Principle Skills Relationship Center

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

Intake Forms

Date Completed:

Name:	**Age:**	**D.O.B.**
Address (Street)	**City, State, Zip**	**Home:** **Cell:**
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**? Y N
Is it OK to communicate via **text**? Y N
Is it OK to send you newsletters and info about upcoming classes/events? Y N

Name:	**Age:**	**D.O.B.**
Address (Street)	**City, State, Zip**	**Home:** **Cell:**
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**? Y N
Is it OK to communicate via **text**? Y N
Is it OK to send you newsletters and info about upcoming classes/events? Y N

Prior Therapists- Name and phone #:	
When?	
For what problems?	
Was it helpful?	

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Emergency Contact – Name/Address/Phone:	
Prescribing Physician - Name/Address/ Phone #:	

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):
Partner 1:
Partner 2:

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):
Partner 1:
Partner 2:

Current Alcohol and/or Drug Use: - Type/Frequency/Amount:
Partner 1:
Partner 2:

Past Alcohol and/or Drug Use: – Type/Frequency/Amount:
Partner 1:
Partner 2:

Legal History:
Have you ever had police/court involvement? (Circle one answer)
Partner 1:
No, Never Yes, within the past month Yes, within the past 6 mos.
Yes, within the past year Yes, over 1 year ago

Partner 2:
No, Never Yes, within the past month Yes, within the past 6 mos.
Yes, within the past year Yes, over 1 year ago

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Briefly for what problems are you seeking counseling? _____

_____

_____

_____

_____

Goals for Treatment (specific desired outcomes):

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

Feel free to add additional goals on another sheet of paper.

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

Client Signature **Date**

Client 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.

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 caralee@principleskills.com

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

I acknowledge the receipt of the Notice of Privacy Practices of Caralee Frederic, LCSW and Principle Skills Relationship Center.

Signature: _____

Signature: _____

Date: _____

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Authorization for Release of Confidential Information

I (Client Name) _____ (D.O.B) _____

(Client Name) _____ (D.O.B) _____

authorize **Caralee Frederic, LCSW/ Principle Skills Relationship Center,** and the persons or entities listed below, or their representatives, to mutually release and disclose my health information:

Name/Agency:

Address/Phone #:

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:

Treatment summary - session dates and progress
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.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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Gottman Method Couples Therapy Overview

The Gottman Method Relationship Therapy is based on Dr. John Gottman's research that began in the 1970's and continues to this day. The research has focused on what makes relationships succeed or fail. From this research, Dr.'s John and Julie Gottman have created a method of therapy that emphasizes a nuts-and-bolts approach to improving client relationships. The method is designed to teach specific principles and tools to deepen friendship and intimacy in your relationship, to help you productively manage conflicts and to support one another's life dreams. We will also help you appreciate your relationship's strengths and gently navigate through its vulnerabilities.

The Gottman Method Couples Therapy consists of 5 parts:

- Assessment
- Treatment
- Phasing Out of Therapy
- Termination
- Outcome Evaluation

The Assessment consists of the first 4 sessions: First: a 90 minute joint session where we will talk about the history of your relationship, areas of concern and goals for treatment. In this session, if you are comfortable with it, I will ask permission to record a 10 minute example of how you typically talk together about difficult topics. You will also fill out an online assessment questionnaire from The Gottman Institute. Next: Two 60 minute individual sessions with each person in the couple to learn your personal histories and give each of you an opportunity to share thoughts, feelings and perceptions of the relationship. Finally, we will meet again all together for 90 minutes for a "summary session" where I will share with you the strengths in the relationship, areas of concern and my recommendations for treatment, and work to define mutually agreed upon goals for therapy. Please note: I have a NO SECRETS policy. Information shared will be used to further the goals of the marriage.

The Treatment phase is where I will meet with you as a couple for 90 minute sessions. There may be times when individual sessions are recommended to enhance the work you do as a couple. I will also recommend exercises to practice between sessions or reading exercises.
The length of therapy will be determined by your specific needs and goals. In the course of therapy, we will periodically evaluate your satisfaction and progress toward your goals. I encourage you to raise any questions or concerns you have about therapy at any time.

In the later stage of therapy, we will begin to "phase out" or meet less frequently in order for you to test out new relationship skills and to prepare for termination of the therapy. Although you may terminate therapy whenever you wish, it is most helpful to have at least one session together to summarize progress, define the work that remains and to say good-bye.

In the outcome-evaluation phase, as per the Gottman Method, follow up sessions are planned. The following time frames are recommended post termination to meet for a session: 6 months; 12 months, 18 months and 2 years. These sessions have been shown through research to significantly decrease the chances of relapse into previous unhelpful patterns. The purpose of these follow up sessions is to fine-tune any of your relationship skills as needed, and to evaluate the effectiveness of the therapy received.