Dominyque Ziermann MA, Registered Psychotherapist
685 Citadel Dr. East Suite 345A
Colorado Springs, Co 80909
719-726-0367

Child Intake Form

Please provide the following information about your child:

Full Name: ____

Nick Name: _______________________________

Birth Date: ___________________ Today's Date: ___________________

Behavioral Excesses:
What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

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Behavioral Deficits:
What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

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Behavioral Assets:
What does your child do that you like? What does he/she do that other people like?

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Others Concerns:
Do you have any other concerns about your child or your family that you have not mentioned yet?

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Treatment Goals:

From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST: and how much must they change for you to be satisfied?

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Family History:

The name of the child's biological parents:

Mother: ___________________________ Father: _________________________

Who has legal guardianship of your child?

Who are other household members with your child?

Names	**Ages**	**Relationship to child**

Who are your child's significant others NOT living with your child?

Names	**Ages**	**Relationship to child**

Please describe any past counseling that either your child or any family member

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? __________ if yes, please describe:

Education History:

What school does your child attend?

Address:

Phone: __________________________ Teacher's Name: _______________________

Current Grade: ______________

What does your child's teacher say about him/her?

Other schools attended (including pre-school):

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Has your child ever repeated a grade? If so which one(s)?

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Has your child ever received special education services?

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Has your child experienced any of the following problems at School?

Fighting	Lack of friends	Drug/Alcohol	Detention
Suspension	Learning Disabilities	Poor attendance	Poor grades
Gang influence	Incomplete homework	Behavior problems	

Medical History:
What is the name of your child's primary care physician? __________________________

Address: ______________________________________ Phone: _______________

Date of your child's last medical examination: _____________________________

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones:

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Did the child's mother have any problems during the pregnancy or at delivery? If so, please describe them:

Has your child experienced any of the following medical problems?

A serious accident	Hospitalization	Surgery	Asthma
A head injury	High fever	Convulsions/seizures	
Eye/ear problems	Meningitis	Hearing problems	
Allergies	Loss of consciousness		Other

Please list any current medical problems or physical handicaps:

Please list any medications your child takes on a regular basis:

Other History:

Has your child ever experienced any type of abuse (physical, sexual, or verbal? If so, please describe:

Has your child ever made statements of wanting to hurt him/herself or seriously hurt someone else?

Has he/she ever purposely hurt himself or another?
If yes to either question please describe the situation:

Has your child ever been bullied?
If yes please describe the situation:

Has your child ever tried to commit suicide?

If yes please describe the situation

Has your child seen or known someone who has self-harmed or committed suicide?

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Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain:

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Finally, what are some of the things that are currently stressful to your child and his/her family?

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Do you have any questions for me?

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Child Name____________________________________ Date__________________

Parent Name____________________________________ Date__________________

Parent signature________________________________ Date__________________

(guardian)

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No Show, Late Cancellation and Co-payment Policy

1. I understand that I will be charged a LATE CANCELLATION fee of $65 if I fail to give at least 24 hour notice prior to cancelling my appointment.

2. I understand that I will be charged a NO-SHOW fee of $65 if I fail to show for my appointment.

4. I understand that I will be charged a $10 service charge if I fail to make my payment and/or co-payment at the time of my appointment.

5. I understand that these charges are an out of pocket expense.

6. I understand that the therapy session will last 45-60 minutes. I understand that if I am late to the appointment, I will still have to end the session at the allotted time. By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive from this therapist.

____
Signature of Responsible Party

____
Date

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Patient Registration Form

Therapist: ____________________________________

Patient Demographic Information

Patient Name:	**Social Security #:**
Street Address:	**Date of Birth:**
City, State, Zip Code:	**Home Phone:**
Gender:	**Work Phone:**
Email Address:	**Mobile Phone:**
Primary Physician:	**Psychiatrist (if any):**
Emergency Contact Person:	**Emergency Contact Phone:**
How did you hear about us?	**Marital Status:**

Responsible Party is the person who will be paying the per-session fee for services (leave blank if same as patient)

Responsible Party:	**Home Phone:**
Street Address:	**Work Phone:**
City, State, Zip Code:	**Mobile Phone:**
Relationship to Patient:	**Responsible Party SSN:**

I currently do not accept any insurance and charge $45 a session. I accept card, cash, or check. Due at time of session.

Signature: ______________________________________
Date: _________________________

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Disclosure Statement

Client Name:____

I have attended the University of Phoenix and received my MA in psychology in 2011. I am currently attending Adam's State University to gain my MA in Clinical Mental Health Counseling and will graduate in 2019. I am currently registered in Dora as a Registered Psychotherapist and would be working on gaining my LPCc.

Regulation of Psychotherapists

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Division of Professions and Occupations. The regulatory boards can be reached at 1560 Broadway, Suite 1350, Denver, CO 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 at least two years of post-Master's supervision.

Your Rights as a Client

a. You are entitled to receive information from me about my methods of therapy and the techniques I use, length of sessions, and treatment recommendations. While I have been trained in most therapy modalities, ones I use regularly include CBT, Family Systems Therapy, Emotion-Focused Couples Therapy, Play therapy, existential therapy, experiential therapy (including art and sandtray therapy), and/or narrative therapy. Sessions are generally :45-60 minutes and take place 2-4x a month.

b. You can seek a second opinion from another therapist or terminate therapy at any time.

c. In a professional and therapeutic relationship, sexual intimacy between a therapist and a client is never appropriate and must be reported to the Board that licenses, certifies, or registers the therapist.

d. Generally speaking, information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and the therapist cannot disclose the information without the client's consent. There are several exceptions to confidentiality, which include the following: I am required to report any suspected or confirmed incident of child abuse or neglect (please note--this applies even if the victim is now over the age of 18 if the perpetrator(s) may be in positions of trust); I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; 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; I am required to report any suspected threat to national security to federal officials; I am required to report suspected or confirmed abuse of a senior who is 70 years of age or older, including institutional neglect, physical injury, financial exploitation, or unreasonable restraint; and I may be required by Court Order to disclose treatment information.

e. When I am concerned about a client's safety, it is my policy to request a Welfare Check through local law enforcement. In doing so, I will disclose to law enforcement officers

information about my concerns. By signing this Disclosure Statement and agreeing to treat with me, you consent to this practice, if it should become necessary.
f. Under Colorado law, C.R.S. § 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children ages 14 and under unless the court has restricted access to such information. If you request treatment information from me, I will provide you with a treatment summary, in compliance with Colorado law and HIPAA Standards. g. Regarding video or audio recording, I agree not to record our sessions without your written consent, and you agree not to record any session or conversation with me without my written consent.

Informed Consent

Therapy can benefit you in many ways, including reducing uncomfortable symptoms and improving relationships. These benefits may require a significant amount of effort and willingness on your part. I will frequently ask for your feedback on therapy and our progress. You may notice that your symptoms seem to feel worse at times. This may be normal as you begin to address different aspects of what has been troubling you. Resolving issues that brought you into therapy may bring about unintentional changes in relationships, behavior, substance abuse, etc,, and as you experience growth, others could potentially experience negative responses to your change. Sometimes change may happen quickly, but often, it can take time to get to where you would like to see yourself. As always, there is no guarantee that therapy will demonstrate results, but it is my responsibility to use methods that have been shown to be effective in treating presenting issues such as your own. It is important to me that you feel I am with you through this process. If for any reason either of us determines I may not be the best clinical fit, or if you have needs outside my areas of expertise, you are entitled to a referral to another provider. At all times, you are entitled to an evaluation with a psychiatric provider to determine if medication may benefit you. I will gladly help you with this process and will respect your wishes, except in certain, necessary circumstances, if you do not desire to use a pharmaceutical approach. My approach to counseling is holistic by nature, and I often refer clients who wish to use non-pharmaceutical interventions to their primary care physicians, naturopathic physicians, functional medicine practitioners, and/or those who assist in mind/body work, such as acupuncturists, massage therapists, and yoga trainers.

Individual and/or Child therapy

I am wanting to help you work on the underlying root of your problems. We can focus on the surface issues first, but to ultimately better yourself, we need to work you gaining mindfulness of your mind, body. and soul in a safe, inviting, and nonjudgmental environment. Focusing on your issues, but also keeping in consideration your background (ethnic, cultural, spiritual, and non-pharmaceutical if this is your desire.) If you are a self-harmer or obtain suicidal ideations there will be an agreement that will work on bridging the gaps to keeping you safe in between our meetings.

Confidentiality

What is said between us, stays between us. Unless you are in imminent danger of harming yourself or others. If you would like to allow me to talk to someone else regarding your care, you will need to fill out a Release of Information before I can do so. If I am working with your child, this also applies unless the child is in imminent danger of him or herself or others.

Crisis or emergencies

Should a crisis arise (a situation not requiring immediate attention or care, usually addressed within the next few days), please leave me a voicemail in my confidential inbox on my cell phone or send an email to cmc@creatingmindfulnesscounseling.com. I will attempt to return all calls or emails within one business day (not on weekends or holidays). Should your situation escalate to emergent, or should you experience an emergency, please call 911 or have someone take you to the nearest emergency room. In case of my own emergency or crisis, I may not be able to reach you in a timely manner before your appointment. In this unforeseeable situation, I will do my best to communicate with you as soon as possible.

Vacations

Occasionally, I may take non-traditional days off of work. If I am out of the county and/or am unavailable for an extended period of time, I will leave an outgoing message on my cell phone and an away message on my email stating such. For extended leaves, another therapist may be accessible to you.

Use of Technology

I prefer that we do not use text messaging (as, unless encrypted, it is never guaranteed secure) for anything other than scheduling purposes and primarily use voice mail and/or email for all private or personal matters related to your therapy. Please be aware that while I take proper precautions to ensure confidentiality, security, and privacy, I may not guarantee such with any such communications. When possible, I use HIPAA-compliant software or platforms. All methods of communication also become part of your permanent file. With your Electronic Health Record (EHR) and Protected Health Information (PHI), information is stored on a cloud, and billing is submitted electronically. All PHI and EHR information maintains HIPAA compliance (encryption, password protection, minimum of 2 locks, etc). I take privacy seriously and take significant precautions to protect your information.

Anti-discrimination Clause

I am committed to maintaining a therapeutic and supervisory practice which recognizes and values the inherent worth and dignity of every person; fosters tolerance, sensitivity, understanding, and mutual respect among its members; develops and nurture diversity; and encourages each individual to strive to reach his or her own potential. I believe that diversity strengthens therapy and supervision, stimulates creativity, promotes the exchange of ideas, and enriches life. I view, evaluate, and treat all persons in any therapeutic or supervisory activity or circumstance in which they may be involved, solely as individuals on the basis of their own personal abilities, qualifications, and other relevant characteristics. I prohibit discrimination

against any individual on the basis of race, religion, color, sex, age, national origin or ancestry, genetic information, marital status, parental status, sexual orientation, gender identity and expression, disability, or status as a veteran. I will conduct my programs, services and activities consistent with applicable federal, state and local laws, regulations and orders and in conformance with the procedures and limitations as set forth.

HIPAA Privacy Statement: Notice of Privacy Rights

This notice contains information concerning how confidential mental health treatment information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully and let me know if you may have questions about this notice. During the process of providing services to you, I may obtain and use mental health and medical information concerning you that is both confidential and privileged. Ordinarily, this confidential information will be used in the manner that is described in this statement, and will not be disclosed without your consent, except for the circumstances described in this Notice. I may use and disclose protected health information in the following ways: Treatment. Treatment refers to the provision, coordination, or management of mental health care and related services by one or more health care providers. For example, I may use your information to plan your course of treatment and consult with other health care professionals or their staff concerning services needed or provided to you. Payment. Payment refers to the activities undertaken by a healthcare provider to obtain or provide reimbursement for the provision of health care. For example, I will use information that identifies you, including information concerning your diagnosis, services provided to you, dates of services, and services needed by you, and may disclose such information to insurance companies and to businesses that review bills for health care services and handle claims for payment of health care benefits in order to obtain payment for services. Health Care Operations. Health Care Operations means activities undertaken by health insurance companies, businesses that administer health plans, and companies that review bills for health care services in order to process claims for health care benefits. These functions include management and administrative activities. For example, such companies may use your health information in monitoring of service quality, staff training and evaluation, medical reviews, legal services, auditing functions, compliance programs, business planning and Accreditation, certification, licensing and credentialing activities. Contacting the Client. I may contact you to remind you of appointments and to tell you about treatments or other services that might be of benefit to you. Required by Law. I will disclose protected health information when required by law. This includes, but is not limited to: (a) reporting child abuse or neglect to the Department of Human Services or to law enforcement; (b) when court ordered to release information; (c) when there is a legal duty to warn of a threat that a client has made of imminent physical violence, health care professionals are required to notify the potential victim of such a threat, and report it to law enforcement; (d) when a client is imminently dangerous to herself/himself or to others, or is gravely disabled, health care professionals may have a duty to hospitalize the client in order to obtain a 72-hour evaluation of the client; and (e) when required to report a threat to the national security of the United States. Health Oversight Activities. Your confidential, protected health information may be disclosed to health oversight agencies for

oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, regulatory programs or determining compliance with program standards. Crimes on the premises. Crimes that are observed by me or those in this geographical area that are directed towards others and/or occur on premises will be reported to law enforcement. Business Associates. Confidential healthcare information concerning you provided to insurers or to plans for purposes or payment for services that you receive may be disclosed to business associates. For example, some administrative, clinical, quality assurance, billing, legal, auditing and practice management services may be provided by contracting with outside entities to perform those services. In those situations, protected health information will be provided to those contractors as is needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them. Research. Protected health information concerning you may be used with your permission for research purposes if the relevant provisions of the Federal HIPAA Privacy Regulations are followed. Involuntary Clients. Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed in compliance with Colorado law. Family Members. Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of that discussion. However, if the client objects, protected health information will not be disclosed. Emergencies. In life threatening emergencies I will disclose information necessary to avoid serious harm or death. Client Release of Information or Authorization. I and other health care professionals may not use or disclose protected health information outside of the limits to confidentiality without a signed release of information or authorization. When you sign a release of information, or an authorization, it may later be revoked, provided that the revocation is in writing. The revocation will apply, except to the extent I have already taken action in reliance thereon.

Your Right as a Client

**To make any of the following requests, please ask me for the appropriate request form.*
Access to Protected Health Information. You have the right to receive a summary of confidential health information concerning you concerning mental health services needed or provided to you. There are some limitations to this right, which will be provided to you at the time of your request, if any such limitation applies. Amendment of Your Record. You have the right to request that I amend your protected health information. I am not required to amend the record if I determine that the record is accurate and complete. Accounting of Disclosures. You have the right to receive an accounting of certain disclosures I have made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment, or health care operations. In addition, the accounting does not include disclosures made to you, disclosures made pursuant to a signed Authorization, or

disclosures made prior to April 14, 2003. There are other exceptions that will be provided to you, should you request an accounting. Additional Restrictions. You have the right to request additional restrictions on the use or disclosure of your health information. I do not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. Alternative Means of Receiving Confidential Communications. You have the right to request that you receive communications of protected health information from me by alternative means or at alternative locations. For example, if you do not want me to mail bills or other materials to your home, you can request that this information be sent to another address. There are limitations to the granting of such requests, which will be provided to you at the time of the request process. Copy of this Notice. You have a right to obtain another copy of this Notice upon request. Technology and Communication E-mail Communications. Unencrypted e-mail may not be confidential, and any information regarding PHI sent by e-mail may not be confidential. Skype, Facetime, Other Similar Video Conferencing Technology, and Internet Communications. Communication and counseling through these means may not be confidential. Storage of Healthcare Information. Health care records and information maintained on a Cloud may not be confidential, depending on the number of servers involved. Voicemail. Telephone messages left through voicemail may not be confidential, if they may be accessed by individuals other than the client. Please let me know if you do not want me to use voicemail in contacting you. Facsimile Communication. The submission of health care information or records by fax may not be confidential, and may lead to a disclosure of confidential information to third parties if the wrong fax number is used to send the information. Communication by U.S. Mail. Communication of information by U.S. mail may lead to disclosure of private information to third parties, depending on who may open the mail. Please let me know if you do not want me to send you correspondence, billing invoices, or other information through the U.S. mail. Privacy Laws. I am required by State and Federal law to maintain the privacy of protected health information. In addition, I am required by law to provide clients with notice of its legal duties and privacy practices with respect to protected health information. That is the purpose of this Notice. Terms of the Notice and Changes to the Notice. I am required to abide by the terms of this Notice, or any amended Notice that may follow. I reserve the right to change the terms of its Notice and to make the new Notice provisions effective for all protected health information that it maintains. When the Notice is revised, the revised Notice will be posted in my service delivery site and/or my website www.creatingmindfulnesscounseling.com and will be available upon request.

Complaints Regarding Privacy Rights. If you believe that I violated your privacy rights, you have the right to file a formal statement to me. Please submit a statement, in writing, addressed to me, concerning your complaint and the basis for it. You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 515F, HHH Bldg., Washington, D.C. 20201. It is my policy that there will be no retaliation for your filing of such complaints.

Additional Information. If you desire additional information about your privacy rights, please ask me any questions that you may have. Confidentiality of alcohol and drug abuse records. The

confidentiality of alcohol and drug abuse patient records maintained by me are protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser unless the patient consents in writing, the disclosure is allowed by a court order; or the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation. Violation of the Federal Law and regulations is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about a crime committed by a patient either at the office site or against any person or about any threat to commit such a crime. Disclosure may be made concerning any threat made by a client to commit imminent physical violence against another person to the potential victim who has been threatened and to law enforcement. Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.
This notice is effective June 3, 2017

I understand these disclosures. I have accessed, reviewed, and had an opportunity to ask question about this Notice of Privacy Rights. I understand I am able to access these Rights in writing at any time.

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Print Sign Date Relationship to client