GreenFox
COUNSELING LLC

PERSONAL INFORMATION

Name: _____ Today's Date: _____

Date of Birth: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Do you give permission to receive: Mail to Your Home Address? Yes/No Voicemails? Yes/No
Text messages? Yes/No Emails? Yes/No

CURRENT SYMPTOMS (CIRCLE ALL THAT APPLY)

Anxiety	Appetite Changes	Trouble Concentrating	Crying Spells
Depression	Low Motivation	Excessive Energy	Fatigue
Hallucinations	Impulsivity	Sleep Changes	Hopelessness
Panic Attacks	Isolation from Others	Low Self-Esteem	Irritability
Paranoia	Substance Abuse	Suicidal Thoughts	Self-Harm

Other (Please specify): _____

PRESENT SITUATION

Work: ☐ Full-Time ☐ Part-Time ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired

Employer: _____ How long have you worked there? _____

Marital/Relationship Status: _____

List anyone who lives in the home with you (include their name, age, and relationship to you):

_____

_____

HEALTH

Primary Care Doctor: _____ Phone: _____

Psychiatrist (if applicable): _____ Phone: _____

Previous mental health diagnosis/treatment (if applicable): _____

_____

List any significant health problems: _____

List any medications you are currently taking and dosage(s): _____

_____

Substance Use (Alcohol, cigarettes, and/or recreational drugs) type and amount used: _____

_____

EMERGENCY CONTACT

In case of emergency who may I contact?

Name: _____ Relationship: _____

Phone: _____

INSURANCE INFORMATION

Please fill out if Green Fox LLC will be billing your insurance.
Note: A copy of your insurance card will be requested for billing purposes.

Primary Insurance Company: _____ Phone: _____

Insurance ID #: _____ Group #: _____

Subscriber's Name: _____

Date of Birth: _____ Relationship to Client: _____

Employer: _____ Occupation: _____

IF GREEN FOX COUNSELING LLC IS CONTRACTED TO BILL YOUR INSURANCE PLAN, PLEASE SIGN THE FOLLOWING SECTION:

ASSIGNMENT OF BENEFITS: I hereby authorize and request my insurance to pay directly to Green Fox Counseling LLC the amount due for services rendered to me or my dependents.
RELEASE OF INFORMATION: I authorize the release of any medical, mental health, or substance abuse information necessary to process insurance claims for services rendered to me or my dependent. This consent is subject to revocation at any time, except where action has already been taken on the basis of this release. Unless revoked earlier, this release will be null and void six months after the final payment has been received on my account. This consent is subject to state and federal confidentiality requirements.

Please sign as either the insured (if you are the subscriber for the insurance) or as client/guardian if you are a dependent or signing on behalf of a dependent.

_____ _____ _____
Insured Client/Guardian Date

FINANCIALLY RESPONSIBLE PARTY

Please fill out if the person that will be financially responsible for payments on this account is **NOT** the client whose information is on the first page of this document.

Name of the Financially Responsible Party: _____

Date of Birth: _____ Relationship to Client: _____

Address: _____

Employer: _____ Occupation: _____

Lauren M. Gould — Master's Level Counselor at Green Fox Counseling LLC
M.A. in Clinical Mental Health Counseling, University of Denver, 2015
B.S. in Psychology, Southern Utah University, 2013

Informed Consent for Psychotherapy

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me.

The Therapeutic Process: You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Rights

The State of Colorado requires you to be informed of your rights as a patient in psychotherapy. These rights are designed to protect you and to facilitate your active participation in your therapy. Your rights include the following:

- The law requires that you be informed of your Behavioral Health Provider's training, credentials, licenses and professional status. If your Behavioral Health Provider is a student or is working under supervision, you should be provided with his/her supervisor's name, credentials, and contact information.
- The law also requires all Behavioral Health Providers to use appropriate terminology when describing their professional status. A psychologist, social worker, marriage and family Behavioral Health Provider, professional counselor, or addiction counselor may only use the title for which he or she is licensed, certified, or registered. The state is responsible for regulating the practice of psychotherapy for unlicensed and licensed Psycho-Behavioral Health Providers. Information about how to file a complaint with the appropriate board can be obtained by contacting the Colorado licensing board.
- You can discuss any aspect of your therapy with your Behavioral Health Provider, and you may request a second opinion or terminate therapy at any time.
- You are entitled to receive information about methods of therapy, techniques used, duration of treatment (if known), and the fee structure.
- Sexual contact between patient and Behavioral Health Provider is illegal and should be reported to the Grievance Board.
- You should know that your Behavioral Health Provider may consult with other experts on treatment issues to ensure that you are receiving proper care. Your identity, should this occur, will be kept confidential.

- You should be aware that you may receive a clinical diagnosis as part of your treatment. If this occurs, your diagnosis will be noted in your medical record.

Confidentiality

Privacy practices at Green Fox Counseling LLC are in compliance with HIPAA (Health Insurance Portability and Accountability Act of 1996) guidelines as well as with state law. In general, information disclosed to a licensed Behavioral Health Provider is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without your consent. Situations in which information about you may be released include, but are not limited to:

- You have signed a written release of information.

- You are a danger to yourself or another. Threats of endangerment to self or others must be reported to both the authorities & the intended victim.
- The abuse or neglect of a child, elderly, or disabled person is suspected, has occurred or is occurring.
- In response to any legal action taken by you against this practice.
- You are gravely disabled or unable to care for yourself.
- Disclosure is allowed by a court order.
- Disclosure is necessitated by a medical emergency.
- A criminal or delinquency proceeding is involved. (Except in the case of information given to a licensed psychologist, legal confidentiality does not apply in criminal or delinquency proceedings).

The Mental Health Practice Act (CRS 12-43101, et seq.) is available at: http://www.dora.state.co.us/mental- health/Statute.pdf. By signing this document, 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.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____ _____

SIGNATURE DATE

Lauren M. Gould — Green Fox Counseling LLC

PRACTICE POLICIES

APPOINTMENTS AND CANCELLATIONS
Please remember to cancel or reschedule 24 hours in advance. You will be responsible for a $45 fee if cancellation is less than 24 hours. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you will lose some of that session time.

A $25 service charge will be charged for any checks returned for any reason for special handling.

TELEPHONE ACCESSIBILITY
If you need to contact me between sessions, please leave a message on my voicemail. I am often not immediately available; however, I will attempt to return your call within one business day. Please note that Face- to-face sessions are highly preferable to phone sessions. However, in the event that you are out of town, sick or need additional support, phone sessions are available but cannot be billed through your insurance. If a true emergency situation arises, please call 911 or any local emergency room. Colorado Crisis is also available 24/7 at 1-844-493-8255.

SOCIAL MEDIA AND TELECOMMUNICATION
Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

ELECTRONIC COMMUNICATION
I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

MINORS
If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

TERMINATION
Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion

with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

LEGAL PROCEEDINGS AND COURT INVOLVEMENT

My goal is to support you in achieving therapeutic goals, not to address legal issues. It is not within my scope of practice or the scope of our agreement to provide evaluations, depositions, or expert testimony. If you become involved in a legal dispute, including divorce and custody, I can support you emotionally through therapy but I will not be involved in the legal process. If you need a formal psychological evaluation or expert testimony, I will be happy to assist you in finding providers who offer this service. By signing below, you release me from any role in legal proceedings. If you enter into therapy with me, you agree not to initiate any subpoena processes directed at the me, Green Fox Counseling LLC, or your records. Additionally, if I agree or I am ultimately required to participate in any legal proceedings/consultation (professional consultation and/or expert testimony, either by deposition or by trial), that is related in any way to my providing therapy services to you, a non- refundable retainer fee of $3,500.00 for services and expenses will be due and payable by you before I provide any work a minimum of two weeks prior to any scheduled legal proceeding, legal consultation with attorney, or court appearance. This retainer fee will be applied to the first 10 hours of work pertaining to your legal proceeding, but will not be applied towards therapy sessions. I may require, and you agree, to promptly provide an additional retainer after the first 10 hours of work pertaining to your legal proceeding. You agree to pay all fees (at a rate of $350.00 per hour), in full, incurred for services & activities including, but not limited to legal consultation, professional consultation, supervision, file review, preparation, travel, writing, delay, testimony (at deposition or trial), and follow-up. If an attorney contacts me on your behalf, that will be understood to be a formal request for involvement and fees will be applied and billed. You also agree to pay for any reasonable costs incurred relating to any such required legal proceeding participation. In the event of a settlement or cancellation of the trial/hearing/deposition/consult with less than 24 hours' notice, fees apply for those hours originally set aside for such. By signing below, you agree that should I elect or be required in the future to provide expert consultation and/or expert testimony, you will pay, in a timely manner, for all services provided within 14 days of receipt of my invoice.

_____ _____

SIGNATURE DATE

Credit Card Agreement

Cancellation and Missed Appointment Agreement

Please sign again below to show that you have read and accept the cancellation and missed appointment policy.

Services are by appointment only and are scheduled in advance. As your appointment time is reserved exclusively for you, it is policy to charge for missed appointments and appointments not cancelled at least 24 hours in advance. Exceptions may be made for emergencies.

If you prefer not to put a card on file, please provide cash or check in the amount of $45 to hold on file, which is refundable at termination of therapy or when it is replaced by a credit card on file. Your credit card information will be kept in an encrypted HIPAA compliant file and not available to anyone except your therapist. This form will be shredded upon entering into the electronic file.

I understand that if I do not cancel my appointment with at least 24 hours notice, or if I miss my scheduled appointment, that I will be charged a $45 fee.

Cardholder Signature: _____ Date: _____

I authorize Green Fox Counseling LLC to keep my signature on file and to charge fees, or partial fees, to the credit or debit card listed below. I understand that this authorization is valid until I cancel it in writing.

Cardholder Name (Please Print): _____

Card Type (Circle One): Visa Mastercard Discover American Express HSA/Flex

Card Number: _____ Expiration Date: _____

Security Code: _____ (3-digit number on the back of your card if Visa, Mastercard or Discover Card; 4-digit number on the front of the card if American Express)

Cardholder Signature: _____ Date: _____

IF the above is an HSA or Flex card used only for healthcare, please provide a non-medical credit card below to cover late cancellations or missed appointments not covered by a medical healthcare card.

Cardholder Name (Please Print): _____

Card Type (Circle One): Visa Mastercard Discover American Express

Card Number: _____ Expiration Date: _____

Security Code: _____ (3-digit number on the back of your card if Visa, Mastercard or Discover Card; 4-digit number on the front of the card if American Express)

Cardholder Signature: _____ Date: _____