GABRIELLE USATYNSKI MA LPC
400 McCaslin Blvd # 210
Louisville, CO 80027
Ph 303-859-1825
gabrielle@couplecounselingboulder.com

Dear Client,

Thank you for booking your first individual therapy session with me. These are your Individual Therapy Forms. Please be aware that there are three separate forms contained herein:

1. Individual Therapy Intake Form: p.2

2. Disclosure Statement (Informed Consent): p.5

Please make sure to read this form very carefully as it contains important information about my practice regarding fees, cancellations and other information that will make your therapy more effective. Please sign on p.9.

3. HIPAA: p.10

Please read this form. Fill out and sign p.13.

Please complete these forms, sign where indicated, print and bring to your first appointment.

I look forward to seeing you soon.

Best,

Gabrielle Usatynski MA LPC

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INDIVIDUAL THERAPY INTAKE FORM

Contact Information

Name:_____

Preferred First Name: _____

Today's Date: _____

Birth date:_____ **Current Age:** _____ **Gender:** _____

Sexual orientation: _____

Address:_____

Phone (Home)_____ **O.k. to leave message:**_____

(Cell) _____ **O.k. to leave message:**_____

(Work) _____ **O.k. to leave message:**_____

Is Text Messaging an acceptable form of communication regarding non-clinical issues such as scheduling?

Yes No

If so, the number to text is: _____

Email: _____

Occupation:_____

Referred by:_____

Family History

Relationship status:_____ **How long:**_____

Other marriages/significant relationships, their duration, and your age at the time:_____

_____

_____

_____

_____

Children:_____

Blended family:_____

Medical History

Current Medications:_____

_____

_____

Physician:_____**Phone:**_____

Addiction issues

Use of drugs or alcohol:_____

Parents use of drugs or alcohol:_____

Other addictions:_____

Therapy history

Previous therapy:

_____

_____

_____

How it went:_____

Visit to psychiatrist:_____

Name:_____

Medications: _____

Hospitalization: _____

Suicidality/attempted:_____

Physical violence:_____

(PLEASE ADD MORE PAGES AS NECESSARY)

Issue that brings you to therapy:

Relevant history

Goals for therapy:

Your perception of your strengths:

Your perception of your challenges:

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DISCLOSURE STATEMENT (INFORMED CONSENT)

1. **INFORMATION**

Name: Gabrielle Usatynski
Business: Couple Counseling Boulder LLC
Address: 400 McCaslin Blvd # 210, Louisville, CO 80027
Telephone: 303-859-1825
email: gabrielle@couplecounselingboulder.com

2. **CREDENTIALS**

Licensure: LPC
Degrees: MA
Professional Experience:

2014-Present **PSYCHOTHERAPIST**
Private Practice, Couple Counseling Boulder LLC
Boulder, CO
Providing mental health services for couples and families.

2011-2014 **MEMBER, THERAPIST'S GUILD**
Blue Sky Bridge Child and Family Advocacy
Boulder, CO
Offering specialized trauma-focused mental health services, designed to meet the unique needs of abused children and non-offending family members.

2008-2014 **PSYCHOTHERAPIST**
Private Practice, Boulder Play Therapy LLC
Boulder, CO
Providing mental health services for couples, individuals, children and families.

2008-2014 **MEMBER/CONSULTANT**
Sexual Assault Response Committee of Boulder County
Boulder, CO
Providing psychological consultation on issues related to child sex assault as a mental health consultant to Blue Sky Bridge Child and Family Advocacy Center.

2008-2009 **MEMBER, PEDIATRIC TEAM**
Colorado Therapies & Aquatic Center LLC
Boulder, CO
Provided mental health services for children as part of an interdisciplinary group of practitioners including speech, occupational, and feeding specialists.

3. **REGULATION OF PSYCHOTHERAPISTS**

The practice of licensed or 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 masters 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-doctorial supervision. A Licensed Social Worker must hold a masters 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 Addiction Counselor I (CAC I) 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 2,000 hours of supervised experience. A CAC III must have a bachelors degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical masters degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified.

4. **CLIENT RIGHTS AND IMPORTANT INFORMATION**

a. You are entitled to receive information from me about my methods of therapy, the techniques I use, and the duration of your therapy. Please ask if you would like to receive this information. My fee is $200.00 per hour for therapy.

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

c. In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Department of Regulatory Agencies.

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: (1) I am required to report any suspected incident of child abuse or neglect to law enforcement; (2) I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (3) 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; (4) I am required to report any suspected threat to national security to federal officials; and (5) I may be required by Court Order to disclose treatment information.

f. At the completion of your therapy, the records will be summarized and filed in a safe place for seven years, after which they will be destroyed.

g. Please be aware that as a part of good clinical practice, I routinely consult with colleagues regarding clinical issues, and clients I am currently treating. On these occasions, I make every effort to maintain confidentiality.

h. No-shows will be billed at full rate.

i. Appointments cancelled with less than **24 hours** notice will be billed at full rate.

j. Unless you contact me in advance of your scheduled session time to let me know that you are going to be late for your appointment, if you are more than 20 minutes late, your appointment will be cancelled and you will be billed at full rate.

k. Please note that as a couple and family therapist, I maintain a “no secrets” policy as defined in the following manner: any information shared with the therapist by one or more member(s) of the couple or family outside of the presence of the other member(s) of the couple or family may be disclosed to the other member(s) of the couple or family at the therapist's discretion. Please be sure to carbon copy the other member(s) of your couple or family on all email communication with me.

l. In regards to couple and family therapy, please note that I cannot cancel, reschedule or change the length of a session unless ALL members of the couple or family notify me in writing regarding the change. If you choose to notify me of your scheduling request by email, you must carbon copy the other member(s) of your couple or family. Note that if you do not carbon copy the other member(s), your scheduling request will not be considered and you will be billed at full rate

for missed appointments. A phone call from one member of the couple or family is insufficient to request a scheduling change as I would need to hear from all parties.

m. If one or both of you arrive at your scheduled appointment under the influence of drugs or alcohol, including marijuana, please note that that day's session will be cancelled and you will be billed at full rate for the missed session.

n. Inclement Weather Policy: If the Adams 12 School District is closed due to inclement weather such as snow, you will not be charged for a missed session due to inclement weather. If on the other hand, Adams 12 is in session and you miss your session due to inclement weather, you will be billed at full rate. Please consult **www.adams12.org** or by calling **(720) 972-4000**, **then press 7**, for school closures due to inclement weather after 5:30am the day of your scheduled appointment.

o. If there are currently other mental health providers involved in one or both of your care, including but not limited to individual, family, or child therapists, group leaders, psychiatrists, shamanic practitioners, or any other professional of this nature, I may require a written release from both of you that will allow me to discuss all of your mental health information with all of these professionals. Unwillingness to provide me with such a release is grounds for me not to enter into a therapeutic relationship with you or to terminate our therapeutic relationship immediately.

5. DISCLOSURE REGARDING DIVORCE AND CUSTODY LITIGATION

If you are involved in divorce or custody litigation, my role as a therapist 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 interests of the family's children.

Signature Page for Gabrielle Usatynski's Disclosure Statement for Psychotherapy
400 McCaslin Blvd # 210, Louisville, CO 80027 303-859-1825

I have read the preceding information and understand my rights as a client/patient. I also acknowledge that I have received a copy of this Disclosure Statement.

_____

Name of Client

_____ _____

Client Signature/Legal Representative Date

_____ _____

Therapist Date

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICES DESCRIBES HOW MEDICAL 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 Notices 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors, other licensed health care providers or treatment team members.

For Payment. We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. 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.

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, reminding you of appointments, providing 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) and we will 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.

<u>Required by Law.</u> 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.

<u>Without Authorization.</u> 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 suspected child abuse or neglect or mandatory government agency audits or investigations (such as the Department of Regulatory Agencies 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.

<u>The following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization</u>

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

<u>Verbal Permission.</u> We may use or disclose your information to family members that are directly involve in your treatment with your verbal permission.

<u>With Authorization.</u> Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization which may be revoked in writing at any time.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your PHI maintained by our office. To exercise any of these rights, please submit your request in writing to Gabrielle Friedman at the address listed above.

-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.

-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.

-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.

-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 services that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

-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.

-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.

-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 Gabrielle Usatynski at the address above, or with the Secretary of Health and Human Services at 200 Independence Ave, S. W., Washington, D. C., 20201, or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.
The effective date of this Notice is April 14th, 2014.

CLIENT ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY PRACTICES

(You may refuse to sign this acknowledgement.)

I/We, _____ have received a copy of the Notice of Privacy Practices with an effective date of April 14th, 2014.

Name of client(s) or parent/guardian of minor child:

_____

_____

Address(es) of client(s):

_____

Signature(s) of client(s) or Personal Representative:

_____

_____

Description of Personal Representative's authority and attach document evidencing authority, such as Power of Attorney:

Name of Witness: _____

Signature of Witness: _____

Date: _____

For Office Use Only:
We have made a good faith attempt to obtain written acknowledgment of receipt of the Notice of Privacy Practices. Acknowledgment could not be obtained for the following reason:
Client(s) refused to sign (Date of Refusal):

Attempt was made by: _____ Date: _____

Signature of clinician: _____