INTAKE PACKET

Please complete the following packet and give it to your therapist during your first session. The packet includes these documents:

a) Disclosure
b) HIPPA Acknowledgement
c) Client Information Form
d) Fee Agreements
e) Treatment Survey

Embark Counseling

8191 Southpark Lane Suite 201
Littleton, CO 80120

EMBARK COUNSELING DISCLOSURE

Thank you for choosing Embark Counseling LLC for your counseling services. The following disclosure is designed to give you information about your time in therapy at Embark. Embark Counseling functions as an administrative business under which individual counselors see clients through their own private practice. All of the Embark Counseling staff are committed to the client's rights of information regarding our policies including confidentiality, consent, and administrative services. In keeping with this policy, we have listed below our various office policies for your information. Please read through these, ask any questions you may have and sign where directed. Thank you for allowing us to serve you.

FULL NAMES AND CREDENTIALS OF THERAPISTS:
I, **Diane Melancon**, am a Colorado Registered Psychotherapist, with my Masters of Arts in Psychology from Antioch University, Seattle and my Bachelor of Arts in Liberal Studies from Sonoma State University, California.

I, **Darcia DeSalvo**, am a Colorado Licensed Professional Counselor, with my Masters of Arts in Counseling from University of Northern Colorado, Greeley, CO and my Bachelor of Arts in Psychology from Illinois Wesleyan University, Bloomington, IL.

The practice of registered psychotherapy is regulated by the Mental Health Section of the Division of Registrations. The Board of Registered Psychotherapist 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:

- 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.
- Certified Addiction Counselor I (CAC I) must be a high school graduate, complete required training hours and 1,000 hours of supervised experience.
- Certified Addiction Counselor II (CAC II) must complete additional required training hours and 2,000 hours of supervised experience.
- Certified Addiction Counselor III (CAC III) must have a bachelor's degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience.
- Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements.
- Licensed Social Worker must hold a master's degree in social work.
- 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.

· Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's 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 post-doctoral supervision.

You are entitled to receive information from your therapist 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.

1. FEE STRUCTURE: Our service fee structures follow that of what you have agreed to in the "Fee Agreement."
2. EMERGENCIES: In an emergency, please go to your nearest emergency room or call 911.
3. SEXUAL INTIMACY: 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.
4. CONFIDENTIALITY: 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 HIPAA 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 suspected child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly. The Mental Health Practice Act (CRS 12-43-101, et seq.) is available at: http://www.dora.state.co.us/mental-health/Statute.pdf.
5. NO SECRETS: Please understand that in order to make progress with family or marriage counseling, a no secrets policy is taken. All members of the family or couple are treated equally and no secrets are kept. Any information shared in individual therapy MUST also be shared in family or couple therapy to ensure the no secret policy. Signing this form acknowledges permission to share confidential information.
6. REGARDING DIVORCE AND CUSTODY LITIGATION: If you are involved in divorce or custody litigation, my role as a therapist is NOT to make recommendations to the court. By signing this agreement you agree not to subpeano me to court for testimony regarding parenting time or decision making; and you agree not to request any written reports to the courts for this use. The court can appoint professionals, who have no prior relationship with family members, as needed.

ATTESTING THAT I UNDERSTAND THE ABOVE AND AGREE TO THERAPY UNDER THE ABOVE LIST OF DISCLOSURES I HAVE SIGNED BELOW:

CLIENT
SIGNATURE____DATE___________

SIGNATURE OF SPOUSE IF
FAMILY/MARITAL COUNSELING ___________________________DATE__________

SIGNATURE OF PARENT OR
GUARDIAN IF CLIENT IS A MINOR ________________________DATE__________

THERAPIST: ____DATE_________

Notice of Privacy Practices---HIPAA Compliance

---This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. You have a right to a copy of this notice.
---We have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
--The law permits us to use or disclose your health information to those involved in your treatment.
--We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to the insurance company.
---We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
---We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
---We may use your information to contact you. For example, we may call to remind you of your appointments. If you do not answer the phone, we may leave this information on your answering machine or with the person who answers the telephone.
---In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law
---Except as described above, this practice will not use or disclose your health information without your prior written authorization.
---You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
---You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. You have the right to transfer copies of your health information to another practice. With your written consent we will mail or fax copies of your records to another practice.
---You have the right to see and receive a copy of your health information, with a few exceptions. A written request regarding the information you want to see is required. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
---You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may
not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add the new information.
---If we change any of the details of this notice, we will notify you of the changes in writing.
---You may file a complaint with the Department of Health and Human Services, 200 Independence Ave., S.W Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.
---This notice goes into effect as of April 14, 2003.

Embark Counseling has permission to contact me at the following:
(check all that apply)

Home telephone:
OK to leave a message with detailed information ☐ yes ☐ no
OK to leave a message with other family members ☐ yes ☐ no

Cell Phone:
OK to leave a message with detailed information ☐ yes ☐ no
OK to leave a message with person answering ☐ yes ☐ no

Work Telephone:
OK to leave a voicemail message with detailed information ☐ yes ☐ no
OK to leave a message with ___________________________

Written Communication
OK to mail to my home address ☐ yes ☐ no
OK to E-mail me at: ______________________________

OK to fax to this number: ___________________________ ☐ yes ☐ no
Other ____

I have received a copy of Embark Counseling's notice of privacy practices.

____ _____________
SIGNED DATE

PRINT NAME

If signing as parent or guardian, please note the name of the client: __________________________

CONFIDENTIAL INTAKE INFORMATION

Client Name:___________________Age:____ Gender:____ Date:_________
Date of Birth:________________
Home Phone:________________ Cell Phone:_______________________________
Employer:______________________Email:_________________________________
Address of Residence:___________________________________
County of Residence:________________________
Is Client the Responsible Party? (circle) yes no
Name of Responsible Party (if different than client):_____________________________
Relationship to Client:_______________________
Client/Responsible Party Billing Address:_____________________________________
____

Marital Status: (circle) Single Married Cohabitating Divorced Re-Married Other
Name of Spouse or Partner:_________________
Spouse or Partner's Address:____
Phone:__________________
Email:___________________Occupation:___________ DOB:___________

Names of Children DOB Living in the Home?
____
____
____
____
____

PLEASE COMPLETE THIS PAGE IF CLIENT IS UNDER 18

Minor Child's Name:___________________________________DOB:_______________
Father's Name: ____________________ DOB:_________
Father's Address (If different than client):____________________________________

Mother's Name: ___________________ DOB:_________
Mother's Address (If different than client):_______________________________________
____
Parents Relationship: (circle) Married Divorced Separated Never Married
Client's Legal Guardian(s): ____
Provide contact information here if not listed elsewhere on form:
Address:____
________________________DOB:____________Phone:__________________________

Child's School:_______________________Grade:______________________________

Is your child currently taking any medication: yes no
If yes, please list:____

If parents are not together or child is currently in foster care or adopted, who has the right to make medical decisions?
____

Please provide therapist with custody and other legal paperwork needed to ensure therapist has permission by guardians to see client. Without necessary paperwork, therapist may be unable to see the client.

PAYMENT AGREEMENT

(Initial each line item and sign below)

____________ Payment is due at the time of your appointment. Cash and check are acceptable forms of payment.

___________ The standard fee for services is:

- Individual Therapy $120/therapeutic hour
- Family and Couples Therapy $140/therapeutic hour
- In-home Therapy $160/therapeutic hour
- Case Management $50/ 30 minutes
- Phone consultation $25/20 minutes

Services may be offered at reduced fees based individual circumstances and prior arrangement.

__________ The agreed upon fee for counseling services is $___________ per 50 minute session.

__________ A fee of $30 will be assessed for a returned check and future payments must be made in cash.

__________ Cancellations require 24 hours notice prior to the time of the appointment. You will be charged the full agreed upon fee (noted above) for cancelling appointments with less than 24 hours notice or for missing appointments without prior notice.

_________ The initial intake session will be dedicated to understanding the client's background and current situation, assessing for immediate risks, evaluating readiness for requested therapy, providing referrals if needed, and establishing treatment goals. There may be no therapeutic counseling or intervention during the initial intake session.

_________ Phone calls in excess of 10 minutes will be billed to the client's account in accordance with the standard session fee.

_________ Treatment may be interrupted or terminated; after 3 unpaid no shows, due to 3 consecutive cancellations, or after unresolved debt of 3 or more sessions.

By initialing each line item above and by signing below, I acknowledge that I understand and commit to the above Payment Agreement and enter into the agreement willingly and voluntarily.

Client Name (please print): ____

Signature of Client or Legal Guardian:

____Date:____________

Signature of Therapist:

____Date:____________

Please check all that apply to you and may be a focus of treatment

- ☐ Anxiety
- ☐ Depression
- ☐ Relationships and Boundary Issues
- ☐ Academic Problems (Children and Adolescents)
- ☐ Behavioral Problems (Children and Adolescents)
- ☐ Marital Concern
  - ☐ Communication
  - ☐ Building or Rebuilding Trust
  - ☐ Intimacy
  - ☐ Conflict Resolution
  - ☐ Infedelity issues
- ☐ Dealing with Divorce
- ☐ **Parenting Concerns**
- ☐ Risk of harming yourself or others
- ☐ Anger Issues
- ☐ Developmental Problems
- ☐ Sleep Problems
- ☐ Feeling Isolated From Others
- ☐ Afraid or Suspicious
- ☐ Nightmares
- ☐ Intrusive Memories
- ☐ Sexual Issues
- ☐ Stress Management
- ☐ Traumatic Experiences
- ☐ Sexual Abuse
- ☐ Physical Abuse (Including Domestic Violence)
- ☐ Emotional/Mental Abuse
- ☐ Loss of Control
- ☐ Destructive Life Patterns
- ☐ Substance Abuse (Past and/or Present)
- ☐ Family of Origin Issues
- ☐ Career Changes
- ☐ Specific Fears or Panic
- ☐ Other:____________________

BRIEF SURVEY

What brings you in to therapy today?

Where did you hear about Embark Counseling?

What are you hoping for in your therapy experience?

What are your concerns about therapy?

Have you ever been in therapy before?

If yes, was your experience positive or negative and why?