Phone (970) 227-2770 | www.FoundationsCounselingLLC.com | Fax (970) 986-4852

Welcome!

I am privileged to have the opportunity to work with you and your family. This packet contains information and forms that I will need to have on file.

Please review and complete these documents:

Office Policies Statement — to be reviewed and signed.

Contact Information Forms — to be completed.

Personal Information Forms — to be completed.

Consent for Counseling Services to Minors — to be reviewed and signed.

Disclosure Statement — to be reviewed and *signed*.

Colorado Notice Form of HIPAA Legislation — to be reviewed and *signed*.

All forms are to be returned to Foundations Counseling, LLC.

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

Sincerely,

Sofie Vera Brodsky

Loveland Office

5250 Hahns Peak Drive
Loveland, CO 80538
Suite 200
(Located northwest of I-25 and Hwy 34, off of Rocky Mountain Avenue)

Central Fort Collins Office

400 E. Horsetooth Road
Suite 100
Fort Collins, CO 80525
(Located on the corner of John F Kennedy Pwky and E Horsetooth Road)

Southeast Fort Collins Office

2809 E. Harmony Rd.
Suite 330
Fort Collins, CO 80528
(Located off of East Harmony Road and Corbett Drive)

Windsor Office

Highland Meadows Health Center
8201 Spinnaker Bay Drive
Windsor, CO 80528
(Located at the corner of Highland Meadows Parkway and Spinnaker Bay Drive)

Office Policies

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

You may call (970) 227-2770 regarding any questions you may have (i.e. billing, appointments, etc.). After hours, leave a voicemail 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

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 **48 hours** in advance. In the event of an emergency, special consideration may be given regarding the cancellation policy.

Sessions

Sessions are typically scheduled for 45-50 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

The regular fee is $160.00 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

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.

Please Sign Below

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.

_____ _____

Client Signature *(parent or guardian for minor)* Date

Contact Information

Date _____/_____/_____

First Name _____ Last Name _____

Date of Birth _____-_____-_____ Last 4 of Social Security # _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Primary Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Email Address _____

Primary Care Physician _____

Methods of payment

Foundations Counseling, LLC accepts cash, check, and charge as methods of payment. Regardless, it is necessary for Foundations Counseling, LLC to keep a charge card on file. Please provide that information below.

I authorize Foundations Counseling, LLC to keep my signature on file and to charge fees, or partial fees, to my credit or debit card account for services provided. I understand that this authorization is valid until canceled in writing. I agree that if I have any problems or questions regarding charges to my account, I will contact Foundations Counseling 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 Foundations Counseling and those attempts have failed.

Cardholder Name _____

Client's Name _____

Relationship to Cardholder _____

Type of card (circle one) Visa MasterCard Discover American Express

Credit Card Number _____

Exp. Date _____

V-Code _____ 3 - 4 digit number printed on the back of your card)

Cardholder Signature _____ Date _____

Personal Information	
Please describe the primary reason(s) for seeking our services?	
Have you had any previous counseling experience?	O Yes O No If yes - please give details:
Are you currently (or recently) taking any prescription or over the counter medications?	O Yes O No If yes - please give details:
Has anyone in your family been diagnosed with mental illness?	O Yes O No If yes - please give details:
Do you drink alcohol?	O Yes O No If yes - please give details:
Do you use any other recreational drugs?	O Yes O No If yes - please give details:
Have you ever suffered from any type of eating disorder?	O Yes O No If yes - please give details:
Have you ever been charged with a crime, arrested, or convicted?	O Yes O No If yes - please give details:
Do you have any work-related problems or difficulties in school?	O Yes O No If yes - please give details:
Do you have a history of trauma? (i.e. abuse, neglect, victim of a natural disaster)	O Yes O No If yes - please give details, you may use the back if you need further space:

Symptoms Checklist

Please circle the description that best fits the symptom on the left. Feel free to explain details.

Sleep	No Problems	Trouble getting up	Trouble getting to sleep	Nightmares
Sleep Frequency	Too much	Not enough	Tired regardless	Tired upon waking
Appetite	No problems	No interest	Increased	Decreased
Exercise	None	Infrequently	Often	Decreased
Energy	Normal	Increased	Low	Up and down
Interest in Sex	Normal	Increased	Low	
Concentration	Good	Difficult	Poor	
Memory	Good	Difficult	Poor	
Depressed and/or Sad	All of the time	Most Days	Some Days	Not at all
Anxiety	All of the time	Most Days	Some Days	Not at all
Panic Attacks	All of the time	Most Days	Some Days	Not at all
Anger and/or Irritation	All of the time	Most Days	Some Days	Not at all
Suicidal Thoughts	All of the time	Most Days	Some Days	Not at all
Suicide Attempts	Yes	No		

If yes - please give details, you may use the back if you need further space:

DISCLOSURE STATEMENT (1)

Sofie Vera Brodsky M.A., LPCC

Foundations Counseling, LLC
5250 Hahns Peak Drive
Loveland, CO 80538
970-227-2770

Credentials

Master of Arts, Clinical Mental Health Counseling
Colorado State University

Bachelor of Arts, Biology
University of California, Santa Cruz

State of Colorado Registration Number
DORA Registration #: LPCC-18095

Regulation of Psychotherapists

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 regulatory boards can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. The regulatory requirements for mental health professionals provide that a Certified Addiction Counselor I must be a high school graduate, complete required training hours, and 1,000 hours of supervised experience. A Certified Addiction Counselor II must complete additional required training hours and 2,000 hours of supervised experience. A Certified Addiction Counselor III must have a bachelor's degree in behavioral health, complete additional required training hours and have 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's degree and meet the Certified Addiction Counselor III requirements. A 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. A Registered Psychotherapist is 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. A Licensed Social Worker must hold a master's degree in social work. A Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's degree in their profession and have two years of post-master's supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.

Client Rights and Important Information

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.

In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs it should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

DISCLOSURE STATEMENT (2)

Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and the therapist cannot disclose or release the information 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 you were provided as well as other exceptions in Colorado and Federal law. Mental health professionals are: 1) required to report any suspected incident of child abuse or neglect to authorities; 2) required to report any threat of imminent physical harm by a client to both law enforcement and to the person(s) threatened; 3) required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental health disorder; 4) required to report any suspected threat to national security to federal officials; and 5) may be required by court order to disclose treatment information. If a legal exception arises during therapy, if feasible, you will be informed accordingly. The Mental Health Practice Act (C.R.S. 12-43-101, et seq.) is available at: http://www/dora.state.co.us/mental-health/Statute.pdf.

Under Colorado law, C.R.S. 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information. If you request treatment information from me, I may provide you with a treatment summary, in compliance with Colorado law and HIPAA standards.

If you are involved in divorce or custody litigation, my role as a therapist is not to make recommendations to the court concerning custody or parenting issues. By signing this Disclosure Statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that I write any reports to the court or to your attorney, making recommendations concerning custody. The court can appoint professionals, who have no prior relationship with family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interests of the family's children.

If you decide to depose me, for any reason, including, but not limited to, being an expert witness in a court case or any court-related matter, the standard rate of $160.00 per hour, with an eight-hour daily minimum (a minimum of $1,280.00 per day), will apply. Payment must be received at least one week in advance of my being called to testify for any reason, again, including, but not limited to, as an expert witness.

For any travel which is more than 25 miles from my primary office location, there will be an additional charge for travel time (at the standard rate of $160.00 per hour) as well as for mileage. Again, payment is to be received at least one week prior to the scheduled departure from my office.

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 Name (please print)

_____

Client Signature

_____

Date

Sofie Vera Brodsky M.A., LPCC
DORA Registration #: LPCC-18095

COLORADO NOTICE FORM OF HIPAA LEGISLATION (1)

I. 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.

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.

COLORADO NOTICE FORM OF HIPAA LEGISLATION (2)

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.

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.

COLORADO NOTICE FORM OF HIPAA LEGISLATION (3)

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
5250 Hahns Peak 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 1st, 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 Name (for minor)
Client Signature	Parent or Guardian Signature (for minor)
Date	Date