

Pikes Peak Family Counseling Center, LLC
 Kenny Dennis, MA, LPC
 709 N. Nevada Avenue, Suite 207
 Colorado Springs, CO 80903
 719.321.1976 kenny@kennydennis.com

Client Information Form

Client Name:		Today's Date:
Street:	City:	State:
Zip:	Home Phone:	Cell Phone:
Sex: <i>Male Female</i>	Ethnicity:	Date of Birth: Age:
Parent/Legal Guardian Name		Phone:
Name of Spouse:		Phone:
E-mail:	Referred by:	

<u>Names of Other Children:</u>	<u>Age</u>	<u>Gender</u>	<u>Living w/ you?</u>	<u>Comments:</u>
_____	_____	<i>M F</i>	<i>Yes No</i>	_____
_____	_____	<i>M F</i>	<i>Yes No</i>	_____
_____	_____	<i>M F</i>	<i>Yes No</i>	_____
_____	_____	<i>M F</i>	<i>Yes No</i>	_____
_____	_____	<i>M F</i>	<i>Yes No</i>	_____

Briefly state your reason for seeking counseling at this time:

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Have you ever been seen by a mental health professional before? Yes No
 If yes, please indicate who, when and why:

Who is your primary physician?	Phone #:
Please list any troublesome or significant medical conditions you may have.	

Please list your current medications (Prescription & Non-Prescription):

<u>Drug</u>	<u>Dose</u>	<u>Frequency</u>	<u>When Started</u>	<u>For what symptom(s)</u>	<u>Prescribing Doctor</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Who should be notified in case of emergency?

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Pager: _____

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Disclosure Statement

As a psychotherapist I am required to give you the following information:

The practice of both licensed and unlicensed persons and certified school psychologists in the field of psychotherapy is regulated by the Colorado State Department of Regulatory Agencies with a Mental Health Occupations Grievance Board that can be contacted at 1560 Broadway, Suite 1350, Denver, Colorado, 80202. (303) 894-7766.

You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy (if I can determine it), and my fee structure.

Payment is due at the time of treatment. My fee is \$100.00 per individual and \$110 per family session unless other arrangements are made. Session length is usually 50 minutes in duration. I have the right to bill for any missed appointment unless twenty-four hour notification is given.

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 State Grievance Board.

Generally speaking, information provided by and to a client during therapy sessions with a psychotherapist is legally confidential, and the therapist cannot disclose the information without the client's consent. All private communication in therapy will remain private except in the case of a serious potential for suicide or possible physical violence to another person. I am also obligated by law to report any known or suspected instance of child abuse. In addition, I am required to report any suspected threat to national security to federal officials.

When I am not immediately available by phone my voice mail will take messages. I will make every effort to return your call on the same day you make it, with the exception of evenings, weekends, holidays and vacations. When I am out of town, the voice mail message will refer you to a colleague on call in case of a clinical emergency. For life threatening emergencies always call 911. ***If you choose to communicate with me by email, please be aware that emailing is not secure and confidentiality may be breached.***

On occasion it is beneficial for me to contact you regarding scheduling and thoughts or questions I may have concerning our previous session. This allows for continuity in your counseling process throughout the week. If you have any reservations concerning these outside contacts please indicate these below.

May I call you at home? _____ Yes _____ No **May I leave a message at home?** _____ Yes _____ No

May I call you at work? _____ Yes _____ No **May I leave a message at work?** _____ Yes _____ No

May I send you an email? _____ Yes _____ No **May I send you text messages?** _____ Yes _____ No

Please be reminded that email is not secure

I have read the preceding information, agree with the terms set forth, and understand my rights as a client.

Client Signature

Date

Client Name (Please Print)

Parent/Legal Guardian Signature

Date

Parent/Legal Guardian Name (Please Print)

Kenny Dennis, MA, LPC

Date

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Payment Contract

Client Name

Date of Birth

Social Security Number

I understand that I will be responsible for payment for the services provided for me or my dependents, and that my portion of the charges are to be paid at the TIME OF SERVICE. I will provide any change of insurance status immediately. I hereby authorize the release of any information necessary to process my claim to my insurance company or other third party payer identified below. I understand that this may include mental health diagnosis and treatment information, including information about drug or alcohol abuse and HIV conditions. It may also include the release of information for the determination of eligibility or coverage and adjudication or subrogation of health benefit claims. It may include billing, claims management, collection activities, obtaining payment under a contract for reinsurance and related health care data processing. It may include at third party payer's review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges. I understand that this information may also be released to any billing services provided for Kenny Dennis. The release/authorization is valid for one year unless indicated otherwise.

_____ Full Fee: I understand that I am responsible for payment in full at time of service at the rate of \$_____ per hour. I also understand that I am responsible for payment of any missed appointments with less than 24 hour notice.

_____ Insurance/Third Party: I request the insurance reimbursement under my policy with _____, or any other insurance or third party coverage which I might be authorized for, be made on my behalf to Kenny Dennis, MA, LPC. Based on my insurance policy, my outpatient co-pay is determined by my insurance company. I understand that I will be responsible for the full amount of the usual fee if I fail to take the necessary steps to obtain insurance payment for Kenny Dennis, MA, LPC. I hereby authorize Kenny Dennis, MA, LPC to submit claims on my behalf to my insurance company or third party carrier for all services I or my dependents receive from Kenny Dennis, MA, LPC. I authorize my insurance company to make payment for all services directly to Kenny Dennis. Kenny Dennis has agreed to accept payment from your insurance company at a contracted rate, which may be below our usual and customary charge.

_____ Medicaid/CHP+: Medicaid # _____ Medicaid County _____
I request the payment of authorized Medicaid benefits be made to Kenny Dennis, MA, LPC for services provided to me or my dependents. I understand that if my benefits are terminated, I am financially responsible for the charges incurred.

Client Signature

Date

Parent or Legal Guardian Signature

Date