

Woodland Counseling Center, LLC

Jamie Andersen
Licensed Marriage and Family Therapist

P.O. Box 625
321 West Henrietta Ave #B
Woodland Park, CO 80866-0625
(719) 360-0802 Fax (719) 687-4801

Client Intake Questionnaire

In order to provide the best clinical service to you please provide information to the questions listed below to the best of your ability.

Client Name:	Date:	
DOB:	Age:	Social Security #:
Mailing Address:		
Physical Address:		
Home Phone:	Cell:	Email:
Employer / School:		
Preferred Method of Contact: <input type="checkbox"/> Call Home <input type="checkbox"/> Text Cell <input type="checkbox"/> Call Cell <input type="checkbox"/> Email		
Appointment Reminders: <input type="checkbox"/> Call Home <input type="checkbox"/> Text Cell <input type="checkbox"/> Call Cell		
Do we have your permission to bill you using the email address listed above? <input type="checkbox"/> Okay <input type="checkbox"/> Not Okay		
Emergency Contact Name:	Phone:	
Insurance Carrier:	Member #:	
Name of Primary Person Responsible for Insurance:		
Primary Person's Date of Birth:	Social Security #:	
Primary Person's Employer:		
Client's Religious / Spiritual Background:		
Referred By:		
Reason for Referral:		
What goals / outcomes would you like to see as a result of participating in therapy:		

Family Members in the Home		
Name	Age	Relationship to the Client

Major Accidents, Illnesses, Head Injuries and Seizures:

Current Medical Problems:

Current Medications:

How often do you drink wine or alcohol?

Please list any other current substances you are using:

Last Physical / Results:

Name of Primary Care Provider:

Do you give permission to coordinate your care with primary care provider? Yes No

- Are You Experiencing Any of the Following:
- | | |
|--|--|
| <input type="checkbox"/> Nervousness / Shakiness | <input type="checkbox"/> Feeling Everything is an Effort |
| <input type="checkbox"/> Feeling Sad or Blue | <input type="checkbox"/> Feeling Fearful or Afraid |
| <input type="checkbox"/> Feeling Hopeless | <input type="checkbox"/> Difficulty at Home |
| <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Difficulty at Work or School |
| <input type="checkbox"/> Decreased Appetite | <input type="checkbox"/> Physical Pain |

Family History

Mental Health Problems:

Attention Problems:

Substance Abuse:

Legal History:

School / Employment History:

Have you ever served in the Armed Forces? Yes No

If Yes, what branch? _____ Year: _____

History of Abuse (Emotional, Physical, Sexual, Verbal & Domestic Violence):

Individual and Family Strengths:

Pregnancy / Developmental / Medical History: (Skip if you are an adult seeking therapy for yourself)

Problems with Pregnancy, Delivery:

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Early Development (Age Crawling, Walking, Potty Trained and Speaking) List Any Delays:

Discipline used with children:

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Disclosure Statement

Colorado law requires that all psychotherapists provide certain information to all clients at the initial consultation.

Name: Jamie Andersen, M.A.

Credentials: Master of Arts in Psychology with an emphasis in Marriage Family and Child Counseling, Chapman University, Orange, California, 1997; Bachelor of Science in Psychology, Florida State University, Tallahassee, Florida, 1993. Colorado State License as a Marriage and Family Therapist #555.

Professional Affiliations: Member of the Colorado Association for Marriage and Family Therapists (CAMFT) Clinical Member of the American Association for Marriage and Family Therapists (AAMFT).

Regulation of Psychotherapists:

The practice of licensed or registered 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, CO 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 Masters 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 Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1,000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a Bachelors degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical Masters degree and meet the CAC III requirements. A Registered Psychotherapist is 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.

Client Rights and Important Information:

- You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy, and my fee. Please ask if you would like to receive this information.
- You can 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 board that licenses, certifies or registers the therapist.
- Generally speaking, information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and the therapist cannot disclose the information without the client's consent. There are several exceptions to confidentiality which include: (1) I am required to report any suspected incident of child abuse or neglect and suspected elder abuse to law enforcement; (2) I am required to report any threat of imminent psychical harm by a client to law enforcement and to the person(s) threatened. (3) I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental disorder; (4) I am required to report any suspected threat to national security to federal officials; and (5) I may be required by Court Order to disclose treatment information.
- 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 Divorce and Custody Litigation:

If you are involved in divorce or custody litigation, my role as a therapist 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 interests of the family's children.

I have read the preceding information, and it has been presented to me verbally. I understand the disclosures that have been made to me. I also acknowledge that I have received a copy of this Disclosure Statement.

Client Signature or Responsible Party

Date

Client Signature or Responsible Party

Date

If signed by Responsible Party, identify that person's legal authority to consent to treatment: _____

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Disclosure and Information Statement

HIPAA - Patient Privacy Practices

Jamie Andersen has made every effort to be compliant with the Protected Health Information (PHI) requirement set forth in the Health Insurance Portability and Accounting Act (HIPAA) of 1996. You have received a separate document entitled Notice of Privacy Rights. By signing this information sheet you acknowledge that you have been provided a copy of Jamie Andersen's Notice of Privacy Rights.

Practice Information

Billing Rates:

Individual / Couples / Family Therapy: \$120.00 per 45 - 50 minute session.

Note: If you are making cash payment on the date of your session, you will be billed at the discounted rate of \$80.00 per 45 - 50 minute session.

Sliding Fee Scale: A Sliding Fee Scale may be an option based on different factors including your household income and number of children in your care. Please ask for further information if needed.

Letters / Reports: If you request that a letter or report be prepared for you, you will be charged the proportionate rate of \$100.00 per hour. These charges are not billable to your insurance.

Visa / Mastercard Payments are accepted.

Waiting: Please wait in the waiting room area. Feel free to let your children play with the toys in the waiting area.

Insurance

In the event that Jamie Andersen is a contracted provider with your insurance, then Jamie Andersen has agreed to accept their managed care rates and will provide billing services for your convenience. Required insurance forms will be provided at no cost to you. However, you are responsible for your co-payment at each session. In the event that your insurance declines payment of services you have received, you will be responsible for payment. It is your responsibility to contact your insurance to determine if prior authorization is needed.

Outstanding Balances: I understand that Jamie Andersen reserves the right to send my account information to a collection agency in the event that my outstanding balance is more than 4 months old. _____(Initial)

Medicaid: My signature below certifies that I am not insured through the Medicaid Program. I understand that Jamie Andersen does not accept Medicaid. In the event that I become a Medicaid recipient, I understand that due to Medicaid rules, Jamie Andersen will not be able to continue as my therapist. I agree to inform Jamie Andersen if I become insured through Medicaid.

I have read the proceeding information and understand my rights.

Client Signature

Date

Parent or Guardian if a Minor

Client Signature

Date

Parent or Guardian if a Minor