Bonnie Mucklow
Licensed Professional Counselor
7000 E. Belleview, Ste. 203
Greenwood Village, CO 80111
720-488-3822 Fax: 303-798-3883

DX_____

CLIENT INFORMATION (Child's Information, if Client)

- Client Name_____

  Address _____

  City _____State _____Zip_____

  Home Phone ( )_____Work Phone ( ) _____

  Client Date of Birth_____Client Social Security # _____

  Email_____

- In case of emergency, you may contact:

  Name _____Phone ( ) _____Relationship _____

- Name of Insured or EAP member: _____

  Name of Insurance Company or EAP Employer _____

  Member ID# _____Group #_____

  Claims Address_____

Claims Phone # ( )_____

Date of Birth: _____

SECONDARY INSURANCE (If Any)

- Secondary Insurance (if any)_____

  Policy # _____ Group # _____

Guarantor Name _____Relationship _____

Address to send insurance claims: _____

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CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

- I voluntarily consent to participate in mental health and/or substance abuse services.
- I understand that I am responsible for payment at the time services are rendered.
- I agree to give at least 24 hours notice in the event I need to cancel an appointment. If I fail to give such notice, I understand that I am responsible for payment of that session.
- I further understand that I am liable for charges in the event of a claims denial. I agree to provide any necessary forms or documentation to assist in settling my account.
- NOTE: Copay and missed appointment charges may not be applicable for EAP clients per benefit plan. You understand that we collect a credit card number to charge your card for remaining co-pays, co-insurance or balance not covered by insurance.

  CREDIT CARD NUMBER: _____

  EXPIRATION DATE _____/_____/_____

  Security Code _____

  You may also provide the therapist with a copy of the credit card, front and back, which will be shredded after data entry.

Signature _____ Date: _____
(Adolescent 15 to 17 must sign with parent cosign)

Signature _____ Date: _____
(Parent or Guardian if a minor)

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STATEMENT OF FINANCIAL POLICY

We will be happy to file your insurance claims for you, and agree to accept your insurance company's fee schedule when processing their payment. You understand that the following conditions apply: (1) You are responsible for meeting your deductibles and/or payment of co-insurance amounts. (2) You understand that you are responsible for any portion of your bill that your insurance company does not pay. (3) Payment is expected within thirty days from receipt of billing. (4) You understand that regardless of the type of insurance coverage you may have, policies are a contract between yourself and the insurance carrier. Furthermore, you understand that services rendered are charged directly to your account and that you are ultimately responsible for payment. (5) You accept responsibility for providing us with a current valid insurance card for the purpose of identification and verification of your insurance coverage. ***(6) You are responsible for obtaining an authorization for services from your company prior to your intake appointment, if your particular insurance coverage requires an authorization and providing the authorization number to your therapist.*** (7) If your claim is denied because of lack of coverage or because your insurance company does not pay for the service rendered, you will be responsible for the entire balance on your account. (8) You will be responsible for any collection costs, including reasonable attorney fees, if the account is turned over to a collection agency. You understand that we collect a credit card number to charge your card for remaining co-pays, co-insurance or balance not covered by insurance.

CREDIT CARD NUMBER:_____

EXPIRATION DATE _____/_____/_____

Security Code _____

You may also provide the therapist with a copy of the credit card, front and back, which will be shredded after data entry.

We accept cash, personal checks, MasterCard of Visa. In the event that your check is returned to us for any reason, there will be a $15.00 service charge added to your account and you will be responsible for paying the service charge in addition to the original amount of the check.

COPAYS

All co-pays are due at the time of treatment. It is the responsibility of the patient to know the amount of their co-pay. If the patient is unable to pay at the time of treatment, other arrangements must be made.

CANCELLATION NOTICE

There must be a 24-hour notice to cancel an appointment. There will be a $65.00 charge to the patient for any missed appointment without notification. This charge will be billed directly to the patient and not to the insurance company.

_____

Date Signature

CLIENT AGREEMENT FOR THERAPY AT INTAKE

Client's Name _____ Date: _____

Social Security Number: _____
Please answer each question. On questions with circles, please fill in the circle that best describes your answer.
Do not leave any blank. Completely blacken the appropriate circle: Like this: O Not like this: O O O
Please use the back of this page if you need additional space to answer any question.

1. What was the PROBLEM(S) that motivated you to seek therapy?

2. What were your GOALS for therapy? What did you want to change through therapy?

3. On a scale of 1 to 10, where does your problem(s) fall?

	1	2	3	4	5	6	7	8	9	10
Problem(s) at its worst:	O	O	O	O	O	O	O	O	O	O

4 a) Of the following EXPECTATIONS for therapy, which are most important for you?

	Importance: None	Minor	Major
• Non-judgmental listening and understanding	O	O	O
• Help focusing on goals to resolve the problem	O	O	O
• Active guidance, and suggestions on steps to take	O	O	O
• Reminders of past successes and personal strengths	O	O	O
• Resources (like books, groups, etc.,) that helped deal with the problem	O	O	O
• Validation of my feelings and a sense of caring	O	O	O
• Homework assignments to practice between sessions	O	O	O
• A different way of seeing myself and my situation	O	O	O
• Referral to a Psychiatrist for medication	O	O	O
• Other	O	O	O

b) How many sessions do you think you will need to work through your problem(s)_____
c) Have you ever been hospitalized for psychiatric or chemical dependency problems? O Yes O No

5. At this time, how much do you agree with the following statements?

	Completely Disagree		Partly Agree		Completely Agree
• I am feeling good about myself, contented with positive self-esteem	O	O	O	O	O
• I am thinking clearly, able to concentrate, remember, and make decisions	O	O	O	O	O
• I have good health, few illnesses, energy, and few physical problems	O	O	O	O	O
• I am doing well at my job/school/home	O	O	O	O	O
• I am getting along with loved ones, friends, co-workers	O	O	O	O	O
• I am able to handle stress and relax	O	O	O	O	O
• I am not abusing alcohol or drugs	O	O	O	O	O

After reviewing this information, I agree with the problem(s) definition, goals and expectations:

✍ Signature of client: _____ Date: _____

✍ Signature of therapist _____ Date: _____

MEDICAL HISTORY QUESTIONNAIRE P1

I. MEDICAL HISTORY:

YES	NO	Please check (✓) YES or NO for each item. If YES, furnish details, including date and name of doctor.
		1. During the last 5 years, have you:
YES	NO	A. Been treated for any medical condition or surgical condition? (specify)
YES	NO	B. Had an X-Ray, EKG, or laboratory test? (specify)
YES	NO	C. Been advised to have an operation? (specify)
		D. Date of last physical exam:_____by Dr._____
YES	NO	2. During the last 5 years, have you taken any prescription or non-prescription MEDICATIONS?
		Medication: Dosage Date started Date ended Prescribing MD:
YES	NO	3. Do you have any ALLERGIES to medications, food, or other? (specify)
YES	NO	4. Have you had any HOSPITALIZATIONS (medical or psychiatric)?
		Year of Hospitalization(s): Hospital name Reason for Hospitalization Length of Stay
YES	NO	5. Do you drink CAFFEINE products (coffee, tea, soda)? How much?
YES	NO	6. Do you SMOKE? How much?
YES	NO	7. Do you drink ALCOHOL? How much and how often?
YES	NO	8. Except as prescribed by an M.D., have you taken any of the following DRUGS? (please indicate date of last use and typical amount)
		❑ heroin ❑ morphine ❑ sedatives ❑ other narcotics
		❑ cocaine ❑ tranquilizers ❑ LSD, hallucinogens ❑ amphetamines
		❑ marijuana ❑ barbiturates ❑ other drugs

II. FAMILY HISTORY INFORMATION:

	Living? (Y or N)	Age or Age at Death	History of Emotional Problem?	History of Medical Problem?	Describe Emotional Problem, Medical Problem, Cause of Death if noted
Father	Y N		Y N	Y N	
Mother	Y N		Y N	Y N	
Sister(s)	Y N		Y N	Y N	
Brother(s)	Y N		Y N	Y N	

CLIENT NAME: _____ **DATE:** _____

Social Security Number: _____

MEDICAL HISTORY QUESTIONNAIRE P2

III. REVIEW OF SYMPTOMS

Never Had	Have Now	Had in Past	Symptom	Never Had	Have Now	Had in Past	Symptom
			sleep disturbance				tuberculosis
			dizziness or fainting				heart trouble / heart attack
			palpitations or pounding heart				high blood pressure
			shortness of breath				kidney disease
			chronic fatigue				stroke
			stomach pains				jaundice / liver disease
			chronic pain				arthritis / gout / rheumatism
			headaches (severe or often)				AIDS / HIV positive
			eating too much/too little				hypoglycermia
			tremor or shakiness				tumor / cancer
			indigestion, nausea, gas				rheumatic fever
			constipation, diarrhea, colitius				venereal disease
			recent weight ❑ gain/ ❑ loss				diabetes
							anemia
			nosebleeds				paralysis
			unusual bleeding				epilepsy / seizures
			eye problem/ glaucoma				neurological disease / neuritis
			hearing problem / earaches				lupus
			head injury				ulcer
			thyroid trouble (too low / high)				multiple schlerosis
			asthma				urination, painful or frequent
			chronic cough				stomach / bowel disease
			FEMALES: treated for any OB/GYN disorder or change in menstrual patterns?				
			FEMALES: currently pregnant or planning a pregnancy in the near future?				
			MALES: prostate trouble				

• please list any other disease or condition you may have that is not listed above:

• Please provide information related to "yes" answers above, such as: date(s) of occurrence, duration, and name of doctor who treated you:

Your medical history questionnaire will be reviewed by your therapist and by a psychiatrist if a referral is made. If your therapist, or psychiatrist is concerned that physical medical problems are partially causing your mental heath problems, or that you may have a physical illness that demands immediate treatment, you will be referred to your primary care physician for further diagnosis and treatment.

You are responsible for attending to your own medical conditions and following up on any recommendations made. Your provider's recommendations will be based on the information supplied by you on your questionnaire only, as of this date. Other information not supplied may significantly alter recommendations made for follow-up referrals.

I have read and understand this statement regarding my responsibilities and the limitations of follow-up referrals made upon the information I have supplied.

_____

Signature of Client (or Parent/Legal Guardian if client is a minor or incapacitated) Date

Social Security Number of Client: _____

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FINANCIAL DISCLOSURE

The professional service of psychotherapy is a reimbursed service for face-to-face and telephone consultation. As a client of Bonnie Mucklow, you understand:

1. You will be billed $65.00 for not giving a minimum of 24 hours notification of cancellation. This outstanding balance must be paid prior to additional psychotherapy services being delivered.

2. All telephone consultation exceeding five minutes duration regarding your clinical situation will be billed to you at a rate of $2.00 per minute. These telephone consultations include any calls between you and Bonnie Mucklow regarding clinical issues, telephone consultation with attorneys and other legal constituents (probation officer, social services, diversion case worker), telephone consultation with school personnel.

3. Telephone calls related to typical case management or rescheduling will not be billed to you. These consultations include: coordinating with your insurance company, discussing your clinical situation with your primary care physical, discussing your clinical situation with your psychiatrist, consulting with another psychotherapist involved in your care.

_____

Signature Date

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Whom may we thank your referring you to our services:

Name _____

_____

_____

_____

Address: _____

_____

_____

_____

May we have your permission to send a letter of thanks to that referring person or agency?

___Yes ___No

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DISCLOSURE STATEMENT

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 Board of Licensed Professional Examiners can be reached at:

Division of Registrations
1560 Broadway, Suite 1350
Denver, CO 80202
(303) 894-7800

As to the regulatory requirements applicable to mental health professions:

- Registered psychotherapist is a psychotherapist 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.
- Certified Addiction Counselor I (CACI) must be a high school graduate, complete required training hours and 1,000 hours of supervised experience.
- *Certified Addiction Counselor II (CACIII) must have a bachelor's degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience.
- Licensed Addiction Counselor must have a clinical masters degree and meet the CACIII requirements
- Licensed Social Worker must hold a masters degree in social work.
- 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.
- 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.

You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy (if known) and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time. Bonnie's treatment model is based on principles of brief therapy, using solution-focused, systemic and cognitive models. Factors that influence length of treatment are medical necessity, and establishing specific goals for treatment

What You Can DO To Make Therapy Successful

Define for your therapist what you want to accomplish in therapy
Define how you will know when therapy has been successful
Be committed to working on homework assignments between sessions.
Keep scheduled appointments

What We Can Do To Make Therapy Successful

Help you define your goals and how you will know when you have achieved them
Help you understand your diagnosis
Be specific about what therapy can or cannot do to help your situation
Suggest to you activities and tasks to do between sessions that will help
Advise you of support groups and activities in the community that might be helpful.

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In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes and the HIPAA Notice of Privacy Rights posted in the waiting area as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report suspected child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly. The Mental Health Practice Act (CRS 12-43-101) is available at: http://www.dora.state.co.us/mentalhealth/Statute.pdf.

Services Not Covered by Health Insurance
Counseling services for any other reason than medical necessity, on-going psychoanalysis, psychological testing or Court-ordered treatment

If you need to cancel or reschedule an appointment, we will try to accommodate your needs. Should you not be able to attend your scheduled appointment time, please notify our office in advance (24 hours) of your scheduled appointment. This may allow us to offer the available time to patients who are having an emergency. You will be charged a late fee of $65.00 per hour for a no-show or late cancellations.

I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the client's responsible party.

Client Signature **Date**

_____

Responsible Party's Signature **Date**
Parent or Guardian

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