NAME: _____

GENDER: : _____

Client Identifies as: _____

DOB: _____

EMAIL: _____

Contact Information

Address: _____

Home No.: _____

Office No.: _____

Mobile No.: _____

Other Information

Alias Name: _____

Is This Your Legal Name: _____

Ethnicity/Race: _____

Language: _____

Religion: _____

Referral Information

Company/Contact Type : _____

Contact /Who was it?: _____

Treatment Information _____

Treatment

Discharge/Transfer(empty if referral): Level of care: _____

First Contact Date: _____

Are you currently employed? _____

Is your job at risk?	Y ☐	N ☐
Have you been previously diagnosed?	Y ☐	N ☐
Do you need assistance with	Y ☐	N ☐
FMLA Paperwork?	Y ☐	N ☐

What led to you seeking treatment at this time?

_____

_____

_____

Willingness for treatment?

Scale of 1-10 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Family Information

Would you like to include/invite any family members to be part of your program? Include name, number and email address (ROI)

*****IOP MUST HAVE AN EMERGENCY CONTACT** Y ☐ N ☐

Substance Use History

Substance Used_____

Days used in the last 30 _____

Route of Use _____

How was this obtained? _____

Usual amount used in a 24-hour day _____

Date of Last use_____

Age first used _____

Years of Abuse_____

Substance Used_____

Days used in the last 30 _____

Route of Use _____

How was this obtained? _____

Usual amount used in a 24-hour day _____

Date of Last use_____

Age first used _____

Years of Abuse_____

Substance Used_____

Days used in the last 30 _____

Route of Use _____

How was this obtained? _____

Usual amount used in a 24-hour day _____

Date of Last use_____

Age first used _____

Years of Abuse_____

Previous treatment

TX Center Name_____

Month/Year_____

Level Of Care ☐ Residential ☐ Detox ☐ IOP ☐ PHP ☐ M1-Hold

What was the response to previous treatment?_____

How long did you stay sober after discharge? _____

Additional Previous Treatment Y ☐ N ☐

What was the response to previous treatment? _____

How long did you stay sober after discharge?_____

What was the response to previous treatment (what worked, what didn't and why?)_____

_____

_____

What is your Relapse History? _____

_____ What do you think will be different about treatment this time? _____

Any current or past history of chronic pain? Y ☐ N ☐

History of other addiction(gambling, cutting, sleeping, sex, internet, gaming, exercise) Y N

Medical History Y ☐ N ☐

Any outstanding health Issues? Y ☐ N ☐

Comments

Are you pregnant? Y ☐ N ☐

Possibility of pregnancy? Y ☐ N ☐

Allergies: Y ☐ N ☐

Comments

Have you been prescribed Psychiatric medications in your life? Y ☐ N ☐

N Medication Dates

1.

2.

3.

4.

5.

Have you ever experienced any intellectual or cognitive functioning issues? Y ☐ N ☐

Behavioral/Emotional Status

Work School/Problems Y ☐ N ☐

Family Functioning Y ☐ N ☐

Personality Changes Y ☐ N ☐

Stays out all night Y ☐ N ☐

Impulse Control Y ☐ N ☐

Ability to Manage Self Y ☐ N ☐

Isolating Y ☐ N ☐

Previous Treatment Y ☐ N ☐

Sad or Angry Often Y ☐ N ☐

Lack of Hygiene Y ☐ N ☐

Violent Outbursts Y ☐ N ☐

Explosive Outbursts Y ☐ N ☐

Inability To Think Clearly Y ☐ N ☐

Severe Mood Swings Y ☐ N ☐

Money Managing Y ☐ N ☐

History Of Violence Y ☐ N ☐

History of eating disorder? Y ☐ N ☐

History of Seizures or Blackouts Y ☐ N ☐

History of Chronic Pain? Y ☐ N ☐

History of Trauma/Abuse? Y ☐ N ☐

Legal Issues

Do you have legal history? Y ☐ N ☐

Have you been arrested? Y ☐ N ☐

Currently Charged? Y ☐ N ☐

Pending Court Decisions? Y ☐ N ☐

Can you leave the state for treatment? Y ☐ N ☐

Any sexual Offense? Y ☐ N ☐

Any physical Offense? Y ☐ N ☐

Upon discharge what will your plan be? _____

Notes

Family Information

Are you married? Y ☐ N ☐

Do You Have Children? Y ☐ N ☐

Ages Sex

1._____

2._____

3._____

4._____

Has your chemical use or mental health affected the relationship with your children? Y ☐ N ☐

How has your relationship with family/significant other been affected by your chemical use or mental health issues?_____

_____

Does anyone in your immediate family have a problem with chemicals? Y ☐ N ☐

Have concerned person(s) complained about your use of chemicals? Y ☐ N ☐

Any history in alcoholism in your family? Y ☐ N ☐

Current living situation _____

Early childhood and adolescence _____

_____

_____

Education _____

Military History (if applicable) Y ☐ N ☐

Occupational (current and past) _____

_____

Legal History (include, and any): _____

current issues _____

past history _____

history of incarceration _____

Sexual History

Normal ☐ Rape ☐ Molestation ☐

Additional Psychosocial History

Academic performance _____

Attitude towards academic achievement: _____

Possibility of future education: _____

Emergency Contact: **(NEED ROI filled out, signed and dated) (MANDATORY FOR IOP)**

Name* _____

Relationship* _____

Responsibility _____

Emergency Contact? _____

Address _____

Home Phone# _____

Mobile#_____

Email _____

Support System_____

Formal/Informal_____

Family History

Family History of addiction and other mental health conditions: _____

Childhood
Characterization:_____

_____

Current Family environment:_____

Educational Level:_____

Additional Family Information

Family circumstances, including bereavement (loss of loved ones) what was the process of grieving?_____

_____

Vocational Screen

Is Client currently working? Y ☐ N ☐ Hours?_____

What job skills does client have?_____

Does client need assistance developing job skills or find a job? Y ☐ N

Has client used vocational rehabilitation services? Y N

Recreation/Leisure Activities

Values _____

Additional Occupational

_____

Inventory of relapse triggers

_____

Additional Occupational

_____

Community services currently accessed

_____

Sleep Pattern

Normally retires at _____

Normally rises at _____

naps per day _____

Nightmares	Y ☐	N ☐
Drug dreams	Y ☐	N ☐
Night sweats	Y ☐	N ☐
Frequent awakening	Y ☐	N ☐
Difficulty Falling Asleep	Y ☐	N ☐
Patient uses sleep aid medications	Y ☐	N ☐
Does patient have a history of sleep apnea?	Y ☐	N ☐

Emotional Pain

On a scale of 0-10, Zero being no pain and 10 terrible pain

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Gender/Sexual orientation and sexual functioning

Orientation: _____

Comfort level with orientation: _____

Any problems with sexual functioning? _____

Spiritual/Religious Assessment

Religious Affiliation: _____

Sources of hope, strength, comfort and peace: _____

Religious practices client would like to have incorporated into treatment:_____

Culture

Ethnic Background, cultural beliefs and practices:_____

We are proud members and a certified facility. JCAHO, the Joint Commission on Accreditation of Healthcare Organizations, is the oldest and largest standard-setting and accrediting organization in the United States. It was founded in 1951 as the Joint Commission on Accreditation of Hospitals. It strengthens community confidence in the quality and safety of care, treatment and services – Achieving accreditation makes a strong statement to the community about an organization's efforts to provide the highest quality services.

A NEW OUTLOOK
RECOVERY SERVICES
YOUR HEALING BEGINS HERE

Couples Counseling
Initial Intake Form

PRINT/FILL OUT 2 OF THESE FORMS

Name:_____ **Date**: _____

Name of Partner:_____

Relationship Status: (check all that apply)

Married ☐
Separated ☐
Divorced ☐
Dating ☐
Cohabitatig ☐
Living together ☐
Living apart ☐

Length of time in current relationship: _____

As you think about the primary reason that brings you here, how would you rate its frequency and your overall level of concern at this point in time?

Concern
No concern ☐
Little concern ☐
Moderate concern ☐
Serious concern ☐
Very serious concern ☐

Frequency
No occurrence ☐
Occurs rarely ☐
Occurs sometimes ☐
Occurs frequently ☐
Occurs nearly always ☐

What do you hope to accomplish through counseling?

_____
_____
_____

What have you already done to deal with the difficulties?

_____
_____
_____

What are your biggest strengths as a couple?

_____
_____
_____

Please rate your current level of relationship happiness by circling the number which your current feelings about the relationship.

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

(extremely unhappy) (extremely happy)

Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does.

_____

_____

_____

Have you received prior couples counseling related to any of the above problems? ☐ Yes ☐ No

If yes, when: _____ Where: _____

By whom: _____ Length of treatment: _____

Problems treated: _____

_____

What was the outcome (check one)**?**

□ Very successful ☐ Somewhat successful ☐ Stayed the same ☐ Somewhat worse ☐ Much worse ☐

Have either you or your partner been in *individual* counseling before?

□ ☐ Yes ☐ No

If so, give a brief summary of concerns that you addressed.

_____

_____

_____

Do either you or your partner drink alcohol to intoxication or take drugs to intoxication?

Yes ☐ No ☐

If yes for either, who, how often and what drugs or alcohol?

_____

_____

_____

Have either you or your partner struck, physically restrained, used violence against or injured the other person?

Yes ☐ No ☐ If yes for either, who, how often and what happened.

_____

_____

_____

Has either of you threatened to separate or divorce (if married) as a result of the current relationship problems?

Yes ☐ No ☐ If yes, who? ☐ Me ☐ Partner ☐ Both of us

If married, have either you or your partner consulted with a lawyer about divorce?

Yes ☐ No ☐ If yes, who? ☐ Me ☐ Partner ☐ Both of us

Do you perceive that either you or your partner has withdrawn from the relationship?

Yes ☐ No ☐

If yes, which of you has withdrawn? ☐ Me ☐ Partner ☐ Both of us

How frequently have you had sexual relations during the last month? _times

How enjoyable is your sexual relationship? (Circle)

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

(extremely unpleasant) (extremely pleasant)

How satisfied are you with the frequency of your sexual relations? (Circle one)

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

(extremely unsatisfied) (extremely satisfied)

What is your current level of stress (overall)? (Circle one)

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

(no stress) (high stress)

What is your current level of stress (in the relationship)?

(no stress) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ (high stress)

Rank order the top three concerns that you have in your relationship with your partner (1 most problematic):

1. _____

2. _____

3. _____

Thank you for completing this. Please bring this with you during your first appointment. Please note that you will be asked to talk about your answers in sessions but your partner will not be shown the answers.

A NEW OUTLOOK
RECOVERY SERVICES
YOUR HEALING BEGINS HERE

PSYCHOTHERAPY INFORMATION DISCLOSURE STATEMENT

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a client in psychotherapy, you have certain rights that are important for you to know about because this is your therapy, whose goal is your well-being. There are also certain limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you.

My Responsibilities to You as Your Therapist

I. Confidentiality

With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act so as to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you. You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically (for example, sending bills or faxing information), it will be done with special safeguards to insure confidentiality. If you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential. All emails are retained in the logs of your or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. Any email I receive from you, and any responses that I send to you, will be printed out and kept in your treatment record.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.
2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 48 hours and Adult Protective Services immediately.
3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. I am not obligated to do this

and would explore all other options with you before I took this step. If at that point you were unwilling to take steps to guarantee your safety, I would call the crisis team.

The next is not a legal exception to your confidentiality. However, it is a policy you should be aware of if you are in couple's therapy with me.

If you and your partner decide to have some individual sessions as part of the couple's therapy, what you say in those individual sessions will be considered to be a part of the couples therapy, and can and probably will be discussed in our joint sessions. Do not tell me anything you wish kept secret from your partner. I will remind you of this policy before beginning such individual sessions.

II. Record-keeping

I keep very brief records, noting only that you have been here, what interventions happened in session, and the topics we discussed. If you prefer that I keep no records, you must give me a written request to this effect for your file and I will only note that you attended therapy in the record. Under the provisions of the Health Care Information Act of 1992, you have the right to a copy of your file at any time, giving me the chance to print it out from my computer. You have the right to request that I correct any errors in your file. You have the right to request that I make a copy of your file available to any other health care provider at your written request. I maintain your records in a secure location that cannot be accessed by anyone else.

III. Diagnosis

If a third party such as an insurance company is paying for part of your bill, I am normally required to give a diagnosis to that third party in order to be paid. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. If I do use a diagnosis, I will discuss it with you. All of the diagnoses come from a book titled the DSM-V or ICD-10; I have a copy in my office and will be glad to let you borrow it and learn more about what it says about your diagnosis.

IV. Other Rights

You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time.

V. Managed Mental Health Care

If your therapy is being paid for in full or in part by a managed care firm, there are usually further limitations to your rights as a client imposed by the contract of the managed care firm. These may include their decision to limit the number of sessions available to you, to decide the time period within which you must complete your therapy with me, or to require you to use medication if their reviewing professional deems it appropriate. They may also decide that you

must see another therapist in their network rather than me, if I am not on their list. Such firms also usually require some sort of detailed reports of your progress in therapy, and on occasion, copies of your case file, on a regular basis. I do not have control over any aspect of their rules. However, I will do all that I can to maximize the benefits you receive by filing necessary forms and gaining required authorizations for treatment, and assist you in advocating with the MC company as needed.

VI. INFORMED CONSENT FOR AI-ASSISTED RECORDING OF THERAPEUTIC SESSIONS

Introduction

This consent form explains how artificial intelligence (AI) recording software will be used during your therapy sessions. Please read this document carefully and ask any questions before signing.

Purpose of AI Recording

Your therapist may use AI-powered recording software during clinical sessions for the following purposes:

- Documentation: To create accurate session notes and treatment records.
- Clinical Analysis: To assist in identifying therapeutic themes, patterns, and progress.
- Quality Improvement: To enhance treatment planning and clinical effectiveness.
- Supervision/Consultation: To facilitate clinical supervision when appropriate (with additional consent).
- Administrative Efficiency: To reduce manual note-taking and allow greater therapeutic presence.

How the AI Recording System Works

- Audio/Video Capture: Sessions may be recorded via audio and/or video
- AI Processing: The recording is processed by secure AI software that may:
- Therapist Review: Your therapist reviews and edits all AI-generated content before finalizing clinical documentation

Data Privacy and Security

Storage and Access

- Recordings and transcripts are stored on HIPAA-compliant, encrypted servers
- Only authorized clinical staff have access to your recordings
- Data is retained according to applicable healthcare regulations and professional standards
- Recordings are typically deleted after clinical notes are finalized, unless there is a documented clinical or legal reason for retention

AI Vendor Information

- AI processing is performed by: [Name of AI Software/Vendor]
- The vendor is a HIPAA Business Associate and has signed appropriate agreements
- The vendor's privacy policy can be reviewed at: [URL/Contact Information]

Third-Party Access

- Your recordings will NOT be shared with third parties except as required by law or with your explicit written consent
- AI vendors may use de-identified data for system improvement purposes only
- No identifiable information will be used for marketing or sold to other parties

Your Rights and Protections

Right to Refuse

- You have the right to refuse AI recording at any time without affecting the quality of care you receive
- You may request that recordings be paused during sensitive discussions
- Refusing AI recording will not impact your treatment or relationship with your therapist

Right to Access

- You may request to review recordings or transcripts of your sessions
- You may request corrections to inaccurate AI-generated content in your clinical records

Right to Revoke Consent

- You may withdraw this consent at any time by providing written notice to your therapist
- Withdrawal applies to future recordings; previously recorded sessions will be handled according to existing retention policies

Limitations of AI Technology

- AI systems may occasionally produce inaccurate transcriptions or interpretations
- Your therapist maintains full professional responsibility for all clinical decisions and documentation
- AI tools are assistive only and do not replace clinical judgment

Confidentiality and Legal Exceptions

- Standard therapeutic confidentiality applies to AI-recorded sessions, with the following legal exceptions:
- Mandatory Reporting: Suspected child, elder, or dependent adult abuse
- Danger to Self or Others: Serious threats of harm or suicide risk

- Court Orders: Valid subpoenas or court-mandated disclosures
- Insurance/Payment: Required documentation for billing purposes
- Professional Consultation: With your consent or in emergency situations

Data Breach Notification

- In the unlikely event of a data breach involving your recordings or transcripts, you will be notified promptly in accordance with HIPAA and applicable state laws.

Consent Duration and Review

- This consent remains in effect throughout your treatment unless you revoke it. Your therapist will review this consent with you annually or when significant changes occur to the AI system or policies.

Questions and Concerns

If you have questions about AI recording, please discuss them with your therapist before signing. You may also contact:

Privacy Officer: Sarah Zubrin sarah@coloradorecoveryservices.org

Practice Manager: Gary Gross gary@coloradorecoveryservices.org

State Licensing Board: Colorado Department of Regulatory Agencies (DORA)
1560 Broadway, Suite 110 Denver, CO 80202 1- 800-886-7675

I acknowledge that:

☐ I have read and understand this consent form

☐ I have had the opportunity to ask questions and receive satisfactory answers

☐ I understand the purpose, benefits, and risks of AI recording

☐ I understand my right to refuse or revoke consent at any time

☐ I understand how my data will be stored, used, and protected

☐ I voluntarily consent to the use of AI recording software during my therapy sessions

- Transcribe spoken content
- Identify emotional patterns or clinical themes
- Generate session summaries or clinical notes
- Highlight key therapeutic moments

Client signature: Date:

My Training and Approach to Therapy

My approach to therapy is Cognitive Behavioral Therapy. Cognitive behavioral therapy (or cognitive behavioral therapies or CBT) is a psychotherapeutic approach that aims to solve problems concerning dysfunctional emotions, behaviors and cognitions through a goal-oriented, systematic procedure. The title is used in diverse ways to designate behavior therapy, cognitive therapy, and to refer to therapy based upon a combination of basic behavioral and cognitive research.

There is empirical evidence that CBT is effective for the treatment of a variety of problems, including mood, anxiety, personality, eating, substance abuse, and psychotic disorders. Treatment is often manualized, with specific technique-driven brief, direct, and time-limited treatments for specific psychological disorders. CBT is used in individual therapy as well as group settings, and the techniques are often adapted for self- help applications. Some clinicians and researchers are more cognitive oriented (e.g. cognitive restructuring), while others are more behaviorally oriented (in vivo exposure therapy).

Other interventions combine both (e.g. imaginal exposure therapy).

CBT was primarily developed through a merging of behavior therapy with cognitive therapy. While rooted in rather different theories, these two traditions found common ground in focusing on the "here and now", and on alleviating symptoms. Many CBT treatment programs for specific disorders have been evaluated for efficacy and effectiveness; the health-care trend of evidence-based treatment, where specific treatments for symptom-based diagnoses are recommended, has favored CBT over other approaches such as psychodynamic treatments. In the United Kingdom, the National Institute for Health and Clinical Excellence recommends CBT as the treatment of choice for a number of mental health difficulties, including post-traumatic stress disorder, OCD, bulimia nervosa and clinical depression, and for the neurological condition encephalomyelitis.

Therapy also has potential emotional risks. Approaching feelings or thoughts that you have tried not to think about for a long time may be painful. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to the relationships you already have. You may find your relationship with me to be a source of strong feelings. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful. You normally will be the one who decides therapy will end, with three exceptions. If we have contracted for a specific short-term piece of work, we will finish therapy at the end of that contract. If I am not in my judgment able to help you, because of the kind of problem you have or because my training and skills are in my judgment not appropriate, I will inform you of this fact and refer you to another therapist who may meet your needs.

If you do violence to, threaten, verbally or physically, or harass myself, the office, or my family, I reserve the right to terminate you unilaterally and immediately from treatment. If I terminate you from therapy, I will offer you referrals to other sources of care, but cannot guarantee that they will accept you for therapy. I am away from the office several times in the year for extended vacations. I will tell you well in advance of any lengthy absences, and give you the name and phone number of the therapist who will be covering my practice during my

absence. I am available for brief between-session phone calls during normal business hours. If you believe that you cannot keep yourself safe, please call 911, or go to the nearest hospital emergency room for assistance.

Your Responsibilities as a Therapy Client

I. You are responsible for coming to your session on time and at the time we have scheduled. Sessions last for 50 minutes. If you are late, we will end on time and not run over into the next person's session. If you miss a session without canceling, or cancel with less than twenty-four hours' notice, you will be charged for the cancellation. The answering machine has a time and date stamp which will keep track of time to cancellation. I cannot bill these sessions to your insurance. The only exception to this rule is if you would endanger yourself by attempting to come (for instance, driving on icy roads without proper tires).

II. You are responsible for paying for your session weekly unless we have made other firm arrangements in advance. My fee for a session is $175.00. If we decide to meet for a longer session, I will bill you prorated on the hourly fee. Emergency phone calls of less than ten minutes are normally free. However, if we spend more than 10 minutes in a week on the phone, if you leave more than ten minutes worth of phone messages in a week, or if I spend more than 10 minutes reading and responding to emails from you during a given week I will bill you on a prorated basis for that time. My fees go up $10.00 every two years, on the even year. If a fee raise is approaching I will remind you of this well in advance. For people who decide to work with me on an ongoing basis I also offer discounted packages of 5 or 10 sessions, prepaid and non-refundable. The 5 session package is to be used within 2 months, the 10 session package within 4 months. As fees are occasionally adjusted, please contact me to discuss my current fees.

    If you have insurance, you are responsible for providing me with the information I need to send in your bill. You must pay me your deductible at the beginning of each calendar year if it applies and any co-payment. You must arrange for any pre-authorizations necessary. I will bill directly to your insurance company via electronic means for you once a month. You must provide me with any forms, completely filled out as needed, your complete insurance identification information, and the complete address of the insurance company. If a check is mailed to you, you are responsible for paying me that amount at the time of our next appointment. If the insurance over-pays me, I will credit it to your account or refund it to you if you would prefer that.

III. I am not willing to have clients run a bill with me. I cannot accept barter for therapy, nor can I take DSHS medical coupons. I am a Medicare participating provider and accept assignment from them.

Complaints

A New Outlook Recovery Services is a substance used disorder and mental health disorder treatment program licensed by the Division of Behavioral Health, Colorado Department of Human Services. The counseling staff employed at A New Outlook and their qualifications are as follows:

Robert Johnson, LAC, MAC, SAP

James Weiss. CAS

Daneille Zeck, MSW, LCSW

Emmakay Benske, LPC-C

Sabrina Herstedt, LPC-C

Sarah Zubrin, MA, LAC

Ann Johnson, MEd, LAC

Julia Nichols, MSW, LCSW-C

Sara Gillett, MFT-C, CAS

The practice of registered, certified or licensed persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. Questions and complaints regarding addiction counselors may be addressed to:

Board of Addiction Counselor Examiners 1560 Broadway, Ste. 1350, Denver, CO 80202 303-894-7800

The Division of Behavioral Health has the general responsibility for regulating practices of licensed substance use disorder treatment programs in the State of Colorado. Questions and complaints may be directed to:

Colorado Department of Human Services, Division of Behavioral Health 3824 Princeton Circle, Denver, CO 80236 (303) 866-7400

If you wish to contact someone at A New Outlook Recovery Services directly with a grievance, you can contact: Robert Johnson, Executive Director at robert@coloradorecoveryservices.org

The regulatory requirements applicable to mental health professionals are as follows:

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 or certified by the State and is not required to satisfy any standardized educational or testing requirements.

Certified Addiction Specialist I (CAS I) must be a high school graduate or the equivalent, complete required training hours and I 000 hours of clinically supervised work experience.

Certified Addiction Specialist II (CAS II) must meet the CAS I requirements, complete additional training hours above the CAS I, and 2000 hours of clinically supervised work experience.

Certified Addiction Specialist Ill (CAS III) must have a Bachelor's degree in the behavioral health sciences or field; complete additional training above the CAS II, and 2000 hours of clinically supervised work experience.

Licensed Addiction Counselor must have a clinical Master's degree, meet the CAS III requirements, and pass a national examination in addiction treatment.

Licensed Social Worker must hold a master's degree in social work.

Psychologist Candidate, Marriage, and Family 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, 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.

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. In a professional relationship, sexual intimacy is never appropriate and should be repo1ted to the Board that registers, certifies or licenses the registrant, certificate holder or licensee.

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 as well as other exceptions in Colorado and federal law. For example, mental health professionals are required to report child abuse to authorities. If a legal exception to confidentiality arises during therapy, if feasible, you will be informed accordingly.

SMS Terms & Conditions

This information is in our privacy policy. The Terms & Conditions include information on the types of messages the user can expect to receive The Terms & Conditions including

Messaging frequency may vary; appointment reminders, billing issues, insurance questions, etc.

Message and data rates may apply.

To opt out at any time, text STOP.

For assistance, text HELP or visit our website at https://coloradorecoveryservices.org/.

Visit [Privacy Policy URL] for privacy policy and [Terms URL] for Terms of Service.

A NEW OUTLOOK
RECOVERY SERVICES
YOUR HEALING BEGINS HERE

Client Consent to Psychotherapy

I understand that my alcohol and/or drug treatment records are protected under the Federal Confidentiality Regulation, 42 C. F. R., Part 2, governing Confidentiality of Alcohol and Drug Abuse Patient Records.

Confidential information cannot be disclosed without my written permission unless otherwise provided for by the regulations. Exceptions to confidentiality may also be found in the Notice of Privacy Rights you were provided.

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I consent to the use of a diagnosis in billing, and to release of that information and other information necessary to complete the billing process. I agree to pay the fee of $225.00 per session. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake therapy with A New Outlook Recovery Services. I know I can end therapy at any time I wish an can refuse any requests or suggestions made by A New Outlook Recovery Services, I am over the age of eighteen.

Client signature: Date:

Parent / Guardian Signature (If Minor) Date:

Therapist signature: Date:

A New Outlook Recovery Services
9200 E Mineral Ave Ste 250
Centennial, CO 80112
Main Office – 303-798-2196
Fax – 303-730-2418

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF DISCLOSURE STATEMENT

"You May Refuse to Sign This Acknowledgement' '

I_____, have received a copy of this office's Notice of Disclosure Statement.

(Please Print Name) _____

(Signature)_____

(Date)_____

For Office Use Only

A New Outlook Recovery Services, LLC attempted to obtain written acknowledgement of receipt of our Notice of Disclosure Statement, but acknowledgement could not be obtained because:

☐ _____Individual refused to sign

☐ _____Communications barriers prohibited obtaining the acknowledgement

☐ _____An emergency situation prevented us from obtaining acknowledgement

☐ _____Other (Please Specify

A New Outlook Recovery Services
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Centennial, CO 80112
Main Office – 303-798-2196
Fax – 303-730-2418

CREDIT CARD AUTHORIZATION

Name on authorized credit card: _____

Credit card #: _____

Expiration date: _____ CCV _____

Billing address: _____

City: _____ State: _____ Zip: _____

I, the undersigned, authorize A New Outlook Recovery Services to charge my credit card $225 for a failed appointment which includes missing a scheduled appointment without notice or with less than 24-hour notice. Unpaid balances upon discharge from the practice will be charged to my credit card. I understand that declined charges may result in loss of scheduling privileges or discharge as a patient from the practice.

Printed Name: _____

Date: _____

Signature: _____

A NEW OUTLOOK

RECOVERY SERVICES

YOUR HEALING BEGINS HERE

INFECTIOUS DISEASE SCREEN

First and Last Name: _____ Date: _____

As part of A New Outlook Recovery Service's icensing under the Colorado Dept. of Behavioral Health, we are part of an effort to help limit the spread of infectious sexually transmitted diseases. We try to identify individuals who engage in high risk behaviors and provide information and counseling to manage these risks. Please be aware that your responsses are protected under federal regulatisons governing the Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R. Part 2) and may not be disclosed under Colorado State Law and may not be disclosed, except under State Law provisions.

I have read and understand the above. _____

The following have been identified as high risk factors. Please check those that apply to you:

- ☐ Having multipe sex partners, i.e. more than two in the past ten years.
- ☐ Having sex without a condom.
- ☐ Having sex with someone who has had a sexually transmitted disease, i.e. HIV, Genital Warts, Herpes, Chlamydia, HPV, Gonorrhea, Syphills, Hepatitis.
- ☐ Having sex in exchange for money, drugs, etc.
- ☐ Unprotected anal sex, i.e. without a condom.
- ☐ Injecting drugs, sharing needles.
- ☐ Having received a blood transfusion or organ transplant prior to 1992.
- ☐ Being stuck or cut by anything that may hav been contaminated.
- ☐ Being born to a mother with hepatitis.
- ☐ Receiving tattoos or body piercing. in unsanitary conditions.
- ☐ Have been in close contact with someone who had *Tuberculosis* (TB).
- ☐ Been in a country with high incidence of TB.
- ☐ Had a persistent cough for more than three weeks.
- ☐ Have swollen or tender lymph nodes.

Would you like to talk with a counselor or have more information about this? ☐ Yes ☐ No

Do you feel you are at risk for any of these conditions? ☐ Yes ☐ No

Would you like information on where to obtain low-cost testing for these conditions? ☐ Yes ☐ No

My SNAP Assessment for Recovery

This worksheet will help us talk with you about your mental health treatment here at Cincinnati VAMC. There are four parts for you to share with us about your **S**trengths, **N**eeds, **A**bilities and **P**references. Please check and/or list the items which best fit you at this time.

STRENGTHS

What personal qualities do you have which we can build upon in treatment?

- ☒ Open minded
- ☒ Friendly
- ☐ Creative
- ☐ Good Listener
- ☐ Quick Learner
- ☐ Good Grooming
- ☐ Organized
- ☐ Takes personal responsibility
- ☐ Strong personal or spiritual values
- ☐ Independent
- ☐ Assertive
- ☐ Hard Worker
- ☐ Able to learn from my experiences
- ☐ Can collaborate/ work with others
- ☐ Good Problem Solver
- ☐ Good Decision Maker
- ☐ Dependable
- ☐ Motivation
- ☐ Good health
- ☐ Other (Please List)

_____

_____

_____

NEEDS

What would help you achieve your goals? Please, check your most important needs.

(Prioritize your top three)

- ☐ Increase my knowledge of resources that provide me with support
- ☐ Referral to resources for job training or education
- ☐ Access to medical care for health related concerns
- ☐ Staying in a sober environment to help me not use drugs and or alcohol
- ☐ Gain more knowledge and understanding about:
  - ☐ My mental health diagnosis
  - ☐ My medication(s)
  - ☐ My symptoms / behaviors related to my mental health diagnosis
- ☐ Get help to stop smoking
- ☐ Learn how to empower myself to take a more active role in my treatment
- ☐ Increasing effective communication skills to improve my relationships with others
- ☐ Learn how to talk about my concerns/issues/feelings
- ☐ Practice my coping skills in a safe environment
- ☐ Learn more about effective coping skills related to:
  - ☐ Improving my sleep
  - ☐ Reducing anxiety and using relaxation
  - ☐ Managing my depression
  - ☐ Leisure skills
  - ☐ Organizing daily activities
  - ☐ Managing anger
  - ☐ Mood Regulation
  - ☐ Improving reality-based thinking
  - ☐ Eating Healthy
- ☐ Other (Please List)

_____

_____

Abilities

What skills do you possess?

- ☐ Basic ability to read and write
- ☐ Computer knowledge and skills
- ☐ Ability to work effectively with others
- ☐ Knowledge or tools that I use to help me manage my emotions
- ☐ Ability to have positive relationships with others
- ☐ Ability to make healthy decisions about my life
- ☐ Job Skills _____
- ☐ Education / Training_____
- ☐ Leisure Skills_____
- ☐ Ability to manage my time and structure my daily activities
- ☐ Other (Please List)

Preferences

How do you want your treatment?

- ☐ I prefer my family or friends to be involved in my treatment
- ☐ I would like to have a family meeting

I learn new information better:

- ☐ Face to face
- ☐ Hands on instruction and practice
- ☐ Reading written material
  - ☐ Alone
  - ☐ In discussion with others
- ☐ Sharing information in a group of my peers

- ☐ I would like to live:
  - ☐ Independently, on my own
  - ☐ Independently, with community support
  - ☐ With others
  - ☐ Other ideas I have about my living situation (Please List)

_____

_____

_____

- ☐ I am interested in learning more about
  - ☐ Outpatient programming
  - ☐ Community resources
  - ☐ Other areas of interest (Please List)

_____

_____

_____

_____

Developed for Inpatient Psychiatry, Cincinnati VAMC, 8/10/2010, DDB

A New Outlook Recovery Services & Colorado TMS

Office #: (303) 798-2196 Fax #:(303) 730-2418

9200 E Mineral Ave Ste 250, Centennial, CO 80112

I, _____ hereby authorize:

Client Name and Date of Birth

_____

Agency or Individual **Address** **Phone or Fax #**

To release the following health information about me, TO: A New Outlook Recovery Services/Colorado TMS: (Please check appropriate boxes)

No	Yes	
☐	☐	Name and/or phone number
☐	☐	Demographic information (age, sex, ethnicity, address, etc.)
☐	☐	Diagnosis(es)
☐	☐	History and/or Physical
☐	☐	Laboratory results _____
☐	☐	Psychological/Psychiatric evaluation summary: _____
☐	☐	Billing/Financial information
☐	☐	Progress Report/Treatment Summary/Family Therapy Summary
☐	☐	Urinalysis/Breathalyzer results record
☐	☐	Other (Specify): _____

**Information contained psychotherapy notes may not be released by this authorization. A special authorization must be obtained.

The information is required for: (Please check boxes that apply, if "Other" is checked, you *MUST* describe the purpose forinformation being provided.

☐	Treatment (to obtain additional)	☐	Court for:_____
☐	Consideration/Maintenance of Employment	☐	School, eligibility, credits
☐	Probation/Parole, ongoing eligibility	☐	Voc Rehab, initial and ongoing eligibility
☐	Social Services, to obtain eligibility for treatment	☐	Family members, to inform them of my care and treatment
☐	Other: (Specify):_____		

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records. 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Part 160 &164, and cannot be disclosed without my written permission unless otherwise provided for by the regulations I also understand that I may revoke this permission in writing at any time (refer to your copy of the HIPAA Notice of Privacy Practices for information on how to revoke this permission) except to the extent that action has been taken in reliance on it, and that in any event this permission expires automatically on the date written below:

_____

Date (2 Years)

I understand that generally, A New Outlook Recovery Services., may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances, I may be denied treatment if I do not sign an authorization form. For example, if funding for my treatment is contingent on the agency providing the funding receiving reports on my progress in treatment, I may be refused treatment funded by that source if I am unwilling to consent to release progress reports. I also understand that the people who get this information may give out my information, and it may no longer be protected. However, A New Outlook Recovery Services. will try to prevent redisclosure of my information by providing notification of prohibition of redisclosure to those receiving my information. I understand that I will be given a copy of this permission once I have signed and dated it.

X _____ X _____

Signature of Client Date

_____ _____

Signature of Parent/Guardian Date

_____ _____

Authorized Representative (Describe relationship) Date

_____ _____

Witness Date

(Send original if requesting information from another party. Send copy if releasing information to another party. Send copy ifinformation requested from A New Outlook Recovery Services, LLC., by another party.) *01/2011*