AK COUNSELING SERVICES

INTAKE FORMS

For Clients of Alice Keshmeshian

The forms in this packet should be completed as directed before your first session.

All clients should read and complete the first four forms:

- **Disclosure Statement**
- **Client Contact Information for Messages and Written Correspondence (HIPAA form)**
- **Client Information Sheet**
- **Telephone Contact, Scheduling, and Payment Information Policy**

Couples entering marital therapy should fill out all forms above individually and jointly complete the sixth form:

- **Marital Therapy Contract**

If your child is entering into counseling with Alice, you should complete the last two forms in addition to the forms described above:

- **Parental Agreement for Confidentiality of Adolescent Sessions**
- **Consent for Counseling Services for Minors**

If you are unable to download these forms, please contact Alice Keshmeshian at (720) 580-1060 or alice@akcounselingservices.com and arrive at least 15 minutes prior to your scheduled appointment time to complete the forms.

Thank you,

AK Counseling Services

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Disclosure Statement

The State of Colorado requires that psychotherapy and psychiatric clinicians provide clients with certain information about the psychotherapy process. Please take the time to read this document carefully, ask about any matters that seem unclear, initial where indicated, and sign the last page of the statement. A copy will be placed in your files.

I, Alice Keshmeshian, am a licensed professional counselor, (license #: LPC.0013189). I am currently pursuing a PhD in General Psychology from Capella University. I earned my Master of Science degree in Clinical Psychology from Capella University in 2007. I obtained 2 Bachelor of Arts degrees (Psychology; Child Development) from California State University of Northridge in 1993.

As a Licensed Professional Counselor, I am under the authority of and am regulated by the Department of Regulatory Agencies, (DORA) Division of Registrations. Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303)894-7800.

You are entitled to receive information from me concerning my methods of therapy, the techniques used, and an estimation of the duration of your treatment, fee structure, risks and benefits of counseling, confidentiality and access to your records. I use an eclectic method of therapy, drawing techniques from various evidenced based methods that I conclude are the most effective form of treatment for your needs. Therapy methods include, but are not limited to: Cognitive Behavioral Therapy (CBT), Client Centered Therapy, Solution Focused Brief Therapy (SFBT) and Dialectical Behavior Therapy, (DBT). I am also trained to administer Eye Movement Desensitization and Reprocessing Therapy (EMDR). I consider the client's needs, background, and goals as well as their psychological, social, spiritual and biological development to determine the best course of action in counseling. You also have the right to know what other treatment options are available and the possible effectiveness of those alternatives. You may at any time seek a second opinion from another clinician and/or terminate the counseling process. I do need to be informed if you are working with more than one counselor.

The practice of licensed and 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 (CACI) must be a high school graduate and complete required training hours and 1000 hours of supervised experience. A CAC II must complete additional required training hours and 1000 hours of supervised experience. A CAC III must have a bachelor's degree in behavioral health, and complete additional required training 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 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.

In a professional relationship, sexual intimacy is never appropriate and should be reported to the Department of Regulatory Agencies, Division of Registrations Mental Health Boards, 1560 Broadway, Suite 1350, Denver, Colorado 80202.

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CONFIDENTIALITY

Within certain limits, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your permission. At times therapy will involve the participation of more than one family member and/or significant persons. While I will attempt to follow your wishes, I do not guarantee confidentiality among participants in the family or couples therapy.

The information provided by a client during therapy sessions is legally confidential and will not be released without the client's written consent. Exceptions to the rule of confidentiality apply in the following cases, listed in Colorado Regulatory Statute 12-43-218:

- If I determine there is a threat of you harming yourself and/or other(s)
- If I suspect child abuse/neglect or dependent adult abuse/neglect
- If legal matters are involved
- If there is a court order for counseling
- If you become unable to take care of yourself and additional help is required
- If there are collection proceedings
- If there is a Grievance Board inquiry
- In some cases if you are under the age of 18
- If you are over 18 and disclose that you were abused by a person who is currently in a position of trust relationship with a child, for any amount of time, AND if there is reasonable cause to suspect that the person has subjected another child who is currently under the age of 18 to abuse or neglect or to circumstances or conditions that would likely result in abuse or neglect.

DISCLOSURE REGARDING DIVORCE AND CUSTODY LITIGATION

If you are involved in divorce or custody litigation, my role as a counselor is not to make recommendations to the court concerning custody or parenting issues. By signing this disclosure statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation and you agree not to request that I write any reports to the court or to your attorney making recommendations concerning custody. The court can appoint professionals who have no prior relationship with family members to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interest of the family's children.

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.

The undersigned, by providing his/her signature in the space below agrees to accept the therapy services provided by Alice Keshmeshian in accordance with and pursuant to the terms and conditions set forth herein.

Printed Name of Client	Signature of Client	Date

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Client Contact Information for Messages and Written Correspondence

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communications of PHI to be made for alternative purposes such as sending correspondence to the individual's office instead of the individual's home.

AK Counseling Services has permission to contact me at the following: (check all that apply):

❒ Home Telephone #_____

- ❒ OK to leave a message with detailed information
- ❒ OK to leave a message with other family members

❒ Cell Phone #_____

- ❒ OK to leave a message with detailed information
- ❒ OK to leave message with person answering

❒ Work Telephone #_____

- ❒ Ok to leave a voicemail message with detailed information
- ❒ OK to leave a message with_____

Written Communication

❒ OK to mail to my home address

❒ OK to email me at _____

❒ OK to fax to this number_____

❒ Other_____

_____	_____	_____
Printed Name of Client	Signature of Client	Date

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CLIENT INFORMATION (For All Clients)			
Client Name (First, Middle Initial, Last)	☐ Single ☐ Married	☐ Male ☐ Female	Birth Date
Street Address	City, State, Zip		
Home Phone	Work Phone	Cell Phone	
Occupation	Employer or School	Primary Care Physician	
Who referred you to this practice	Have you seen our website? ☐ Yes ☐ No	General Health Status	
Any previous counseling? With whom?			
List all medications			

Emergency Contact	Relationship to Client	
Home Phone	Work Phone	Cell Phone
Responsible for Payment	Home Phone	Cell Phone
Street Address	City, State, Zip	

IF MARRIED		
Spouse's Name (First, Middle Initial, Last)	Birth Date	Cell Phone
Occupation	Employer or School	Work Phone

IF A MINOR		
Mother's Name	Occupation	Employer
Street Address	City, State, Zip	
Home Phone	Work Phone	Cell Phone
Father's Name	Occupation	Employer
Street Address	City, State, Zip	
Home Phone	Work Phone	Cell Phone
Siblings (first and last names and ages)		

The above information is true to the best of my knowledge.

_____ _____

Patient/Guardian Signature Date

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Telephone Contact Information, Scheduling, and Payment Policies

Please read the following and INITIAL each item:

_____1. You may leave a message for Alice at (720) 580-1060. She will return your call within 24hours on business days.

_____2. Standard counseling sessions are offered in 60 min and 90 min sessions, at the rate of $120/hr. Any sessions that require additional time will be prorated at the rate of $120/hr in 15 min intervals.

_____3. Counseling by phone may be provided for individual therapy only upon request and necessity. Phone consultation session rates are $120/ per 60 min. session.

_____4. Payment is due before your counseling session.

_____5. Payment methods accepted include cash or credit card only.

_____6. **The full session fee is charged for missed appointments and cancellations not made 24 hours in advance.** Exceptions to this will be in case of severe weather, illness, or auto accident.

_____7. Fees for auxiliary services are pro-rated and charged at the regular hourly rate of $120. This includes (but not limited to) written reports, phone calls exceeding 10 minutes.

_____8. Alice Keshmeshian cannot guarantee, but will use reasonable means to maintain security and confidentiality of conversations via phone and email both sent and received. All emails will be printed and filed into the client's medical record. Alice Keshmeshian is not liable for improper disclosure of confidential information that is not caused by intentional misconduct. Clients should use their best judgment as to the content they share using these communication methods.

_____9. Court appearances are charged at a rate of $250/hr (this includes travel, preparation, and any other services related to the court appearance).

_____ _____

Client Signature Date

IF YOU ARE EXPERIENCING A LIFE-THREATENING EMERGENCY CALL 911 OR GO TO YOUR NEAREST HOSPITAL EMERGENCY ROOM.

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Marital Therapy Contract

Please read the following statements regarding AK Counseling Services for Marital Therapy.

1. Couples Therapy starts with an assessment of the relationship past and present.
2. The clients understand the information discussed in couple's therapy is for therapeutic purposes and is not intended for use in any legal proceedings involving partners.
3. The clients agree not to subpoena the therapist to testify for or against either party or to provide records in a court action.
4. By entering couples therapy, the clients understand that working toward change may involve experiencing difficult and intense feelings, some of which may be painful, to reach our set goals.
5. The clients accept that such changes can have both negative and positive effects and agree to clarify and evaluate potential effects of changes before we undertake them.
6. Phone calls and/or emails between sessions should be used for making appointments, emergencies, or clarifying assignments only.
7. In the event the relationship breaks up and either or both of the clients wish to re-contract with the counselor for individual counseling, the decision on who the counselor works with is at her discretion. In some situations, a referral will be made.
8. If the counselor sees either member of the couple for individual sessions or has contact between sessions with either member of the couple, the contents of those contacts will be brought up in the next session with both partners present. No secrets will be kept.
9. Since a regular session time is limited to 60 minutes, the clients will try to be concise in presenting their thoughts and feelings.

We agree to the above guidelines.

Partner 1	Partner 2
Date	Date

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Parental Agreement for Confidentiality of Adolescent Sessions

Dear Parent or Guardian,

A young person is more likely to disclose sensitive information to a counselor if he or she is provided with confidential services and has time alone with the counselor to discuss his or her issues. The most practical reason for clinicians to grant confidentiality to an adolescent client is to facilitate accurate and appropriate treatment.

Experienced clinicians recognize that candid and complete information can be gathered only by speaking with the adolescent client alone and by clarifying with whom the information will be shared. If an assurance of confidentiality is not extended, this may create an obstacle to the safe environment of the counseling relationship.

Some areas of teenage health that we may talk about during the appointments are:

- Diet, exercise, and body image
- Fighting, danger, and violence
- Sexuality and sexual behavior
- Safety and driving
- Smoking, drugs, and alcohol
- Working/Jobs
- Depression and stress
- Peer pressure and school
- Relationships
- Family life

I encourage teenagers to share information about their emotional and mental health with their parents or guardians. However, there will be some things that your teenage son or daughter would rather talk about exclusively with a counselor.

Work with an adolescent is generally more productive if parents voluntarily agree to not request information about the adolescent's private session. I ask your permission to keep what is discussed in our sessions confidential. Confidential means I will only share information with you if your teenage son or daughter says it's permissible to do so. The counselor agrees to share with the parent(s) any information which is necessary for the safety of the adolescent.

I agree that the therapist will determine what information, in her professional judgment, is appropriate to be shared with the parent/guardian(s) concerning treatment issues, and what information, in the discretion of the therapist, will remain confidential between my adolescent child and the therapist.

_____ _____

Parental/Guardian Signature Date

AK COUNSELING SERVICES, LLC
1745 SHEA CENTER DRIVE, 4TH FLOOR, HIGHLANDS RANCH, CO 80129. PHONE: (720)580-1060

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Consent for Counseling Services to Minors

In order for minor children/adolescents to receive psychological services, it is necessary for the parent or legal guardian to grant permission for such services to occur.

Names and date of birth of child(ren) to receive psychological services:

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name of person requesting services: _____

Your relationship to child(ren):

Parent Stepparent Guardian Grandparent Other:_____

Are you the legal parent or custodian to above named children? Yes No

I hereby swear that I have legal right to obtain treatment for the above named children: Yes No

> In instances of divorce, it is essential that the legal custodian of the child(ren) grant permission for the services. If you are a divorced parent, a stepparent, a grandparent, a guardian, or other, you may be asked to provide a copy of the court order which names you the legal custodian of the above child(ren). Are you willing to do so? Yes No
>
> *If the answer to any of the above questions is "No" counseling services cannot be provided to the above-named child(ren) until a copy of the court order which names you the legal custodian is provided to this office.*

I acknowledge that both natural parents, even though divorced, may have a right to obtain from the provider named below information regarding the nature and course of treatment of the child(ren).

- Colorado State law mandates the reporting of certain types of child abuse, including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional and psychological abuse. All actual or suspected acts of child abuse will need to be reported to the appropriate agency.
- This treatment may also include referral to other appropriate State and County agencies for further counseling.

I, _____, consent to Alice Keshmeshian providing psychological services to the child(ren) named above.

_____ _____

Signature of Person Authorizing Consent Date

_____

Relationship to Child