Diamond Counseling
Carole Brooks, Ph.D., LPC
7220 W. Jefferson Ave., Suite 330
Lakewood, CO 80235
303-550-4592

Client Informed Consent/Disclosure Agreement

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully. Once you sign this, it will constitute a binding agreement between us as well as your consent for us to begin treatment/counseling. Thank you for choosing me as your counselor.

My credentials

I am a Licensed Professional Counselor with the state of Colorado Department of Regulatory Agencies (License #4993) and I hold a Doctorate Degree in Christian Counseling from Northwestern Theological Seminary obtained January, 2012, a Master's Degree in Counseling from the University of Phoenix obtained May, 2006, and a Bachelor of Arts in Management Degree from the University of Phoenix obtained September 30, 1997.

My counseling philosophy and services

I believe in a team approach to counseling. Together we will work toward your goals. I will assist you in exploring your present and past issues and struggles. The final goal of your counseling will be for you to one day have the necessary coping skills to handle the struggles that brought you in today without my assistance. While it is impossible for me to guarantee the outcome of your counseling, I will do my professional best to help you resolve your life issues while staying within accepted ethical guidelines. To better serve you, I may take notes during our sessions.

Client rights and important information

You are in complete control of your counseling and number of sessions needed. You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy (if I can determine it), and my fee structure. Please ask if you would like to receive this information. You have the right to terminate therapy at any time, but please discuss this decision with me first. You also have the right to obtain a second opinion from another therapist at any time. If you need a referral to another therapist I would be happy to assist you.

Counseling limitations and risks

My counseling services are limited to the scheduled sessions we have together. There are some risks to counseling. You may experience uncomfortable levels of sadness, anger, frustration, etc. as you explore your personal history. Therapy can help people gain new understanding and coping strategies to deal with these feelings. With new skills, people often gain insight about their past, have a reduction in stress, and experience improved relationships.

To better serve you, our relationship will remain purely professional and not be considered a friendship. In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate and should be reported to the Department of Regulatory Agencies, Mental Health Section. It is important for you to remember that you are experiencing me only in the professional role. In the event you feel your mental health requires emergency attention or if you have and emotional crisis, you should report to the emergency room of a local hospital and request mental health services, or call 911.

Confidentiality: No recording devices are allowed in the counseling office (including cell phone use)

Generally, the information provided by and to a client during therapy sessions is legally confidential if the therapist is a licensed professional counselor. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent. Information disclosed to a licensed professional counselor is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

I will keep confidential anything you say to me with the following general exceptions required by law (Colorado Statutes C.R.S. 12-43-218): you direct me to tell someone else and sign a written release; I determine you are a danger to yourself or others, I have reason to suspect child abuse or neglect, or I am ordered by a court to disclose information. Please be aware that provisions concerning disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in section 13-90-107 C.R.S.

Payment terms

In return for a fee of $120 per 50 minute session for individuals and/or $220 per 90 minute session for couples/families/two or more people, I agree to provide counseling services for you. Sessions will start on time. The fee for each session will be due and must be paid at the conclusion of each session, and can be paid by cash, credit card, or check. I will provide you with a receipt for all fees paid. All fees are subject to change, and in the event of fee changes, you will be notified at least 30 days in advance of such changes. There is a $40 fee charged for each returned check. I also charge fees for phone calls with you exceeding 15 minutes in length.

Should I become involved in any legal matter such as giving testimony, depositions, etc., the fee is $250 per hour for preparation, review of materials, travel time, and any other time involved. A minimum of $250 must be paid in advance of the court date, and will be nonrefundable should the proceedings be cancelled.

Appointment Cancellation Policy

In the event you will not be able to keep an appointment, you must notify me 24 hours in advance either by phone or email communication (no texts) to cancel your appointment. If I do not receive such advance notice, you will be responsible for paying for the session you missed which may be paid by your credit or debit card.

I have read the Appointment Cancellation Policy above and agree to the terms of this policy. Initial: ____

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.

In the event you are dissatisfied with my services for any reason, please let me know and I will try to the best of my abilities to resolve your concerns. If you have any questions, please feel free to ask.

You have the legal right to report your complaints to the State of Colorado Department of Regulatory Agencies, which has the general responsibility of regulating the practice of licensed psychologists, licensed social workers, licensed professional counselors, licensed marriage and family therapists, licensed school psychologists practicing outside the school setting, and unlicensed individuals who practice psychotherapy. For your information, Colorado State Law 12-43-214 is related to a client's rights to know about therapist and client rights and C.R.S. 12-43-218 law lists exclusions to confidentiality. Any questions, concerns, or complaints regarding the practice of mental health professionals by both licensed and unlicensed persons in the field of psychotherapy may be directed to:

Colorado Department of Regulatory Agencies
Mental Health Section
1560 Broadway, Suite 1350
Denver, Co 80202, Phone: 303-894-7766

I have read the preceding information; I understand and agree to the terms stated in this two page document. I understand my rights as a client and I have received a copy of this document.

I have also received a copy of the HIPAA laws and statements.

Client's Full Name (printed): _____

Client Signature: _____ Date: _____

If patient is a minor: Minor's Name & Date of Birth: _____

Parent's Signature (constitutes permission to treat child): _____

Therapist Signature: _____ Date: _____

Diamond Counseling Individual Client Intake Form

Carole Brooks, Ph.D., LPC
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Date: _____

Name: _____ D.O.B.:____/____/____

Address:_____ City: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

Email address: _____

Occupation: _____ Employer: _____

Marital Status: ___Single ___Cohabitating ___Married ___Separated ___Divorced ___Widowed

Name(s) of Children (Ages):

_____ (___), _____(___),_____(___), _____ (___)
Name Age Name Age Name Age Name Age

How did you find out about Diamond Counseling? (Circle One Below)

Psychology Today *Network Therapy* *Good Therapy* *Ad on Internet Search Results Page*

General Internet Search Results *Referred By Someone*_____ *Other* _____
(Name of Person)

What prompted you to seek help at this time?_____

_____

_____

_____

What are you feeling positive about at this time?

_____

_____

_____

Have you been in counseling before? _____ With whom? _____

When?_____Why? _____

Have you ever been hospitalized for mental or emotional problems? If so, please describe: _____

_____

_____

_____

Do you use drugs or alcohol?_____ How often? _____

Have you had any previous treatment for drug or alcohol problems? _____

_____

_____

Please list any health problems: _____

_____

Please list any medications and/or herbs you currently use: _____

_____

Any current suicidal thoughts? _____ Y _____N

Do you have a specific plan to end your life?_____ Y _____ N

Do you have a history of childhood violence and/or abuse?_____Y _____N

Explain any YES responses indicated above:

_____

_____

_____

Please circle any current symptoms you are experiencing:

Depression/Sadness	Isolation/Withdrawal	Frequent Suicidal Thoughts	Aggression/Violence
Frequent Homicidal Thoughts	Anxiety/Panic/Worry	Appetite Problems	Impulse Control Difficulty
Phobia/Fear	Sleep Disturbance	Difficulty Expressing Feelings	Obsessions and/or Compulsions
Anger/Irritability	Victim of Abuse	Low Self-Esteem/Confidence	Domestic Violence
Perpetrator of Abuse	Problems Thinking/Concentrating	Relationship Conflicts	Addictive Behavior
Pronounced Mood Swings	Workplace Stress	Alcohol/Substance Abuse	Stress/Feeling Overwhelmed
Communication/Trust Problems	Grief/Loss	Legal/Financial Problems	Chronic Medical Problems
Parenting Issues	Religious/Spiritual Issues	Binging/Purging	Sexual/Intimacy Issues
Sex-Role/Gender Questioning	Destructive of property or self		

Has you ever been diagnosed with a mental disorder/issue? If so, what was the diagnosis?

_____

_____

_____

Who is in your support system?

_____

_____

_____

Do you have any religious preferences and/or cultural background you would like me to know about?

_____

Additional Issues: _____

_____

_____

_____

_____

_____

NOTICE OF PRIVACY PRACTICES (Including HIPAA Client Rights)

Diamond Counseling
Carole Brooks, Ph.D., LPC
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PHONE: 303-550-4592

(8-09-06)

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

Effective April 14, 2003

If you have any questions or requests about this Notice, please contact Carole Brooks.

The Practice is required by State and Federal law to maintain the privacy of protected health information. In addition, the Practice is required by law to provide clients with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to your mental health information, and to request that you sign the attached written acknowledgement that you received a copy of this Notice. This Notice describes how the Practice may use and disclose your protected health information. This Notice also describes your rights regarding your protected health information and how you may exercise your rights.

"Protected Health Information, PHI", is information the Practice has created or received about your physical or mental health condition, the health care we provide to you, or the payment for your health care; and identifies you or could be reasonably used to identify you. It includes your identity, diagnosis, dates of service, treatment plan, and progress in treatment.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Permissible Uses and Disclosures Requiring Your Written Authorization: Your mental health information may be used and disclosed in the following ways only if you provide written permission to Carole Brooks, Diamond Counseling:

•Treatment: Your mental health information may be used and disclosed in the provision and coordination of your healthcare. For example, this may include coordinating and managing your health care with other health care professionals. Your mental health information may be used and disclosed when consulting with another professional colleague, or if you are referred for medication, or for coverage arrangements during the clinician's absence. In any of these instances only information necessary to complete the task will be provided.

•Payment: Your mental health care information will be used to develop accounts receivable information, to bill you, and with your consent to provide information to your insurance company or other third party payer for services provided. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnosis, dates and type of service, and other information about your condition and treatment, but will be limited to the least amount necessary for the purposes of the disclosure.

•Health Care Operations: Your mental health information may be used and disclosed in connection with our health care operations, including quality improvement activities, training programs and obtaining legal services. Only necessary information will be used or disclosed.

- Exceptions to your record confidentiality are only when: Required or Permitted by Law: Your mental health care information may be used or disclosed when required or permitted to do so by law or for health care oversight. This includes, but is not limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when there is a legal duty to warn or to take action regarding imminent danger to others; (d) when the client is a danger to self or others or gravely disabled; (e) when a coroner is investigating the client's death; or (f) 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, or regulatory compliance.

•Contacting the Client: You may be contacted to remind you of appointments and to tell you about treatment or other services that might be of benefit to you.

•Crimes on the premises or observed by the provider: Crimes that are observed by the therapist or the therapist's staff, crimes that are directed toward the therapist or the therapist's staff, or crimes that occur on the premises will be reported to law enforcement.

•Business Associates: Some of the functions of the practice may be provided by contracts with business associates. For example, some of the 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.

•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.

•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 the discussion. However, if the client objects, protected health information will not be disclosed.

•Emergencies: In life threatening emergencies the practice will disclose information necessary to avoid serious harm or death.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION OR RELEASE OF INFORMATION

Except as described above, or as permitted by law, other uses and disclosures of your mental health information will be made only with your written authorization to release the information. When you sign a written authorization, you may later revoke the authorization in writing as provided by law. However, that revocation may not be effective for actions already taken under the original authorization.

- Psychotherapy Notes: Psychotherapy notes are maintained separate from your mental health record. These notes will be used only by your therapist and disclosure will occur only under these circumstances: (a) you specifically authorize their use or disclosure in a separate written authorization; or (b) the therapist who wrote the notes uses them for your treatment; or (c) they may be used for training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills; or (d) if you bring a legal action and we have to defend ourselves; and (e) certain limited circumstances defined by the law.

YOUR RIGHTS AS A CLIENT

Additional Restrictions: You have the right to request additional restrictions on the use or disclosure of your mental health information. However, the clinician does 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 from the practice by alternative means or at alternative locations. For example, you may request that bills and other correspondence be sent to an address other than your home address.

Access to Protected Health Information: You have the right to inspect and obtain a copy of your protected health information in the mental health and billing record. However, any psychotherapy notes are for the use of your therapist, and are treated differently. If it is thought that access to your mental health records would harm you, your access may be restricted.

Amendment of Your Record: You have the right to request an amendment or correction to your protected health information. If the clinician agrees that the amendment or correction is appropriate, the Practice will ensure the amendment or correction is attached to the record.

Accounting of Disclosures: You have the right to receive an accounting of certain disclosures the practice has 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 authorized by you, or disclosures made prior to April 14, 2003. Other exceptions will be provided to you, should you request an accounting.

Right to Revoke Consent or Authorization: You have the right to revoke your consent or authorization to use or disclose your mental health information, except for action that has already taken place under your consent or authorization.

Copy of this Notice: You have a right to obtain a copy of this Notice upon request.

The Practice is required to abide by the terms of this Notice, or any amended Notice that may follow. The Practice reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that it maintains. When changes are made, the revised Notice will be posted at the Practice's office and copies will be available upon request.

If you believe the Practice has violated your privacy rights, you may file a complaint with the person designated within the Practice to receive your complaints, Carole Brooks. 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 the policy of the Practice that there will be no retaliation for your filing of such a complaint.