INTAKE FORMS
Sarah Rasche, LCSW

Please note: Information you provide here is protected as confidential information.

Legal Name:
Name I prefer to be called:

Name of parent or guardian (if under 18 years):

Birth Date: Age: Gender: Pronoun:

Relationship Status:
□ Single □ Partnered □ Married
□ Separated □ Divorced □ Widowed

Employment:

Cultural Considerations:

Spiritual Considerations:

Please list any children and their ages:

Address (City/State/Zip):

Cell: May we leave a message? □Yes □No

Work Phone: May we leave a message? □Yes □No

E-mail: May we email you? □Yes □No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any):

GENERAL HEALTH INFORMATION

1. How would you rate your current physical health?

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

2. How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise?

What types of exercise do you participate in?

4. Please list any difficulties you experience with your appetite or eating patterns:

5. Are you currently experiencing overwhelming sadness, grief or depression?

□ Yes, for approximately how long?
□ No

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

□ Yes, when did you begin experiencing this?
□ No

7. Are you currently experiencing any chronic pain?

□ Yes, please describe:
□ No

8. Are you currently in a romantic relationship?

□ Yes, for how long?
□ No

Have you experienced historical or current Intimate Partner Violence (including physical, psychological, financial, sexual violence) within this relationship?

9. How many alcoholic beverages do you consume in one week?

10. How often do you engage in recreational drug use?

11. Do you use tobacco?

12. What significant life changes or stressful events have you experienced recently?

13. What do you consider to be some of your strengths?

14. What would you like to accomplish out of your time in therapy?

BRIEF FAMILY HEALTH HISTORY

Please identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

Alcohol/Substance Abuse □ No □ Yes: _____

Anxiety □ No □ Yes: _____

Depression □ No □ Yes: _____

Child Abuse or Neglect □ No □ Yes: _____

Eating Disorders □ No □ Yes: _____

Intimate Partner Violence □ No □ Yes: _____

Pregnancy Loss or Stillbirth (Please specify) □ No □ Yes: _____

Obsessive Compulsive Behavior □ No □ Yes: _____

Schizophrenia □ No □ Yes: _____

Suicide Attempts □ No □ Yes: _____

Please provide any additional family history that you feel is pertinent to your situation:

MEDICAL HISTORY AND RELEASE

1) Primary Care Physician:

Address (include City/State/Zip):

Phone:

2) Specialist (if applicable; name and specialty):

Address (include City/State/Zip):

Phone:

2) Psychiatrist (if applicable):

Address (include City/State/Zip):

Phone:

3) Have you previously sought counseling?

□ Yes; Dates:
□ No

Name of Therapist (most recent):

Address (include City/State/Zip)

Phone:

4) Have you ever been hospitalized for psychiatric reasons?

□ Yes; When: Where:
□ No

5) Have you ever been or are you currently being treated for substance abuse?

□Yes; Dates:
□No

6) Please list any physical illnesses that are currently being treated by a physician:

7) Please list any mental health diagnoses you have received:

8) Please list any medications and/or supplements you are currently taking (include dosage):

Should coordination of care or safety concerns arise, I authorize Sarah Rasche, LCSW to contact by telephone the above listed providers for the purpose of consulting and coordinating care for my therapy and treatment.

_____ _____

Authorization Signature Date

STATEMENT OF FEE POLICY AND TELETHERAPY DISCLOSURE STATEMENT

TELETHERAPY DISCLOSURE STATEMENT - Videoconferencing or Skype - I follow industry best practices to protect confidentiality in all formats of communication, but it is important to recognize that there are confidentiality risks when using technology to communicate. According to Skype's privacy practices, the technology is encrypted to protect your privacy. You can read about Skype's privacy practices at http://www.skype.com/intl/en/security/. Though Skype is encrypted, confidentiality cannot be guaranteed when communicating through teleconferencing technology. By choosing to engage in online therapy through Skype, you are consenting that you understand that there are confidentiality risks involved in utilizing a distance counseling relationship.

NO RECORDING - In order to preserve the vulnerability and openness necessary for effective therapy to occur, neither client nor therapist will record therapy sessions at any time for any reason unless otherwise discussed and approved by both parties in writing.

FEES/PAYMENT - The therapy fee is $_____ per _____ minute session. All payment is due at the time of treatment unless otherwise indicated. Payment will be collected through cash, check or card. Please make checks out to Anchored Denver. Credit or debit card payment via Square is available.

INSURANCE AND MANAGED CARE – I currently accept Mines and Associates (EAP) referrals. I am actively pursuing various insurance panels and will provide updates to all clients when available. I am able to provide an out-of-network statement upon request.

CANCELLATION - All appointments must be cancelled 24 hours in advance, with exceptions made for medical emergencies or circumstances that are completely out of your control. If an appointment is missed without 24-hour notification, you will be billed for the full hourly fee.

CRISIS SERVICES– I do not offer services outside of my scheduled hours. When possible, I check my voicemail during the day within working hours, and when available, I attempt to respond to crisis needs via phone contact or urgent appointment. All crisis communication via phone or email will accrue a prorated fee according to the hourly therapy rate we have agreed upon.

In the event that I am not available for a crisis situation, please call 911 if you feel that you, or someone else, is in danger of being physically harmed. For crisis support outside of my office hours, you can contact **Colorado Crisis Services for urgent behavioral health needs at 1-844-493-8255**.

CONSENT FOR TREATMENT – If you have any questions about this agreement, I invite you to discuss them with me. In signing this agreement, you are stating that you have read and understand this contract and that you give your informed consent to the procedures and risks described above.

I, _____ have read and understand this policy statement and agree to all of the above terms. I authorize Sarah Rasche, LCSW to provide counseling services at my request and with my informed consent.

Client or Guardian Signature: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

Sarah Rasche, LCSW

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Please provide contact information for two primary support persons:

Name:
Relation:
Telephone Number:

Name:
Relation:
Telephone Number:

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Sarah Rasche, LCSW, at 815 E 17th Ave Denver, CO 80218.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you have questions about this notice or any complaints about my privacy practices, please contact me at 720-515-9540. You may also file a complaint with the Secretary of the Department of Health and Human Services, Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is December 2015

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:
DOB:

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Sarah Rasche, LCSW.

_____

Signature of Patient/Client *Date*

_____

Signature of Parent, Guardian or Personal Representative *Date*

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ *Patient/Client Refuses to Acknowledge Receipt:*

_____

Signature of Clinician *Date*

Clinician Name:	Sarah Rasche, MSW, LCSW
Degrees, Credentials, Registrations, Licenses:	Degrees: Bachelor of Arts: George Washington University, 2009 Master of Social Work: University of Denver, 2013 License: CSW (Licensed Clinical Social Worker) Colo. DORA #09924626
Education, Experience, Training:	Sarah is co-owner of Anchored Denver, which provides therapeutic services to individuals, couples and families. Areas of expertise and interest include: infertility, postpartum mood and adjustment issues, perinatal bereavement support and social-emotional development in early childhood. She has completed the DC: 0-3 Training for Infant and Early Childhood Mental Health through JFK Partners. Additionally, she offers support to social workers and health care professionals experiencing compassion fatigue and vicarious trauma. She also offers clinical supervision to social workers seeking licensure.
Business Address:	815 E. 17th Avenue Denver, Colorado 80218
Business Phone:	720-515-9540

Mandatory Disclosure Statement

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. Questions and complaints may be addressed to:

Colorado State Department of Regulatory Agencies
Division of Professions and Occupations
1560 Broadway, Room 1350
Denver, Colorado 80202
303-894-7800

You are entitled to obtain name, business address, business phone number, and a listing of any degrees, credentials, certification, registrations, and licenses held or obtained, including education, experience and training for providers. Please contact me if you have any questions or need additional information in this regard.

These are the regulatory requirements applicable to mental health professionals.

• A Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's degree in their profession and have two years of post-masters supervision.
• A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.
• A Licensed Social Worker must hold a master's degree in social work.
• A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.
• A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1,000 hours of supervised experience.
• A CAC II must complete additional required training hours and 2,000 hours of supervised experience.
• A CAC III must have a bachelor's degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience.
• A Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements.
• A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required.

I provide services in accordance with the following guidelines:

• You are entitled to receive information about the methods, the techniques used, the duration of individual or group sessions and the fee structure.
• You may seek a second opinion from another provider or may withdraw from therapy at any time.

• In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.
• The information provided by you during individual or group sessions is legally confidential except as required by law.
• If you participate in group therapy, it is necessary for you to agree to protect and respect the privacy of other group members. You need to agree not to share personal information, including the names of other group members, with people outside of the group. You may expect other group members to show the same respect for your confidentiality.

Treatment Agreement: I agree to services from Sarah Rasche, LCSW.

Confidentiality: I understand that my records will be held in confidence according to Notice of Privacy Rights provided and as defined by the Division of Behavioral Health pursuant to Colorado Revised Statutes (CRS 27-10-101 et.seq. & Standard CF.1 et.seq.) and the Division of Alcohol and Drug Abuse pursuant to code of Federal Regulations (42 C.F.R. Part 2). There are exceptions to the rule of confidentiality that can be explained and will be identified to you should any such situations arise during individual and group sessions. In general, the exceptions include a "threat of serious harm to yourself or others" as in the case of child abuse, suicide, grave disability; medical emergencies; under a court order; or in response to any legal action taken by you against Sarah Rasche, LCSW or her business.

As a client, you have the following rights:
• You have the right to revoke this consent at any time.
• To receive services only if you or your legal guardian gives permission in writing.
• To complain about services at any time without retaliation.
• To be treated with respect and recognition of your need for dignity.
• To receive services based on your individual needs, in a setting which supports your individual freedoms.
• To actively participate in individual and group sessions.
• To confidentiality, and to expect that none of the information within individual or group participation will be given to anyone without your permission except as required by law.
• To refuse services unless you are court ordered to receive services and to be informed of the consequence of your refusal.
• To have your family members involved in your care, at your request.
• To inspect your records, or have them shown to anyone designated by you in writing. If you are denied access to records, to know why and how to appeal.
• To receive written information about the clinician’s services and therapeutic guidelines.
• To not be discriminated against due to race or ethnicity, sex, age, disability, sexual orientation, genetic information or source of payment.
• To be informed of the rights in a way you understand.

I have been informed of my provider's degrees, credentials, certifications, registrations, and licenses, as well as the education, experience, and training required for other types of mental health treatment providers. I hereby acknowledge I have read and received a copy of the information on both sides of this page. This information has also been provided to me verbally and I had any questions I had have been answered.

_____ _____
Client Signature Date

_____
Print Client Name

_____ _____
Provider’s Signature Date