Counseling Colorado, PLLC
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Client Information:

Client Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Birth: _____

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____

Employer/School: _____

Employer/School Address: _____

Responsible Party:

If you are the parent or legal guardian of a client who is under the age of 18, please complete the following with your information. If you are over the age of 18, please proceed to the next section.

Name of Parent(s) or Legal Guardian(s): _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Birth: _____

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____

Employer/School: _____

Employer/School Address: _____

Emergency Contact Information:

Name: _____ Relationship to Client: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Who Were You Referred By?

Name: _____

May I contact this person to thank them? Yes: _____ No: _____

Name of Physician:

Name: _____ Phone: _____

May I contact your Physician for continuity of care? Yes: _____ No: _____

Clinical/ Psychosocial History:

Client marital status: _____

Names and ages of Immediate Family Members: _____

_____

_____

_____

Currently a Student? Yes: _____ No: _____ Current Occupation: _____

Partner's Occupation: _____

Client's spiritual/ religious involvement, interests, commitments ect._____

_____

_____

_____

Client's cultural involvement, interests, commitments ect._____

_____

_____

_____

What goals do you hope to achieve from therapy?

1) _____
2) _____
3) _____
4) _____

Medical and Psychiatric History: (Please list dates and reason why) Include major illnesses, surgeries, hospitalizations, accidents, injuries, and traumas:

_____

_____

_____

_____

_____

Current Medications: _____

_____

_____

_____

Current and or past substance abuse (include tobacco, illicit, prescribed & OTC substance:

_____

_____

_____

Allergies (include medication allergies): _____

_____

_____

Psychiatric History (List Family members, conditions, hospitalizations and diagnosis:

_____

_____

_____

Counseling History:

Have you ever consulted a therapist before? Yes: _____ No: _____

If so, when? _____

If so, how long? _____

Briefly state the reasons you sought counseling at that time?

_____

_____

_____

What was helpful in your past counseling experiences?

_____

_____

_____

Have you recently or in the past thought about suicide? Yes: _____ No: _____

If so, when? _____

Have you ever attempted suicide? Yes: _____ No: _____

If your answer is yes to either of these questions, please describe what treatment you had:

_____

_____

_____

Strengths:

How do you reduce stress?_____

_____

_____

_____

What are your strengths and the strengths of your family?_____

_____

_____

_____

Financial Agreement

Standard Service Fees:
Please review the rates for the following services. The rates listed below are based on a 50 minute clinical hour. Therapeutic sessions lasting over 50 minutes in length may be subject to additional service fees.

- Individual: $150
- Couple and Family Rate: $200
- Phone Consultations: $150/hr or $37.50 for every 15 min.
- Emergency or After-Hours Consultations: $200
- Consultation and Correspondence Rate: $150 per hour
- Group Rate: $65 per group session

If a report or consultation with an outside party is requested. I understand I will be billed for any time needed to prepare documentation or to conduct an in-person or phone consultation. My therapist's standard service fee will apply.

Policy for Non-Payment:
In the event billing efforts fail, delinquent accounts may be subject to collections. This therapist will make every attempt to develop a payment plan with any client struggling to pay a past due balance prior to sending a balance to collections.

I certify the information provided above is accurate to the best of my knowledge. I understand and agree to the proceeding Financial Agreement and Consent for Treatment. I also authorize any service fees to be deducted from the form of payment designated on this form. Should any of the information provided change, I agree to update my provider as soon as possible.

_____ _____

Signature of Client or Legal Guardian Date

Treatment Planning and Evaluation:
Since Counseling Colorado is not a 24-hour crisis-intervention agency, in case of emergency, you may call 911 or go to the nearest hospital emergency room.

Your therapist can approximate length of treatment and probable results; however, as response differs on an individual basis, guarantees cannot be made as to treatment outcome. If we cannot provide the services you need, your therapist will offer you referral information.

Periodically, client and therapist will assess progress toward treatment goals. It can be mutually beneficial if termination is discussed in advance.

As a client of Counseling Colorado, I understand that there may be times when it is necessary to communicate with my counselor outside of the office setting. Therefore, I,

_____

(Please Print Your Full Name)

Consent to communication with Counseling Colorado in the following ways:

Please initial each area where consent is given.

_____ Voicemail Home
_____ Voicemail Cell
_____ Text Message
_____ Email

I understand that these forms of communicating may not be confidential. By signing below, I give my written consent to these forms of communication.

_____ _____
Adult Signature Date

I have been given a copy of the CLIENT- THERAPIST AGREEMENT, the CLIENT INFORMATION, the MANDITORY DICLOSURE STATEMENT, and the NOTICE OF PRIVACY PRACTICES. I have read the preceding information and understand my/my child's rights as a client. I consent to treatment at Counseling Colorado. _____Client initials

_____ _____
Adult Signature Date

_____ _____
Therapist Signature Date

_____ _____
Teen Signature (ages 15-18) Date

_____ _____
Therapist Signature Date

For Families:

I attest that I am authorized to give permission for my children to have counseling at Counseling Colorado.

_____

Name(s) of Client (s) if minors

_____ _____

Parent/ Guardian Signature (of children age 14 and under) Date

_____ _____

Parent/ Guardian Signature (of children age 14 and under) Date

_____ _____

Parent/ Guardian Signature (of children age 14 and under) Date