Lisa Joyce, MA, LPC
5527 N. Union Blvd., Suite 203 Colorado Springs, CO 80918
Office (719)598-0982 Fax (719)264-7618 www.lisajoycelpc.com

NEW CLIENT INFORMATION

Client Name: _____ Sex: ☐M ☐F
DOB: _____ **SSN**: _____
Address: _____
City, State, Zip Code: _____

		Okay to contact you at this number?	Okay to leave a message?
Home Phone:	_____	☐Yes ☐ No	☐Yes ☐ No
Cell Phone:	_____	☐Yes ☐ No	☐Yes ☐ No

I give permission to leave messages with the following person(s) in the event that I am unable to take your call. Please note the Name, Relationship, and any alternate contact numbers. If none, then please note N/A and date and sign.

_____
_____
_____

_____ _____
Client/Parent Signature **Date**

Your provider is happy to correspond via email, but it is important to know that there is no way to guarantee confidentiality when using unencrypted email addresses. If you wish to be able to communicate with your therapist via email, please provide your email address.
Email Address:
_____
Would you like to receive appointment reminders via email? ☐Yes ☐No

Preferred method of communication: ☐Home # ☐Cell phone # ☐Text msg. ☐Email

Current Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other: _____

Emergency Contact:
Name: _____ Relationship to Client: _____ Phone Number: _____
Address: _____City, State _____

Primary Insurance Information:
Insurance Provider: _____ Policy Holder: _____ DOB: _____
Policy Holder SSN: _____ Client's Relationship to Policy Holder: _____
Member ID #: _____ Group/Plan: _____
Deductible: _____ Met for this year? ☐Yes ☐ No Coinsurance: _____ Copay: _____

Secondary Insurance Information:
Insurance Provider: _____ Policy Holder: _____ DOB: _____
Policy Holder SSN: _____ Client's Relationship to Policy Holder: _____
Member ID #: _____ Group/Plan: _____
Deductible: _____ Met for this year? ☐Yes ☐ No Coinsurance: _____ Copay: _____

If client is a Minor:
Parent/Guardian Name: _____ DOB: _____
Address (if different than client): _____
Home Phone: _____ Cell Phone/Work Phone: _____
Email Address: (please note same advisory about email noted above) _____
Are there custody orders related to this child? ☐Yes ☐No
If yes, who has medical decision making responsibility? _____

Please briefly describe what brings you to counseling?

_____
_____
_____
_____

HISTORY

Name and Phone Number of Primary Care Physician:

_____

Name and Phone Number of current Psychiatrist, if any:

_____

May this provider communicate with your Physician and/or Psychiatrist regarding your treatment needs, progress and recommendations? ☐Yes ☐No

Any current or past significant health issues? _____
_____

Are you currently taking any medication? ☐Yes ☐No
If so, please list the medications and dosage.

_____
_____

Have you attended counseling in the past? ☐Yes ☐No If yes, when and with whom?

_____
_____

Have you had any recent history of suicidal or homicidal thoughts? ☐Yes ☐No
If yes, explain:_____
_____
Have you ever attempted to commit suicide? ☐Yes ☐No When? _____

Do you have any history of self harming behaviors? ☐Yes ☐No If yes, ☐Current ☐Past
Explain:_____
_____

Do you have any history of addictions? (alcohol, drugs, gambling, sex, etc) ☐Yes ☐No
If yes, explain: _____
_____
_____
☐Current addiction issues ☐Past addiction issues only

Have you ever been the victim of: ☐childhood physical abuse ☐childhood sexual abuse
☐ childhood neglect ☐domestic violence ☐sexual assault ☐physical assault
☐other significant trauma: _____ ☐None
Explain: _____
_____
_____
_____

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CLIENT DISCLOSURE STATEMENT AND CONSENT TO TREAT

MY CREDENTIALS:
Lisa Joyce, MA, LPC, DBTC
I have a Bachelor's Degree in Psychology from the University of Colorado at Colorado Springs and a Master's Degree in Community Counseling from the University of Northern Colorado. I am a Licensed Professional Counselor (CO License #4610) and a Certified Dialectical Behavior Therapist (DBT National Certification and Accreditation Association).

PSYCHOTHERAPY
Psychotherapy services vary depending on the client's needs, personality and the particular issue being addressed. There are different methods that may be used to address different issues. Therapy is different from other healthcare services in that it requires a very active effort on the client's part. Therapy can have benefits and risks. There are no guarantees on how therapy will impact a client.

REGULATION OF PSYCHOTHERAPISTS
The practice of both licensed and unlicensed persons and certified or licensed school psychologists in the field of psychotherapy is regulated by the Department of Regulatory Agencies. 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 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 by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.
- A Certified Addiction Counselor I (CAC I) must be a high school graduate or equivalent, complete required training hours and 1,000 hours of supervised experience.
- A Certified Addiction Counselor II (CAC II) must be a high school graduate or equivalent, complete the CAC I requirements, and obtain additional required training hours, 2,000 additional hours of supervised experience, and pass a national exam.
- A Certified Addiction Counselor III (CAC III) must have a bachelor's degree in behavioral health, complete CAC II requirements, and complete additional required training hours, 2,000 additional hours of supervised experience, and pass a national exam.
- A Licensed Addiction Counselor must have a clinical master's degree, meet the CAC III requirements, and pass a national exam.
- A Licensed Social Worker must hold a master's degree from a graduate school of social work and pass an examination in social work.
- A Licensed Clinical Social Worker must hold a master's or doctorate degree from a graduate school of social work, practiced as a social worker for at least two years, and pass an examination 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 Licensed Marriage and Family Therapist must hold a master's or doctoral degree in marriage and family counseling, have at least two years post-master's or one year post-doctoral practice, and pass an exam in marriage and family therapy.
- A Licensed Professional Counselor must hold a master's or doctoral degree in professional counseling, have at least two years post-master's or one year postdoctoral practice, and pass an exam in in professional counseling.
- A Licensed Psychologist must hold a doctorate degree in psychology, have one year of post-doctoral supervision, and pass an examination in psychology.
Any complaints filed with DORA must be done within 7 years of your last appointment or for minors, within 7 years of their 18th birthday (up to 12 years max) as your records are only retained for that length of time.

CLIENT RIGHTS AND IMPORTANT INFORMATION
1. The client is entitled to receive information about the methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure;
2. The client may seek a second opinion from another therapist or may terminate therapy at any time;
3. In a professional relationship, sexual intimacy is never appropriate and should be reported to the director or the board that regulates, registers, certifies, or licenses such unlicensed psychotherapist, registrant, certificate holder, or licensee;
4. The information provided by the client during therapy sessions is legally confidential in the case of licensed marriage and family therapists, social workers, professional counselors, psychologists, licensed or certified addiction counselors, and unlicensed psychotherapists, except as provided in section 12-43-218 and except for certain legal exceptions that will be identified by the licensee, registrant, certificate holder, or unlicensed psychotherapist should any such situation arise during therapy. 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.
5. 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 HIPAA Standards.

PROFESSIONAL FEES
Regular fee for services is $140 for the initial intake session, $130 per individual/family session (45-50 minutes). All fees are due at the time services are rendered and a $35 fee will be assessed for any returned checks. Clients will also be responsible for a fee of $75 if they request that their therapist complete any disability related paperwork. Lisa Joyce, MA, LPC reserves the right to refuse services if your account is past due. Lisa Joyce, MA, LPC also reserves the right to use the services of a collection agency for collection of fees on delinquent accounts, and only information pertinent to fee

collection will be disclosed. If your account is referred to a collections agency, you agree to pay the balance owed plus any collections expenses of 30-50% of any balances owing, plus any attorney's fees. ***A $50 fee will be assessed for any missed appointments or group sessions if the client fails to cancel the appointment with at least 24 hours notice, unless due to an emergency.*** This fee is NOT billable to insurance and is the client's responsibility.

COURT DIRECTED TREATMENT OR EVALUATIONS, TESTIMONY AND COURT REPORTS
If your treatment is related to court involvement, or you are planning to request that your treatment information be provided to the court, there are additional things you need to be aware of. If you are COURT ORDERED to participate in treatment or evaluation, your compliance with treatment can be released to the court without further release from you. If you are not court ordered to attend treatment, but would like Lisa Joyce, MA, LPC to submit treatment reports to the court, or provide court testimony on your behalf, you (if individual therapy) or ALL FAMILY MEMBERS (if family therapy) must sign a release of information. Any report writing will be billed to you at a rate on $200 per hour, and is not covered by insurance. If your counselor is requested to testify, or required to respond to a subpoena for testimony, you will be charged $200 per hour, which will be billed for the entire amount of time required to include court preparation, travel time, time waiting in court, and time testifying. For these requests, Lisa Joyce, MA, LPC requires that you have a signed credit card authorization on file to cover all costs.

TELEHEALTH SERVICES
Please note that not all insurances cover telehealth services. Telehealth sessions are operated via Doxy.me, which is a secure, HIPAA compliant video chat platform. To log in for telehealth session, you go to https://doxy.me/ljoyce. Your therapist will ensure confidentiality to the degree possible on her end by only conducting telehealth sessions in a secure location outside of the presence of others who may be able to overhear sessions and she will utilize a secure internet connection. You will be responsible for securing confidentiality on your end in the same way. There are some risks of technological difficulties that may result in dropped calls. If this happens, your therapist will call you by phone to discuss backup platforms to try or will reschedule your session. There are certain times where your therapist may determine that telehealth is not appropriate.

CONTACTING YOUR THERAPIST AND EMERGENCIES
Due to the nature of the business, Lisa Joyce, MA, LPC may not be immediately available by telephone at all times. Clients are always welcome to leave a message on the confidential voicemail, which is checked frequently. If it is more urgent, clients may contact Lisa Joyce, MA, LPC by cell phone at 719-229-5348. If it is an emergency and you are unable to reach your therapist or cannot wait for a return call, clients should contact the local crisis center at 719-635-7000 or call 911.

CONSENT TO TREAT

I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree (or agree for my child) to undertake therapy with Lisa Joyce, MA, LPC. I accept financial responsibility for all services rendered, and for any no show or late cancellation fees incurred by me (or my child).

_____ _____
Client Signature (adults and children age 12 or older) **Date**

NOTICE OF PRIVACY RIGHTS (HIPAA)

I received a copy of this statement and have received the agency's Notice of Privacy Rights. A copy of Privacy Rights is always available on Lisa Joyce's website or in the office.

_____ _____
Client/Parent Signature **Date**

_____
Client Representative (sign, print, and list relationship to client)

SURPRISE/BALANCE BILLING DISCLOSURE

I received a copy of this statement and have received the surprise/Balance billing disclosure. A copy of the Surprise/Balance Billing Disclosure is always available on Lisa Joyce's website or in the office.

_____ _____
Client/Parent Signature **Date**

_____
Client Representative (sign, print, and list relationship to client)

INSURANCE/COMMUNITY RESOURCE/AGENCY BILLING

If you are using your insurance benefits or other community resource for the services being provided by Lisa Joyce, MA, LPC, please be aware that certain Protected Health Information must be released to your insurance company in order to submit billing claims, and that your insurance company may request supporting documentation including your diagnosis and treatment notes. It is the client's responsibility, not the providers, to verify insurance coverage and limitations (such as number of allowed sessions). Clients are responsible for any claims that are denied or otherwise not covered by insurance.

I agree to the release of Personal Health Information to my current insurance provider the purpose of claims and billing and authorize insurance payments to be assigned to Lisa Joyce, MA, LPC. If I change insurance, this consent will continue for the new carrier unless I specifically revoke consent.

_____ _____

Client/Parent Signature **Date**

APPOINTMENTS AND CANCELLATION POLICY

Current clients are welcome to schedule their own appointments either by phone, email, or online via my website at www.lisajoycelpc.com. All clients are expected to provide at least 24 hours notice if you need to cancel or change an appointment. ***If you fail to provide 24 hours notice, you will be assessed a $50 missed appointment fee (except Medicaid—see below). This fee is strictly enforced and must be paid before your next scheduled appointment.***

If you miss your appointment and normally have a standing appointment time, be aware that you may lose that time slot. This is particularly important to remember if you have a high demand time slot, such as afterschool or evenings. Likewise, if I have a waiting list, more than 2 late cancellations or missed appointments may result in your slot being given away and you may have to go back on the waiting list before you can be rescheduled.

This cancellation policy applies for individual, family and group appointments.
Any late cancellation fees must be paid before any further appointments will be rescheduled. Payments can be made through my website www.lisajoycelpc.com

***MEDICAID CLIENTS—Because Federal government prohibits providers from charging missed appointment fees, please be aware that if you cancel any appointment with less than 24 hours notice FOR ANY REASON or no show for any appointment more than one time in any 6 month period, you will be discharged and referred to another provider or facility.

I have been advised of the late cancellation and missed appointment policy and agree to abide by this policy.

_____ _____

Client/Parent Signature **Date**

Credit Card Authorization

It is requested that all clients keep a credit card on file to cover session fees, co-pays and deductibles. Session fees and no-show/late cancellation fees will typically be charged to the card within a week of when the service was provided or as soon as claim is processed by your insurance company.

If you choose not to keep a card on file, all copays and missed appointment fees must be paid before your next appointment. Fees can be paid in person or by credit card through my website www.lisajoycelpc.com.

Credit Card Information

Cardholder Name: _____
Card Type: ☐Mastercard ☐Visa ☐Other: _____
Card #: _____ Exp. Date: ____/____
Billing Zip Code: _____ CVV code (on back of card): _____
Email address for receipt: _____

I authorize Lisa Joyce, MA, LPC to retain my card information for the purpose of payment for ongoing therapeutic services, no show/late cancellation fees, and any fees that are not reimbursed by my insurance carrier. I understand that my payment method can be discontinued or changed at any time by notifying your therapist by email or in writing. I know that if my credit card is declined, I am obligated to arrange an alternate method of payment for services rendered.

Cardholder Signature: _____ Date: _____

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RELEASE OF INFORMATION FOR COORDINATION OF CARE WITH PRIMARY CARE PHYSICIAN AND/OR PSYCHIATRIST

It is both the policy of Lisa Joyce, MA, LPC and most major insurance carriers that information related to your treatment should be coordinated with your health care providers in order to ensure the highest level of care. This also allows for Lisa Joyce to make the most appropriate recommendations and referrals for clients.

I _____ (Client's name) Date of Birth: _____
authorize Lisa Joyce, MA, LPC to provide information to and receive information from my primary care physician: _____ and/or my psychiatrist: _____ for the purpose of coordinating care.

The information disclosed and requested includes my medical and mental health/substance abuse symptoms, diagnosis, medication information, progress, concerns and recommendations.

Please be aware that this release of information may include mental health condition and treatment information and/or alcohol or substance abuse information. A copy of this release of information may be used with the same effectiveness of the original.

This authorization shall remain active as long as I am a client of Lisa Joyce unless otherwise specified. I understand that I may revoke this consent at any time except to the extent Lisa Joyce has already taken action in reliance on this authorization. The information disclosed may be subject to redisclosure by the recipient and thus no longer protected by HIPAA privacy regulation.

_____ _____
Signature of Client if 15 years or older Date

_____ _____ _____
OR Signature of parent/guardian authorized to release information Relationship to Client Date

_____ _____
Clinician Signature Date

Notice to Recipients of this Release/Authorization: prohibition on Redisclosure
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.