Intake Forms

Caralee Frederic, LCSW, CGT, SRT

7710 N. Union Blvd., Suite 202, Colorado Springs, CO 80920

719-494-7412

c.frederic@yahoo.com, www.principleskills.com

Date Completed:

Name:	**Age:**	**D.O.B.**
Name:	**Age:**	**D.O.B.**
Address (Street)	**City, State, Zip**	**Home:** **Cell:**
Email:	**Email:**	**Work:**

Is it OK to leave messages at: **Home**? Y N **Work**? Y N **Cell**? Y N
Is it OK to communicate via **email** at times? Y N

Referred by:	
Prior Therapists?	
When?	
For what problems?	
Was it helpful?	
Emergency Contact – Name/Address/ Phone:	
Prescribing Physician - Name/ Address/Phone:	

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Medical History:
Do you have or have you ever had any significant medical problems or been hospitalized?
Y N
If so, please list (you may use a separate page as needed):

Are you on any medications? (include birth control pills) Y N
If so, please list name, dosage and how long you've been taking them (you may attach another page as needed):

Current Alcohol and/or Drug Use: - Type/Frequency/Amount:

Past Alcohol and/or Drug Use: – Type/Frequency/Amount:

Legal History:
Have you ever had police/court involvement? (Circle one answer)

No, Never Yes, within the past month Yes, within the past 6 mos.
Yes, within the past year Yes, over 1 year ago

For what problems are you seeking counseling? _____

_____

_____

_____

_____

_____

Goals for Treatment (specific desired outcomes):

1. _____
2. _____
3. _____
4. _____

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By signing below, I affirm that the above information provided is true as stated.

Client Signature **Date**

Client Signature **Date**

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Welcome to my practice. The following information is known as **Informed Consent** and is intended to assist you in making your counseling experience as productive and comfortable as possible. Please read this form carefully and note any questions or concerns you may have. We will discuss these before beginning therapy. After you and I both sign this document it will constitute a binding agreement between us.

Therapy Process/Benefits and Risks:
As a collaborative process, therapy requires your active effort and honesty in order to achieve your desired outcome. I will periodically ask for your feedback on therapy and expect that you will respond openly. Most people experience improvement or resolution to the concerns that brought them to counseling, however, I am not able to guarantee a particular outcome.

There are some risks, including increased levels of awareness that may cause discomfort for you or your family members. You may find yourself having to discuss very personal information, which you may find difficult or embarrassing. You might experience some anxiety or depression during and after such conversations. While therapy is intended to alleviate problems, change is often difficult and requires time to adjust. As you learn more about yourself, you might experience increased conflict with friends, co-workers and family members. Sometimes, it may seem the problems get worse before they get better. This is a common experience in the change process. I may ask you to do things that, at first, seem awkward or uncomfortable. Change sometimes requires trying new ways of doing things. You will always be free to move at your own pace, however.
I will challenge you and your old ways of thinking and doing, but I cannot offer any promise about the results you will experience. Your outcome will depend on many factors. If you choose to not pursue therapy for your problems, you may experience a worsening of your symptoms, an improvement over time, or no change.

If I believe that your problems require knowledge that I do not have, I may refer you for a consultation with someone who has specific training or experience. I will discuss any such referral with you before I act.

At the beginning of therapy, we will create a treatment plan together. That is, we will consider what you would like to change, what we will do to change it, how we will know when you are succeeding, and approximately how long it will take. We will periodically review this plan to measure progress and to update it as needed.

Initial:_____ _____

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Emergencies:

Due to the part-time nature of my work, I am often not available immediately by telephone. I do, however, check my phone periodically for messages. If you need immediate help or have a psychological emergency, please call 911, the National Crisis Line **(800) 784-2433**, or go to your nearest hospital emergency room.

If you need to set up a telephone consult between sessions, please call (719) 494-7412 for my confidential voicemail and I will return your call as soon as I am able, most often within 48 hours after I receive your message, except over weekends or holidays. The cost for these consults will be prorated at the regular billing rate and are to be used in addition to, not in place of, your regular appointment.

Initial:_____ _____

Office Policies

Fees/Cancellations:

I schedule appointments to begin on the hour or half hour. Except for initial assessments, which are typically longer, these sessions last 45-50 minutes, or what is known as the therapist's hour, and we must end each session promptly.

- The initial assessment for **individual and family therapy** is scheduled for **75 minutes** at **$150.00**. An additional 15 minutes is built in to the fee for time spent writing up the diagnostic evaluation.
- The initial **marital** assessment is scheduled for **75 minutes** at **$200.00**. This fee includes the additional time for writing up the diagnostic evaluation, as well as the time spent analyzing your completed marital assessment packet.
- Regular session fees are **$110.00** per **50-minute session**.
- The client's portion of the fee, when applicable, must be paid in full at each session. Fees may be paid in cash or with personal checks. You are primarily responsible for all payments for service. If a 3rd party payor does not pay as expected, you will be billed for the remaining fees.
- My time spent on **client requested** letters, reports, or extended sessions will be prorated at the regular billing fee.
- Except for unpredictable emergencies and unique circumstances (discretion is given by the therapist) payment will be expected for missed appointments. Clients who do not give **24 hours** notice of cancellation will be charged the **full counseling fee**. No-show and cancellations will not be billed to ecclesiastical leaders or other third party payors, but are the responsibility of the client. Please understand that because I see a limited number of clients, there are often people waiting to be seen, so missed appointments not only affect your care, but also the availability for others to receive care. Repeated cancellations may result in the termination of therapy, referral to another provider, or arrangements made for a payment plan. If 2 consecutive payments are missed, we will suspend scheduling of future appointments until the account is brought up to date. Any returned checks will incur a $30.00 charge.

Initial:_____ _____

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Confidentiality: Trust is the foundation of a healthy therapeutic relationship. I strive to provide a safe atmosphere where you can explore personal issues. All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law. You should be aware of the following information about confidentiality:

Circumstances where disclosure is required by the law are as follows:

- A reasonable suspicion of abuse or neglect of a child, dependent, or vulnerable adult. I am mandated by law to make a report to appropriate protective agencies.
- When you present or threaten grave bodily harm to others or to property. I have a legal duty to warn those threatened, and to contact law enforcement.
- When you are actively suicidal or threaten significant bodily harm to yourself. I have a duty to obtain help form others to do what is necessary to keep you safe.
- Disclosure may be required pursuant to legal proceedings, if ordered by the court. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the therapy records and/or testimony by Caralee Frederic, LCSW. Also, in a custody dispute, my records may be open to the court, by order of a judge.
- If there has been a divorce and you are seeking therapeutic services for your child(ren), please bring with you to the first session a copy of the court order detailing who can/must consent for therapeutic services for the minors involved.
- When you express a threat to national security.

Initial:_____ _____

My record keeping of client mental health information involves paper documentation, typed notes from therapy sessions, and storage on computerized files which are password protected. In order to maintain strict privacy and confidentiality, notes, client forms and computer files (disks, thumbnail drives, etc.) are locked in a private filing cabinet.

Any communication between us via social media, including email or texting, is not a totally secure medium for purposes of transmitting privileged information. Professional advice will not normally be provided via the internet. Any inquiry or contact with my website or office via the internet should not be considered a substitute for telephonic, written, or in-person communication. If you send a message by email or other electronic form of transmission, **you acknowledge/agree that you may be compromising confidentiality** by using such means of communication. Clients with professional inquiries are requested to contact my office in person, by telephone or in writing. I also request that you not communicate with me via texting, Facebook or other social media. Again, I cannot protect your confidentiality via these means of communication.

Initial:_____ _____

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Litigation Limitation:

My professional time is best spent assisting clients in the therapeutic setting rather than participating in legal proceedings. Therefore, you agree that should you be involved in legal proceedings, **neither you nor your attorney** will call on me to testify in court or at any other proceeding, **nor will a disclosure of the therapy records be requested.** If, for any reason, I am summoned to court on your behalf, **my fees will be substantially higher than my regular fees**. Time charged to you will include all time spent in preparation and "door to door" for travel and appearance in court, as well as any and all other expenses incurred by me as a result. My fees for any and all involvement in litigation proceedings are $250/hour for reports, communication, case, review, legal consults, door to door travel costs, etc. Depositions, either by phone or in person, are $500/hour. If you choose to involve me in litigation, contrary to this agreement, it may result in termination of therapy with me. I will provide referrals to the best of my ability.

Initial:_____ _____

Completion of Therapy:

Therapy is complete when you assess that you have met your goals and believe that you can maintain growth on your own. Most clients find it helpful to have an ending or termination session to bring closure to therapy, assess progress made, and explore issues related to separation and loss. This ending session is an important part of the therapeutic process. Throughout treatment we will regularly discuss your progress towards the therapeutic goals and plan for the ending session.

Consent to Treatment:

My signature below affirms my informed and voluntary consent to enter therapy (and/or have my child enter therapy). I affirm that prior to becoming a client of Caralee Frederic, LCSW, she gave me sufficient information to understand the nature of therapy, including the possible risks and benefits. I understand her office policies and procedures. I have had an opportunity to ask questions and have had my questions answered satisfactorily. I consent to psychological services for myself (or for my child).

Print Client Name: _____

Print Client Name: _____

Client Signature: _____ **Date:** _____

Client Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

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MANDATORY DISCLOSURE FORM

Except in emergency situations or where psychotherapy is being administered pursuant to a court order, every licensed and unlicensed psychotherapist shall provide the following information in writing to each client during the initial contact:

Therapist:	**Caralee Frederic, LCSW, CGT, SRT**
Business Address:	7710 N. Union Blvd, Suite 202 Colorado Springs, CO 80918 719-494-7412 c.frederic@yahoo.com www.principleskills.com
Degrees:	BS Social Work – Brigham Young University, 1995 MS Social Work – San Jose State University 1997
License:	Licensed Clinical Social Worker – Colorado License #470
Certifications:	Certified Gottman Therapist - The Gottman Institute, 2013 Certified Sexual Recovery Therapist - AASAT, 2014
Fees:	Individual and Family Therapy **$110.00 for 50 minute session** Initial Assessment (individuals/families) - **$150.00 for 75 minute session** Initial Couple/Marital Assessment - **$200.00 for 90 minute session** Couple/Marital Therapy - **$165.00 for 90 minute session**

****Your portion of payment is to be *paid in full* at the beginning of each session; fees are subject to change.**

CRS 12-43-2 14 (1)(c) provides that the practice of both licensed and unlicensed persons in the field of psychotherapy is regulated by the Department of Regulatory Agencies. Questions or complaints may be addressed to:

State of Colorado Department of Regulatory Agencies
State Grievance Board
1560 Broadway, Suite 1340
Denver, CO 80202
303-894-1766

CRS 12-43-214(1)(d) provides the following: A client is entitled to receive information about the methods of therapy, the techniques used, the duration of therapy (if known), and the fee structure. A client may seek a second opinion from another therapist or may terminate therapy at any time. In a professional relationship, sexual intimacy is always inappropriate and should be reported to the grievance board. CRS 12-43-214(1)(d) Privileged Communications – The information provided a client during therapy sessions is legally confidential, except as provided in section 12-43-218, and except for certain legal exceptions which will be identified by the therapist, should any such situation arise during therapy. Examples would be the *mandatory reporting of child abuse*, or where there may be harm to the client or others. You should be aware that in the case of a board complaint, it is likely that your file will be subpoenaed and reviewed by the board and its attorneys.

I have been informed of my therapist's degrees, credentials and licenses. I have read the preceding information and understand my rights as a client and also acknowledge that I have satisfied myself as to concerns or any questions relating to this disclosure form before signing below.

Client Signature (Parent/Guardian for a minor) **Date:**

Therapist Signature **Date:**

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Notice of Privacy Practices

I. 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.

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices and such Notice must explain how, when and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply or analyze such information within my practice. PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice.
However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office. You can also request a copy of this Notice from me, or you can view a copy of it in my office.

III. HOW I MAY USE AND DISCLOSE YOUR PHI

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior written authorization. For others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment of Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:

1. For Treatment: I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I can disclose your PHI to physicians, psychiatrists, psychologists and other licensed health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.
2. To Obtain Payment for Treatment: I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies and others that process my health care claims.
3. For Health Care Operations: I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.
4. Patient Incapacitation or Emergency: I may disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent is not required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent

but you are unable to communicate with me(for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization: I can use and disclose your PHI without your consent or authorization for the following reasons:

1. When federal, state or local laws require disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect.
2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim for worker's compensation benefits, I may have to use or disclose your PHI in response to a court or administrative order. I may also have to use or disclose your PHI in response to a subpoena.
3. When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in response to a search warrant.
4. When public health activities require disclosure. For example, I may have to disclose your PHI to report to a government official an adverse reaction that you have to a medication.
5. When health oversight activities require disclosure. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.
6. To avert a serious threat to health or safety. For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.
7. For specialized government functions. If you are in the military, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.
8. To remind you about appointments and to inform you of health related benefits or services. For example, I may have to use or disclose your PHI to remind you about your appointments, or to give you information about treatment alternatives, or health care services, or other health benefits that I offer that may be of interest to you.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object: Disclosures to Family, Friends or Others. I may provide your PHI to a family member, friend or other person that you indicate is involved in your care or the payment of your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization: In any other situation not described in section II A, B, or C above, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action on reliance of such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The Right to Request Restrictions on My Uses and Disclosures. You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members or friends or others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests, but I am not legally required to accept them. If I do accept you requests, I will put them in writing and I will abide by them,

except in emergency situations. However, be advised that you may not limit the uses and disclosures that I am legally required to make.

B. The Right to Choose How I Send PHI to You. You have the right to request that I send confidential information to you (for example, sending information to your work address rather than to your home address) or by alternate means (for example, email, instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

C. The Right to Inspect and Receive a Copy of Your PHI. In most cases, you have the right to inspect and receive a copy of the PHI that I have on you, but you must make the request to inspect and receive a copy of such information in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to your requests within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. If you request copies of your PHI, I will charge you not more that $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Receive a List of Disclosures I Have Made. You have a right to receive a list of instances, i.e., an Accounting of Disclosures, in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use or disclosure permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel, or disclosures made before May 1, 2009. I will respond to your request for an Accounting of Disclosures within 60 days of receiving such request. The list I will give you will include disclosures made I the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide a list to you at not charge, but if you make more than one request in the same year, I may charge you a reasonable, cost based fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update you PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve you request I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. The Right to Receive a Paper Copy of this Notice. You have the right to receive a paper copy of this notice, even if you have agreed to receive it via email.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that I may have violated your privacy rights or you disagree with a decision I made about your access to your PHI, you may file a complaint with me at the address listed in Section VI. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W., Washington D.C., 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

7710 N. Union Blvd., Suite 202, Colorado Springs, CO 80920
719-494-7412
c.frederic@yahoo.com, www.principleskills.com

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at:

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on May 1, 2009

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ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPPA)

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that I have given you. My Notice of Privacy Practices includes information about how I may use and disclose your protected health information. I encourage you to read it in full.

My Notice of Privacy Practices is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at c.frederic@yahoo.com.

If you have any questions about my Notice of Privacy Practices, please contact me at: c.frederic@yahoo.com.

I acknowledge the receipt of the Notice of Privacy Practices of Caralee Frederic, LCSW.

Signature: _____

Signature: _____

Date: _____

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Authorization for Release of Confidential Information

Client Name	Client Name

I authorize **Caralee Frederic, LCSW** and the persons or entities listed below, or their representatives, to mutually release and disclose my health information:

I have received and reviewed the *Notice of Privacy Practices*.
I understand that by signing this *General Authorization* I am authorizing Caralee Frederic, LCSW to disclose my health information to the persons and entities listed below and that any health information or other confidential information in the possession of the persons and entities listed below may be disclosed to Caralee Frederic, LCSW.
My health information includes (please check the following):

records and reports
test results
opinions and recommendations
assessments
any other information relating to medical, emotional, educational or psychological condition

I understand that I may revoke this authorization at any time by signing a written notice of revocation to Caralee Frederic, LCSW. I understand that my revocation of this *General Authorization* will not affect a disclosure that Caralee Frederic, LCSW has already made under this authorization.
I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by Caralee Frederic's confidentiality rules.
This authorization is only valid until _____(fill in date), or until 3 months after my file is closed with Caralee Frederic, LCSW.

Name	Address/Phone/Fax	Initials	Date

Client Signature: _____Date: _____

Client Signature: _____Date: _____

Therapist Signature: _____Date: _____