Darleen Gegich, MA LPC

CLIENT INFORMATION AND CONSENT

Therapist
The undersigned therapist is a licensed professional counselor engaged in a private practice providing mental health care services to clients.

Mental Health Services
While it may not be easy to seek help from a mental health professional, it is hoped that you will be better able to understand your situation and feelings and move toward resolving your difficulties. The therapist, using her knowledge of human development and behavior will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to explore your own feelings and thoughts and to try new approaches in order for change to occur. You may bring other family members to a therapy session if you feel it would be helpful or if this is recommended by your therapist.

Appointments
Appointments are made by calling (720) 515-4711 Monday through Friday between the hours of 9:00 A.M. and 5:00 P. M. **Please call to cancel or reschedule at least 24 hours in advance, or you will be charged for the missed appointment.** Third-party payments will not usually cover or reimburse for missed appointments.

Number of Visits
The number of sessions needed depends on many factors and will be discussed by the therapist.

Length of Visits
Individual therapy sessions are 60 minutes in length. Couples and family sessions generally run 90 minutes in length.

Relationship
Your relationship with the therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The therapist cares about helping you but is not in a position to be your friend or to have a social or personal relationship with you. Gifts, bartering and trading services are not appropriate and should not be shared between you and the therapist.

Cancellations
Cancellations must be received at least 24 hours before your scheduled appointment; otherwise, YOU will be charged the customary fee for that missed appointment. You are responsible for calling to cancel or reschedule your appointment.

Payment for Services
The charge for individual sessions is $150 for each 60-minute session thereafter. The charge for couples and family 90-minute sessions is $250. Additional time is $40 per 15 minutes. **The undersigned therapist will look to you for full payment of your account, and you will be responsible for payment of all charges.**

Although it is the goal of the undersigned therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. In the event disclosure of your records or testimony is required by law, you will be responsible for and shall pay the costs involved in producing the records and the therapist's normal hourly rate for the time involved in preparing for and giving testimony. Such payments are to be made at the time or prior to the time the services are rendered by the therapist.

Confidentiality
Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions' child custody cases; suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose; fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the licensing board. If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing this information and consent form, you are giving your consent to the undersigned therapist to share confidential information with all persons mandated by law and with the agency that referred you and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment of those services, and you are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

Duty to Warn
In the event that the undersigned therapist reasonably believes that I am a danger, physically or emotionally, to myself or another person, I specifically consent for the

therapist to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel:

NAME **TELEPHONE NUMBER**

Risks of Therapy

Therapy is the Greek word for change. You may learn things about yourself that you don't like. Often, growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety, or pain. The success of our work together depends on the quality of the efforts on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from therapy. Specifically, one risk of marital therapy is the possibility of exercising the divorce option.

After-Hour Emergencies

Emergencies are urgent issues requiring immediate action. If you feel that you need assistance with a life-threatening emergency, please call The Suicide and Crisis Center Hotline at (303) 447-1665 or Dial 911.

Consent to Treatment

I, voluntarily, agree to receive Mental Health services, and authorize the undersigned therapist to provide such services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my treatment, or services, and that I may stop such treatment, or services that I receive through the undersigned therapist at any time.

By signing this Client Information and Consent form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____ _____

Client/Parent or Guardian Date

_____ _____

Client/Parent or Guardian Date

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Patient Information Sheet

Patient Name: _____ D.O.B. _____

Address: _____

City: _____ State _____ Zip Code: _____

Home Phone: _____ Work: _____ Cell:_____

Email address: _____

If patient is a minor, name of parent or legal guardian:

_____ Relationship to patient: _____

Work #: _____ Cell #: _____

How were you referred to the office? _____

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The notice provides in detail that uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the even of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relation to patient (if signed by a personal representative of Patient): _____

ALCOHOL/SUBSTANCE USE SURVEY
(EACH CLIENT TO COMPLETE SEPARATE FORM)

Client Name: _____

How often do you have a drink containing alcohol?

☐ Never ☐ 1/month or less ☐ 2-4/month ☐ 2-4/week ☐ more than 4/week

How many drinks do you consume on a typical day that you are drinking?

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 or 9 ☐ 10 or more

Have you ever received a DUI? ☐ **Yes** ☐ **No** Other alcohol violations? _____

Do you use marijuana or other illegal drugs? (This is confidential) ☐ **Yes** ☐ **No**

Do you abuse any prescription medications? ☐ **Yes** ☐ **No**

Please list all types of drugs you may be using: _____

How much and how often do you use: _____

Briefly describe your current presenting issues that have brought you in today:

_____

_____

_____

_____

What are your desired goals for therapy? _____

_____

_____

_____

_____

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Intake Form

Primary Client or Clients: _____

List all persons currently living in your household and complete all associated questions for each person

Name					
Relationship to you (mother, child, etc.)	**Myself**				
Birthdate					
Gender					
Marital Status (S, M, D, Sep., W)					
Occupation/School					
Highest Grade Completed? (10th, 1yr college, etc.)					

Circle Yes or No for each person (*Give details for each "Yes"answer)*

Currently taking prescription drugs?	**Y N**	**Y N**	**Y N**	**Y N**	**Y N**
Ever considered or attempted suicide?	**Y N**	**Y N**	**Y N**	**Y N**	**Y N**
Ever received therapy?	**Y N**	**Y N**	**Y N**	**Y N**	**Y N**
Ever hospitalized for psychological problems?	**Y N**	**Y N**	**Y N**	**Y N**	**Y N**
Ever sexually abused?	**Y N**	**Y N**	**Y N**	**Y N**	**Y N**
Ever experienced family violence?	**Y N**	**Y N**	**Y N**	**Y N**	**Y N**
Ever arrested?	**Y N**	**Y N**	**Y N**	**Y N**	**Y N**
Ever had any serious health problems?	**Y N**	**Y N**	**Y N**	**Y N**	**Y N**

Staff Only:					
Init DX					
Init GAF/CGAS					

Darleen Gegich, MA LPC *Individual, Couple, Family & Group Counseling*
1910 7th Street, Boulder, CO 80302 Tel: (720) 515-4711
600 S. Airport Rd., Longmont, CO 80503

Credit Card Authorization Form

All appointments must be cancelled 24 hours in advance. Same-day cancellations (a "late cancel") will incur a $150 fee for 60-minute sessions and $250 for 90-minute sessions. Failure to attend a scheduled appointment without cancellation (a "no-show") will incur the full session fee that will be automatically charged to your credit card listed below. This policy is not meant to be punitive, but appointment times you schedule are reserved for you at the exclusion of others who may be waiting to see the therapist. **3.5% additional fee is charged by credit card processor**.

Checks that are written and not honored by your bank for any reason will result in a $25 returned check fee. The credit card below will be charged in the amount of the bounced check and the $25 returned check fee. Outstanding balances on your account due to co-insurance, deductible, or for any non-covered services (e.g., marital/family counseling/telephone consultations, etc.) for more than 30 days will also be charged to the card listed below. Thank you for your understanding.

******All information must be provided******

Patient Name: _____

Credit Card Type (check one): ☐Visa ☐ Master Card

Card # _____ Expiration Date (mm/yy): _____ CVC

Code: _____ Cardholder Name (as it appears on the card):_____

Billing Address for the Credit Card: Street _____

City, State, Zip: _____

By signing below, I certify that my above information is true, accurate and an authorized user on the account. I authorize and agree to have my above credit card information kept on file and charged for Late Cancel appointments, No Show appointments, and outstanding balances on my account that have not been paid or payment arrangements made after 30 days.

Cardholder Signature: _____ Date: _____

Patient Release of Information to Guarantor/Third Party Agency: I authorize Darleen Gegich, to release my financial information to a third-party collection agency (in the case that further collection assistance is required).

Cardholder Signature: _____ Date: _____

I do ____ do not ____ want a copy of this release.