



INTAKE FORMS

For Clients of Kris Cameron, M.A, N.C.C, L.P.C.

The forms in this packet should be completed as directed before you come in for your first visit.

All clients should read and complete the first five forms:

- State Mandatory Disclosure Statement
- Client Contact Information for Messages and Written Correspondence (HIPAA Form)
- Client Information Sheet
- Credit Card Authorization
- Scheduling and Payment Information Policy
- Telephone Contact Policy
- Skype Policy (if applicable)

Couples entering marital or pre-marital therapy should fill out all forms above *individually* and jointly complete the last form:

- Marital/Pre-Marital Therapy Contract

If you are unable to download these forms, please contact Kris Cameron at 303-351-5153 extension 102 or kcameron@redwoodcounselingservices.com and arrive at least 15 minutes prior to your scheduled appointment time to complete the forms.

Thank you,

Kris Cameron

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State Mandatory Disclosure Statement

Kristine B. Cameron, M.A., N.C.C., L.P.C.

7851 S. Elati Street, Suite 203

Littleton, CO 80120

303.351.5153

kcameron@redwoodcounselingservices.com

The State of Colorado requires that psychotherapy and psychiatric clinicians provide clients with certain information about the psychotherapy process. Please take time to read this document carefully, ask about any matters that seem unclear, initial where indicated, and sign the last page of the statement. A copy will be placed in your files.

1. I am a Licensed Professional Counselor, (LPC.0013133) and a Nationally Certified Counselor (NCC #291368). I received my Bachelor of Science from Radford University in 1987. I received my Master of Arts (M.A.) in Community Counseling from Denver Seminary in May of 2012.

2. As a Licensed Professional Counselor, I am under the authority of and am regulated by the Mental Health Licensing Section of the Division of Professions and Occupations. The Licensed Professional Counselor Examiners Board can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, 303-894-7800.

3. You are entitled to receive information from me concerning my methods of therapy, the techniques used, an estimation of the duration of your treatment, fee structure, risks and benefits of counseling, confidentiality and access to your records. I use an eclectic method of therapy, drawing primarily from Cognitive Behavioral, Client Centered and Emotion Focused theories. I consider the client's needs, background, and goals as well as their psychological, social, spiritual and biological development to determine the best course of action in counseling. You also have the right to know what other treatment options are available and the possible effectiveness of those alternatives. You may at any time seek a second opinion from another clinician and/or terminate the counseling process. I do need to be informed if you are working with more than one counselor.

4. The regulatory requirements for mental health professionals provide that a Licensed Professional Counselor must hold a Masters degree in their profession and have two years of post-masters supervision.

5. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Department of Regulatory Agencies, Division of Registrations Mental Health Boards, 1560 Broadway, Suite 1350, Denver Colorado 80202.

6. Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the clients consent. There are exceptions to this confidentiality, some of which are listed below, and in the Colorado Revised Statute 12-43-

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218. If a legal exception arises during therapy, if feasible, you will be informed accordingly. **Mental health providers are required by law to report cases of child neglect or physical/sexual abuse to County Child Protective Services. Additionally, if any individual becomes dangerous to himself/herself or others, or is incapable of caring for himself/herself, confidentiality will be broken in order to arrange for appropriate care.**

DISCLOSURE REGARDING DIVORCE AND CUSTODY LITIGATION

7. If you are involved in divorce or custody litigation, my role as a counselor is not to make recommendations to the court concerning custody or parenting issues. By signing this disclosure statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation and you agree not to request that I write any reports to the court or to your attorney making recommendations concerning custody. The court can appoint professionals who have no prior relationship with family members to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interest of the family’s children.

8. Under Colorado law, C.R.S. 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children unless the court has restricted access to such information. If you request treatment information from me, I may provide you with a treatment summary in compliance with Colorado law and HIPAA standards.

By *signing* below, I acknowledge I have read the preceding information, understand my rights as a client and received information regarding my counselor’s credentials both in writing and verbally. I agree to counseling under these conditions.

Printed Name of Client(s)

Signature of Client(s) Date

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Client Contact Information for Messages and Written Correspondence

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. (PHI). The individual is also provided the right to request confidential communications or that a communications of PHI be made to alternative means, such as sending correspondence to the individual's office instead of the individual's home.

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

- Home Telephone # _____
 - OK to leave a message with detailed information
 - OK to leave a message with other family members

- Cell Phone # _____
 - OK to leave a message with detailed information
 - OK to leave message with person answering

- Work Telephone # _____
 - Ok to leave a voicemail message with detailed information
 - OK to leave a message with _____

Written Communication

- OK to mail to my home address
- OK to email me at _____
- OK to fax to this number _____
- Other _____

Client Signature

Printed Name

Date

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| CLIENT INFORMATION (For All Clients) | | | | |
|---|--|---|--|------------|
| Client Name (First, Middle Initial, Last) | | <input type="checkbox"/> Single <input type="checkbox"/> Married | <input type="checkbox"/> Male <input type="checkbox"/> Female | Birth Date |
| Street Address | | City, State, Zip | | |
| Home Phone | Work Phone | Cell Phone | Email | |
| Occupation | Employer or School | | Primary Care Physician | |
| Who referred you to this practice | Have you seen our website? <input type="checkbox"/> Yes <input type="checkbox"/> No | | General Health Status | |
| Any previous counseling? With whom? | | | | |
| List all medications | | | | |

| | | | | |
|-------------------------|------------|------------------------|--|--|
| Emergency Contact | | Relationship to Client | | |
| Home Phone | Work Phone | Cell Phone | | |
| Responsible for Payment | Home Phone | Cell Phone | | |
| Street Address | | City, State, Zip | | |

| IF MARRIED | | |
|---|--------------------|------------|
| Spouse's Name (First, Middle Initial, Last) | Birth Date | Cell Phone |
| Occupation | Employer or School | Work Phone |

| IF A MINOR | | |
|--|------------|------------------|
| Mother's Name | Occupation | Employer |
| Street Address | | City, State, Zip |
| Home Phone | Work Phone | Cell Phone |
| Father's Name | Occupation | Employer |
| Street Address | | City, State, Zip |
| Home Phone | Work Phone | Cell Phone |
| Siblings (first and last names and ages) | | |

| | |
|--|--|
| The above information is true to the best of my knowledge. | |
| <hr/> Patient/Guardian Signature | |

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CREDIT CARD AUTHORIZATION

Name on Card (cardholder)

Billing address for card



(circle one)

Credit Card Number _____ - _____ - _____ - _____

Exp. _____ - _____ 3-digit security code _____

- I understand that the above card will automatically be charged for a missed appointment, or an appointment not cancelled **48 hours** in advance.
- I authorize Redwood Counseling Services LLC to continue to charge counseling services to this card.
- I understand that I may revoke this authorization at any time by written notification to Redwood Counseling Services LLC. This authorization will be in effect until the card's expiration date or until revoked by the cardholder, whichever comes first.
- I certify that I am the authorized signer for this card.

Signed,

Cardholder signature

Date

Phone number

Client Name

Relationship to cardholder
(self, child, spouse, friend)

Fee

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REDWOOD
Counseling Services
Scheduling and Payment Policies

Please read the following and initial each item:

- ___ 1. Standard counseling sessions are 50 minutes. Appointments can be made in session or by calling Kris Cameron at 303-351-5153. Ms. Cameron utilizes email to schedule appointments: kcameron@redwoodcounselingservices.com
- ___ 2. Payment is due at the beginning of your counseling session.
- ___ 3. Ms. Cameron's fee is **\$105** per session paid by cash, check or charge. Longer sessions may be possible and they will be charged on a prorated basis of the normal hourly fee. There will be a \$25.00 charge for returned checks.
- ___ 4. Redwood Counseling Services will maintain a credit card number to be used for payment (if you wish) or to be used to charge for a late cancellation/missed appointment.
- ___ 5. The full session fee is charged for missed appointments and cancellations not made **48 hours in advance**. Third parties will not be charged for the client's late cancellation or for not showing. Exceptions to this will be in case of severe weather, illness, or auto accident.
- ___ 6. Ms. Cameron is out of network for insurance companies; therefore, it is the client's responsibility to file with their insurance company for reimbursement. Redwood Counseling Services can provide paperwork for the client to use in submitting to insurance companies.
- ___ 7. Fees for auxiliary services are pro-rated and charged at the regular hourly rate. This includes (but not limited to) written reports, insurance correspondence, phone calls exceeding 10 minutes, and court appearances (including travel).
- ___ 8. Your counseling file will be closed if there is no contact for more than 45 days. You are always welcome to return at any time.

Client Signature

Date

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Telephone Contact Information Policy

- * Charges for telephone calls exceeding 10 minutes will be prorated based on the hourly counseling fee.
- * You may leave a message on Ms. Cameron's confidential business voicemail at 303- 351- 5153 x102. She will seek to return calls within 24 hours on business days.
- * If it is necessary to speak with Ms. Cameron on the day you call, please leave a message on her voicemail expressing that need. She will call you at the earliest time possible, which may be at the end of the business day.
- * If you are experiencing a life-threatening emergency, leave a message on her confidential 24-hour voicemail. She will return your call at his earliest convenience (which may be delayed if she is with clients). Unless otherwise previously arranged with her in your treatment plan, please use this number only for situations of an urgent nature.
 - Uncontrolled anxiety or panic attack
 - Escalating conflict that may lead to violent behavior.
 - Notification of police department.
 - Suicidal thoughts or plan.
 - Runaway
 - Symptoms preventing normal functioning.
 - Accidents involving physical injury.

***If you are experiencing a life-threatening emergency and Ms. Cameron cannot be reached, go to your nearest hospital emergency room and call her number from there.**

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Consent for Videoconferencing via Skype

Kristine Cameron MA, NCC, LPC, offers patients in the state of Colorado the ability to communicate via the videoconferencing platform, Skype, if, the arrangement is agreed to by both parties.

Ms. Cameron cannot and does not guarantee the privacy or security of any session content being sent over the internet. There is potential that videoconferencing sessions via Skype can be intercepted and reviewed by others, and it is possible that there could be disruptions to therapy due to technological difficulties. I understand that communicating via the internet is not 100% secure.

Public parts of your Skype profile can be seen by everyone else on Skype. Do not put details in your profile that you do not want to be publicly available. Skype may disclose personal information to respond to legal requirements, to protect Skype's interests, to enforce their policies or to protect anyone's rights, property or safety. For more information about Skype security and privacy, please see: <http://www.skype.com/en/security/>

Insurance companies typically do not provide reimbursement for Skype therapy sessions. Ms. Cameron will not provide you with documentation or a procedure code to seek reimbursement from insurance companies for Skype sessions. You will be responsible for the cost of Skype sessions.

Agreement

Patients who are experiencing suicidal ideation may not be ideal candidates for Skype sessions. I understand that if Ms. Cameron thinks I would be better served by another form of psychotherapy services (e.g., face-to-face, in person sessions), even if Skype therapy has already begun, she will either refer me to participate in face-to-face sessions with her, or another therapist who can provide such services in my area. If I am in a crisis, emergency, or I am considering seriously harming myself or others, I agree that I will dial 911 or go to the hospital. I have been informed of and understand the risks and procedures involved with using the videoconferencing technology, Skype.

I agree to the terms listed above and I hereby voluntarily consent to the use of Skype for therapy sessions with my provider. I agree that Kristine Cameron MA, NCC, LPC should not be held liable in the event that any outside party passes Skype's security and discovers personal or confidential information.

Client Name: _____ Date of Birth: _____

Skype Name: _____

Signature of Client: _____ Date: _____

Signature of Provider: _____ Date: _____

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Marital & Pre-Marital Therapy Contract

Please read the following statements regarding Redwood Counseling Services Marital Therapy.

1. Couples Therapy starts with an assessment of the relationship past and present.
2. The clients understand the information discussed in couple's therapy is for therapeutic purposes and is not intended for use in any legal proceedings involving partners.
3. The clients agree not to subpoena the therapist to testify for or against either party or to provide records in a court action.
4. By entering couples therapy, the clients understand that working toward change may involve experiencing difficult and intense feelings, some of which may be painful, to reach our goals.
5. The clients accept that such changes can have both negative and positive effects and agree to clarify and evaluate potential effects of changes before we undertake them.
6. There will be times when the therapist may appear on either person's side but is in reality on the side of the marriage.
7. Phone calls/emails between sessions should be used for making appointments, emergencies, or clarifying assignments only. Phone and/or email counseling cannot be provided.
8. If the relationship breaks up and either or both of the clients wish to re-contract with the counselor for individual counseling, the decision on who the counselor works with is at his/her discretion. In some situations, a referral will be made.
9. If the counselor sees either member of the couple for individual sessions or has contact between sessions with either member of the couple, the contents of those contacts will be brought up in the next session with both partners present. No secrets will be kept.
10. Since session time is limited to 50 minutes, the clients will try to be concise in presenting their thoughts and feelings.

We agree to the above guidelines.

Partner 1

Partner 2

Date

Date

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