Please fill out and sign in 2 places, page 5 and 6.

Confidential Client Information:

Name_____ Date:_____

Address:_____
Street City Zip

Child's Name (if client):_____DOB_____

Type of Counseling: Individual Couple Family Other_____
describe

Phone(s):(H)_____(W)_____(C)_____

Please circle the phone # where messages can be left. ***Texting? Yes or No***

E-mail(s):_____***OK to send general email messages***?_____

Sex: ___ Male___Female Social Security #:_____DOB:_____

How did you find SDP? _____May we acknowledge the person doing the referring? (not required)_____. If yes, phone number of referring person/agency. _____

Employer:_____Occupation:_____

Employer's Address:_____

Religion:_____ Level of involvement: High____ Medium_____Low_____

Relationship Status:

____Single ____Married ____Separated ____Divorced____ Widowed____Coupled.

Relationship composition: ____Male/Female____Male/Male____Female/Female

Name of Spouse or partner:_____ Work Phone:_____

Address:_____Phone:_____

Family of origin / immediate family members (children, siblings, etc, living with you or not):

Name Age Relationship Live with you?

_____

_____

_____

_____

_____

_____

Which child in family order were you in your family of origin? (1st, 2nd, etc) _____

Number of children in your original family_____ Parents living at home_____

Other significant family (step parents, siblings etc):_____

_____

_____

Have you ever consulted a therapist before? Yes _____ No_____ If yes, when?

_____For how long?_____

Briefly state the reason(s) you sought counseling in the past?_____

_____

_____

Do you think that, either now or in the past you have had an addiction to anything?

Yes_____No_____ If yes, what?_____

Have you ever seriously considered or attempted suicide? Yes_____ No _____

When?_____

Are you now taking any medications? Yes _____ No _____ If yes, please list medications, dosages and for what problem._____

_____

Medications taken in the past five years but now discontinued? Please list medications, dosages, and for what problem._____

_____

Please describe any current or past experiences with abuse (physical, emotional, sexual):_____

_____

_____

Any major medical issues affecting your current mental health? Describe._____

_____

Your Physician:_____ Phone:_____

Physician Address:_____

Briefly describe why you are seeking counseling now. _____

_____

_____

_____

_____

_____

_____

In case of emergency, contact: _____

Phone:_____Address:_____

Disclosure Statement

Therapist name:	Pamela Kennel, LPC, MA
Business address:	2305 E. Arapahoe Road, Centennial, CO 80121
Business phone number:	303-730-1144
Degrees & Credentials:	M.A. Counseling at Regis University
	B.A. Psychology at Metropolitan State College
	Licensed Professional Counselor; CO # 5737
	Certificate in Marriage & Family Therapy; Denver Family Institute

Colorado State Law requires that I provide you with the following information:

The practice of licensed and unlicensed psychotherapists is regulated by the Colorado Department of Regulatory Agencies. The address and phone number of the Grievance Board is 1560 Broadway, Suite 1340, Denver, CO, 80202; telephone , 303-894-7766.

You are entitled to receive information about the methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure. You may seek a second opinion from another therapist or may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the grievance board.

The information provided by the client during therapy session is legally confidential except for certain legal exceptions which include: 1) I am required to report suspected child abuse or neglect; 2) If I receive information from a client concerning a serious threat in imminent physical violence against a specific person, I must inform that person of the threat and notify law enforcement authorities; 3) I am required to initiate a mental health evaluation of a client who is dangerous to self or others due to mental disorder; 4) specific authorization from the client; 5) consultation with another professional; 6) defense of lawsuit or grievance; 7) third party payment, 8) specific order of the court, and 9) the knowledge of service rendered if it becomes necessary to collect fees through a collection agency.

I may consult with a colleague for peer consultation or obtain supervision. Supervisors and colleagues are subject to the same confidentiality laws described above.

If you are a couple or in any relationship counseling, please be aware that I have a no secrets policy. My client in these cases will be each of you individually and the relationship. My assumption will always be that each of you are trying repair the relationship, as such, secrets do harm to the trust necessary for a strong foundation.

During the usual course of business, I use facsimile machines and cellular phones when required. They are not encrypted and confidentiality can not be guaranteed though no one has authorized access to either.

My psychotherapy practice is not able to handle 24 hour contact and/or emergencies. Any personal emergency should be directed to emergency personnel such as the services provided by calling 911, the police, the fire department, a hospital, or your county mental health department.

Counseling Agreement

Welcome to South Denver Psychotherapy, LLC. Your therapist is Pamela Kennel, LPC. Signing below *does not* bind you to therapy; it *does* make you responsible for all charges incurred prior to therapy termination. The following are my fees and policies.

Fees: $90 per 50 minutes for individual, couple or family therapy, in person or by phone.
$50 per hour for group therapy. $135 for 75 Minutes.
$200 per hour for court appearances, including travel time, plus travel expenses, lodging, and meal reimbursement.
Costs of any assessment tools, as disclosed before being used.

Policies: Payment due at the time of service; cash, check, or online credit card payment.
Cancellation : Full fee with less than 24 hour notice
Returned check fee: $30.

Insurance: There is no guarantee that your insurance will reimburse you for your counseling. The therapist will provide a statement of services for the client to submit to their insurance company. It is expected that the client will pay the full amount of the fees and receive reimbursement directly from the insurance company. Please be advised that confidentially is difficult to maintain with third party payment.

Collections: Unpaid fees will be turned over to a collection agency.

I have read all of the above information including the disclosure. I understand its content and significance and have received a copy.

_____

Client signature (and parent signature for a minor) **date**

_____

Client signature (and parent signature for a minor) **date**

_____

Pamela Kennel, Therapist **date**

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Please print or read "Privacy Practices" before signing.

NAME _____ Date _____

By signing this form, you acknowledge that this office has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. All clients receiving services on or after April 14, 2003 will be asked to sign this form.

If your first date of service with us is on an emergency basis, or if unforeseen circumstances prohibit acknowledgement, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as possible after admission.

By my signature below I acknowledge that I have received a copy of this office's PRIVACY NOTICE regarding confidential health information, and have been given an opportunity to discuss my concerns and questions.

_____

Signature of Client or Legal **Date**

Therapist complete below if Acknowledgement of Receipt of Privacy Notice form is not signed:

1. Does the client have a copy of the Privacy Notice? ____Yes ____ No

2. Please explain why the client (or his / her legal representative) was unable to sign an acknowledgement form and the therapist's efforts in trying to obtain the client's signature:

_____

Therapist Date