



(Please Print)

Today's date: _____

ST. RAPHAEL
COUNSELING

CLIENT INFORMATION (FOR ALL CLIENTS)			
Client Name (First, Middle, Initial, Last)		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Street Address		City, State and Zip Code	
Home/Cell Phone		Work Phone	
Can we add you to our monthly email newsletter? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employer/Occupation		Yearly Family Income
Who Referred You to This Practice ?	Have you seen our Website? <input type="checkbox"/> Yes <input type="checkbox"/> No	Religious/Spiritual Denomination	
Email Address	Are you Interested in using prayer during Therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Any Previous Counseling? With Whom? How Long?			
List All Medications That You Are Currently Taking.			
Emergency Contact	Relationship to the Client	Home/Cell Phone	
IF MARRIED			
Spouse's Name (First, Middle Initial, Last)		Birth Date	Cell Phone
Occupation	Employer/School	Years Married	
IF A MINOR			
Mother's Name	Living at Home? <input type="checkbox"/> Yes <input type="checkbox"/> No	Home/Cell Phone	
Father's Name	Living at Home? <input type="checkbox"/> Yes <input type="checkbox"/> No	Home/Cell Phone	
OTHER INFORMATION			
Please Describe the Primary Reason you are Seeking Counseling:			

The following items are common concerns of individuals coming to St. Raphael's. Please check all that apply to you. This will help us serve you better. Answer as honestly as possible. You may discuss your answers in detail with your counselor.

- ____ My parents are divorced/separated.
- ____ I cannot talk to my family about my personal concerns and problems.
- ____ My relationship with my family is unsatisfactory.
- ____ My family is not emotionally close.
- ____ I am not happy with my living arrangements.
- ____ I do not have close friends I can talk to about personal issues.
- ____ I use alcohol/drugs: ____ times per week.
- ____ My social/dating life is not satisfactory.
- ____ There are sexual concerns I'd like to discuss.
- ____ I've had an unwanted sexual experience.
- ____ I am dissatisfied with my personal appearance.
- ____ I have felt like or have tried harming myself. (Past or Present)
- ____ I have felt like or have tried harming others. (Past or Present)
- ____ I do not handle stress well.
- ____ I have difficulty expressing my emotions.
- ____ I often get extremely angry.
- ____ At times, I have acted in a violent manner.
- ____ I am having academic or work problems.
- ____ I have suffered a recent death loss.
- ____ I have suffered a recent life loss. (e.g., relationship ending, job loss)
- ____ I am interested in using prayer during counseling sessions

The above information is true to the best of my knowledge.

Patient/Guardian signature

Date:

St. Raphael Counseling

Disclosure Statement

Please take the time to read this page carefully, ask about any matters that seem unclear, initial where indicated, and sign the back page of the statement. Signing this form indicates you agree to and understand the policies of St. Raphael Counseling. A copy will be placed in your file. As licensed and registered psychotherapists/clinicians, we endeavor to integrate sound psychological, medical, and spiritual principles in your treatment. You are entitled to receive information from any counselor concerning their methods of therapy, the techniques used, an estimation of the duration of your therapy, fee structure, risks and benefits of therapy, confidentiality, and access to records. Therapists under supervision will at times need to discuss your case with their supervisor for professional development and to meet State regulations on acquiring a license from the state. Your therapist will discuss this with you, if they are being supervised.

Scheduling Policies

Standard counseling sessions are 50 minutes. Scheduling is handled through your therapist, who will provide you with a non-emergency phone number for you to communicate regarding scheduling.

Practice Policies: we are deeply committed to the therapeutic climate and want your therapeutic experience to be focused on you and your treatment goals. By following and understanding these policies it allows us as professionals to conduct our practice freely and with integrity so we can avoid taking time away from your therapeutic work.

Please read and **INITIAL** each item:

- ___ **1. PAYMENT IS DUE ON THE DAY OF YOUR COUNSELING SESSION.** (Unless other plans have been made)
- ___ **2. Fee:** The standard fee is \$150 per 50-minute counseling session. However, in certain circumstances, clinicians may work on a sliding scale depending on your family's financial circumstances. There will be a \$25.00 charge for returned checks.
- ___ **3. The full session fee is charged for MISSED appointments and cancellations not made 24 BUSINESS HOURS IN ADVANCE. If your insurance is paying for your services, know that if you miss an appointment without giving proper notice, you will be personally responsible for paying for your session.**
- ___ **4. St. Raphael Counseling, is out-of-network coverage for most insurance companies; therefore, in most cases, it is the client's responsibility to file with their insurance provider for reimbursement.** After full payment, at the time of service, SRC can provide an itemized statement for you to file with your insurance. If insurance does not reimburse as anticipated, it is the client's responsibility to address the issue with their insurance provider.
- ___ **5. Fees for auxiliary services are pro-rated and charged at the regular hourly session fee.** This includes (not limited to) written reports, insurance correspondence, phone calls exceeding 10 minutes, court appearances and school meetings (including travel time).
- ___ **6. Limits of Confidentiality.** Your therapist is required to disclose information under the following circumstances:
 - Situations of suspected or confirmed child abuse or neglect;
 - Abuse or exploitation of an at-risk adult or elder, including imminent risk of such abuse;
 - Threats of harm to others, including people identifiable by their association with a specific location or entity, schools or workplaces;
 - Threats of harm to yourself.
 - (see HIPPA disclosure below for more information)

___ **7. Waiting Room Policy.** St. Raphael Counseling is not responsible for unattended minors. If your child is under 12, he/she may not be left alone in the waiting area. If unforeseen circumstances require you to bring a minor to your appointment, you may need to reschedule your session, or arrange to do meet over the phone.

___ **8. Electronic Communications:** Confidentiality applies to all forms of communication, including phone, text, email, etc., we cannot ensure that electronic communications we be secure and confidential and that an unauthorized third party may attempt to gain access to these. While we use reasonable security measures, there is always a risk that the security of these communications could be compromised. By initialing below, you are authorizing St. Raphael Counseling to communicate with Protected Health Information (PHI) through the following unsecure forms:

_____ Cell phone, including text messages and voicemails
Cell number: _____

_____ Unsecured email
Client's email address: _____
Therapist's email address: _____

_____ I do not wish to have my protected health information transmitted electronically

EMERGENCY CONTACT

Clients will be provided specific information regarding emergency contact with their counselor/clinician. **IF YOU ARE EXPERIENCING A LIFE-THREATENING EMERGENCY, CALL 911 OR GO TO THE NEAREST HOSPITAL EMERGENCY ROOM AND CONTACT YOUR COUNSELOR FROM THERE.**

YOUR RIGHTS AND INFORMATION

The Colorado State Department of Regulatory Agencies regulates the practice of both licensed and unlicensed persons in the profession of psychotherapy and advanced practice registered nursing. Any questions, concerns or complaints regarding the practice of psychotherapy may be directed to the State Board. Please note that sexual intimacy between client and therapist is illegal in Colorado and should be reported to the Board:

Mental Health Occupations Grievance Board
1560 Broadway, Suite 1340
Denver, CO 80203
303-894-7766

Generally speaking, information provided to and by the client during therapy sessions is ethically confidential if the therapist is a licensed clinical social worker, a licensed marriage and family therapist, a licensed professional counselor, a licensed psychologist, advanced practice registered nurse, or an unlicensed therapist practicing under the supervision of a licensed psychotherapist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent except under the following conditions (Colorado Statute 12-43-218, C.R.S. 1998): legal confidentiality does not apply in a criminal or delinquency proceeding, client-initiated court cases or grievance inquiries, providing information to insurance companies, supervision or consultation, grave disability, court order, or client's authorization to release information. **Mental health providers are required by law to report cases of any child neglect or physical/sexual abuse to County Child Protective Services. Additionally, if any individual becomes dangerous to himself/herself or others, or is incapable of caring for himself/herself, confidentiality will be broken in order to arrange for appropriate care.**

MINOR CLIENTS & THEIR PARENTS

Clients under eighteen (18) years of age who are not emancipated from their parents should be aware that the law allows parents to examine their child's treatment records. Privacy in psychotherapy is often crucial to successful progress, particularly with teenagers. For this reason, SRC employs a confidentiality agreement. With this confidentiality agreement, the parent(s), minor, and therapist determine what kind of information may be shared with the parents. After this agreement has been signed, parents will be provided only with general information about the progress of the child's treatment and his/her attendance at scheduled sessions. Parents will also be provided with a summary of their child's treatment when it is completed. If the child is a danger to him/herself or someone else, the parents will be notified immediately.

750 W. Hampden Ave Suite 415, Englewood, CO 80112

You should know that _____ will provide your therapist with ____supervision or ____consultation. As such, information regarding your case will be available to him/her. Information regarding your case will also be provided to other staff members of St. Raphael Counseling for administrative and/or clinical care coordination purposes.

As to 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 Masters 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 Masters 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 supervision for licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1000 supervision hours of supervised experience. A CAC II must complete additional required training hours and 2000 hours of supervised experience. A CAC III must have a Bachelors degree in behavioral health, and complete additional required training and 2000 of supervised experience. A Licensed Addiction Counselor must have a clinical Masters 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.

By signing below, I acknowledge I have read the preceding information, understand my rights as a client and agree to counseling under these conditions.

Name of Client (s) PLEASE PRINT

Signature of Client(s) or Legal Guardian

Date

Personal Credentials List

Please check off your therapist and sign below (continues on next page)

Lauren Accolla, LMFT

Licensed Marriage and Family Therapist
Gonzaga University, B.A. Psychology
University of San Diego, Master of Marital and Family
Therapy

Allison Anyamele, M.S., LPC

Licensed Professional Counselor
Benedictine College, B.A. Psychology
Institute for the Psychological Science, M.S. Clinical
Psychology

Katie Bardsley, MA

Licensed Professional Counselor Candidate
Nebraska Wesleyan University, B.A. Communication Studies
Colorado Christian University, M.A. Clinical Mental Health
Counseling

Michelle Connor Harris, Psy. D.

Licensed Clinical Psychologist
Illinois Institute of Technology, MS Industrial/
Organizational Psychology
University of Denver, Doctorate of Psychology

Grace Cole, MA, LPC

Licensed Professional Counselor
University of Northern Colorado, B.A. Elementary
Education/Psychology
Grand Canyon University, M.S. Professional Counseling

Alexandra Coursol, MA

Pre-Doctoral Intern
University of Minnesota, BA, Psychology
University of St. Thomas, MA Psychology

Kevin Cure, LMFT

Licensed Marriage and Family Therapist
Metropolitan State College of Denver: B.A. Behavioral
Science
St. Mary's University, M.A. Marriage and Family Therapy

Dianna Haas, Ph.D.

Licensed Professional Counselor
University of Northern Colorado, MA Rehabilitation Counseling
Capella University, Ph.D. Counseling Studies

Elizabeth Higbie, LCSW

Licensed Clinical Social Worker
New York University, B.A. Psychology
University of Denver, MSW Master of Social Work

Susan Hyatt, LPC

Licensed Professional Counselor
University of Colorado, M.A. Counseling Psychology and
Counseling Education

Kate Johnson, MS, LPC

Licensed Professional Counselor
University of Denver, B.S. Biology/Psychology
Institute for the Psychological Science, M.S. Clinical
Psychology

Jim Langley, Psy. D.

Licensed Clinical Psychologist
University of Denver, M.A. Clinical Psychology
University of Denver, Clinical Psychology

Michelle Long, MA

Licensed Professional Counselor
Adams State University, MA Community Counseling

Matthew McCall, Psy. D.

Licensed Clinical Psychologist
Institute for the Psychological Science, M.S. Clinical
Psychology
Institute for the Psychological Science, Psy. D. Clinical
Psychology

Christina Pavlov, MA

Pre-Doctoral Intern
University of Alabama, BS Psychology and Biology
Franciscan University of Steubenville, MA, Counseling

Matthew Reinhardt, MA

Licensed Professional Counselor
Teacher's College, Columbia University, MA, Clinical
Psychology
Institute for the Psychological Sciences, MS, Clinical
Psychology

Mark Sanders, MA, LPC, CAC III

Licensed Professional Counselor
Carnegie Mellon University, B.A. Psychology/Applied
History
University of Pittsburgh, M.S. Clinical and Health
Psychology

Rebecca Showalter, Psy.D.

Licensed Clinical Psychologist
Institute for the Psychological Sciences, Psy.D. Clinical
Psychology
Institute for the Psychological Sciences, MS, Clinical
Psychology

Joshua Stephens, LMFT

Licensed Marriage and Family Therapist
Regis University, M.A. Marriage and Family Therapy

Alyssa de la Torre, LPC

Licensed Professional Counselor
University of Northern Colorado, M.D. Clinical Mental Health
Counseling

Stacie Webb, Psy. D.

Licensed Clinical Psychologist
Institute for the Psychological Sciences, MS, Clinical
Psychology
Institute for the Psychological Sciences, Psy.D. Clinical
Psychology

Kathleen Widlund, MA

Registered Psychotherapist
University of Minnesota, BIS in Communications, Business, and
Economics
University of St. Thomas, M.A. Counseling Psychology

Student Associate

Name/Degree: _____

Under Supervision With: _____

Please Print Client Name

Please Print Client Name

Acknowledgment of Receipt of Notice of Privacy Practices

You may refuse to sign this Acknowledgment

Your signature indicates that you have received the NOTICE OF PRIVACY PRACTICES AGREEMENT and agree to their terms.

Please Print Client Name

Client/Legal Guardian Signature

(Date)

Clinician

(Date)

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

Individual refused to sign

Other (Please Specify) _____

COLORADO NOTICE FORM OF HIPAA LEGISLATION And Notice of Privacy Practices

Notice of Psychotherapist's Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Your counselor may *use* or *disclose* your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- “*PHI*” refers to information in your health record that could identify you.
- “*Treatment, Payment, and Health Care Operations*”
 - *Treatment* is when your counselor provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when your counselor consults with another health care provider, such as your family physician or another psychotherapist.
- *Payment* is when you obtain reimbursement for your healthcare. Examples are if your counselor discloses your PHI to your health insurer for reimbursement for health care.
- *Health Care Operations* are activities that relate to the performance and operation of your Counselor's practice. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits, administrative services, case management, and care coordination.
- “*Use*” applies only to activities within your counselor's [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “*Disclosure*” applies to activities outside of your counselor's [office, clinic, practicegroup, etc.] such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

Your counselor may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An “*authorization*” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when your counselor is asked for information for purposes outside of treatment, payment or health care operations, your counselor will obtain an authorization from you before releasing this information. Your counselor will also need to obtain an authorization before releasing your Psychotherapy Notes. “*Psychotherapy Notes*” are notes your counselor has made about your conversation during a private, group, joint, or family counseling session, which your counselor has kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) your counselor has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

Your counselor may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If your counselor has reasonable cause to know or suspect that a child has been subjected to abuse or neglect, your counselor must immediately report this to the appropriate authorities.
- *Elder Adult and Domestic Abuse* – If your counselor has reasonable cause to believe that an at-risk adult has been mistreated, self-neglected, or financially exploited and is at imminent risk of mistreatment, self-neglect, or financial exploitation, then your counselor must report this belief to the appropriate authorities.
- *Health Oversight Activities* – If the Grievance Board for Unlicensed Psychotherapists or an authorized professional review committee is reviewing my services, your counselor may disclose PHI to that board or committee.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and your counselor will not release information without your written authorization or a court order. The privileged does not apply when you are being evaluated or a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety* – If you communicate to your counselor a serious threat of imminent physical violence against a specific person or persons, your counselor has a duty to notify any person or persons specifically threatened, as well as a duty to notify an appropriate law enforcement agency or by taking other appropriate action. If your counselor believes that you are at imminent risk of inflicting serious harm on yourself, your counselor may disclose information necessary to protect you. In either case, your counselor may disclose information in order to initiate hospitalization.
- *Worker's Compensation* – your counselor may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provided benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychotherapist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information regarding you. However, your counselor is not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing your counselor. On your request, your counselor will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in your counselor's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Your counselor may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, your counselor will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your counselor may deny your request. On your request, your counselor will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, your counselor will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychotherapist's Duties:

- Your counselor is required by law to maintain the privacy of PHI and to provide you with a notice of his or her legal duties and privacy practices with respect to PHI.
- Your counselor reserves the right to change the privacy policies and practices described in this notice. Unless your counselor notifies you of such changes, however, your counselor is required to abide by the terms currently in effect.
- If St. Raphael Counseling revises their policies and procedures, we will notify you by mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision your counselor makes about access to your records, or have other concerns about your privacy rights, you are encouraged to discuss this with your counselor prior to your first session.

If you believe that your privacy rights have been violated and wish to file a complaint with Your therapist, you may send your written complaint to:

750 W. Hampden Ave Suite 415, Englewood, CO 80112

St. Raphael Counseling
750 W. Hampden Ave Suite 415
Englewood, CO 80110

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services or the Colorado Department of Regulatory Agencies. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on the date you sign this notice.

St. Raphael Counseling reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that your counselor maintains.

St. Raphael Counseling will provide you with a revised notice by mail within ten business days prior to changes.