A Fresh Start Counseling Service, LLC
7660 Goddard St., Suite 130 Colorado Springs, CO 80920
Office & Scheduling: 719.639.2494 Emer: 719.339.8097
www.afreshstartcounseling.com / rochejoni@gmail.com

Office & Appointment Policies

First and foremost, welcome! We look forward to working alongside you and your loved ones during your counseling experience. Below are a few highlights to assist you with your first appointment.

- Before the initial appointment, print and complete the following forms. *Please fill them out in their entirety*. Read them carefully to be informed of what you are signing. Having these ready ahead of time will saves you about twenty minutes of the initial counseling session. Should you not be able to bring these New Client Forms with you, contact us at (719) 639.2494, *prior* to your arrival and the forms will be waiting for you in the reception area to fill out.

- Please check in and wait in the reception area until we come for you at your scheduled appointment time. There are several therapists in session throughout our hallway during the day. Doing this ensures professional respect and privacy for their clients.

- Payments/Co-Pays are collected at the *beginning* of each session. Checks, cash, and credit cards are accepted.

- All sessions are forty-five minutes in length. A wrap up typically begins a couple of minutes before the end of our time together. This is usual and customary and abides with the ethical standards of the therapeutic process and guidelines. Appointments begin at the scheduled time. If a client arrives late, the session will be that much shorter. Conversely, if I am running late, the session will begin when the client enters the counseling office. Appointments are held for **twenty minutes** past your scheduled time. **If a client is more than twenty minutes late, the appointment will be canceled and rescheduled, and a fee of $135.00 will be charged to the client, not the insurance company. If a client is a "No Show" or does not cancel the appointment 24 hours prior, the client, not the insurance company, is responsible for the payment of $135.00.**

- The National Board of Certified Counselors (NBCC) prohibits counselors from "friending" or communicating with clients through all social media.

Again, welcome to our practice. We look forward to seeing you soon.

A Fresh Start Counseling Service, LLC

7660 Goddard St., Suite 130
Colorado Springs, CO 80920
Office & Scheduling: 719.639.2494 www.afreshstartcounseling.com rochejoni@gmail.com

CLIENT INTAKE FORM

(Please Print)

Today's Date _____/_____/_____ **Therapist: Joni Roche, M.A., LPC, NCC**

CLIENT INFORMATION

Client's Last Name	First	M.I.	❑ Mr. ❑ Ms.	Marital Status (Circle One) Single / Married / Other

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Social Security - -	Home Phone No. ( )

P.O. Box	City	State	ZIP Code	Cell Phone No. ( )

Occupation	Employer	Work Phone No. ( )

How did you hear about us? (Please check one box & list) ❑ Dr. _____ ❑ Insurance Plan ❑ Website
❑ Family ❑ Friend ❑ Close to Home/Work ❑ Local.com ❑ Other _____

Email Address:	Alternate Email Address:

INSURANCE / PAYMENT INFO. (PLEASE GIVE YOUR INSURANCE CARD TO THE COUNSELOR)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Email Address:			Cell Phone No. ( )

Occupation	Employer	Employer Address	Work Phone No. ( )

Is this client covered by insurance? ❑ Yes ❑ No	Is this an EAP visit? ❑ Yes ❑ No	Total Annual EAPs allowed? _____

Please Select Your Primary Insurance Provider

❑ Aetna ❑ Amer. Beh. ❑ Behav. Health ❑ Blue Cross/Blue Sheild ❑ ChoiceCare ❑ ComPsych
❑ Cigna ❑ ComPsych ❑ Kaiser ❑ HealthSmart ❑ Humana ❑ Aetna ❑ Military OneSource
❑ MultiPlan ❑ MHN/MHNet ❑ PHCS ❑ PMHS ❑ Mines & Assoc ❑ TriCare ❑ Univ. of CO
❑ United Healthcare ❑ Beacon Health ❑ Other _____

What is the authorization number? ❑ Self Pay

Insured's Name	Insured's S.S. #	Birth Date	Group / Member ID #	Policy #	Co-Payment $

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if any)	Insured's Name	Group #	Policy #

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

A Fresh Start Counseling Service, LLC

CLIENT INTAKE FORM

(Continuation)

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment/copay at the *beginning* of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. I also understand if I do not give a 24-hour cancellation notice, I am responsible for the full payment, not my insurance company, of $135.00 for the missed session.

X _____

CLIENT/GUARDIAN SIGNATURE **DATE**

I hereby consent to treatment by Joni Roche, M.A., LPC, NCC. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

X _____

CLIENT/GUARDIAN SIGNATURE **DATE**

I hereby authorize the release of necessary medical and/or billing information for client reminder calls, insurance reimbursement and/or collection purposes to Joni Roche, M.A., LPC, NCC.

X _____

CLIENT/GUARDIAN SIGNATURE **DATE**

I authorize the payment of medical benefits to Joni Roche, M.A., LPC, NCC.

X _____

CLIENT/GUARDIAN SIGNATURE **DATE**

Client Information

(If you are here for couples or for family counseling, put the first letter of the person's name next to the symptom(s) he/she is experiencing.)

Underline or circle any of the following, which have applied to you in the last two weeks:

FAINTING	*FINANCIAL CONCERNS*	*FREQUENT WORRIES*
DIZZINESS	*LEGAL DIFFICULTIES*	*DIFFICULTY RELAXING*
PROBLEM CONCENTRATING	*PAST COURT INVOLVEMENT*	*PROBLEMS WITH ANGER*
HEART PALPITATIONS	*EMPLOYMENT CONCERNS*	*DEPRESSED*
NO APPETITE	*SCHOOL/WORK PROBLEMS*	*FEEL PANICKY*
OVEREATING	*DRINK TOO MUCH*	*SUICIDAL IDEAS/THOUGHTS*
BOWEL PROBLEMS	*DRUG PROBLEMS*	*PAST SUICIDE ATTEMPT*
DON'T TRUST PEOPLE	*DIFFICULTY SLEEPING*	*FEEL LONELY*
FEEL TENSE/ANXIOUS	*THINGS SEEM UNREAL*	*FAMILY PROBLEMS*
TAKE SEDATIVES	*CAN'T MAKE DECISIONS*	*INFERIORITY FEELINGS*
CRYING	*IRRITABLE*	*ANGRY*
OTHER: _____	_____	_____

Approximate date of onset of problem(s) with which you are now concerned? _____

What would you like to accomplish/work towards in counseling? _____

_____

_____

_____

Spouse/Ex-Spouses	**Date of Marriage(s)**	**Date of divorce/separation**
_____	_____	_____
_____	_____	_____

Briefly describe your current marriage/relationship, if any:

_____

_____

What is your average number of social contacts outside of home and work per week? _____

Describe:

_____

_____

GENERAL HEALTH PATTERNS

Name of your medical or family doctor _____Phone _____

Approximate date of your last physical exam _____

Do you currently have any health problems/concerns? _____

_____

Have you had a problem with alcohol in the past? _____ When? _____

Approximately how much do you drink each day? _____

Do you use street or recreational drugs? _____Which ones? _____

_____

Have you ever been in counseling before? _____When? _____

What traumas, if any, have you experienced in your life? _____

_____

_____

_____

Are there any addictions in your family?_____Who? _____

_____

Is there any mental illness in your family? _____ Who? _____

_____

Describe your general outlook in life: _____

_____

What have you found that brings you joy/peace in your life? _____

_____

Is there anything you would like me to know? _____

_____

_____

_____

A Fresh Start Counseling Service, LLC

Joni Roche, M.A., LPC, NCC
7660 Goddard St., Suite 130, Colorado Springs CO, 80920
Email: rochejoni@gmail.com. Website: www.afreshstartcounseling.com

Therapist: Joni Roche, M.A., LPC, NCC **Education:** MA in Education, Community Counseling, University of Colorado, 1999
Licensure: LPC – CO #2843. **Certification:** Nationally Certified Counselor, #56058

Clients are entitled to receive information about the methods of therapy, the techniques used; the duration of therapy (if known) and the fee structure. A client may seek a second opinion from another therapist or may terminate therapy at any time. In a professional relationship, sexual intimacy between client and therapist is inappropriate and should be reported to the department of regulatory agencies: Department of Regulatory Agencies, 1560 Broadway, Suite 1340, Denver, Colorado 80202. Phone: 303.894.7766

What You Can Expect From Counseling: If you sincerely desire to work on your concerns and conflicts with yourself or others and believe that you have the capacity to do so, then we can work effectively together in counseling. A counselor cannot resolve problems. It is our responsibility of help you identify your beliefs and feelings, conflicts, and challenge inconsistencies, explore new choices and be supportive of your efforts to make changes that you want to make in your behaviors, feelings or responses to others.

Privileged Communication: Generally speaking, the information provided by and to a client during therapy session is legally confidential. There are exceptions to the general rule of legal confidentiality. The information provided by the client during therapy session is legally confidential, except as provided in section 12.43.218 and except for certain other legal issues. These include: a) Potential danger to self or others, b) Notes or summary of care is Court ordered, c) Suspect of abuse or neglect to a child or elderly person, d) Clients of military status may be more susceptible to open information.

Appointments: Therapy sessions are usually made on a regular schedule, although sometimes more visits will be beneficial. My office availability is Monday, Wednesday and Thursday. The therapy hour is 45 minutes and I try to stay on schedule. If you suspect you may be late, please call ahead, as the session will be cancelled and rescheduled after 20 minutes.

Cancellations: When appointments are forgotten or canceled without a 24 hours notification, the client, not the insurance company, is responsible to pay the fee of $135.00. Clients who are chronically absent will be referred to other agencies. Accounts go to collections at 90-days past due.

Confidentiality: Your sessions are considered legally as privileged communications and are therefore protected as private with the exception referred to above or when using insurance confidentiality is in a manner with your EAP or PPO or HMO agreement. If you need to have records made available to other professionals, a Release of Information Form will need to be signed. All written information provided to the courts OR other sources require notice ahead of time and a $75.00 per page fee will be charged. Anytime the therapist is called to court, a $2000.00 retainer fee is required up front. The fee for court is $225.00 per hour which includes travel time as well as time spent at the court.

Emergencies: In emergency situations or after hours call 911 or go to a hospital emergency room.

Payment: At this time, I accept cash, check or major credit cards. Payment/Copayment, in full, is due *before* each counseling session begins.

I HAVE BEEN INFORMED OF MY THERAPIST'S EDUCATION AND CREDENTIALS. I HAVE ALSO READ THE PRECEEDING INFORMATION AND UNDERSTAND AND COMMIT TO MY RIGHTS AND RESPONSIBILITIES AS A CLIENT.

_____ _____
Client signature (parent or guardian for a minor) **Date**

_____ _____
Client signature **Date**

_____ _____
Therapist signature **Date**

A Fresh Start Counseling Service, LLC

Joni Roche, M.A., LPC, NCC

7660 Goddard St., Suite 130 Colorado Springs, CO 80920

Office & Scheduling: 719.639.2494

Website: www.afreshstartcounseling.com / Email: rochejoni@gmail.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW BEHAVIORAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

A. HOW WE MAY USE AND DISCLOSE BEHAVIORAL HEALTH INFORMATION ABOUT YOU:

1. **For Treatment.** Your PHI may be used and disclosed by those who are involved in your care for the purpose of scheduling, providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

2. **For Payment.** We may use or disclose PHI so that we can receive payment for the treatment services provided to you. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

3. For Health Care Operations. **We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.**

4. **Required by Law.** I may use or disclose PHI when I am required or permitted to do so by law. For example, I may disclose PHI to appropriate authorities if I reasonably believe that you are a possible victim of abuse neglect, or domestic violence or the possible victim of other crimes. In addition, I may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures to public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful processes; disclosures for research when approved by an institutional review board; and disclosures to military or nation security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

   I may also disclose PHI for the purpose of reminding my clients of their appointments, sending them information about treatment alternatives or other health related services, disclosure to family member or other persons involved in my client care.

   State law requires me to obtain your authorization to disclose your health information for payment purposes.

Without Authorization. **Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:**

- **Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)**
- **Required by Court Order**
- **Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.**

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Abuse and Neglect	**Judicial and Administrative Proceedings**
Emergencies	**Law Enforcement**
National Security	**Public Safety (Duty to Warn)**

Verbal Permission. **We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.**

Written Authorization. **Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked by you at any time. These authorizations include**

1. **Psychotherapy Notes**
2. **Marketing Communications**
3. **Other disclosures such as Insurance companies, schools, or attorneys.**

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to our Privacy Officer, Joni Roche M.A., LPC, NCC at 7660 Goddard St., Sute 130, Colorado Springs, CO 80920:

- **A. Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **B. Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
- **C. Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **D. Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **E. Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **F. Breach Notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself
- **G. Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with The Colorado Department of Regulatory Agencies, Mental Health Section, at 1560 Broadway, Suite 1350, Denver, CO 80202, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

Effective Date and Changes to This Notice

A. The effective date of this Notice is April 14, 2003.

B. Changes to this notice: I may change the terms of this notice at any time. If I change this Notice, I may make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice.

A Fresh Start Counseling Service, LLC

Joni Roche, M.A., LPC, NCC

7660 Goddard St., Suite 130 Colorado Springs, CO 80920

www.afreshstartcounseling.com rochejoni@gmail.com

Office & Scheduling: 719.639.2494

Notice of Privacy Practices

Receipt and Acknowledgment of Notice

Patient/Client Name:_____

Patient/Client Name:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of A Fresh Start CounselingService, LLC Privacy Practices.

_____ _____

Signature of Patient/Client *Date*

_____ _____

Signature of Patient/Client *Date*

_____ _____

Signature or Parent, Guardian or Personal Representative *Date*

_____

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

BELOW IS FOR OFFICE USE ONLY

- ❑ *Patient/Client Refuses to Acknowledge Receipt:*
- ❑ *Communication barriers prohibited obtaining the acknowledgement*
- ❑ *An emergency situation prevented the obtaining of the acknowledgement*
- ❑ *Other (Please Specify)* _____

_____

_____

_____ _____

Joni Roche, M.A., LPC, NCC *Date*