

## **Welcome!**

I am privileged to have the opportunity to work with you or your organization. This packet contains information and forms that I will need to have on file before our second meeting.

Please review and complete these documents:

### ***Office Policy Statement-to be reviewed and signed.***

1. Client Information Form — to be completed and signed.
2. Disclosure Statement — to be reviewed and signed.
3. Colorado Notice Form of HIPAA Legislation — to be reviewed and signed.
4. All signed forms are to be returned to Foundations Counseling, LLC.

I encourage you to retain a copy of this information for your records.

Sincerely,

Bob Davidson

### **Loveland Office**

*Foxtrail Office Park at Centerra  
1635 Foxtrail Drive  
Loveland, CO 80538  
(Located northwest of the intersection of I-25  
and Hwy 34, off of Rocky Mountain Ave.)*

### **Fort Collins Office**

*Front Range Business Center  
155 East Boardwalk Drive  
Fort Collins, CO 80525  
(Located at the southeast corner of College  
Avenue and Boardwalk Drive)*

### **Windsor Office**

*Sunstone Natural Therapy Center  
130 North 6th Street  
Windsor, CO 80550  
(Located at the corner of 6th Street and Birch  
Street, two blocks north of Main Street)*

# Foundations Counseling, LLC

1635 Foxtrail Drive, Loveland, CO 80538 | 155 East Boardwalk Drive, Fort Collins, CO 80525 | 130 North 6th Street, Windsor, CO 80550  
Phone (970) 227-2770 | Fax (970) 776-3301 | www.FoundationsCounselingLLC.com

## OFFICE POLICIES

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It is the policy of Foundations Counseling, LLC to regard every client with the same level of consistency and professionalism. Each client will have the opportunity to meet with a counselor for an initial session in order to get a feel for the style and expertise of the counselor. Additional sessions will be scheduled as the patient or family feels confident in the intended treatment goals.

## MESSAGES

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You may call (970) 227-2770 regarding any questions you may have (i.e. billing, appointments, etc.). After hours, leave a voice mail message with your contact information and you will be contacted the next business day. Foundations Counseling, LLC is not a 24 hour counseling center. In an emergency, please call 911.

## SCHEDULING

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Services are by appointment only and normally scheduled weeks in advance. As this time is reserved exclusively for you, it is necessary to charge for appointments that are not canceled at least 24 hours in advance. In the event of an emergency, special consideration may be given regarding the cancellation policy.

## SESSIONS

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Sessions are typically scheduled for 50 minutes at a frequency to be determined by the counselor and client. You may be referred to a health care provider or support group in the community, or a combination of the two if necessary.

It is essential for you to feel comfortable with your counselor. For this reason, you are invited to ask me about my clinical training, credentials, supervision, professional experience, therapeutic orientation, methods and techniques.

## BILLING

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The regular fee is \$100.00 per session. Payment is due at the time of each session. Cash, checks, and credit card payments are accepted. Therapeutic phone calls longer than ten minutes, consultations and other auxiliary services requested will also be prorated accordingly. Additional traveling fees may be charged for out of office services.



## INSURANCE

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If you have a health insurance plan, your visits may be partially paid for by your insurance company. Billing statements will be available the first week of each month for the previous month's services. Statements will contain all pertinent information required by the insurance company for reimbursement.

## SIGNATURE

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I have read and I understand the above information. I agree to the session fees and understand that I am responsible for full payment of this amount.

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Client Signature (*parent or guardian for minor*)

Date

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## PERSONAL INFORMATION

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Referred by: \_\_\_\_\_  
First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Soc. Sec. # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Apt # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ + \_\_\_\_\_  
Primary Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_  
Employer \_\_\_\_\_

Primary reasons for seeking our services:

Have you had any previous counseling experience? Yes No  
*If yes, please give details (when, where, how long, provider name, medications, etc.):*

Are you currently (or recently) taking any prescription or over the counter medications? Yes No  
*If yes, please give details:*

Has anyone in your family been diagnosed with a mental illness? Yes No  
*If yes, please give details:*

Do you drink alcohol? Yes No  
*If yes, please give details (how much, how often, any blackouts, etc.):*

Do you use any other recreational drugs? Yes No  
*If yes, please give details (what drugs, how often, last use etc.):*

Have you ever suffered from any type of eating disorder? Yes No  
*If yes, please give details:*

Have you ever been charged with a crime, arrested or convicted? Yes No  
*If yes, please give details:*

Do you have any work-related problems or difficulties in school? Yes No  
*If yes, please give details:*

Do you have a history of trauma (i.e. abuse, neglect, victim of natural or other disaster)? Yes No  
*If yes, please give details:*

**SYMPTOMS CHECKLIST**

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*Please circle appropriate responses:*

Sleep: No problems   Not enough   Trouble getting to sleep   Nightmares  
Too much sleep   Trouble getting up   Tired upon waking up

Appetite: No problems   No interest   Increased   Carbohydrate craving

Exercise: None   Infrequently   Often   Frequency: \_\_\_\_\_ x per month / week / day

Energy: Normal   Increased   Low   Up and down

Interest in sex: Normal   Increased   Low

Concentration: Normal   Difficult   Poor   Terrible

Memory: Good   Some difficulty remembering   Poor

Depressed or sad: All the time   Most days   Some days   Not at all

Suicidal thoughts: All the time   Most days   Some days   Not at all

Past suicidal attempts: No   Yes

*If yes, please give details:*

Anxiety: Panic attacks   All the time   Most days   Some days   Not at all

Anger / Irritation: All the time   Most days   Some days   Not at all

Any other comments:

**DISCLOSURE STATEMENT**

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Bob Davidson  
(970) 227-2770

1635 Foxtrail Drive  
Loveland, CO 80538

- University of Kentucky  
Masters in Social Work
- University of Kentucky  
Bachelor's in Social Work
- Licensed Clinical Social Worker, State of Colorado  
License Number CSW-989601

Dear Counselee:

My desire is to help you in the best possible fashion while always being upstanding and above reproach legally and ethically. Since counseling can raise differing expectations, it is my desire to give you some up-front information and set some clear guidelines for our counseling relationship.

I offer comprehensive mental health services including: individual, couples, family, and adolescent counseling. Payment for services is expected at the time the service is rendered unless an agreement has been made as an exception.

Counselee's Rights

I strive to maintain the highest quality of service. I follow ethical guidelines set by various organizations including the American Counseling Association. You are entitled to receive information about methods of therapy, techniques, duration of therapy (if determinable), and fee structure. Please ask if you would like to receive this information. You may accept or reject any suggested counseling intervention. You can also seek a second opinion from another therapist or terminate therapy at any time.

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 Department of Regulatory Agencies, Mental Health Section.

Generally speaking, the information provided by and to a client during therapy sessions is legally confidential. The therapist cannot be forced to disclose the information without the client's consent. Information disclosed is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

There are exceptions to the general rule of legal confidentiality. Exceptions are listed in the Colorado statutes (C.R.S 12-43-218). These exceptions include child abuse/neglect and serious threats of violence to self or others. You should be aware that provisions concerning disclosures of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in section 13-90-107 C.R.S.

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of individuals who practice psychotherapy. The agency within the Department that has responsibility specifically for licensed and unlicensed psychotherapists is the Department of Regulatory Agencies, Mental Health Section, 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone: (303) 894-7766. If you have any questions or would like additional information, please feel free to ask.

I have read the preceding information and understand my rights as a client / patient.

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Client Signature (*parent or guardian for minor*)

Date

## COLORADO NOTICE FORM OF HIPAA LEGISLATION

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### Notice of Psychotherapist's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

#### I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

“*PHI*” refers to information in your health record that could identify you.

“*Treatment, Payment, and Health Care Operations*”

– *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychotherapist.

– *Payment* is when I obtain reimbursement for your healthcare. Examples are when I disclose your PHI to your health insurer for reimbursement for health care or to determine eligibility or coverage.

– *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits, administrative services, case management, and care coordination.

“Use” applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

“Disclosure” applies to activities outside of my [office, clinic, practice group, etc.] such as releasing, transferring, or providing access to information about you to other parties.

#### II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An “*authorization*” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. “*Psychotherapy Notes*” are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

#### III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

*Child Abuse* – If I have reasonable cause to know or suspect that a child has been subjected to abuse or neglect, I must immediately report this to the appropriate authorities.

## COLORADO NOTICE FORM OF HIPAA LEGISLATION

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*Adult and Domestic Abuse* – If I have reasonable cause to believe that an at-risk adult has been mistreated, self-neglected, or financially exploited and is at imminent risk of mistreatment, self-neglect, or financial exploitation, then I must report this belief to the appropriate authorities.

*Health Oversight Activities* – If the Grievance Board for Unlicensed Psychotherapists or an authorized professional review committee is reviewing my services, I may disclose PHI to that board or committee.

*Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privileged does not apply when you are being evaluated or a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

*Serious Threat to Health or Safety* – If you communicate to me a serious threat of imminent physical violence against a specific person or persons, I have a duty to notify any person or persons specifically threatened, as well as a duty to notify an appropriate law enforcement agency or by taking other appropriate action. If I believe that you are at imminent risk of inflicting serious harm on yourself, I may disclose information necessary to protect you. In either case, I may disclose information in order to initiate hospitalization.

*Worker's Compensation* – I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provided benefits for work-related injuries or illness without regard to fault.

### IV. Patient's Rights and Psychotherapist's Duties

#### **Patient's Rights:**

*Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information regarding you. However, I am not required to agree to a restriction you request.

*Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)

*Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

*Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

*Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

*Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

#### **Psychotherapist's Duties:**

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

**COLORADO NOTICE FORM OF HIPAA LEGISLATION**

I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

If I revise my policies and procedures, I will notify my client by mail.

**V. Questions and Complaints**

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact the Records Administrator, Chris Berger, at (970) 227-2770.

If you believe that your privacy rights have been violated and wish to file a complaint with me / my office, you may send your written complaint to:

Foundations Counseling, LLC  
Attention: Records  
1635 Foxtrail Drive  
Loveland, CO 80538

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

**VI. Effective Date, Restrictions, and Changes to Privacy Policy**

This notice will go into effect on September 1<sup>st</sup>, 2007.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail within ten business days prior to changes.

**VII. Client Signature**

I have read the above terms and understand them as stated. I have been informed of my therapist's policies and practices to protect the privacy of my health information.

\_\_\_\_\_  
Client Name (please print) Parent or Guardian (for Minor) Name

\_\_\_\_\_  
Client Signature Date Parent or Guardian Signature Date

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### CREDIT/CHARGE/DEBIT CARD PREAUTHORIZATION

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*If you intend to use a credit / charge / debit card for fees, please complete this page.*

I authorize Foundations Counseling, LLC to keep my signature on file and to charge fees, or partial fees, to my credit, charge or debit card account for services provided to

\_\_\_\_\_  
Client Name

(please print)

I understand that this authorization is valid until canceled in writing. I understand that charges for ongoing services will normally be posted to my credit card account within a day of each service date.

I agree that if I have any problems or questions regarding charges to my account, I will contact Bob Davidson for assistance. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Bob Davidson and those attempts have failed.

Cardholder Name (please print):

\_\_\_\_\_

Billing Address (where statements are mailed):

\_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Card Type (circle one):    Debit    Credit

Card (circle one):    Visa    MasterCard    Discover    American Express

Acct No.: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

V-Code: \_\_\_\_\_

(The V-Code is a 3- or 4-digit number on the back of your card by your signature, usually after the account number.)

Cardholder Signature: \_\_\_\_\_ Date: \_\_\_\_\_