Client Name: _____

Crazy Wisdom Journey, LLC
5921 S. Middlefield Rd. Suite 100
Littleton, CO 80123
Phone: 303-515-0987
Email: dfoster@3crazywisdom.com
Web: www.3crazywisdom.com

INTAKE INFORMATION & CONSENT FOR TREATMENT

Date_____

CLIENT'S NAME_____ _____
FIRST M. INITIAL LAST AGE

STREET
ADDRESS_____

CITY, STATE, ZIP
CODE_____

DATE OF BIRTH_____/_____/____ _____ MALE_____ FEMALE

CELL PHONE # (_____) _____ HOME# (_____) _____

EMPLOYER_____

EMAIL ADDRESS _____

INSURANCE INFORMATION

INSURANCE
COMPANY_____

INSURANCE I.D. #: _____GROUP # _____

INSURED'S NAME _____

ADDRESS_____

INSURED'S DATE OF BIRTH: _____INSURED'S EMPLOYER____ _____

IS THERE A COPAYMENT? ____YES ____ NO IF SO, HOW MUCH PER SESSION? ____

Client Name: _____

FAMILY INFORMATION

SPOUSE or PARENT/GUARDIAN NAME_____

HOME PHONE (____) _____CELL PHONE: _____

EMERGENCY CONTACT: _____ PHONE #: (____)_____

RELATIONSHIP TO CLIENT: _____

MEDICAL INFORMATION

DIAGNOSIS (IF ANY)

_____

CHECK ANY OF THE FOLLOWING THE CLIENT HAS BEEN DIAGNOSED WITH

Epilepsy _____ Heart Trouble _____ Nervous Condition_____ Headaches _____

Diabetes _____ Cancer _____ Shortness of Breath _____ Asthma _____

Hepatitis _____ Tuberculosis _____ Seizures _____ Allergies _____

Frequent Ear Infections _____ Traumatic Brain Injury _____ High Blood Pressure_____

IS THE CLIENT BEING TREATED FOR MENTAL HEALTH SERVICES ANYWHERE ELSE?

_____YES _____ NO IF YES, WHERE? _____

NAME OF THERAPIST/PSYCHIATRIST: _____

PHONE: _____

IS THE CLIENT ON ANY MEDICATIONS? (IF YES, PLEASE LIST EACH DRUG, DOSAGE, AND DR. MONITORING MEDICATION) _____

Client Name: _____

WHO REFERRED YOU TO OUR OFFICE? (PLEASE CHECK ALL THAT APPLY)

____ INTERNET SEARCH

____ YOUR PRIMARY CARE PHYSICIAN

____ PSYCHOLOGY TODAY

____ FRIEND/FAMILY MEMBER

____ INSURANCE

____ THERAPIST/COUNSELOR

____ OTHER _____

CONSENT FOR TREATMENT OF <u>CHILDREN AND ADOLESCENTS:</u>

I/We consent that _____ may be treated as a client
(CLIENT NAME)

Or clients by Crazy Wisdom Journey, LLC.

Signature(s) _____Date_____

CONSENT FOR TREATMENT OF <u>ADULTS</u>:

I/We consent that _____ may be treated as a client
(CLIENT NAME)

Or clients by Crazy Wisdom Journey, LLC.

Signature(s) _____Date_____

Client Name: _____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully!

We are required by federal privacy laws to make uses and disclosures of your protected health care information for the purposes of treatment, payment, and health care operations known to you. Such information may include documenting your symptoms, ongoing treatment progress, and diagnoses.

Your Health Information Rights

The health and billing records we maintain are the physical property of the Crazy Wisdom Journey, LLC.

You have the following rights with respect to Protected Health Information laws and you may give a written request to:

1. Restrict certain uses and disclosures of your health information.

2. Inspect and copy your health record and billing record.

3. Have your health care record amended to correct incomplete information. If your request is denied, you can file a statement of disagreement to be attached to the file and sent with any disclosures of that information.

4. Receive a listing of disclosures of your information that we have given to others.

5. Have communication of your Protected Health Information done in alternative means or at an alternative location.

- ✓ **Client Signature:_____**

Client Name: _____

Our Responsibilities

1. Maintain the privacy of your Protected Health Information as required by law.
2. Provide you with written notice of the Client Bill of Rights and the information we collect and maintain about you.
3. Abide by the terms of this notice.
4. Notify you if we cannot accommodate a request or requested restriction.
5. Accommodate your reasonable request for an accounting of disclosure of information.
6. Accommodate your request for an accounting of disclosure of information.

Filing a Complaint

If you feel your rights have been violated, you may file a written complaint with us or you may file a complaint with the Secretary of Human Services, 200 Independence Avenue, South West, Washington, DC 20201, phone 1-877-696-6775, or go through the website at www.hhs.gov.

Uses and Disclosures Allowed By the Privacy Rule

Patient Contact: We may contact you regarding appointments, with information about alternative treatments, or with information about other health-related benefits and services that may be of interest to you.

Child Abuse & Neglect: We are a mandated reporter and are required by law to disclose information pertaining to the suspected, reported, and or observed abuse or neglect of a child.

Elder Abuse & Neglect: We are a mandated reporter and are required by law to disclose information pertaining to the suspected, reported, and or observed abuse or neglect of an elder person.

Threat to self or others: Using professional judgment, we are required to report to the appropriate authorities if you (or your child) threaten in earnest to harm self or someone else. If you (or your child) in earnest, discloses a threat against another, we are required to relate that information to the person being threatened.

Judicial Proceedings: We cannot disclose your private information without your written consent unless directed to do so by a proper court order or subpoena from a judge.

In the event that an account is overdue and turned over to our collection agency, only your name, address, contact information, dates of charges, and amount owed will be disclosed to the agency.

Client Signature:_____ Date: _____

Client Name: _____

Authorization to Disclose Protected Health Information to
Primary Care Physician

Communication between your behavioral health provider(s) (therapist) and your primary care physician (PCP) is important to make sure all care is complete, comprehensive, and well-coordinated. This form allows your behavioral provider to share valuable information with your PCP. No information will be released without your signed authorization.

_____
Client Name: Last First MI

____/____/____ (_____)_____
Date of Birth Phone Number

The following behavioral health provider(s) may disclose information:
Crazy Wisdom Journey, LLC (303) 515-0987

The information may be disclosed to the following **Primary Care Physician**:

_____
Name (Physician, or an organization if you are naming a practice) Phone Number & Fax

_____
Address State Zip Code

Signature of the Client or Client's Guardian

Signature_____ Date_____

Signature of Personal Representative (If Applicable)

Signature_____ Date_____

Relationship to Client_____

_____I do not currently have a Primary Care Physician

Signature_____ Date_____

_____I choose to not have any records be released to my Primary Care Physician:

Signature_____ Date_____

Crazy Wisdom Journey, LLC
Phone: 303-515-0987
Email: info@3crazywisdom.com
Web: www.3crazywisdom.com

Client's Name_____ D.O.B. _____

Confidentiality

I give permission for the staff of Crazy Wisdom Journey, LLC to consult and share information with the individuals listed below for the purpose of developing a behavioral treatment plan and to relay progress and updates. Permission expires one year after the date this form is signed.

_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

I have read the above information and understand the issues of confidentiality.

- ✓ **Signed: _____Date: _____**

Client Name: _____

POLICIES AND PROCEDURES

This policy and procedures statement is to help answer frequently asked questions regarding confidentiality, fees, services offered, etc. As a valued client we want you to be informed on all such issues. If other questions come up for you, please feel free to talk to any of the staff of Crazy Wisdom Journey, LLC, as we will be glad to assist you.

CONFIDENTIALITY AND EMERGENCY SITUATIONS:

Your verbal communication and clinical records are strictly confidential except for:

a) information shared with our staff out of session
b) information you and your child or children report about physical or sexual abuse; (then, by Colorado State Law, we are obligated to report this information to the Colorado Department of Children's Services)
c) information shared with your insurance company to process your claims
d) when you sign a release to have specific information shared,
e) if you provide information that informs us that you are in danger of harming yourself or others.

If an emergency arises for which the client or their guardian feels immediate attention is necessary, the client or the guardian understands they are to contact the emergency services in the community for those services. Crazy Wisdom Journey, LLC will follow those emergency services with standard counseling and support to the client or the client's family.

If you are referred by your physician or other health care professional, it is professional courtesy to maintain contact, as necessary, with that referral source. This will be done unless you request otherwise.

Parents or legal guardians will have access to pertinent information related to their minor children (under the age of 16), unless the courts have terminated parental authority. Both parents can have access to the records and information regarding minor children, as long as both parents hold full custody.

FINANCIAL AND INSURANCE ISSUES:

Fees for services are based on a 50-minute hour, unless arranged otherwise with your clinician. **All cancellations must be made 48 hours in advance** unless there is an extreme emergency.

Master Card, Visa, and Discover are accepted for service payment.
As a courtesy, we will bill your insurance company, HMO or responsible party if you wish. We ask that at each session you pay your co-pay, if indicated. In the event that you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the

Please Initial_____

balance due at that time. After 60 days, any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. Lastly, we ask that every client authorize payment of medical benefits directly to Crazy Wisdom Journey, LLC. We sincerely appreciate your cooperation and if at any time you have questions regarding insurance, fees, balances or payments, please feel free to ask.

PROFESSIONAL SERVICES:

Office hours for Crazy Wisdom Journey, LLC may at times vary. Go to www/schedulicity.com to find available appointments times and to book appointments.

When the phone is not answered, please leave a message. Your phone call will be returned that day, if during business hours, or the next business day if after hours. Should you be unable to reach your therapist in or during an emergency, you may obtain assistance by calling 888-885-1222, or by going to your local hospital emergency room.

BENEFITS AND RISKS OF COUNSELING:

When considering counseling you should realize significant changes in your life may happen. Clients often change their perspectives, emotions, attitudes, and behaviors. Changes may also happen in your private life, such as changes within marriages or significant relationships, with parents, friends, children, relatives, etc. Clients may change employment, begin feeling differently about themselves, and may change other aspects of their lives. While the professional staff will assist the client in effecting change, we cannot guarantee a specific outcome. Each client is ultimately responsible for making changes in their own personal growth.

CREDENTIALS

All Counseling staff at Crazy Wisdom Journey, LLC has a minimum of a Master's Degree in Counseling, Psychology or a related field, and is licensed or seeking licensure with the Colorado Department of Regulatory Agencies.

All Counselors follow the American Counseling Association's Code of Ethics, which ensures ethical standards of practice.

By signing this form, I agree that I have read and that I understand the Policies and Procedures set forth by Crazy Wisdom Journey, LLC and agree to the set conditions of the Practice Policies.

Signature_____ Date_____