

Marian Camden, Psy.D., LLC
Licensed Psychologist
7500 E. Arapahoe Road, Suite 375
Centennial, CO 80112
720-493-4827 camdencounseling.com

ADULT REGISTRATION FORM

Patient Name _____ DOB _____

Street _____ City _____ State _____ Zip Code _____

Home number _____ Work number _____ Cell number _____

Email address, if desired _____ SSN _____

Employer _____ Position _____

How were you referred to this practice? _____

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. You will also be offered a copy to take with you. Although these documents are long and sometimes complex, it is important that you read them carefully. We can discuss any questions you have about the procedures at any time. When you sign this document, it will also represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often

leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a commitment of time, money, and energy, so you should be careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I normally conduct an evaluation, which may or may not include formal psychological testing, that will last from two to four sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week or every other week at a time we agree on, although some sessions may be longer or more or less frequent. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation or unless I can fill the open slot with another patient.** A appointment scheduled for Monday must be cancelled by noon on Friday to avoid having to pay for the session. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.

PROFESSIONAL FEES

My hourly fee is \$175.00 (or \$3.00 discount for check or cash.) In addition to appointments, I charge this amount for other professional services you may need, although I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than five minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you or your representative may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the complexity and liability of legal involvement, I charge \$200 per hour for preparation for and participation in any legal proceeding.

CONTACTING ME

Because I spend most of my day in session with patients, I am not often immediately available by telephone. While I am usually in my office, Monday through Thursday and on some Fridays, I do not answer the phone when I am with a patient. The best time to reach me is often between noon and 2:00 PM or between 7:00 and 7:30 PM. When I am unavailable, you may leave a message on my confidential voicemail. I will make every effort to return your call within 24 hours, with the exception of Fridays, weekends and holidays. If you are also difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or Highlands Behavioral Health at 720-348-2800. If your emergency is life threatening, call 911 or go to the nearest emergency room and ask for the psychologist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- You should be aware that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as, billing, filing, and quality assurance. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the psychologist-patient privilege law. I cannot provide any information without either your written authorization or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I am required to provide it for them.
- If a patient files a complaint or lawsuit against me, I will disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, I am required to submit a report to the Workers' Compensation Division.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reasonable cause to know or suspect that a child has been subjected to abuse or neglect or if I have observed a child being subjected to circumstances or conditions which would reasonably result in abuse or neglect, the law requires that I file a report with the appropriate governmental agency. Once such a report is filed, I may be required to provide additional information.
- If I have reasonable cause to believe that an at-risk adult has been or is at imminent risk of being mistreated, self-neglected, or financially exploited, the law requires that I file a report with the appropriate governmental agency. Once such a report is filed, I may be required to provide additional information
- If a patient communicates a serious threat of imminent physical violence against a specific person or persons, or toward a specific location, I must make an effort to notify such person or location; and/or notify an appropriate law enforcement agency; and/or take other appropriate action including seeking hospitalization of the patient.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Colorado has a psychotherapist-patient privilege which means mental health professionals cannot be asked about any knowledge gained during the course of therapy without the consent of the person to whom the testimony relates (C.R.S. 13-90-107 (g)). This privilege extends to treatment records including psychotherapy notes.

Juvenile patients in particular require the privacy protection provided by the psychotherapist-patient privilege due to the sensitive nature of children's mental health care (Dill v. People, 927 P.2d 1315, 1321 Colo. 1996.)

While patients have the right to submit in writing a request to examine and/or receive a copy of the Clinical Record, these are professional records and can be misinterpreted and/or upsetting to untrained readers. If I believe disclosure of records may cause psychological harm to the patient, I may instead provide you with a written summary of the records (C.R. S. 25-1-802 (1) (a)). If I refuse your request for access to records, you have a right of review, which I will discuss with you upon request.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized;

determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

You also have a right to inquire about my professional training and credentials and you are always welcome to do so. In summary, I am a psychologist, licensed in the state of Colorado since 1997. I completed a master's degree in counseling and general psychology at the University of West Florida in 1991 and a doctorate in professional psychology at the University of Denver in 1995. I hold a bachelors degree in Social Work and English Literature. My training at the University of Denver was approved by the American Psychological Association as was my pre-doctoral internship site at Indiana University Counseling and Psychological Services. I specialize in family systems, child, couple, and family therapy, trauma recovery, and psychological testing. I have been trained in Eye Movement Desensitization Reprocessing (EMDR) since 2000 and continue to study and implement this therapy technique. I also pursue continuing education in variety of areas, particularly trauma recovery, divorce-related matters, and clinical applications of neurobiology and the field of epigenetics.

You are entitled to request information about the methods of therapy, techniques used, probable duration of therapy if known, and the fee structure. You may seek a second opinion from another therapist or terminate therapy at any time.

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 Board of Psychologist Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

Regulatory requirements applicable to mental health professionals: a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a masters degree in their profession and have two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a masters degree in social work. 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 Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1,000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelor's degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required.

MINORS & PARENTS

Patients under 15 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records, unless I decide that such access is likely to injure the child ((C.R. S. 25-1-802 (1) (a)). Because privacy in psychotherapy is often crucial to successful progress, it is my policy to request an agreement from parents that they consent to give up access to their child's records.

During treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions, except in the case of very young children. Upon written request, I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization to release records, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents and/or appropriate authorities of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the beginning of each appointment, with a check or in cash, unless we agree otherwise. (Credit card payment is not preferred but can be arranged if necessary). Fees for other services will be billed in increments of tenths of an hour. In circumstances of unusual financial hardship, I may be able to negotiate a temporary fee adjustment or temporary installment plan.

If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court, which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

Your signature below indicates that you have read this agreement and agree to abide by all of its terms, including waiver of access to a child patient's records, and also serves as an acknowledgement that you have received the HIPAA notice form described above.

Signature

Date

Printed Name

ADULT INFORMATION FORM

Please answer as openly and fully as you reasonably can. All information will be held in confidence.

SECTION I: IDENTIFYING INFORMATION

Today's Date: _____

Name _____ DOB _____

How were you referred to this office? _____

Whom do you authorize the psychologist to contact in case of emergency?

Name _____ Phone _____ Relationship _____

SECTION II: DESCRIPTION OF PRESENTING CONCERN

What problem/s brings you to this office?

How would you estimate the severity of the problem/s at this time?

Mild		Moderate			Serious		Severe		
1	2	3	4	5	6	7	8	9	10

Have you ever met with a mental health professional before? Yes No
If yes, how was it helpful or not helpful to you?

Have you ever been given a mental health diagnosis in the past? Yes ____ No ____

If yes, as you understand it, what is/was that diagnosis? _____

SECTION III: SYMPTOMS

What symptoms have you experienced in the past month? (Please check all that apply)

overeating restless rapid heart rate compulsive behaviors taking drugs depressed mood
sweating impulsive behaviors odd behavior/thoughts crying trembling or shaking fears/phobias
recent weight gain difficulty concentrating shortness of breath anxiety recent weight loss low
motivation muscle tension vomiting recent appetite changes aggressive behavior outbursts of
temper distrust social withdrawal feelings of worthlessness nightmares jumpy family emotional
problems stomach problems easily distracted dizzy or lightheaded chest pain sleeping too
much decreased need for sleep fatigue/loss of energy difficulty falling asleep problems with school
housing problems obsessions difficulty staying asleep pain drinking alcohol relationship
problems experienced a traumatic event financial problems can't turn my mind off other:

If applicable, please describe any incidents or problems that may have contributed to the problem (e.g., relationship problem, past abuse, parenting problem, accident or illness, etc)

SECTION IV: MEDICAL HISTORY

Your doctor's name and phone number _____

Approximate last date and reason you visited the doctor _____

Please list any significant past or current health, medical, or psychiatric issues (including anything resulting in hospitalizations):

Approximate Dates Problem & Treatment Hospitalized (Y/N) How Long?

If applicable, please list all medications you are now taking or have taken in the past three months, including birth control pills, vitamins, herbs and supplements.

Medication Dosage Person prescribing How long Helpful (Y/N)

Have any members of your current or original family had problems with: (check all that apply)

Family Member	Depression	Anxiety	Other mental illness	Alcohol /Drugs	Learning problem	Seizures	Heart Disease	Cancer	Other Illness (Specify)
Mother									
Father									
Sibling									
Aunt/Uncle									
Cousin									
Spouse									
Child									

If applicable, amount of caffeinated beverages you consume per day: _____ coffee _____ soda _____ tea

If applicable, number of cigarettes smoked per day: _____

If applicable, how often do you use marijuana per week? _____

Consider a typical week during the past month. Please fill in a number for each day of the week indicating the typical number of drinks you usually consume on that day and the typical number of hours you usually drink on that day. Note: 1 Drink = 12 oz. beer / 10 oz. microbrew / 8 oz. malt liquor or 4 oz. of wine /1 o hard alcohol (shot glass)

Approximate:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Number of drinks							
Number of hours drinking							

Circle all that apply:

In the past year, have you taken any medications other than as prescribed or used any recreational drugs other than marijuana?

If yes, please list (this information will be kept in confidence along with everything else in this form):

Have you dealt with gambling, pornography, internet/gaming overuse, or other addictions?

Have you ever experienced: (Please mark all that apply)

Emotional abuse ___ Physical abuse _____ Sexual abuse _____ Sexual assault _____

Comments:

SECTION V: FAMILY OF ORIGIN INFORMATION

Please include parents, siblings, stepparents, and other relatives with whom you lived or to whom you were particularly close

_____ Name _____ Quality of your relationship growing up? _____ Now? _____ Living?

SECTION VI CURRENT FAMILY

_____ First name _____ Age _____ Relationship _____ Quality of Relationship _____ Living with you?

SECTION VI: SOCIAL, CULTURE, AND SPIRITUALITY

In terms of friendship and social support outside your family, are you:

Very satisfied Satisfied Unsatisfied Very unsatisfied

Among your friends, family, and co-workers, whom, if anyone, do you count on for support?

What is your cultural/ethnic background? _____

How connected to this heritage do you feel? _____

Are you experiencing any problems due to cultural or ethnic issues? ___ Yes ___ No

How important to you are spiritual matters? ___ Not ___ Little ___ Moderate ___ Much

Are you affiliated with a spiritual or religious group? ___ Yes ___ No

If Yes, describe:

Would you like your spiritual/religious beliefs incorporated in this counseling?

___ Yes ___ No ___ Do not know

What other information would you like to share about yourself?

The following pages are yours to print and keep as your copy of the notification and contract you signed above:

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consultations in your Clinical Record (which is called “PHI” in my Notice of Psychologist’s Policies and Practices to Protect the Privacy of Your Health Information).

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You also have a right to inquire about my professional training and credentials and you are always welcome to do so. In summary, I am a psychologist, licensed in the state of Colorado since 1997. I completed a master's degree in counseling and general psychology at the University of West Florida in 1991 and a doctorate in professional psychology at the University of Denver in 1995. I hold a bachelors degree in Social Work and English Literature. My training at the University of Denver was approved by the American Psychological Association as was my pre-doctoral internship site at Indiana University Counseling and Psychological Services. I specialize in family systems, child, couple, and family therapy, trauma recovery, and psychological testing. I

have been trained in Eye Movement Desensitization Reprocessing (EMDR) since 2000 and continue to study and implement this therapy technique. I also pursue continuing education in variety of areas, particularly trauma recovery, divorce-related matters, and clinical applications of neurobiology and the field of epigenetics.

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Regulatory requirements applicable to mental health professionals: a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a masters degree in their profession and have two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a masters degree in social work. 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 Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1,000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelor's degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required.

MINORS & PARENTS

Patients under 15 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records, unless I decide that such access is likely to injure the child ((C.R. S. 25-1-802 (1) (a)). Because privacy in psychotherapy is often crucial to successful progress, it is my policy to request an agreement from parents that they consent to give up access to their child's records. During treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions, except in the case of very young children. Upon written request, I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization to release records, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents and/or appropriate authorities of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the beginning of each appointment, with a check or in cash, unless we agree otherwise. (Credit card payment is not preferred but can be arranged if necessary). Fees for

other services will be billed in increments of tenths of an hour. In circumstances of unusual financial hardship, I may be able to negotiate a temporary fee adjustment or temporary installment plan.

If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court, which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.