Intake Packet

Daniels Counseling, LLC
Fort Collins, Colorado
2024-2025

FEE SCHEDULE

One Time Consultation:	30 minutes 50 minutes	$75 $125
Individual Counseling:	50 minutes	$125
Child Counseling	30 minutes	$75
Family and Couples Counseling:	50 minutes	$125
Group Counseling:	Per Session	$40
ADOS-2 Complete ASD Evaluation	Full Eval	$2200
Phone Consultation (up to 10 minutes)	Per Call	$25
No Show/Late Cancellation (24 hours' notice)		FULL FEE

The client is responsible for all fees at the time of service. A no show/late cancellation charge (in full) applies to missed and cancelled appointments less than before 24 hours before the appointment time. As a courtesy, a one-time waiver will be provided to a cancelled or missed appointment. However, after missed appointments and/or cancellations, Daniels Counseling has a right to reevaluate the scheduling of services. After three such appointments, services may be terminated, and the client referred.

My signature below shows that I understand and will adhere to this agreement.

_____ _____

Signature of client (or person acting for client) Date

FINANCIAL AGREEMENT

Payment for Services: Payment is due at the time of service. Self-pay clients are responsible for paying the self-pay rates in full at the time of billing. Emily Daniels will send a Square Link for payment via email. Checks (sent to office address) are also accepted.

Missed Appointments: Clients must give 24 hours notice when canceling an appointment. A no-show/late cancelation charge (in full) applies to all appointments. The client will be provided a one-time fee waiver for a missed appointment.

Past Due Balances: Payments are due at the time of billing. Any outstanding balances over 30 days past due are subject to be sent to an outside collection agency.

I have read, understand and agree to the above financial policy for payment of professional fees.

The client is ultimately responsible for payment of all professional fees.

Date: _____

Signature: _____

Printed Name: _____

Daniels Counseling

CONSENT FOR TREATMENT & LIMITS OF LIABILITY

Limits of Services and Assumption of Risks:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect

If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults

If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances

Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers

Insurance companies and other third-party payers are only given information that they request regarding services to the clients with full consent of the client.

The type of information that may be requested includes types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

_____ _____

Printed name DOB

_____ _____

Therapist Date

CLIENT INTAKE FORM

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 our therapy.

CONTACT INFORMATION

Name _____

Birthday _____

Address _____

_____

_____

Telephone _____

Email _____

What is the best way to reach you?

_____

Emergency Contact

Name _____

Telephone _____

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 _____

How many times per week do you exercise? _____

Approximately how long each time? _____

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?

_____

How often do you engage recreational drug use?

( ) daily ( ) weekly ( ) monthly ( ) rarely ( ) never

Do you smoke cigarettes or use other tobacco products? ( ) yes ( ) no

Have you had suicidal thoughts recently?

( ) frequently ( ) sometimes ( ) rarely ( ) never

Have you had them in the past?

( ) frequently ( ) sometimes ( ) rarely ( ) never

Are you currently in a romantic relationship? ( ) no ( ) yes

If yes, how long have you been in this relationship? _____

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship? _____

In the last year, have you experienced any significant life changes or stressors? If yes, please explain:

_____

_____

Have you ever experienced any of the following? Please * if in the last month.

Extreme depressed mood	Yes / No
Dramatic mood swings	Yes / No
Rapid speech	Yes / No
Extreme anxiety	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Unexplained memory lapses	Yes / No
Alcohol/substance abuse	Yes / No
Frequent body complaints	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing	Yes / No
Homicidal thoughts	Yes / No
Suicidal attempts	Yes / No If yes, when?

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

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?

_____

_____

Is there anything else you think I should know?

_____

_____

Release of Private Health Information

Client name:	**DOB:**
Address:	**Phone number:**

I give permission for Successful Therapy to release/receive information from:

Person or Agency: **Address:** **Phone number:** **Fax/Email:**

The following information regarding the client/family: (check box)

	Initial Assessment
	Information on Progress in Therapy
	Treatment Plan
	Medical Information
	Termination Summary
	Other:

For the purpose of:

	Coordination of Services
	To Assist in Evaluation
	To Provide Continuity of Treatment
	Other:

I understand that I can revoke this authorization at any time, except to the extent that action has already taken place. If not revoked at an earlier date, this authorization will expire one year from the date signed.
I understand that the specific type of information to be disclosed may include a history of DRUG or ALCOHOL, ABUSE, or MENTAL HEALTH TREATMENT.

_____

Client name Date

_____

Parent/ Legal Guardian Date