**Client Data Form**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Message Okay? Yes/No Text Okay? Yes/No

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Message Okay? Yes/No

Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is it okay to email you? Yes/No

Emergency Contact (Name and Number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Current Psychiatrist or prescribing doctor (if applicable)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Insurance:*** *(fill out if applicable)*

Name of Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claims Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_

Address of the Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_Relationship to the Insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Policy Group # or FECA # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Subscriber ID #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office use only-----------------------------------------------------**

Rate/Co-pay\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Procedure code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis Code:\_\_\_\_\_\_\_\_\_***\_\_\_\_\_\_\_\_\_\_\_\_*90791 Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child and Adolescent Permission for Treatment**

**R**

All Parent/Guardian(s) with Mental Health Treatment Decision Making Rights Must Complete this document before treatment begins for any child under the age of 18 years unless entering treatment without parental consent which the age for treatment would then be 12 years of age in accordance to Colorado HB 19-1120.

**Parent/Guardian 1:**

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give express permission for my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

 Parent Name Child’s Name

to enter into treatment with Therapy Matters Therapist, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 Therapists Name

I am aware that at any time I may revoke permission for treatment at any time, communicated in writing to Therapy Matters LLC. I have been made aware that if I have any questions about treatment, confidentiality or otherwise I may contact Colleen Todd MA LPC CACIII, Owner, directly at 720 684 9845.

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

Printed Name of Guardian Signature of Guardian Date

**Parent/Guardian 2:**

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give express permission for my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

 Parent Name Child’s Name

to enter into treatment with Therapy Matters Therapist, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 Therapists Name

I am aware that at any time I may revoke permission for treatment at any time, communicated in writing to Therapy Matters LLC. I have been made aware that if I have any questions about treatment, confidentiality or otherwise I may contact Colleen Todd MA LPC CACIII, Owner, directly at 720 684 9845.

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

Printed Name of Guardian Signature of Guardian Date

# **HIPAA Privacy Practices Receipt Form**

 R

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have received an offer to review and attain a copy of HIPAA Privacy Practices from Therapy Matters LLC. My therapist offered to explain any part of the privacy practices during our meeting today, \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

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

Signature Witness

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

Date Date

**Policies**

 **R**

**Please review thoroughly**

**LIMITATIONS TO CARE**

**It is important to note that most outpatient psychotherapy is different from crisis care and hospital care. The following are some limitations to our outpatient care. Please check all boxes indicating you are aware of the specific limitations.**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ acknowledge that Therapy Matters therapists:

* **Do NOT provide 24 hour services**
* **Do NOT provide on-call services**
* **Do NOT provide emergency services**
* Can schedule an appointment, based on availability, for additional sessions if there is need however are **NOT always available for immediate appointments** within the same week as the request
* Will try to return phone calls as promptly as possible, however given the limited access to communication inherent in late hours and providing sessions the majority of working hours, the therapists **return calls could be delayed for up to 24 to 72 hours.**

Please check the items on this list of resources indicating that you have been informed that if there should be a psychologically urgent or emergent issue you can contact or utilze any of the following.

* **Calling 911 or going to your nearest emergency room**
* Avista Adventist (Centura) Hospital (100 Health Park Dr Louisville, CO 80027)
* Centennial Peaks Hospital (2255 S 88th St, Louisville, CO 80027)
* Boulder Community Hospital (4747 Arapahoe Ave, Boulder, CO 80303)
* Suicide prevention hotline **1-800-273-8255**

If there is a need to **schedule an appointment with your therapist** you may go online to:

* TherapyMattersLLC.com
	+ Click on “Make an Appointment”
	+ Choose your therapists name and gain access immediately to your therapists availability
	+ Choose an appointment time
	+ Simply arrive at that time

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

Signature acknowledging “Limitations to Care” Date

**CANCELATIONS OF SESSIONS**

**Cancellations:**

Cancellations/Rescheduling must be arranged prior to **24 hours** before the session otherwise it will be considered a late cancel and subject to the policy below.

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

Initials

 ***Method of communication changes:***

If clients need to change the communication method of treatment 24 hours notice must be given. All appointments are scheduled to be in person unless other arrangements are made with the therapist. Any session scheduled, in person, phone, Skype, Facetime, Zoom, or otherwise, must be attended in the scheduled communication method unless 24 hours notice is given or the client is able to reach the therapist in person.

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

Initials

 ***Missed Appointment/Late Cancel:***

If a session is missed or cancelled/rescheduled within **24 hours** of the session the client will be charged for the cost of the session. If a client uses insurance for payment then a missed session will be $100 (and insurance will not pay for a late cancel or missed appointment).

* Fee will be waived in the cases of **emergency**.
* All No Show/No Call appointments will be charged.
* Clients will not be charged for the first “late cancel” a year due to illness. Additional late cancellations due to illness will be charged. Please be sure to call 24 or more hours in advance if you are concerned that you may not be well at the time of appointment.

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

Initials

***Standing Appointments***

If there is a standing appointment time made on a weekly, biweekly, or monthly basis the client agrees that though this appointment is not created the session before it is still the client’s responsibility to cancel the appointment within 24 hours or the above charges will apply.

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

Initials

If a client has a standing appointment and does not attend without communication (No Call/No Show), all following sessions are considered cancelled and the client will only incur the cost of first missed session.

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

Initials

***Payments:***

Payment is due at the time of service. If using third party reimbursement (health insurance) the co-pay is due at the time of service. Initialing below indicates that you are aware that you are fully responsible for payment should your insurance not cover one or more sessions.

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

Initials

***Payment arrangements:***

Payment arrangements may be made. If the payment arrangement exceeds being tracked past the following session there will be a $25 administrative fee applied per calendar year where all payment arrangements made that year will be covered.

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

Initials

***Appointment Type:***

All appointments are face-to-face appointments unless otherwise arranged by phone or videoconference. If you are unable to attend your session in person and it is less than 24 hours before you appointment time I ask that you attend by phone or video conference (Zoom, Face Time or Skype.) Please indicate below which method you would prefer.

**Only initial one please**

Face Time Skype Zoom Phone

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

Initials initials initials initials

***Phone Sessions/Texting/Emails***

If there is a psychological **emergency** or a **highly urgent** issue that cannot wait until the following session I would like to invite you to please contact me so we can speak as soon as possible. No Fee will apply.

If you are calling/Texting/Emailing in between sessions because you have a matter that you find **pressing** that you would like to discuss I can try to be, but not guarantee that, I will be available. For such contact, the Therapy Matters inter-session communication fee will apply. It is then recommended that in the future you utilize the inter-session communication service offered by Therapy Matters.

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

Initials

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

Client Signature Date Witness Signature Date

**AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

**R**

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

CLIENT NAME ADDRESS

**\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY, STATE, ZIP DATE OF BIRTH

Authorizes Release Of Protected Health Information between:

Therapy Matters LLC AND \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1070 W. Century Dr, Ste. 200 **PRIMARY CARE PHYSICIAN**

Louisville CO 80027 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 PHONE NUMBER

Therapy Matters LLC AND \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1070 W. Century Dr, Ste. 200  **PSYCHIATRIST**

Louisville CO 80027 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 PHONE NUMBER

Therapy Matters LLC AND \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1070 W. Century Dr, Ste. 200 OTHER/or PRIMARY THERAPIST

Louisville CO 80027 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 PHONE NUMBER

**Information To Be Released:**

\_\_\_ CONSULTATION \_\_\_INPATIENT RECORDS

\_\_\_ FULL RECORDS \_\_\_ PRESCRIPTIONS

\_\_\_ PSYCHOLOGICAL OR PSYCHIATRIC RECORDS \_\_\_ OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose For Need Of Disclosure:** (Check applicable categories)

\_\_\_ ASSESSMENT \_\_\_ CONTINUITY OF CARE \_\_\_ OTHER (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

**Your Rights With Respect To This Authorization:**

**Right to Inspect or Copy the Health Information to Be Used or Disclosed -** I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting THERAPY MATTERS LLC Privacy Officer. **Right to Receive Copy of This Authorization -** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization -** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization -** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact: THERAPY MATTERS LLC Privacy Officer. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

**Expiration Date:** This authorization is good until the following date(s) or six months following termination of treatment. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

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

**Client/Parent/Guardian Signature Date Witness Signature Date**

**Consent for Non-Secure Communications**

 **R**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have discussed with a Therapy Matters therapist and understand that the use of unencrypted email, texting, video sessions poses some risk of confidential communication/information being breached by others. I am aware that by choosing unencrypted avenues of communication my protected health information has potential to be discovered/read/viewed/ or listened to by a third party. By signing this form, I am choosing to receive participate in the communication methods stated above though I am aware of the potential risks and consequences.

\_\_\_\_ I *choose* to receive the unencrypted communications methods below though I realize it may not be secure. (Initial all methods you are comfortable with)

\_\_\_\_\_Emails

\_\_\_\_\_Texts

\_\_\_\_\_Zoom Video Conferencing

\_\_\_\_\_Skype conversations

\_\_\_\_\_Face time conversations

\_\_\_\_I *do not choose* to participate in any non-secure method of communication.

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (Text) numbers \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Skype Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Face time Address (cell phone number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Signature date Witness date

**NON:R**

1. What characteristics do you look for in a counselor?

2. In the past, what has and/or hasn’t worked for you in therapy? (If first time in therapy mark N/A)

3. I see a therapist’s role as:

* Empathic listener
* Life coach
* Truth seeker
* Advocate
* Unconditional love/kindness
* Tough love
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. How do you view counseling?

* Brief/short term
* Natural maintenance to well being and growth
* Conscious relationship
* Problem focused/evidence-based
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. How would you let your therapist know if something wasn’t working for you?

* I likely wouldn’t
* It would take some time and I would likely have to feel pretty frustrated in order to do so
* I would eventually let me therapist know
* I would get quiet
* I would get angry
* I would likely begin to cancel my sessions
* I would let me therapist know relatively quickly
* I see therapy as a collaboritive experience and see my feedback as essential to the process

 **Medical:**

|  |  |  |  |
| --- | --- | --- | --- |
| Medical Condition | Treatment Regime | Symptoms Controlled? (0-5 scale: 0 = uncontrolled) | Degree of discomfort (0-10 scale: 0 = no discomfort) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Current Medications:**

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dosage | Rate Effectiveness (0-10 scale: 10 being most effective | Prescribed by?(specialty?) |
|  |  |  |  |
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**Sleep: check all that apply**

|  |  |  |  |
| --- | --- | --- | --- |
| * Trouble with Onset
* Waking with anxiety/panic
* Disruption from others
* Medical issue affecting sleep
 | * Trouble w maintenance of sleep
* Waking with depressed mood
* Disruptions by pets
 | * Trouble with early waking
* Parent of young child
* Sleep Varies by time of year/month/week
* Other: \_\_\_\_\_\_\_\_\_\_
 | * Rumination
* Poor sleep hygiene
* Disruption with time change or seasons
* Other: \_\_\_\_\_\_\_\_\_\_
 |

**Appetite: check all that apply**

|  |  |  |  |
| --- | --- | --- | --- |
| * Over-active
* Varies greatly
* Other \_\_\_\_\_\_\_\_\_\_\_\_
 | * Usual
* Increased/decreased with stress
* Other \_\_\_\_\_\_\_\_\_\_
 | * Under-active
* Increased/decreased with medications
* Other \_\_\_\_\_\_\_\_\_\_
 | * Increased/decreased w/ medical issues
* Changed recently
* Other \_\_\_\_\_\_\_\_\_\_
 |

**Energy Level: Circle all that apply**

|  |  |  |  |
| --- | --- | --- | --- |
| * Poor in the morning/afternoon/evening
* High overall
* Normal
 | * High in the morning/afternoon/evening
* Varies greatly
* Predictable
 | * Low overall
* Undependable
* Excessive
* Moderate overall
 | * Concerning
* Other\_\_\_\_\_\_\_\_\_\_\_
* Other\_\_\_\_\_\_\_\_\_\_\_
* Other\_\_\_\_\_\_\_\_\_\_\_
 |

**Elements that *Significantly* affect Mood or Anxiety**

|  |  |  |  |
| --- | --- | --- | --- |
| * Winter
* Allergies (pollen)
* Weather
* Sleep
* Relationship
* Extended Family
* Too much sensory stimulation
 | * Spring
* Mentstral cycle
* Immediate Surroundings
* Physiological conditions
* Stress
* Other\_\_\_\_\_\_\_\_\_\_\_
 | * Summer
* Time of day
* Energy level
* Pain Levels
* Specific people
* Workplace
* Exercise
* Other\_\_\_\_\_\_\_\_\_\_\_
 | * Autumn
* Daylight changes
* Diet
* Under stimulation
* Lack of alone time
* Too much alone time
* Chronic Illness
* Other\_\_\_\_\_\_\_\_\_\_\_
 |

Briefly Describe how your mood or anxiety are affected by the items you have checked above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Thoughts of Suicide:** Thoughts of suicide are more common than many people know. Please circle what box summarizes your thoughts.

THOUGHTS IN THE **PAST**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| It has never occurred to me to harm myself | At times I think it would be easier if I wasn’t here, didn’t wake up or was never born. | At times I have thought about suicide and how it would be a relief, an escape, or somehow easier on others or myself. | At times, I have thought of suicide and imagined a plan of how to do so. | At times, I have thought of suicide, created a plan or took steps to make the plan a reality Or I have attempted in the past. |

THOUGHTS IN THE **PRESENT** (in the past several weeks)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| I am not having any thoughts of suicide or self harm | At times I think it would be easier if I wasn’t here, didn’t wake up or was never born. | Recently, I have thought about suicide and how it would be a relief, an escape, or somehow easier on others or myself | Recently, I have thought of suicide and imagined a plan of how to do so. | Recently, I have thought of suicide, created a plan or took steps to make the plan a reality Or I have recently attempted suicide |

 **`**

**Thoughts of harming others:**

THOUGHTS IN THE **PAST**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| I have never thought of bringing harm to another person. | At times, I have fleeting thoughts or an occasional desire to harm someone but it has never been considered seriously. | At times, I have thoughts of harming others but have never created a plan to harm someone. | At times, I have thought of harming someone and created a plan but never followed through. | In the past, I have thought of harming someone, created a plan and executed part or all of the plan. |

THOUGHTS IN THE **PRESENT** (in the past several weeks)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| I am not having any thoughts of harming others | Recently, I have fleeting thoughts or an occasional desire to harm someone but I have not considered it seriously. | Recently, I have had thoughts of harming others but have not created a plan to harm someone. | Recently, I have thought of harming someone and have created a plan but do not believe I will follow through with the plan. | Recently, I have thought of harming someone, created a plan and plan on following through with the plan. |

**This Document For Office Use Only R**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Client Name: |  |  |  |  |
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|  |  |  |  |  |
|  | Date of Service: | Amount Paid: | Amount Owed: | Notes: |
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**Credit Card on File**

**R**

Credit cards are kept on file to make payments easier at the end of session and when credit is extended to the client through Therapy Matters waiting for payment.

Credit cards will be run for no show or late cancel sessions.

Name on card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit card number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date:\_\_\_\_\_\_\_\_\_\_\_\_\_3 digit code on the back of the card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Signature acknowledging the above statements: Date:

**Client Therapy and Pricing Plan**

**NON:R**

**Choose Frequency and customization:** (Items client is interested in for the future please check off and write “future”)

* **Weekly** choice of Face to Face and/or Zoom/Skype/Facetime/ Video Conference and/or Phone Therapy (55 minutes)
	+ - $\_\_\_\_\_\_\_ a session (discounted $10)
	+ Texting between sessions during business hours
		- $\_\_\_\_\_\_\_
	+ Add 25 min to sessions
		- $\_\_\_\_\_\_ a session
	+ Reduce 10 min from sessions
		- - $\_\_\_\_\_\_\_ a session
	+ Late Cancel/No Showl Mitigation Fee for late cancel without mitigation is the full price of the session. Client can sign up monthly for mitigation and not pay late cancel fees or no show fees.
		- $\_\_\_\_\_\_\_\_ Weekly
	+ Meditation group
		- Donation Based
* **Bi-weekly** choice of Face to Face and/or Zoom/Skype/Facetime/ Video Conference and/or Phone Therapy (55 minutes)
	+ - $\_\_\_\_\_\_\_\_ a session (discounted $5)
	+ Texting between sessions during business hours
		- $\_\_\_\_\_\_\_\_
	+ Add 25 min to sessions
		- $\_\_\_\_\_\_ a session
	+ Reduce 10 min from sessions
		- - $\_\_\_\_\_\_\_ a session
	+ Late Cancel Mitigation (charged fee per session but not charged if you cancel within 24 hours) Fee for late cancel without mitigation is the full price of the session.
		- $\_\_\_\_\_\_ Biweekly
	+ Meditation group
		- Donation Based
* **Monthly** choice of Face to Face and/or Zoom/Skype/Facetime/ Video Conference and/or Phone Therapy (55 minutes)
	+ - $\_\_\_\_\_\_\_\_ a session
	+ Texting between sessions during business hours
		- $\_\_\_\_\_\_\_\_
	+ Add 25 min to sessions
		- $\_\_\_\_\_\_\_\_\_ a session
	+ Reduce 10 min from sessions
		- - $\_\_\_\_\_\_\_\_\_ a session
	+ Late Cancel Mitigation (charged fee per session but not charged if you cancel within 24 hours) Fee for late cancel without mitigation is the full price of the session.
		- $\_\_\_\_\_\_\_\_ Monthly
	+ Meditation group
		- Donation Based
* **Couples Therapy** (sliding scale available)
	+ $\_\_\_\_\_\_\_\_
* **Couples Workshops**
	+ Cost determined by format of workshop
* **Family Therapy** (sliding scale available)
	+ $\_\_\_\_\_\_\_\_
* **DBT Groups**
	+ $65 per group
	+ Usually 12 to 15 weeks in length
	+ Offered in the following forms:
		- Mixed Men’s and Women’s Groups
		- Women’s Groups
		- Men’s groups
		- Adolescent boys groups
		- Addictions groups
* **Substance Abuse Groups**
	+ $65 per group
* **Eco-Therapy Groups**
	+ Cost TBD
* **Art-Therapy Groups**
	+ Cost TBD
* **Independent Self Work Facilitation**
	+ - $\_\_\_\_\_\_
	+ Biblio-therapy
	+ Exercises
	+ Intention setting
	+ Homework
	+ Meditations
* **Resourcing Sessions (55 min)**
	+ - $30
	+ Financial
	+ Career
	+ Educational
	+ Organizational
	+ Med change support
	+ Relationship skills
	+ Organization and Managing of Chronic illness
* **Biofeedback Training (45 Min)**
	+ - $75
	+ Em-Wave/Heart Math

**Application for Reduced Cost Treatment** (Within Sliding Scale)

**R**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently in treatment with Therapy Matters?

* Yes
* No

If so, Current cost for therapy: \_\_\_\_\_\_\_\_ Duration of session (in minutes) \_\_\_\_\_\_\_

Current Household Income\_\_\_\_$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Household Expenditures\_\_\_$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reasons why you may not have access to household income and what is the income you do have access to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Explanation of need for reduced cost of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration of time for reduced cost treatment requested for (up to 1 year, then client can reapply):

|  |  |  |
| --- | --- | --- |
| * 6 months
 | * 1 year
 |  |

If Duration unknown, please name the events that need to transpire for you to return to regular rate treatment (example: becoming employed, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Client signature Date

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

Therapist signature Date

**Attach all supporting documentation to this form for submission**

Office use only:

* Application Approved
* Application Denied

Reason for Approval:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Denial:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DISCLOSURE STATEMENT: R**

 My degrees, credentials, and licenses are as follows:

· Rutgers University, New Brunswick NJ – Bachelor of Arts, Psychology

· University of Colorado, Denver CO – Masters of Arts, Counseling Psychology & Counselor Education

· Licensed Professional Counselor, Colorado License #4325

· Certified Addictions Counselor III, ACC #6291

· 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. The Board of Professional Counselors and Certified Addictions Counselors Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. 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 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 bachelors 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 masters degree and meet the CAC III requirements. 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.

· I understand that there may be times when my psychotherapist may need to consult with a colleague or another professional, like an attorney, about issues raised by me in therapy. My confidentiality is still protected during consultation by my psychotherapist and the professional consulted. Signing the disclosure statement gives my psychotherapist permission to consult as needed to provide professional services to me as a client.

· I understand that in marriage and family counseling, Colleen Todd holds a “no secrets” policy. All members of the couple or family system are treated equally and “secrets” are not kept by the psychotherapist that requires differential or discriminatory treatment of family members. I understand that any information shared in any individual therapy MUST be also shared in couple or family therapy to insure this “no secrets” policy. Signing this disclosure statement affirms permission for my psychotherapist to share this confidential information as deemed necessary for treatment.

· I understand Colleen Todd provides non-emergency psychotherapeutic services by scheduled appointment. If she believes my psychotherapeutic issues are above her level of competence, or outside of her scope of practice, she is legally required to refer, terminate, or consult. If, for any reason, I am unable to contact Colleen Todd by telephone, (720) 684-9845, and I am having a true emergency, I will call 911 or check myself into the nearest hospital emergency room immediately if my personal safety or mental health is at stake.

· I understand that if I have any questions or would like additional information; I may feel free to ask during the initial session and any time during psychotherapy process. By signing this disclosure statement I also give permission for the inclusion of my partners, spouses, significant others, parents, legal guardians, or other family members in psychotherapy when deemed necessary by myself, or Colleen Todd for purposes of assessment or treatment.

· I understand that I am legally responsible for payment for my psychotherapy services, if, for any reason, my insurance company, HMO third-party payer, etc. does not compensate Colleen Todd, I understand that signing this form gives permission to my psychotherapist to communicate with my insurance company, HMO, third-party or anyone connected to my psychotherapy funding source.

· I understand that confidentiality cannot be assured for electronic communication like cell phones, e-mails, and faxing. I do not hold Colleen Todd responsible or liable for breach of confidentiality if I choose to communicate with my psychotherapist by these electronic means. I also give permission for such electronic communications to take place in consultation by my psychotherapist.

· I understand that sometimes in psychotherapy things get worse (because of repressed issues and systematic dynamics) before things get better. I understand this may be a natural part of the psychotherapeutic process.

· You are entitled, to receive information from Colleen Todd MA LPC CACIII 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.

· 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.

· 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 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 child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly.

· Any person who alleges that a mental professional has violated the licensing laws related to the maintenance of records of a client eighteen years of age or older, must file a complaint or other notice with the licensing board within seven years after the person discovered or reasonably should have discovered this. Pursuant to law, this practice will maintain records for a period of seven years commencing on the date of termination of services or on the date of last contact with the client, whichever is later.

· When the client is a child, the records must be retained for a period of seven years commencing either upon the last day of treatment or when the child reaches eighteen years of age, whichever comes later, but in no event shall records be kept for more than twelve years.

· Colleen Todd MA LPC CACIII is currently listed in the Front Range and EMDR Group, which is located on the Front Range DBT and EMDR websites. You should be aware that other than this marketing service, there is no other relationship between Colleen Todd MA LPC CACIII and the Front Range DBT and EMDR group. The professionals listed in the Front Range DBT and EMDR Group are each in their own individual practice and do not supervise one another; they are not in a partnership; and they have no responsibility for each others’ practice.

· 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.

CLIENT SIGNATURE, ACKNOWLEDGEMENT, AGREEMENT, AND CONSENT

I have read the preceding information and understand my rights as a client. By signing below I acknowledge my understanding and agree to all the terms discussed in this disclosure statement. By signing this disclosure statement, I also agree to permit consultation and I provide release for my psychotherapist to seek consultation with other psychotherapists or professionals as the need arises, I also affirm, by signing this form, that I am the legal guardian and/or custodial parent with legal right to consent to treatment for any minor child or children that I am requesting psychotherapy and/or psychotherapuetic services from Colleen Todd. Consistent with HIPAA requirements this disclosure statement expires after six months and can be revoked at will by the client or the consenting parent or guardian. Revocation is not retroactive.

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

Client Signature Date

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

Charlotte Irving, MA, LPCC Date

**Clinician Notes**