



Welcome!

The following form is intended to help you become acquainted with myself and my practice, as well as to provide me with some preliminary information which will help me serve you better. Please take time to read it carefully. I will gladly discuss any (or all) of these items with you in more detail, if needed.

DEMOGRAPHICS:		
Name:	DOB:	Age:
Address:		
Phone:		
Email:		
Marital Status:	Gender	
Who referred you to this office:		

SYMPTOM CHECKLIST - Please check any of the following that apply:					
<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Inferiority feelings	<input type="checkbox"/>	Marked mood changes
<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Homicidal Ideas	<input type="checkbox"/>	Loneliness
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Suicidal ideas	<input type="checkbox"/>	Legal difficulties
<input type="checkbox"/>	Memory problems	<input type="checkbox"/>	Past suicidal attempts	<input type="checkbox"/>	Past court involvement
<input type="checkbox"/>	Irritability	<input type="checkbox"/>	Guilt	<input type="checkbox"/>	Employment problems
<input type="checkbox"/>	Restlessness	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Difficulty making decisions	<input type="checkbox"/>	Brooding	<input type="checkbox"/>	Compulsions
<input type="checkbox"/>	Inadequate income	<input type="checkbox"/>	School problems	<input type="checkbox"/>	Domestic abuse
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Thought racing	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	Unwanted thoughts	<input type="checkbox"/>	Preoccupations	<input type="checkbox"/>	Heart palpitations
<input type="checkbox"/>	Eating disorder	<input type="checkbox"/>	Problems with anger	<input type="checkbox"/>	Drinking too much
<input type="checkbox"/>	Frequent worries	<input type="checkbox"/>	Overeating	<input type="checkbox"/>	Insomnia
<input type="checkbox"/>	Problems concentrating	<input type="checkbox"/>	Family problems	<input type="checkbox"/>	Hallucinations
<input type="checkbox"/>	Past drug/alcohol abuse	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	Difficulty making friends
<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>	Weight change	<input type="checkbox"/>	Excessive sleep
<input type="checkbox"/>	Difficulty relaxing	<input type="checkbox"/>	Loss of relationship	<input type="checkbox"/>	Difficulty trusting people
<input type="checkbox"/>	Nightmares	<input type="checkbox"/>	Paranoid thoughts/feelings	<input type="checkbox"/>	Difficulty keeping friends
LEVEL OF DISTRESS :					
Are you experiencing suicidal thoughts?					
Do you have a plan to commit suicide?					
Are you thinking about harming yourself in any way?					
Do you have a plan to harm yourself?					
Have any of your friends or family ever committed or attempted suicide?					
Are you experiencing thoughts of hurting others?					
Do you have a plan to hurt others?					



FEE SCHEDULE:

Individual / Family Therapy (55 min)	\$90/session
Group Therapy (90 min)	
1 – 3 people	\$60/person
4 – 7 people	\$50/person
8 or more people	\$40/person
Informed Supervision Training (2-3 hours)	
1 – 3 people	\$100/person
4 – 7 people	\$75/person
8 or more people	\$50/person
Supervision / Case Consultation	\$65/session

I reserve the right to raise fees at any time. Prior to doing so, I will give you notice of the change and an opportunity to consult about any difficulties the changes may cause you or your family.

It is customary to pay for services when rendered. You agree to accept full responsibility for payment of any balance incurred for services. Appointment cancellations must be made within 24 hours of the scheduled appointment, or they will be subject to the cost of a usual session. If you should encounter financial difficulties while in counseling, please discuss your situation with me as soon as possible.

If your account or your family's account has not been paid for more than 30 days and arrangements for payments have not been agreed upon, I have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court. The costs of such legal actions will be included in the final claim.

Phone consultations lasting more than 15 minutes will be charged based upon the hourly rate. Additionally, any written documentation that you might require will be billed based upon the hourly rate.

SERVICES

Psychotherapy differs depending on the personalities of the client and therapist and the goals of the client. I use a combination of methods to provide the best services to each individual client and will tailor your treatment plan to best suit your needs. Most clients start therapy by meeting one time per week, but the frequency of services will be decided on an individual basis.

Psychotherapy has benefits and risks. Confronting difficult situations in your life may lead to unpleasant feelings and possible disruption to your life. However, psychotherapy has proven to be beneficial to those who have internalized the treatment and learned to work through their struggles. Therapy promotes better relationships, strengthens healthy family dynamics, opens family communication, and reduces feelings of distress. You should evaluate your comfort with me and with the therapeutic process. At any time, you may decide that this is not the right choice for you and your family. If therapy has already begun and you decide to discontinue, please discuss this with me first so proper arrangements can be made.

TELETHERAPY

In the event that the client and/or therapist are unable to meet in-person, teletherapy services will be offered. These services can be conducted via telephone, Zoom, or other HIPAA-compliant platform.



Teletherapy is the delivery of psychological treatment and consultation provided through interactive internet technologies where the patient and the clinician are not in the same physical space. A lack of access to the information that might be achieved in a face-to-face visit, but not in a teletherapy session, may result in errors in psychological judgment. There might be a risk of deficiencies, delays, or failures during the transfer of services due to electronic circumstances. All information provided will be held confidential and will not be disclosed without permission, except where disclosure is required by law. The electronic systems that are used throughout the service incorporate network and software security protocols (encryption) in order to protect the confidentiality of the patient information and data. By engaging in teletherapy services, you acknowledge that some insurance companies may not cover services provided in this manner.

Teletherapy does not provide emergency services.

APPOINTMENTS AND CANCELLATIONS

Appointments are scheduled by contacting me directly or by scheduling online at <https://calendly.com/gmtambone/aldovina-counseling-services>. Sessions are approximately fifty minutes in length unless other arrangements have been made. If you need to cancel or reschedule your appointment, please do so at least 24 hours in advance by calling my cell phone at (719) 598-8560.

CONFIDENTIALITY

The confidentiality of your records is protected by Colorado State law. If you wish me to discuss your case with another party, you must complete an Authorization to Release Information. In some cases (suspected child abuse, potential harm to self or others, plans to commit a crime) the law requires me to release confidential information without your prior consent.

CONSULTATION WITH COLLEAGUES

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my clients. The consultant is also legally bound to keep the information confidential. Unless you object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your clinical record.

PHONE CALLS, EMAILS, EMERGENCIES, ETC.

You may e-mail me to make, cancel, or reschedule an appointment, to make brief reports about your progress, or to ask simple questions that can be answered in a few words. But deep therapy issues, questions, or crises will not be addressed by e-mail.

You may also call me to make, cancel, reschedule appointments, or to ask simple questions. Please be mindful of time and make every effort to make your calls between the hours of 9:00am and 7:00pm.

I will make my best efforts to return all calls and emails within 24 hours. If you are experiencing a mental health crisis, please do not wait for me to get back to you. Call 911 or go directly to your nearest emergency room.

SOCIAL NETWORKING



As a policy, I will not “friend” clients (past or current) on social networking sites. Know that if you try to add me to your network, I will decline or ignore the invitation. I believe that this crosses a professional boundary and can adversely impact the therapeutic process.

ENDING TREATMENT

In most cases, the time comes when the circumstances that indicated psychological treatment are fully understood and resolved. A natural ending point or termination becomes evident to both of us. Either of us may terminate our work together if we believe it is in your best interest. Termination should not be done causally, as it can be a most valuable part of our work together. Typically the decision is made jointly between you and me, allowing sufficient time to review our work together including accomplishments and any outstanding issues that remain. If referrals are warranted, they will be made at this time. Sometimes, circumstances arise that result in an arbitrary ending date for treatment. In those situations, I ask for at least two sessions after the decision to end treatment has been made to conclude our work together.

I, _____, give permission to Gina Tambone, LPC to provide psychotherapeutic treatment. I understand that services will be rendered in a professional manner, consistent with accepted ethical standards. By my signature I am affirming that the contents of this document have been satisfactorily explained to me.

Signature

Date

I truly appreciate the opportunity you have given me to be of professional service to you. I am eager to receive your questions, comments, suggestions or concerns at any time. I look forward to our work together and a relationship that I believe you will find productive and beneficial.

Thank you!


Gina Tambone, LPC



Professional Disclosure Statement

1. Contact Information:

Gina Tambone, LPC
2790 N. Academy Blvd., Suite 312
Colo. Spgs., CO 80917
Phone: (719) 598-8560
Fax: (719) 426-2969
Email: gmtambone@gmail.com
Website: www.aldovinacounseling.com

2. Credentials:

<u>Licensure:</u>	Licensed Professional Counselor	2013
<u>Certification:</u>	SOMB Full Operating Level Treatment Provider - Juvenile	2013
<u>Degrees:</u>	University of Colorado at Colorado Springs, Clinical Psychology, MA	2010
	University of Colorado at Colorado Springs, Psychology, BA	2005

3. Regulation of Mental Health Professionals:

- The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Professions and Occupations. The Board of Licensed Professional Counselors can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800.
- A Registered Psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado, but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.
- A Certified Addiction Counselor I (CAC I) must be a high school graduate or equivalent, complete required training hours and 1,000 hours of supervised experience. A Certified Addiction Counselor II (CAC II) must be a high school graduate or equivalent, complete the CAC I requirements, and obtain additional required training hours, 2,000 additional hours of supervised experience, and pass a national exam. A Certified Addiction Counselor III (CAC III) must have a bachelor's degree in behavioral health, complete CAC II requirements, and complete additional required training hours, 2,000 additional hours of supervised experience, and pass a national exam. A Licensed Addiction Counselor must have a clinical master's degree, meet the CAC III requirements, and pass a national exam.
- A Licensed Social Worker must hold a master's degree from a graduate school of social work and pass an examination in social work. A Licensed Clinical Social Worker must hold a master's or doctorate degree from a graduate school of social work, practiced as a social worker for at least two years, and pass an examination in social work.
- A Licensed Marriage and Family Therapist must hold a master's or doctoral degree in marriage and family counseling, have at least two years post-master's or one year post-doctoral practice, and pass an exam in marriage and family therapy.
- A Licensed Professional Counselor must hold a master's or doctoral degree in professional counseling, have at least two years post-master's or one year postdoctoral practice, and pass an exam in in professional counseling.
- 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 Licensed Psychologist must hold a doctorate degree in psychology, have one year of post-doctoral supervision, and pass an examination in psychology.



4. Client Rights and Important Information:

- a. You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy, and my fee structure. Please ask if you would like to receive this information.
- b. You can seek a second opinion from another therapist or terminate therapy at any time.
- c. Client records are kept for seven years and then destroyed.
- d. 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 Department of Regulatory Agencies, Mental Health Section.
- e. Generally speaking, the information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and the therapist cannot disclose the information without the client's consent. There are several exceptions to confidentiality which include: (1) I am required to report any suspected incident of child abuse or neglect to law enforcement; (2) I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (3) I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental disorder; (4) I am required to report any suspected threat to national security to federal officials; and (5) I may be required by Court Order to disclose treatment information. Information disclosed to a licensed psychologist, licensed social workers, licensed professional counselors, licensed marriage and family therapists, licensed school psychologists practicing outside the school setting, licensed or certified addiction counselors, or an unlicensed psychotherapist is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

5. Disclosure Regarding Divorce and Custody Litigation:

If you are involved in divorce or custody litigation, my role as a therapist is not to make recommendations to the court concerning custody or parenting issues. By signing this disclosure statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that I write any reports to the court or to your attorney, making recommendations concerning custody. The court can appoint professionals, who have no prior relationship with family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interests of the family's children.

I have read the preceding information and it has been presented to me verbally. I understand the disclosures that have been made to me. I also acknowledge that I have received a copy of this Disclosure Statement.

Client Name

Signature

Date

Parent or Legal Guardian Name

Signature

Date

Gina Tambone, LPC
Therapist Name

Signature

Date



Health Insurance Portability and Accountability Act

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

YOUR RIGHTS:

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	<ul style="list-style-type: none">You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	<ul style="list-style-type: none">You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.We may say “no” to your request, but we’ll tell you why in writing within 60 days.
Request confidential communications	<ul style="list-style-type: none">You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.We will say “yes” to all reasonable requests.
Ask us to limit what we use or share	<ul style="list-style-type: none">You can ask us not to use or share certain health information for treatment, payment, or our operations.We are not required to agree to your request, and we may say “no” if it would affect your care.If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.We will say “yes” unless a law requires us to share that information.
Get a list of those with whom we’ve shared information	<ul style="list-style-type: none">You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	<ul style="list-style-type: none">You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	<ul style="list-style-type: none">If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.We will make sure the person has this authority and can act for you before we take any action.



File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES:

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts
- *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES:

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.



HOW ELSE CAN WE SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	<ul style="list-style-type: none"> We can share health information about you for certain situations such as: <ul style="list-style-type: none"> Preventing disease Helping with product recalls Reporting adverse reactions to medications Reporting suspected abuse, neglect, or domestic violence Preventing or reducing a serious threat to anyone’s health or safety
Do research	<ul style="list-style-type: none"> We can use or share your information for health research.
Comply with the law	<ul style="list-style-type: none"> We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.
Respond to organ and tissue donation requests	<ul style="list-style-type: none"> We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	<ul style="list-style-type: none"> We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers’ compensation, law enforcement, and other government requests	<ul style="list-style-type: none"> We can use or share health information about you: <ul style="list-style-type: none"> For workers’ compensation claims For law enforcement purposes or with a law enforcement official With health oversight agencies for activities authorized by law For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	<ul style="list-style-type: none"> We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and in our office.



Acknowledgment of Receipt of Notice of Privacy Practices (HIPAA)

Name of client: _____

I hereby acknowledge I have received a copy of the Notice of Privacy Rights (HIPAA).

Client or Client Representative Signature

Date

If not the client, please print name and state legal authority to sign for client

Witness

Date

For Office Use Only

The Notice of Privacy Rights was presented to the client or legal guardian today, but the client or legal guardian *did not sign* this acknowledgment because:

- The client refused to sign
- The legal guardian refused to sign
- The client was incapable of signing
- Other: _____

Witness

Date