DOROTHY R. SANCHEZ, LPC
6638 W. Ottawa Avenue, Suite 140-3
Littleton, CO 80128
720-275-6890

Today's Date: _____

CLIENT INTAKE FORM

COUNSELING is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counseling, there may be periods of increased anxiety or confusion. In spite of these uncomfortable emotions, I am available to support you throughout the counseling process. Things CAN get better.

Personal Information

Client Name: _____Date of Birth: _____ Age: _____

Street Address: _____

City/State:_____ Zip Code:_____

Sex: ☐ Female ☐ Male ☐ Other:_____ ☐ Decline to Answer

Religious Affiliation (if any): _____

Home Phone_____ Is it okay to leave a message? ☐ Yes ☐ No

Work Phone _____ Is it okay to leave a message? ☐ Yes ☐ No

Cell Phone_____ Is it okay to leave a message? ☐ Yes ☐ No

Email Address: _____May we e-mail you? Yes No

In an emergency, who do we call? Contact Name: _____

Contact Phone #: _____

Name, address, and phone # of person responsible for bill (if not client):_____

_____

If the above-named individual is responsible financially, I give Dorothy R. Sanchez, LPC permission to contact this person about issues related to billing. Please initial:_____.

Insurance Information:

Name of Insurance Company:_____ Insurance Co. Phone #:_____Phone # (Mental Health): _____ Plan Name:_____

Policy Owner's Name: _____ Policy Owner's Date of Birth: _____

Policy Owner's SS#: _____ Insurance ID #:_____Policy or Group#: _____

Policy Owner's Address (only if different than above): _____

Please be prepared to provide our office staff with your insurance card so that we may make a copy.

Please provide the following information for our records. Leave blank any question you would rather not answer, or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as therapy.

TREATMENT HISTORY

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ( ) yes ( ) no

Have you had previous psychotherapy?
( ) no
( ) yes, with (previous therapist's name)_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)? ( ) yes ( ) no

If yes, please list: _____

Prescribed by: _____

HEALTH AND SOCIAL INFORMATION

Do you currently have a primary physician? ( ) yes ( ) no

If yes, who is it? _____

Are you currently seeing more than one medical health specialist? ( ) yes ( ) no

If yes, please list: _____

When was your last physical? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.: _____

_____

Are you currently on medication to manage a physical health concern? If yes, please list:
_____
_____

Are you having any problems with your sleep habits? ( ) yes ( ) no

If yes, check where applicable:
( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep
( ) Disturbing dreams ( ) other _____

Are you having any difficulty with appetite or eating habits? ( ) no ( ) yes

If yes, check where applicable: ( ) Eating less ( ) Eating more ( ) Bingeing
( ) Restricting

Have you experienced significant weight change in the last 2 months? ( ) no ( ) yes

Do you regularly use alcohol? ( ) no ( ) yes

In a typical month, how often do you have 4 or more drinks in a 24 hour period?

_____

Do you engage in recreational drug use? ( ) daily ( ) weekly ( ) monthly

Have you had suicidal thoughts recently?
( ) frequently ( ) sometimes ( ) rarely ( ) never

Have you had them in the past?
( ) frequently ( ) sometimes ( ) rarely ( ) never

In the past year, have you experienced any significant traumatic event(s)? Please describe_____
_____
_____
_____
_____
_____.

SOCIAL/FAMILY INFORMATION

Which best describes you? Choose all that apply: ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐ Living Together ☐ Same-Sex Partners

If you are currently in a romantic relationship, for how long?_._____ On a scale of 1 to 10 (with 10 being best), how would you rate your satisfaction with your current relationship? _____.

Do you have children? If so, please provide names and ages. _____
_____
_____

Please list any other individuals living in your home (other than you and any children listed above. _____.

OCCUPATIONAL INFORMATION

Are you currently employed? ( ) no ( ) yes

If yes, who is your currently employer/position? _____

If yes, are you happy with your current position? _____

Please list any work-related stressors, if any _____

_____

_____

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? ( ) no ( ) yes

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? ( ) no ( ) yes

Current symptoms/issues: (check ones that apply):

- ☐ Depressed mood, feeling sad
- ☐ Decreased energy/lacking motivation
- ☐ Lack of interest/enjoyment
- ☐ Frequent crying
- ☐ Suicidal thoughts, thoughts of death
- ☐ Grief/loss issues
- ☐ Hopelessness/helplessness
- ☐ Worthlessness
- ☐ Guilt/Inferiority feelings
- ☐ Difficulty making decisions
- ☐ Memory problems
- ☐ Withdrawing/isolating self
- ☐ Irritability/anger
- ☐ Elevated mood
- ☐ Increased energy
- ☐ Mood swings
- ☐ Increased self esteem
- ☐ Increased goal direction
- ☐ Temper problems/poor control
- ☐ Racing thoughts
- ☐ Past use of chemicals
- ☐ Current use of chemicals
- ☐ Shyness/sensitive to criticism
- ☐ Anxiousness/excessive worry
- ☐ Panic attacks
- ☐ Obsessive thoughts/behaviors
- ☐ Compulsive thoughts/behaviors
- ☐ Pounding or racing heart
- ☐ Dizziness
- ☐ Sweating
- ☐ Nausea/vomiting
- ☐ Hot/cold flashes
- ☐ Fear of dying
- ☐ Shortness of breath
- ☐ Trembling
- ☐ Choking
- ☐ Numbness/tingling
- ☐ Fear of situation/places
- ☐ Fear of going out of control
- ☐ Difficulty concentrating
- ☐ Impulsiveness
- ☐ Poor decision making
- ☐ Difficulty paying attention
- ☐ Excessive activity
- ☐ Procrastination/difficulty getting
- ☐ Disorganized thoughts
- ☐ Difficulty with thinking
- ☐ Delusions
- ☐ Unusual beliefs or thoughts
- ☐ Hearing voices
- ☐ Seeing things
- ☐ Paranoia/suspicious of others
- ☐ Feeling disconnected
- ☐ Flashbacks
- ☐ Nightmares
- ☐ Physical complaints
- ☐ Coexisting medical conditions
- ☐ Increased appetite
- ☐ Decreased appetite
- ☐ Binging, purging, restricting
- ☐ Difficulty with sleep
- ☐ Sleeping excessively
- ☐ Emotional/Verbal abuse
- ☐ Physical
- ☐ Sexual abuse

Symptoms have been present for: ☐ Less than one month ☐ 1-6 months ☐ 7-11 months ☐ One year or more

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

Difficulty	**Yes / No**	**Family member**
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	

OTHER INFORMATION

What do you consider to be your strengths? _____

_____

What do you like most about yourself? _____

_____

What are effective coping strategies that you have learned? _____

_____

What are your goals for therapy? _____

_____

Limits of Confidentiality

I understand that the contents of a counseling, intake, or assessment session are protected under the confidentiality laws of the State of Colorado. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of this office not to release any information about a client without a signed release of information. Noted exceptions are as follows:

- Signed authorization to release information to a specific individual or organization.
- Therapist determination that you may harm yourself or someone else.
- Disclosure of abuse, neglect, or exploitation of a child, the elderly, or disabled.
- If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the therapist/patient privilege law. I cannot provide any information without your written authorization, unless a court order is presented. In the latter case, I may be obligated to provide information about treatment.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, I am required to submit a report to the Workers' Compensation Division. The same may be true for Social Security Disability Assistance.
- If a government agency is requesting the information for health oversight activities, I am required to provide it for them.

By signing my initials next to the statements below and signing this document, I agree to the following statements:

_____ I am consenting to receive mental health services from Dorothy R. Sanchez, LPC.

_____ I understand my right to confidentiality and the above noted exceptions.

Client Name (please print): _____

Client Signature: _____Date: ___/_____/_____

PROFESSIONAL FEES

Individual, Couples, and Family Counseling Fees
Initial consultation – up to 60 minutes – $150
On-going 45-minute session – $120
On-going 60-minute session – $150

NOTE: Some services including report writing, telephone conversations lasting longer than 15 minutes with you, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request may not be covered by your insurance plan.

Cancellations and No-Show Charges For individual, couples, and family appointments. I charge a Late Cancellation and No-Show fee of $120. This fee is assessed for the time you reserved for services that could not be rendered to you or other clients. You will not be charged for any appointments that are cancelled **at least 24 hours** (1 day) in advance or if your slot can be filled with a new appointment. It is important to note that insurance companies do NOT provide reimbursement for cancelled or "no-show" sessions so these will not be eligible for insurance reimbursement. It will be your responsibility to pay.

Due to legal and contractual obligations, **Medicaid and EAP** clients will not be charged this fee. However, to be fair to other clients who could use the scheduled time, Unity Counseling reserves the right to refer clients out if appointments are missed/cancelled several times. Please be advised that it is important for YOU to keep track of your scheduled appointment time since you will not receive a reminder call or email. If there are school or business closings due to inclement weather, in the city where you live or by the practice location, you may cancel with less than 24hour notice without any charge. Inpatient hospitalizations or other imminent and major medical issues to the client or immediate family member may be excused.

Other Financial Information

A $30 insufficient funds fee will be charged for any returned checks. You will also be responsible for any and all costs associated with collecting outstanding balances for services rendered including reasonable attorney fees and interest rate charges.

INSURANCE REIMBURSEMENT

In-network: Currently, I accept payments directly from select insurance companies. Please call the office for more information AND inquire with your insurance company to see if the specific service you are seeking is reimbursed through your plan. It would be your responsibility to verify the terms under which mental health services would be covered, as each plan is different. Please call your insurance provider BEFORE any services are rendered, asking:

1) How many sessions are covered per year or if you have session # limitations

2) What your copay and coinsurance are (payable at time of service). A copay is a set fee paid each time you see your therapist – if your plan requires that you pay a copay, you need to clarify if your plan considers your mental health provider a primary care professional or specialist, as the fees may be different. Coinsurance is a percentage of the negotiated or contracted rate. 3) If prior authorization or a doctor referral is required (including for additional sessions) 4) If there are any exclusions written into your mental health policy

5) If you have to meet an annual deductible before your plan will pay out for services and when this deductible begins; also how much of your deductible have you met so far?

6) Please confirm your ID#, Group#, insurance carrier, plan name, insurance address, and provider phone. Please have this information available prior to your first appointment. You will be asked to fill out information that will be submitted to your insurance company for reimbursement to Dorothy R. Sanchez, LPC. You would be responsible for any costs of service that your insurance does not cover such as deductible, copay and coinsurance. If your plan does not cover services, you will be responsible for full payment at $120-150/hr, so it is important that you check with them.

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AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ Date of Birth: _____

Address: _____ City, State, Zip:_____

Phone: _____ Today's Date: _____

I authorize Dorothy R. Sanchez, LPC to (please check appropriate box):
☐ release information to
☐ obtain information from

_____ _____
Name of Person, Provider or Facility Address

_____ _____
Phone #/ Fax# (include area code) City, State, Zip Code

PURPOSE OF THIS REQUEST: (check one)
☐ Social Security / Disability ☐ Personal ☐ Other
☐ Insurance ☐ Psychological Testing
☐ Legal ☐ Healthcare

Continued

TYPE OF RECORDS / COMMUNICATION AUTHORIZED: (check all that apply)
☐ Psychiatric/Psychological Evaluation and/or Treatment
☐ Medical Evaluation and/or Treatment
☐ Disordered Eating Evaluation and/or Treatment
☐ Drug/Alcohol Evaluation and/or Treatment
☐ Verbal Communication with Person, Provider, or Facility

SPECIFIC INFORMATION AUTHORIZED: (select all that apply)

☐ Assessment Reports
☐ Clinical Notes
☐ Diagnostic Impression Treatment Summary/Plan
☐ Consultation Reports
☐ Other: (please describe)_ _____

SPECIFIC INFORMATION NOT AUTHORIZED: (please describe thoroughly)

_____
_____

One-time Use/Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified. My authorization will expire:

☐ When the requested information has been sent/received.
☐ 90 days from this date.
☐ Other: _____

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document. My authorization will expire:

☐ When I am no longer receiving services from Dorothy R. Sanchez, LPC.
☐ One year from this date.
☐ Other: _____

Signature of Client: _____ Date: _____

Relationship to Client (if requester is not the client):

☐ Parent ☐ Legal Guardian ☐ Other: _____

Reason client is unable to sign:

☐ Minor ☐ Deceased ☐ Gravely Disabled ☐ Other: _____

Therapist's Name: _____

Therapist's Signature: _____

Date:_____