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 all 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
- DOXY.ME Policy (Tele-health counseling)

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

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
(CONTINUED ON NEXT PAGE)

this confidentiality, some of which are listed below, and in the Colorado Revised Statute 12-43-218. 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
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) clients are protected under the ethics cods of 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.

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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

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

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	Email
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

REDWOOD Counseling Services

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 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

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

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 her 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.**

Consent for Tele-Health Conferencing via Doxy.Me

Kristine Cameron MA, NCC, LPC, offers patients in the state of Colorado the ability to communicate via the Tele-Health conferencing platform, Doxy.Me, if, the arrangement is agreed to by both parties.

1. I understand that my health care provider wishes me to engage in a telehealth consultation.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE TELEHEALTH BY DOXY.ME

Telehealth by Doxy.me is the technology service we will use to conduct telehealth videoconferencing appointments. By signing this document, I acknowledge:

1. Telehealth by Doxy.me is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither Doxy.me nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by Doxy.me Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by Doxy.me Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by Doxy.me Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY Signing BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

____

Printed Name and Signature Date

Redwood Counseling Services •7851 S. Elati, Ste. 203, Littleton CO 80120 • 303-351-5153