DFI
DENVER FAMILY INSTITUTE
Therapy and Trainings for Stronger Relationships

Mandatory Client Information Form

Date of First Session: _____

Name: _____ Birth date: _____/_____/_____

Gender: _____ Gender Pronouns (ex: she/he/they/etc.): _____

Address: _____
street city state zip

Email: _____

Phone: (check preferred)
☐ Cell: _____ May we leave messages here? ☐ Yes ☐ No
☐ Home: _____ May we leave messages here? ☐ Yes ☐ No
☐ Work: _____ May we leave messages here? ☐ Yes ☐ No

Other family members who may attend therapy:
Name: _____ Age: ____ Relationship: _____
Primary Phone: _____ Secondary Phone: _____ Gender: _____
Name: _____ Age: ____ Relationship: _____
Primary Phone: _____ Secondary Phone: _____ Gender: _____
Name: _____ Age: ____ Relationship: _____
Primary Phone: _____ Secondary Phone: _____ Gender: _____
Name: _____ Age: ____ Relationship: _____
Primary Phone: _____ Secondary Phone: _____ Gender: _____
Name: _____ Age: ____ Relationship: _____
Primary Phone: _____ Secondary Phone: _____ Gender: _____

Other important family members or members of household, not involved in therapy:
Name: _____ Age: ____ Relationship: _____ Gender: _____
Name: _____ Age: ____ Relationship: _____ Gender: _____
Name: _____ Age: ____ Relationship: _____ Gender: _____
Name: _____ Age: ____ Relationship: _____ Gender: _____
Name: _____ Age: ____ Relationship: _____ Gender: _____

Sexual Orientation: _____

Are you currently partnered? ☐ Yes ☐ No
If so, please describe your partnership(s): _____
_____

Primary Care Physician: _____ Phone: _____
Address: _____
Psychiatrist:_____ Phone: _____
Address: _____

How were you referred to us? _____
May we acknowledge the referral? (this is not required) ☐ Yes ☐ No
If yes, phone number of referring person/agency: _____

Revised 02/12/2016

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What are the primary reasons you choose DFI (check up to three that apply best):

- ☐ Affordability
- ☐ Reputation of DFI
- ☐ Trust in person who referred me/us
- ☐ Location
- ☐ Other: _____
- ☐ Strength-based services
- ☐ Focus on relational therapy
- ☐ Timeliness of first appointment
- ☐ Person who took my intake call

Race/Ethnicity (check all that apply to family members):

- ☐ African-American
- ☐ Asian-American
- ☐ Caucasian/White
- ☐ Hispanic-American/Latino
- ☐ Native-American
- ☐ Multiracial
- ☐ _____

Income Level for Family per year:

- ☐ $1 – $10,000
- ☐ $10,001 – $20,000
- ☐ $20,001 – $30,000
- ☐ $30,001 – $40,000
- ☐ $40,001 – $50,000
- ☐ $50,001 – $60,000
- ☐ $60,001 – $70,000
- ☐ $70,001+

Please indicate your religious affiliation(s), if any. List all, if more than one in the family:

_____

Have you participated in therapy or counseling in the past? ☐ Yes ☐ No

If yes, tell me about your experience of therapy (positive, negative, mixed, etc.): _____

_____

_____

What would you like to gain from our work together? (What are your therapy goals?) _____

_____

_____

_____

What is going well in your family at this time? _____

_____

Have you or members of your family been or are currently the victims of abuse (physical, sexual, emotional): _____

_____

Are you or someone in the family currently suicidal or homicidal: ☐ Yes ☐ No

Medications being taken by yourself and family members (name – medications):

_____

_____

_____

Describe any *compulsive/addictive behaviors* in yourself or other family members (drug, alcohol, gambling, spending, sex, etc): _____

_____

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Communication: Briefly describe strengths and/or concerns about family communication.

_____

_____

Physical: Briefly describe strengths and/or concerns about the physical health of yourself or family members). _____

_____

_____

Play/Recreation/Fun Together: Briefly describe strengths and/or concerns about play and recreation for yourself or the family). _____

_____

Stresses: Please describe any significant stresses that are affecting you or your family at this time, or from the past. _____

_____

Safety: Please share any issues of safety such as violent behavior, hitting, pushing, shoving, physically restraining another person, or intimidation that are a concern in the family. _____

_____

_____

Resources/Strengths: Please describe some of the resources and strengths you have in your life for yourself or your family (friends, family, job, spiritual beliefs, support, etc). _____

_____

_____

What are you or your family not willing to do differently at this time? _____

_____

When therapy is successful, how will we know? _____

_____

How motivated are you and your family members to succeed in therapy at this time:
(on a scale from 1 to 10; 1 – no motivation to 10 – most important thing to me now):

Name: _____ Rating (1 to 10): _____
Name: _____ Rating (1 to 10): _____
Name: _____ Rating (1 to 10): _____
Name: _____ Rating (1 to 10): _____
Name: _____ Rating (1 to 10): _____
Name: _____ Rating (1 to 10): _____

Who might you want to be involved in the therapy that is not here today? _____

_____

_____

If you prefer to do individual therapy without family members, partner/spouse, please share the primary reason that you have for that preference? _____

_____

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PLEASE READ THIS ENTIRE DOCUMENT AND OTHERS GIVEN TO YOU:

Thank you for sharing this personal information. I look forward to our work together. This information will be kept confidential within the limits described in the **Mandatory Disclosure/Right to Privacy** documents. Please read them thoroughly. Let me know if you feel uncomfortable signing any of them or if you have any questions.

FEES/PAYMENT:

I/We understand that DFI offers the lowest fees possible on a sliding scale (based my family's annual income) and I/We understand that the ***fee for myself or my family will be $*** ☐ ***per session***. All checks made payable to **"Denver Family Institute."**

By signing below, I/We accept responsibility for the **payment of services at the time** they are rendered. I/We also accept responsibility for **payment of sessions cancelled less than 24 hours** before the scheduled appointment time.

Court testimony, depositions, and court preparation result in additional costs at the rate of $125 per hour.

INVOLVEMENT IN THERAPY – CONSISTENCY OF APPOINTMENTS:

You and your family have a right to terminate or quit therapy at any time. As long as you are in therapy with DFI, we strongly encourage you to keep all scheduled appointments. Life can be busy, and things get in the way. Therapy is an investment in your well-being and health. Making time for it can be a major step forward. Talk to me if you are having difficulty keeping appointments.

Therapy works best when you come to sessions with goals and ideas about what you want to address for the session. Please give me feedback about our work together. I am open to feedback. These are your sessions.

Sometimes in the course of therapy, individuals or family members may feel more pain, discomfort, or upset as issues are explored. Please let me know if that is happening to you or one of your family members.

FAMILY SECRETS:

When I am working with couples and families, I and the Denver Family Institute have a "no secrets" policy. This means that I as a therapist will not keep significant secrets about the family from others participating in therapy. If you have questions about this, please ask me. If you are seeing me as an individual client, then except for those items mentioned in the mandatory disclosure, I will keep what you say confidential without written permission.

TAPES/OBSERVATION:

As you know, DFI is also a training program. To assure the highest quality services, and to better serve you, you agree to allow the taping of sessions and the live observation of your therapy sessions for clinical supervision and peer consultation. Your therapist will always try to inform you if a session is being observed, and you can always meet those persons if you prefer to. You have the right to refuse taping or

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live observation in special situations when feeling vulnerable, but must allow it generally to receive services.

INTAKE PROCESS:
We welcome your feedback. Please take a moment to tell us about the intake process for you at DFI:

1) First Contact with DFI:
   - ☐ Able to talk to someone the first time we called.
   - ☐ Left message and someone called back in 24 hours or one day.
   - ☐ Left message and someone called back in 48 hours or two days.
   - ☐ Left message and someone called back in 72 hours or three days.
   - ☐ Left message and someone called back in more than 72 hours.

2) The person we talked to was named: _____ and I would describe them:
   - ☐ Very welcoming and professional
   - ☐ Welcoming and professional
   - ☐ Somewhat welcoming and professional
   - ☐ Not as friendly, helpful, or professional as I expected

By signing below, I or we (adults and minors 15 and older) have read this document and attest that the information we added is true to the best of our knowledge. We agree to all the terms and conditions describe in this document

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date

By signing below, I the assigned therapist, have answered any questions, reviewed the mandatory disclosure required by DORA, and have discussed the fee agreement.

_____ _____
Signature of Therapist Date

This form is required for all cases opened at Denver Family Institute. Clients may be given this form to complete prior to the first session, either by having them access the form online, mailing a form to them, or by having the form available at the office prior to the session. 30 minutes is a recommended amount of time to give clients to complete this form if given to them prior to the session. Completing the form should not be used as part of the initial therapy session time.

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THERAPIST COPY

MANDATORY DISCLOSURE/INFORMED CONSENT FOR DFI CLIENTS

The Denver Family Therapy Clinic is a COAMFTE accredited training program in relationship and family therapy. We work from strength-based, systemic or relational focus generally. The approach may be adjusted on a case-by-case basis. Graduate and post-graduate students who are unlicensed therapists and trainees at DFI provide these services. Supervision is provided by faculty members who are licensed, experienced clinicians. Your therapist will share information about you and your case with their supervisor(s) at DFI and other trainees in supervision or peer consultation.

Your therapist receives **supervision** from one or more of the faculty at Denver Family Institute. By signing this document, you give permission for your therapist to discuss your case information with supervisors and colleagues at Denver Family Institute for professional and educational purposes only.

REGULATION OF PSYCHOTHERAPISTS:
The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The regulatory boards can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. The regulatory requirements for mental health professionals provide that a Licensed Clinical Social Worker, a Licensed Marriage and Family therapist and a Licensed Professional Counselor must hold a Master's degree in their profession and have two years of post-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 Master's 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 Addictions 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 listed in the State's Database and is authorized by law to practice psychotherapy in Colorado, but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain registration from the state.

CLIENT RIGHTS AND IMPORTANT INFORMATION:
a. 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. Please ask if you would like to receive this information.

b. You can seek a second opinion from another therapist or terminate therapy at any time.

c. 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 Department of Regulatory Agencies, Mental Health Section.

d. Generally speaking, information provided by and to a client in a professional relationship with a psychotherapist is legally confidential and the therapist cannot disclose the information without the client's consent. There are several exceptions to confidentiality which include: (1) I am required to report any suspected incident of child abuse or neglect to law enforcement; (2) I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (3) I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled as a result of a mental disorder; (4) I am required to report any suspected threat to national security to federal officials; and (5) I may be required by Court Order to disclose treatment information.

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

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NOTICE FOR MEDICAID MEMBERS: Under Colorado law effective 7/1/2015, 10 CCR 2505-10 8.061 Section .9, regarding use of other resources in the provision of medical assistance benefits, "a [Medicaid[client may enter into an agreement with a third party or provider whereby the client agrees to be personally liable for payment of services not covered by the third party or Medicaid. This agreement must set forth the specific services provided by the third party or provider, the approximate cost of services provided and the method of payment by the client. The agreement must be signed and dated by both the client and the third party or provider in advance of the services being rendered."

I understand that I am choosing a therapy service that is not a Medicaid provider and that my private pay fee and method of payment for all therapy services have been determined by standard DFI policies. _____ (Initial if applicable)

LIMIT OF SERVICES AVAILABLE: **DFI does not provide emergency** and after-hours services. If you find yourself in a **life-threatening situation** and are unable to contact your DFI therapist, you agree to take the necessary steps to keep yourself safe, up to and including calling 911 or going to the emergency room (at your cost) if necessary.

We do not provide medications, psychiatric services, or psychological testing.

If you are involved in a divorce or custody litigation, you need to understand that my role as a therapist is not to make recommendations for the court concerning custody or parenting issues or to testify in court concerning opinions on issues involved in the litigation. By signing this disclosure statement, you agree not to call me as a witness in any such litigation. Experience has shown that testimony by therapists in domestic dispute cases causes damage to the clinical relationship between a therapist and client. Only court-appointed experts, investigators, or evaluators can make recommendations to the court on disputed issues concerning parental responsibilities and parenting plans.

PLEASE NOTE: Child abuse refers to any child abuse you discuss in therapy or that is observed. This includes illegal sexual contact between two minors, or abuse of children outside your family. We are mandated to report suspected child abuse.

I have read the preceding information and it has been presented to me verbally. I understand the disclosures that have been made to me. I acknowledge that I have received a copy of this Disclosure Statement.

Therapist Name and Credentials_____

Supervisor Name and Credentials_____

_____
Print Client's Name

_____ _____
Client Signature or Responsible Party Date

_____
Print Client's Name

_____ _____
Client Signature or Responsible Party Date

_____ _____
Therapist Signature Date

Revised 02/12/2016

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NOTICE OF RIGHT TO PRIVACY AND MANDATORY DISCLOSURE SIGNATURE FORM

I/We, _____ (print name), and

_____ (print name) have received a copy of the DFI "Right to Privacy" form in compliance with federal HIPAA regulations. I/We have also received a copy of the "Mandatory Disclosure/Informed Consent" form for DFI. That form is also included in the Mandatory Client Information Form that I/we completed prior to the session. I/We understand that it is my/our responsibility to read this document. I/We had the opportunity to ask questions regarding these two documents.

_____ _____
Client Signature Date

_____ _____
Client Signature Date

I, _____ (print name), gave a copy of the DFI "Right to Privacy" form in compliance with federal HIPAA regulations. I reviewed the Mandatory Disclosure/Informed Consent document with the clients and answered any questions that they had.

_____ _____
Therapist Signature Date

Therapists place this document in the DFI client file. Failure to give clients copies of these documents later than the second session is a violation of DFI Policy and Colorado Mental Health Statutes.

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CLIENT COPY

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Supervisor Name and Credentials_____

_____
Print Client's Name

_____ _____
Client Signature or Responsible Party Date

_____
Print Client's Name

_____ _____
Client Signature or Responsible Party Date

_____ _____
Therapist Signature Date

Revised 02/12/2016

Denver Family Institute Notice of Privacy Practices

This notice describes how medical information (including mental health) about you may be used and disclosed and how you can get access to this information.

Please read carefully.

During the process of providing services to you, I will obtain, record, and use mental health and medical information about you that is protected health information. Ordinarily that information is confidential and will not be used or disclosed, except as described below.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

A. ***General Uses and Disclosures Not Requiring the Client's Consent***. I may use and disclose PHI about you without your authorization in the following circumstances:

1. *Treatment*. Treatment refers to the provision, coordination, or management of health care and related services by one or more health care providers. For example, I may use your information to plan your course of treatment and to consult with another health care provider to ensure the most appropriate methods are being used to treat you.
2. *Payment*. Payment refers to the activities undertaken by a health care provider to obtain or provide reimbursement for the provision of care. I may use and give your information to others to bill and collect payment for the treatment and services provided to you. For example, I may share portions of your information with billing services and billing personnel, collection services, insurance companies, health plans, and third party payers that provide you coverage. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnoses, type of service, date of service, provider name/identifier, and other information about your condition and treatment.
3. *Health Care Operations*. Health Care Operations refers to activities that are regular functions of the management and administrative activities. For example, I may use your health information in monitoring of service quality, training and education, medical reviews, legal services, auditing functions, compliance programs, business management and general administrative activities, and planning for future operations.
4. *Contacting the Client*. I may contact you to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.
5. *Required by Law*. I will disclose protected health information when required by law. This includes, but is not limited to the following situations:
    i. Reporting child abuse or neglect;
    ii. When the disclosure is for judicial and administrative proceedings, for example in response to an order of a court or administrative tribunal;
    iii. When there is a legal duty to warn or take action regarding imminent danger of others;
    iv. When the client is a danger to self or others or gravely disabled;
    v. When required to report certain communicable diseases and certain injuries;
    vi. When a Coroner is investigating the client's death; and
    vii. To government regulatory and oversight agencies which are authorized by law to oversee my operations.
6. *Crimes on the premises or observed* by Denver Family Institute. Crimes observed by me, which are directed toward me or occur on the premises of our office, will be reported to law enforcement.
7. *Business Associates*. Some of the functions of the health care providers are provided by contracts with business associates. For example, some clinical, quality assurance, legal, auditing, and practice management services may be provided by contracting with outside entities to perform these services.
    i. In those situations, protected health information will be provided to those contractors as is needed to perform their contracted tasks. In those situations, the business associates

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are required to enter into an agreement maintaining the privacy of the protected health information released to them.

8. *Research*. I may use or disclose protected health information for research purposes if the relevant limitations of the Federal HIPAA Privacy Regulations are followed. 45CFR §164.512(i).
9. *Involuntary Clients*. Information regarding clients who are being treated involuntary will be shared with other treatment providers, legal entities, and others, as necessary to provide the care and management coordination needed.
10. *Family Members*. Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of that discussion. However, if the client objects, protected health information will not be disclosed.
11. *Emergencies*. In life threatening emergencies, I will disclose information necessary to avoid serious harm or death.

B. ***Client Authorization or Consent.*** I may not use or disclose protected health information in any other way without a signed **Authorization or Release of Information**. When you sign an Authorization or Release of Information, it may later be revoked, provided that revocation is in writing. The revocation will apply except to the extent that I have already relied on it.

C. ***Psychotherapy Notes.*** I may maintain psychotherapy notes separately from the remainder of my records. Use or disclosure of these notes will only occur under these circumstances: (a) you specifically authorize their use or disclosure in a separate written authorization; (b) I use them for your treatment; (c) I may use them for my own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family or individual counseling; (d) if you bring a legal action and I have to defend myself; and (e) certain limited circumstances defined by law.

II. YOUR RIGHTS AS A CLIENT

A. ***Additional Restrictions*****.** You have the right to request additional restrictions on the use or disclosure of your health information. I am not required to agree to your request, and there are certain limits to any restriction, which will be provided to you at the time of your request. To exercise your right, discuss it with me.

B. ***Alternative Means of Receiving Confidential Communications.*** You have the right to request that you receive communications of protected health information by alternative means or alternative locations. For example, if you do not want to receive bills or other materials at your home, you may request that this information be sent to another address. To exercise this right, discuss it with me.

C. ***Access to Protected Health Information.*** You have a right to inspect and obtain a copy of the protected health information contained in clinical, billing and other records used to make decisions about you. Your request must be in writing. We may charge you related fees. There are some limitations to this right, which will be provided with you at the time of your request, if any such limitation applies. To exercise this right, discuss with me.

D. ***Amendment to Your Record.*** You have the right to request amendment of your protected health information. Your request must be in writing and it must explain why the information should be amended. We are not required to amend the record if it is determined that the record is accurate and complete. There are other exceptions, which will be provided to you at the time of your request, relevant, along with the appeal process available to you. To exercise this right, discuss this with me.

E. ***Accounting of Disclosures.*** You have the right to receive an accounting of certain disclosures I have made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment, or health care operations. In addition, the accounting does not include disclosures made to you, disclosures authorized by you, or disclosures made prior to April 13, 2003. There are other exceptions that will be provided to you, should you request an accounting. To exercise this right, discuss with me.

F. ***Copy of the Notice.*** You have a right to request a paper copy of this Notice at any time.

III. ADDITIONAL INFORMATION

A. ***Privacy Law.*** We are required by law to maintain the privacy of your protected health information. We are also required to provide clients with notice of my legal duties and privacy practices with respect to protected health information. That is the purpose of this notice.

B. ***Terms of the Notice.*** We are required to abide by the terms of this Notice, or any amended Notice that may follow.

C. ***Changes to the Notice.*** We reserve the right to change our privacy practices and the terms of this Notice at any time, and to make the new Notice provisions effective for all protected health information that we maintain. When changes are made, the revised Notice will be posted in my office. Copies of this Notice will be available upon request.

D. ***Complaints Regarding Privacy Rights.*** If you are concerned that I have violated your privacy rights, you may file a complaint with me directly, in writing, using the contact information provided at the end of this Notice. You also have the right to complain to the United States Secretary of Health and Human Services, 200 Independence Avenue, SW, Room 515F, HHH Bldg, Washington, DC 20201. It is our policy that there will be no retaliation for your filing such a complaint.

E. ***Effective Date.*** This Notice is effective April 15, 2003.

F. ***Additional Information.*** If you want more information about our privacy practices or have any questions or concerns, please contact our HIPAA officer directly.

G. ***Contact:*** **Jamie Leach, LPC**

DFI Executive Director
Denver Family Institute
3600 S Yosemite St. Suite 1050
Denver, CO 80237
303-756-3340

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