phone: Pager:  |

**Disclosure Statement**

The practice of both licensed and unlicensed persons and certified school psychologists in the field of psychotherapy is regulated by the Colorado State Department of Regulatory Agencies with a Mental Health Occupations Grievance Board that can be contacted at 1560 Broadway, Suite 1350, Denver, Colorado, 80202. (303) 894-7766. As to the regulatory requirements applicable to mental health professionals a Licensed Professional Counselor must hold a master’s degree in their profession and have two years of post-masters supervision.

You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the

duration of your therapy (if known), and the fee structure. You can seek a second opinion from another therapist or

terminate therapy at any time.

Payment is due at the time of treatment. My fee is $100.00 per individual and $110 per family session unless other arrangements are made. Session length is usually 50 minutes in duration. I have the right to bill for any missed appointment unless twenty-four hour notification is given.

In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the State Grievance Board.

Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and

cannot be released without the client’s consent. There are exceptions to this confidentiality, some of which are listed in

section 12-43-218 of the Colorado Revised Statutes, and the HIPAA Notice of Privacy Rights you were providedas well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report suspected child abuse to authorities. If a legal exceptionarises during therapy, if feasible, you will be informed accordingly.

When I am not immediately available by phone my voice mail will take messages. I will make every effort to return your call on the same day you make it, with the exception of evenings, weekends, holidays and vacations. When I am out of town, the voice mail message will refer you to a colleague on call in case of a clinical emergency. For life threatening emergencies always call 911. ***If you choose to communicate with me by email, please be aware that emailing is not secure and confidentiality may be breached.***

**May I call you at home and leave a message if necessary? \_\_\_\_\_\_ Yes \_\_\_\_\_\_\_ No**

**May I call you on your cell phone and leave a message if necessary? \_\_\_\_\_\_ Yes \_\_\_\_\_\_\_ No**

**May I send you an email? \_\_\_\_\_\_ Yes \_\_\_\_\_\_\_ No May I send you text messages? \_\_\_\_\_\_ Yes \_\_\_\_\_\_\_ No**

I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the

client’s responsible party.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Client’s Name

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Client’s or Responsible Party’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If signed by Responsible Party, please state relationship to client and authority to consent:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Kenny Dennis, MA, LPC Date

**Payment Contract and Consent to Release Confidential Information**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name Date of Birth Social Security Number

I understand that I will be responsible for payment for the services provided for me or my dependents, and that my portion of the charges are to be paid at the TIME OF SERVICE. I will provide any change of insurance status immediately. I hereby authorize the release of any information necessary to process my claim to my insurance company or other third party payer identified below. I understand that his may include mental health diagnosis and treatment information, including information about drug or alcohol abuse and HIV conditions. It may also include the release of information for the determination of eligibility or coverage and adjudication or subrogation of health benefit claims. It may include billing, claims management, collection activities, obtaining payment under a contract for reinsurance and related health care data processing. It may include at third party payer’s review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges. I understand that this information may also be released to any billing services provided for Kenny Dennis, MA, LPC. The release/authorization is valid for one year unless indicated otherwise.

\_\_\_\_\_ Full Fee: I understand that I am responsible for payment in full at time of service at the rate of $\_\_\_\_\_ per hour. I also understand that I am responsible for payment of any missed appointments with less than 24 hour notice.

\_\_\_\_\_Insurance/Third Party: I request the insurance reimbursement under my policy with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, or any other insurance or third party coverage which I might be authorized for, be made on my behalf to Kenny Dennis, MA, LPC. Based on my insurance policy, my outpatient co-pay is determined by my insurance company. I understand that I will be responsible for the full amount of the usual fee if I fail to take the necessary steps to obtain insurance payment for Kenny Dennis, MA, LPC. I hereby authorize Kenny Dennis, MA, LPC to submit claims on my behalf to my insurance company or third party carrier for all services I or my dependents receive from Kenny Dennis, MA, LPC. I authorize my insurance company to make payment for all services directly to Kenny Dennis. Kenny Dennis has agreed to accept payment from your insurance company at a contracted rate, which may be below our usual and customary charge.

\_\_\_\_\_Medicaid/CHP+: Medicaid #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request the payment of authorized Medicaid benefits be made to Kenny Dennis, MA, LPC for services provided to me or my dependents. I understand that if my benefits are terminated, I am financially responsible for the charges incurred.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Parent or Legal Guardian Signature Date

Please verify that you have received a copy of our ***Notice of Privacy Practices*** by initialing here: \_\_\_\_\_\_\_\_\_\_ INITIALS

|  |
| --- |
| Primary Care Physician Name:       |
| Address:       | Telephone:           |
| City:        | State:       | Zip:       | Fax:           |
|  |
| Dear Dr.  |       |  |
| Your patient |       | was recently referred by  |       |
| **We hope that the following information will be helpful in coordinating this patient’s care.**  |
| Date of Initial Consultation: |       | Date of Next Appointment: |       |
| Presenting Problems: |       |
| Diagnosis: |       |
| Treatment Plan and Recommendations: |       |
|       |
| Medications: |       |
|       |
| **Please call me if further information would be helpful.**  |
| Clinician’s Name: | Kenny Dennis, MA, LPC |
| Address: | 1864 Woodmoor Drive, Ste 214 | Telephone: | 719 321 1976 |
| City:  | Monument | State:  | CO | Zip: | 80132 | Fax:  | 866 384 1465 |
| Sincerely, |  |
|  |  |
| Clinician’s Signature |  |
|  |
| **NOTICE TO RECIPIENT OF INFORMATION**This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. |
|  |
| AUTHORIZATION |
| I |       | hereby authorize | Kenny Dennis |
|  | Enter Patient’s Name |  | Enter Treating Clinician’s Name |
| Please check one: | [ ]  | To release any applicable mental health information to my primary care manager (PCM)  |
|  | named above for the purpose of coordinating my health care.  |
|  | [ ]  | To release any applicable substance abuse information to my PCM named above. |
|  | [ ]  | To release only medical information to my PCM named above. |
|  | [ ]  | Not to release any information to my PCM named above. Note: Refusal to authorize  |
| release of information will not jeopardize ongoing medical or mental health treatment. |
|  |
| I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it.  |
| If I do not revoke this authorization, it will expire one (1) year after I have terminated treatment or as designated by state law.  |
|  |  |       |
| Signature of Patient or Guardian |  | Date of Birth |

**Primary Care Physician Communication Letter**