REDWOOD
Counseling Services

INTAKE FORMS
for Clients of Aaron Eichman

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 six forms:

- Disclosure Statement
- Client Contact Information for Messages and Written Correspondence
- Client Information Sheet
- Credit Card Authorization
- Telephone Contact Information Policy
- Scheduling and Payment Policy

Couples entering couples counseling should fill out all forms above individually and jointly complete the last form:

- Couples Counseling Contract

If your child is entering into counseling with Aaron, you should complete the following two forms in addition to the forms described above.

- Parental Agreement for Confidentiality of Adolescent Sessions
- Consent for Counseling Services for Minors

If you are unable to download these forms, please contact Aaron Eichman at 303-351-5153, ext. 105, or aeichman@redwoodcounselingservices.com and arrive at least 15 minutes prior to your scheduled appointment time to complete the forms.

Thank you,
Aaron Eichman

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DISCLOSURE STATEMENTS

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 page carefully, ask about any matters that seem unclear, initial where indicated, and sign the back page of the statement. A copy will be placed in your files.

As licensed and unlicensed psychotherapists we desire to integrate sound psychological, medical, and spiritual principles in your treatment. You are entitled to receive information from any counselor concerning their methods of therapy, the techniques used, an estimation of the duration of your treatment, fee structure, risks and benefits of counseling, confidential and access to your records. 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. Counselors/clinicians need to be informed if you are working with more than one counselor.

DISCLOSURE REGARDING REGULATION OF PSYCHOTHERAPISTS

The practice of licensed and unlicensed persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The regulatory boards can be reached at 1560 Broadway, Suite 1350, Denver Colorado 80202, 303-894-7800. The regulatory requirements for mental health professionals provide that a Licensed Clinical Social Worker, a Licensed Marriage and Family therapist, and a Licensed Professional Counselor must hold a masters 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. A Licensed Social Worker must hold a master's degree in social work. A 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. A Certified Addictions Counselor I (CACI) must be a high school graduate and complete required training hours and 1000 hours of supervised experience. A CAC II must complete additional required training hours and 1000 hours of supervised experience. A CAC III must have a bachelor's degree in behavioral health, and complete additional required training and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. An unlicensed 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.

You are entitled to receive information from your counselor about the methods of therapy, the techniques used, the duration of your therapy and the fee structure. You can seek a second opinion from another counselor or terminate counseling at any time.

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.

As an unlicensed psychotherapist, Aaron Eichman is under the authority of and is regulated by the Department of Regulatory Agencies, Division of Registrations, the Board of Registered Psychotherapists. Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, 303-894-7800.

The information provided by the client during counseling sessions is legally confidential and cannot be released without the client's consent. If the information is legally confidential, the counselor cannot be forced to disclose the information without the client's consent. There are exceptions to this confidentiality, some of which are listed below, and in the Colorado Statute 12-43-218, C.R.S. 1998,: legal confidentiality does not apply in a criminal or delinquency proceeding, client-initiated court cases or grievance inquiries, providing information to insurance companies, supervision or consultation, grave disability, court order, or client's authorization to release information. 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, is threatening violence to others, or is incapable of caring for himself/herself, confidentiality will be broken to arrange for appropriate care.** If abuse/neglect is reported regarding an incompetent person, confidentiality will be broken and the situation will be reported as required by law.

DISCLOSURE REGARDING DIVORCE AND CUSTODY LITIGATION

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.

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.

DISCLOSURE REGARDING ADMINISTRATIVE MANAGEMENT OF CLIENT INFORMATION

The privacy and confidentiality of Redwood Counseling Services (RCS) patients are protected under the ethics codes of the mental health professions, state laws and regulations, and federal HIPAA regulations. While client names and bank account/credit card information may be disclosed to RCS support staff in the normal course of operations for mental health services, this information is protected by our staff in accord with those requirements. In no situation will the content of counseling sessions be disclosed to anyone other than the client's counselor.

DISCLOSURE INFORMATION REGARDING AARON EICHMAN

Aaron Eichman is an unlicensed psychotherapist in the state of Colorado.

Counseling Specialties

Adolescent	Families	Teen/parent relationships
Anger	Pre-marital	Young adults
Clergy/church issues	Communication/conflict resolution	Grief/loss
Couples/marriage	Pornography addiction	

Education

- **M.A. Counseling,** CACREP, Denver Seminary,
- **M.A. Youth and Family Ministries,** Denver Seminary, 2006
- **B.S. Horticulture,** Clemson University, 2003

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By *signing* below, I acknowledge I have read and had discussed with me the Disclosure Statements and understand my rights as a client. 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)	❒ Single ❒ Married	❒ Male ❒ Female	Birth Date
Street Address	City, State, Zip		
Home Phone	Work Phone	Cell Phone	
Occupation	Employer or School	Primary Care Physician	
Who referred you to this practice	Have you seen our website? ❒ Yes ❒ 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.

_____ _____

Patient/Guardian Signature

** Payment due at time of service**

Truth • Hope • Transformation

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CREDIT CARD AUTHORIZATION

_____
Name on Card (cardholder)

_____
Billing address for card

VISA MASTERCARD DISCOVER (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 Aaron Eichman to continue to charge counseling services to this card.
- I understand that I may revoke this authorization at any time by written notification to Aaron Eichman. 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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Aaron Eichman

Telephone Contact Information Policy

* Charges for telephone calls exceeding 10 minutes will be prorated based on the hourly counseling fee.

* Aaron Eichman is an unlicensed psychotherapist. Colorado does not require licensure.

* You may leave a message on Aaron Eichman's confidential business voicemail at 303-351-5153, ext. 105. He will seek to return calls within 24 hours on business days.

* If it is necessary to speak with Aaron Eichman on the day you call, please leave a message on his voicemail expressing that need. He 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 his confidential 24-hour voicemail. He will return your call at his earliest convenience (which may be delayed if he is with clients). Unless otherwise previously arranged with him 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 Aaron Eichman cannot be reached, go to your nearest hospital emergency room and call his emergency number from there.**

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 Aaron Eichman at 303-351-5153, ext. 105.

___2. Payment is due at the beginning of your counseling session.

___3. Aaron Eichman's fee is $90 per session. Longer sessions may be possible and 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. Aaron Eichman 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).

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Couples Counseling Contract

Please read the following statements regarding Redwood Counseling Services Couples Counseling.

1. Couples counseling starts with an assessment of the relationship past and present.
2. The clients understand the information discussed in couple's counseling 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 counseling, 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

REDWOOD Counseling Services

PARENTAL AGREEMENT FOR CONFIDENTIALITY OF ADOLESCENT SESSIONS

Dear Parent or Guardian,

A young person is more likely to disclose sensitive information to a counselor if he or she is provided with confidential services and has time alone with the counselor to discuss his or her issues. The most practical reason for clinicians to grant confidentiality to an adolescent client is to facilitate accurate and appropriate treatment.

Experienced clinicians recognize that candid and complete information can be gathered only by speaking with the adolescent patient alone and by clarifying with whom the information will be shared. If an assurance of confidentiality is not extended, this may create an obstacle to the safe environment of the counseling relationship.

Some areas of teenage health that we may talk about during the appointment are:

- Diet, exercise, and body image
- Fighting, danger, and violence
- Sexuality and sexual behavior
- Safety and driving
- Smoking, drugs, and alcohol
- Working/jJobs
- Depression and stress
- Peer pressure and school
- Relationships
- Family life

I encourage teenagers to share information about their emotional and mental health with their parents or guardians. However, there will be some things that your teenage son or daughter would rather talk about exclusively with a counselor.

Work with an adolescent is generally more productive if parents voluntarily agree to not request information about the adolescent's private session. I ask your permission to keep what is discussed in our sessions confidential. "Confidential" means I will only share information with you if your teenage son or daughter says it's permissible to do so. The counselor agrees to share with the parent(s) any information which is necessary for the safety of the adolescent.

I agree that the therapist will determine what information, in his professional judgment, is appropriate to be shared with the parent/guardian(s) concerning treatment issues, and what information, in the discretion of the therapist, will remain confidential between my adolescent child and the therapist.

_____ _____

Parental/Guardian Agreement Date

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CONSENT FOR COUNSELING SERVICES TO MINORS

In order for minor children/adolescents to receive psychological services, it is necessary for the parent or legal guardian to grant permission for such services to occur.

Names and date of birth of child(ren) to receive psychological services:

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name of person requesting services _____

Your relationship to child(ren): Parent Stepparent Guardian Grandparent Other

Are you legal parent or custodian to above-named children? Yes No

I hereby swear that I have legal right to obtain treatment for the above-named children: Yes No

In instances of divorce, it is essential that the legal custodian of the child(ren) grant permission for the services. If you are a divorced parent, a stepparent, a grandparent, a guardian, or other, you may be asked to provide a copy of the court order which names you the legal custodian of the above children. Are you willing to do so? Yes No

If the answer to any of the above questions is "No," counseling services can not be provided to the above-named child(ren) until a copy of the court order which names you the legal custodian is provided to this office.

I acknowledge that both natural parents, even though divorced, may have a right to obtain from the provider named below information regarding the nature and course of treatment of the child(ren).

- Colorado State law mandates the reporting of certain types of child abuse, including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional and psychological abuse. All actual or suspected acts of child abuse will need to be reported to the appropriate agency.

- This treatment may also include referral to other appropriate State and County agencies for further counseling.

I, _____, consent to Aaron Eichman providing psychological services to the child(ren) named above.

_____ _____

Signature of person authorizing consent Date