

Client Registration

Date _____

Patient Information

Name _____ Home Phone _____

Address _____
Street City State Zip

Birthdate _____ Age _____

Place of Work _____ Work Phone _____ Cell _____

Email (optional) _____ Gives permission to send appointment reminders, notices of new therapy groups and learning opportunities, or for homework assignments and session notes. *Your email address will NEVER be shared.*

Spouse/Partner Information

Name _____ Home Phone _____

Place of Work _____ Work Phone _____ Cell _____

Are you married? _____ For how long? _____ Have you been divorced? _____ How many times? _____

List names of children in the family, their ages and who they live with if other than parents. Also list others who live in the home.

Have you experienced any deaths of family members or others close to you in the past three years? Briefly describe.

Primary Care Physician _____ Last time seen _____

List any medications you are presently taking _____

Have you been hospitalized in the last four years? _____ If yes please describe reason and date of hospitalization.

Have you gained or lost more than 5 pounds in last six months? _____ Do you smoke? _____ How many packs per day? _____ How much alcohol do you consume on a daily basis? _____

On a weekly basis? _____ Do you consider yourself an alcoholic? _____

How many cups of coffee do you drink on a daily basis? _____ Have you ever used illegal drugs? _____

How many jobs have you held in the past 5 years? _____ Have you ever been suicidal? _____

If you have been to counseling before briefly describe when, who the counselor was and the reason for counseling.

How did you learn of my services?

May I send a verbal or written thank you to this individual or organization?

Have you ever felt you ought to cut down on your drinking or drug use?

Yes No

Have people annoyed you by criticizing your drinking or drug use?

Yes No

Have you ever felt bad or guilty about your drinking or drug use?

Yes No

Have you ever had a drink or used drugs first thing in the morning as an eye opener to steady your nerves or get rid of a hangover?

Yes No

Patricia Lee, LLC

Licensed Professional Counselor, Colorado License 587

1633 Medical Center Point, Suite 253 • Colorado Springs, CO 80907 • (719) 268-6882

Your Rights as a Client

The practice of both licensed and unlicensed persons in the field of psychotherapy including psychological testing is regulated by the Colorado State Department of Regulatory Agencies. Any questions, concerns or complaints regarding the practice of mental health counseling may be directed to the State Grievance Board, 1560 Broadway, Suite 1340, Denver, CO 80202; (303) 894-7766.

You are entitled to receive information from me about my methods of therapy, techniques I use, duration of therapy, if I can determine it, and my fee structure. Please ask if you would like to receive this information. You may seek a second opinion from another therapist or may terminate therapy at any time.

You should know that in a professional relationship, sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the State Grievance Board.

Information provided by a client during therapy sessions is legally confidential except for certain legal exceptions which include: 1) I am required to report suspected child abuse or neglect to the appropriate law enforcement agency; 2) If I receive information from a client concerning a serious threat of imminent physical violence against a specific person, I must inform that person of the threat, and also 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 a mental disorder. You should be aware that legal confidentiality does not apply in a criminal or delinquency proceeding. You should also be aware that confidentiality does not apply if I become aware that you are physically or sexually abusing another individual, that you plan to hurt yourself or someone else or that you plan to commit suicide.

I am licensed to practice psychotherapy in the state of Colorado as a Licensed Professional Counselor, Colorado License #587. I have a Master of Education Degree in Learning Disabilities from Trenton State College (1975) and a Master of Arts Degree in Counseling and Human Services from the University of Colorado (1989). You should be aware that it is usual and customary for mental health professionals to seek peer consultation on cases and this is done in a manner that protects the confidentiality of the client. You should be aware that when you sign your request for reimbursement from your insurance company that you give permission for them to obtain information about your diagnosis and the progress of your therapy. In addition, you should understand that if either one of us uses cellular or portable telephones (I use both from time to time), information transmitted by one or both of us may be intercepted by a third party.

Also, you authorize with your signature below that in the event of my death or grave disability, one or more of my selected colleagues may review confidential information I have collected about you or your child in order to advise you of options for the continuity of treatment.

I have been informed of my counselor’s degrees, credentials and licenses. I have also read the preceding information and understand my rights as a client.

Client Signature (Parent or guardian for minor)

Date

Patricia A. Lee

Date

Patricia Lee, LLC
Licensed Professional Counselor
1633 Medical Center Point, Suite 253 Colorado Springs, CO 80907 (719) 268-6882

FEE AGREEMENT

My standard fees for office visits and telephone sessions are \$125 for a full session (50 minutes) and \$65 for a short session (25 minutes). Payment is due at the time of service by cash, check or charge. If you pay by check please have your check written in advance to make best use of our time together. You also have the option of prepaying and receiving 4½ sessions for the price of four full sessions. Sessions purchased in advance may be transferred to another member of the same family, are non-reimbursable and must be used within three months. Charges incurred for failing to show for an appointment or for late cancellations will be deducted from pre-paid sessions. Time spent on written correspondence or a report requested by you or professionals working with you is billed by the minute based on a fee of \$150 per hour. Time spent with attorneys, court time or any written correspondence or tasks related to legal matters will be billed at \$250 per hour.

The duration of therapy is affected by the nature of your concerns and what your goals are. It is very important that you feel you are benefiting from treatment. If at any time you feel you are not getting what you want or need out of therapy, I urge you to discuss this with me so that we can find a solution for your concerns.

Appointment Cancellations: My fees are based on the time I commit to work with you in sessions. Any scheduled session not cancelled 24 hours in advance will be charged at the full established fee including pre-paid appointments.

Emergencies: I do not interrupt client sessions and business appointments to answer calls. If your needs are immediate and of a crisis nature you should do one of the following: call Cedar Springs Hospital at 633-4114; call the Pikes Peak Mental Health Crisis Center at 635-7000; visit your nearest emergency room; or call 911. If your needs can wait, call me at 719-268-6882, state that your message is urgent, and leave a number where you can be reached in the next few hours. I check my messages on a regular basis during the work day but do not check them on weekends. If you have caller ID on your phone and I am returning your call from my home you should be aware that I will not temporarily unblock my residence phone line to return your call. It is your responsibility to change your caller ID to accept a call from a blocked line. If you have caller ID and do not hear from me within a reasonable time you should use one of the emergency measures listed above. You should also be aware that calls made from cell phones and portable phones may not be secure and confidential.

Insurance and confidentiality: People who use their medical insurance or disability insurance to pay for psychotherapy waive some of their rights to confidentiality. When you use your insurance, a psychiatric diagnosis must be assigned and transmitted to your insurance company. In cases where a therapist is "in network," detailed clinical information often must be provided by the therapist and total access to patient files often must be provided to insurance company employees. So, there is no way to ensure that confidential information will be treated as private once it is transmitted to an insurance company. For example, employers sometimes are able to obtain personal information from insurance records. Finally, psychiatric diagnoses may affect your ability to obtain future health or life insurance at a reasonable cost.

For these reasons, I do not directly submit claims for my services to insurance companies and have removed myself from all insurance networks. I am happy to provide you with a simple billing statement that you may submit for "out-of-network" insurance reimbursement or for tax purposes. However, before submitting billing statements to your insurance company, I encourage you to consider the confidentiality ramifications.

Financial Contract:

I, the undersigned, understand and agree to the professional fees and attendance policy described above. If for some reason charges accrue resulting in an overdue account and attempts to resolve nonpayment are unsuccessful, any overdue account may be referred to an attorney or collection agency for collection. I understand that interest will accrue at the rate of 18 percent per year or 1 1/2 percent each month on any unpaid balance. Signature on this agreement indicates acceptance of such referral and responsibility for all costs of collection, including a reasonable attorney fee. I am ultimately responsible for all charges including those denied by my insurance provider. In the unlikely event that check funds are dishonored, I am aware that I will be charged a \$25 (or legal limit) processing fee. I agree that, in signing this Fee Agreement, I have read and fully understand the terms contained herein.

Name of Client _____

_____ Date

Signature of Responsible Party _____

Patricia Lee LLC
Licensed Professional Counselor
1633 Medical Center Point, Suite 257 Colorado Springs, CO 80907
719-268-6882

By my signature below I, _____, acknowledge that I either received a copy of the Notice of Privacy Practices for Patricia Lee LLC or read the policy at www.PatriciaLeeLLC.com/PrivacyNotice.htm.

Check all of the following that apply to your situation:

- _____ You may leave a message with anyone who answers my home phone.
- _____ You may leave a message with anyone who answers my home phone but do not divulge the message relates to counseling.
- _____ You may only leave a message with this person: _____
- _____ You may leave a message on my work voicemail.
- _____ You may leave a message with someone answering my work phone but do not divulge the message relates to counseling.
- _____ You may contact me by email at _____
- _____ You may leave a message on my cell phone # _____

Signature of Client (or personal representative)

Date

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: _____

Relationship to Client: _____

For Office Use Only

Patricia Lee LLC attempted to obtain written acknowledgement of the receipt of the Notice of Privacy Practices, but acknowledgement could not be obtained because:

- _____ Individual refused to sign
- _____ Communication barriers prohibited obtaining the acknowledgement
- _____ An emergency situation prevented obtaining acknowledgement
- _____ Other (Please specify) _____

This form will be retained in your medical record.