GUARDED HEARTS GUARDED MINDS INTAKE DOCUMENTS

Kenny Dennis, MA, LPC
1864 Woodmoor Drive, Suite 214 Monument, CO 80132
719.321.1976 kenny.dennis.lpc@gmail.com

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:

GUARDED HEARTS GUARDED MINDS INTAKE DOCUMENTS

Kenny Dennis, MA, LPC
1864 Woodmoor Drive, Suite 214 Monument, CO 80132
719.321.1976 kenny.dennis.lpc@gmail.com

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

Who should be notified in case of emergency?

Name: Relationship:

Home Phone: Work Phone: Pager:

GUARDED HEARTS GUARDED MINDS INTAKE DOCUMENTS

Kenny Dennis, MA, LPC
1864 Woodmoor Drive, Suite 214 Monument, CO 80132
719.321.1976 kenny.dennis.lpc@gmail.com

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 provided as 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 exception arises 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

_____
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

GUARDED HEARTS GUARDED MINDS INTAKE DOCUMENTS

Kenny Dennis, MA, LPC
1864 Woodmoor Drive, Suite 214 Monument, CO 80132
719.321.1976 kenny.dennis.lpc@gmail.com

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

GUARDED HEARTS GUARDED MINDS INTAKE DOCUMENTS

Kenny Dennis, MA, LPC
1864 Woodmoor Drive, Suite 214 Monument, CO 80132
719.321.1976 kenny.dennis.lpc@gmail.com

Primary Care Physician Communication Letter

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