

Denver Counseling & Executive Life Coaching
www.counselingexeclifecoach.com
Confidential Client Information Personal Information
Today's Date: _____

Personal Information:

Last Name: _____ First: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

I give permission to leave voicemails/text messages: Yes _____ No _____ (Please INITIAL)

I give permission to email me regarding scheduling, billing, or education at the following email: _____ (Initial)
(Please don't send personal, clinical information via email, as it is not considered a secure format)

Email Address: _____

Birth Date: _____ Sex: Male _____ Female _____

Occupation: _____ Employer: _____

Relationship Status:

Single _____ Married _____ Widowed _____ Divorced _____ Separated _____ Engaged _____ Live-In _____ Partner _____

How Long? _____ Spouse or Significant Other's Name: _____

Do you have children? _____ Names & Ages: _____

Who are your closest relational supports?: _____

In case of emergency please notify: _____

Address: _____ Phone: _____

By whom were you referred, or if on-line, what website? _____

Counseling History & Goals: Have you previously received psychological counseling or treatment? _____

If yes, please explain: _____

Previous Psychological Diagnosis (if any): _____

Name of Therapist/Provider	From When to When?	Primary Reasons:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Diagnosis: _____

Presenting Problems: What are the main issues you'd like to address in counseling?

Medical History: Are you currently under medical care? _____ If yes, for what reason?

Physician's/Psychiatrist's Name: _____ Phone: _____

Do you take any prescription medications? _____ If yes, please explain:

Type of Medication	Dosage	Approx Start Date?	For What Purpose?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other current/ongoing significant medical/physical problems:

Denver Counseling & Executive Life Coaching, PLLC

Frances Forgione, MSW-LCSW, LAC
1416 Larimer St. #207, Denver, CO 80202

Disclosure Statement

Client Name: _____ Date: _____

Welcome to my practice. Colorado State law requires me to provide you with the following information:

Therapist Credentials: Frances Forgione, MSW-LCSW, LAC

Education, Licenses & Certifications:

M.S.W. – U. of Texas at Arlington, Arlington, TX 1990 LCSW – CO Licensed Clinical Social Worker #959
B.S.W. - Washburn University, Topeka, KS 1985 LAC – CO Licensed Addictions Counselor #367
EMDR Certified - (Eye Movement Desensitization Reprocessing) Maiberger Institute Certification Completion
EFT Trained (Emotionally Focused Therapy). Completed Externship, Advance Training Core Skills & Supervision
Gottman Training, Level 1 & 2 Couples Therapy

Explanation of Licenses & Certifications: (Frances' licenses are in bold)

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

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 of post-doctoral supervision.

Regulatory Agencies:

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed clinical social workers, licensed professional counselors, and unlicensed individuals who practice psychotherapy. The State Board of Social Work Examiners can be reached at

https://www.colorado.gov/pacific/dora/social_work or 1560 Broadway, Suite 1350, Denver, CO 80202, 303-894-7800 and ask for the Social Work State Board of Examiners, which oversees Licensed Clinical Social Workers.

As of October 1, 2017, 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.

Client Rights & Important Information:

You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy if I can determine it, and my fee structure. You may seek a second opinion from another therapist or terminate therapy at any time. In a professional relationship such as ours, sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the State Board of Social Work Examiners. Closure is an important part of therapy and at the termination of counseling, a closing session is requested.

Confidentiality:

Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the therapist is a certified school psychologist, a licensed clinical social worker, a licensed marriage and family therapist, a licensed professional counselor, a licensed psychologist, or an unlicensed psychotherapist practicing under the

supervision of a licensed psychotherapist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent. There are exceptions to the general rule of legal confidentiality. These exceptions are listed in the Colorado Statutes (see 12-43-218, C.R.S. 1998). You should be aware that, except in the case of information given to a licensed psychologist, legal confidentiality does not apply in a criminal or delinquency proceeding. There are other exceptions that I will identify to you as the situations arise during therapy. The Mental Health Practice Act (CRS 12-43-101, it seq.) is available at: <http://www.dora.state.co.us/mental-health/Statute.pdf>. Unless you grant permission to do so in writing, the content of any session is confidential. However, examples of circumstances under which such professional confidentiality may be broken are:

- A. Disclosure of serious physical danger to himself/herself or to someone else.
- B. Disclosure of neglect, physical or sexual abuse or molested a child, an incompetent or disabled person. If abuse or neglect is disclosed under the conditions given above, it is mandated by Colorado law that such information be reported by therapists to the appropriate state agency.
- C. If a health insurance plan is utilized, a diagnosis code and other pertinent data may be disclosed for claim processing.

Confidentiality in Couples, Adolescent & Family Therapy:

At times, instances arise where one partner in a couple, or a family member, wants to tell me something without the other knowing about it. Please be aware that anything you choose to tell me, individually, that is particularly pertinent to the work with you as a couple or family, may need to come out in therapy and I hold a "no secrets" policy. This means that if information is critical to therapy, we would discuss the best way for this to be discussed in couples or family work.

For adolescents 15-17 years old, therapists may notify parents that their child is in therapy, however specific information shared by their son or daughter in counseling is confidential even from parents, unless the adolescent signs a release of information form. For adolescents, we ask parents to agree that the therapist will determine what information, in his or her professional judgment, is appropriate to be shared with the parent/guardian(s) concerning treatment issues, and what information, at the discretion of the therapist, will remain confidential between the adolescent and the therapist. Adolescents need to be aware that there may be times when information shared needs to come out in family therapy with parents present and they will be guided & supported to do so. Exceptions to confidentiality between adolescents and parents are made if the adolescent is a danger to self or someone else or when there is neglect or physical, emotional, sexual abuse, which must be reported to appropriate authorities.

Fees:

Payment by cash, check or credit card is due at the beginning of each session. To make the most of our time together, please make out checks out to "DCELC" in advance; or sign a consent authorizing use of your credit card.

Rates are: \$150 per 55-minute session for individual therapy. Longer sessions are available in additional 15-minute increments and prorated based on the \$150 per hour rate (37.50 per 15-min segment)

Recommended length of session for couples therapy is 85 minutes, at \$225 per session.

Recommended length of session for EMDR therapy is 85 minutes, at \$225 per session.

Intensive sessions for couples therapy or EMDR therapy lasting 3-4 hours are available and based on \$150 per hour.

Phone therapy available at individual rate or billed by 15-minute segments prorated at 37.50.

Brief 5-10 min. phone calls are allowed without charge on a limited basis.

I provide non-emergency services. If you are experiencing an emergency, please call 911, or call the Colorado Crisis Line at 844-493-8255 (TALK) or go to your nearest emergency room.

If you are in need of financial assistance, please discuss a reduced rate with your therapist (ranging from \$100-up to full fee,). Adjusted rate: _____ Initials: ____ (Client) ____ (Therapist)

Insurance: I am considered and "out-of-network" provider. Payment is due at each session. However, some may wish to submit statements to their insurance for possible reimbursement. You are advised to first call your insurance company and inquire about your plan's coverage for "out-of-network" providers and what your deductible amount is. **Please note that it is your responsibility to complete and file any insurance paperwork.** If you elect to use your health insurance plan to assist in the payment of treatment, your insurance carrier and the National Information Center will have access to your diagnosis code and other pertinent data needed for claim processing.

My insurance provider is: _____ Statement Requested? Yes ___ No ___

Business Relationships:

Frances Forgione, LCSW, LAC and Lynn McGregor, LCSW and any other therapists or coaches in our office are independent mental health professionals with their own practices who share office space. McGregor & Associates, PLLC is an independent counseling business, separate from Denver Counseling and Executive Life Coaching, PLLC and vice versa. In the unlikely event of your therapist's death or incapacity to perform therapy, Lynn McGregor, LCSW is appointed to follow up with notification and referrals to ensure proper care of clients. Client records are kept for a period of seven years, then destroyed except for general dates of therapy.

Cancellations & Authorization:

It is understandable that at times it may be necessary to cancel an appointment. To help to insure efficient and responsible use of time, any changes or cancellations must be made at least 24 hours in advance or a charge of \$100 may apply.

Client Contact Information:

I give Frances Forgione, LCSW, LAC, permission to contact me for scheduling, billing statements, sending psycho-educational information, sharing resources, referrals through the following means. I agree to not send personal, confidential information through these means and I understand the risks of electronic transformation of information. (Please initial any forms of communication for which you give permission)

___ Leave a message at phone number(s) _____

___ Leave a text message at phone number _____

___ Send ground mail to address: _____

___ Fax information to fax number: _____

___ Send email to email address: _____

By signing below, I authorize services & will pay all fees. Denver Counseling & Executive Life Coaching reserves the right to send clients with unpaid fees to collections. I have been informed of my therapist's credentials and understand my client rights. I understand that there are no guarantees as to therapy outcomes. I have access to a copy of this agreement.

Client Signature: _____ Date _____

Client Signature: _____ Date _____

Parent/Legal Guardian Signature (Minors) _____ Date _____

Therapist Signature _____ Date _____