CLIENT INFORMATION FORM

Jana Briggs Counseling, LLC
(303) 495-0317
www.janabriggs.com
8 W. Dry Creek Circle, Suite 207
Littleton, Colorado 80120

Name: ____

Parent(s) name (if client is under the age of 18):______________________________

Address: ____

Phone: H ( ) ________________ W ( ) ________________ C ( ) ________________

Email Address: ____

Date of Birth: ______________ Age: ____ Relationship Status (if applicable): ______________

Referred by: ____

Please state in your own words what difficulty brings you to counseling.

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Any prior counseling experience? If so, was it helpful?

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In case of an emergency, contact:

Name ______________________________ Relationship ________________

Address ____

Phone ____________________

☐ I have received copies of the Professional Disclosure/Informed Consent and Privacy Forms of Jana Briggs, M.A., NCC, LPC.

______________________________ ________________
Client Signature (over 15) Date

______________________________ ________________
If a Minor (under 18) - Parent/Guardian Signature Date

Jana Briggs, M.A., NCC, LPC #5357 8 W. Dry Creek Circle, #207
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Degrees, Licensing & Credentials

I hold a Bachelor's Degree in Education and Art from the University of North Texas and a Master's Degree in Counseling, with a specialization in Marriage and Family Therapy, from Sam Houston State University. I am a Licensed Professional Counselor in the State of Colorado (LPC # 5357), and a National Certified Counselor (NCC #239373) with the National Board for Certified Counselors (NBCC). I started my Littleton private therapy practice in 2007 after relocating with my family from The Woodlands, Texas.

My license, practice and professional behavior are overseen by the Colorado Department of Regulatory Agencies - Mental Health Licensing Section of the Division of Professions & Occupations. The Board of Licensed Professional Counselor Examiners can be reached at 1560 Broadway, Ste.1350, Denver, CO 80202, (303) 894-7800. The practice of licensed professional counseling is regulated by the Mental Health Licensing Section of the Division of Registrations and must be in compliance with the provisions of the Mental Health Practice Act. The regulatory requirements for mental health professionals provide that a Licensed Professional Counselor must hold a master's degree in their profession of counseling and have two years of post-master's supervision. As a Licensed Professional Counselor, I meet all of the educational, experience and training requirements for licensure. In addition to being governed by the Colorado Mental Health Statutes, I also adhere to NBCC, ACA, and AACC Codes of Ethics and standards. You can expect me to practice in a manner that is consistent with these codes.

Regulatory Requirements for Mental Health Professionals in compliance with § 12-43-214(1)(b)(I), C.R.S includes the following:

- A Registered Psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado, but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.
- A Certified Addiction Counselor I (CAC I) must be a high school graduate or equivalent, complete required training hours and 1,000 hours of supervised experience.
- A Certified Addiction Counselor II (CAC II) must be a high school graduate or equivalent, complete the CAC I requirements, and obtain additional required training hours, 2,000 additional hours of supervised experience, and pass a national exam.
- A Certified Addiction Counselor III (CAC III) must have a bachelor's degree in behavioral health, complete CAC II requirements, and complete additional required training hours, 2,000 additional hours of supervised experience, and pass a national exam.
- A Licensed Addiction Counselor must have a clinical master's degree, meet the CAC III requirements, and pass a national exam.
- A Licensed Social Worker must hold a master's degree from a graduate school of social work and pass an examination in social work.
- A Licensed Clinical Social Worker must hold a master's or doctorate degree from a graduate school of social work, practiced as a social worker for at least two years, and pass an examination 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 Licensed Marriage and Family Therapist must hold a master's or doctoral degree in marriage and family counseling, have at least two years post-master's or one-year post-doctoral practice, and pass an exam in marriage and family therapy.
- A Licensed Professional Counselor must hold a master's or doctoral degree in professional counseling, have at least two years post-master's or one year postdoctoral practice, and pass an exam in in professional counseling.
- A Licensed Psychologist must hold a doctorate degree in psychology, have one year of post-doctoral supervision, and pass an examination in psychology.

Client Rights & Responsibilities

Some clients need only a few counseling sessions to achieve their goals, while others require months or even years of counseling. As a client, you maintain control of yourself, and you may end our counseling relationship at any time, although I recommend that you participate in a termination session. You have the right to refuse or discuss with me any of the counseling techniques and suggestions that I use. If you are dissatisfied with my work for any reason, please let me know. In some situations, I may help you find another counselor with whom you may be able to work more effectively. It is your right to seek a second opinion from another therapist. If counseling is successful, you should feel you are able to face life's challenges without the support or involvement of a counselor, and you should feel a sense of success in satisfactorily resolving your problems. Should you or I feel that a referral is needed, I will provide you with some alternatives including professionals, specialists, and/or programs to assist you. It will be your responsibility to contact and evaluate these referrals.

Counseling Relationship & Effects of Counseling

While our sessions may be psychologically intimate, it is important for you to understand that our relationship is strictly professional and not social. Our contacts, other than chance meetings, will be limited to appointments you arrange with me. During the time that we work together, we will meet at mutually agreed upon times. If we should run into each other outside of counseling, I will let you acknowledge me or initiate a conversation if you choose to. You will be best served if our relationship remains professional and our sessions concentrate exclusively on your concerns. While you will learn much about me as we work together, it is imperative that you remember that you are experiencing my professional role. Within the professional relationship, sexual intimacy is never appropriate and should be immediately reported to the Department of Regulatory Agencies, Division of Registrations, Mental Health Section.

It is my intention to render services in a professional manner consistent with accepted standards of practice. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. It is possible that these changes can affect your relationships, job, and/or understanding of self. At any time, you have the right to initiate a conversation regarding any possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling.

Records & Confidentiality

The information provided by the client(s) during therapy is legally confidential. All of our communication becomes part of clinical records. All written records of our counseling sessions will be maintained by me and kept in a confidential and secure place. I will keep confidential the things you tell me, and they will not be disclosed to others unless you give me written consent. However, Colorado law does specify some exceptions to the general rule of confidentiality, some of which are listed in the Colorado Statutes (C.R.S. 12-43-218), the HIPAA Notice of Privacy Rights you were provided, as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report suspected child abuse to authorities. You should also be aware that provisions concerning disclosure of confidential communications will not apply to any delinquency or criminal proceedings, except as provided in section 13-90-107 C.R.S. If a legal exception arises during therapy, if feasible, you will be informed accordingly.

Supervision & Consultation

I provide and participate in clinical / professional supervision, meaning that I supervise students and/or master's level candidates who are working toward their licensure in Professional Counseling in the State of Colorado. I also participate in professional, confidential consultation to provide the best possible services for the clients I counsel. Therefore, occasionally it may be necessary for me to discuss your case with a student, licensure candidate, another therapist, pediatrician, family physician, psychiatrist, supervisor, supervisee, or other helping professional. All of those I supervise are under the same legal and ethical requirements, and your confidentiality will be protected according to the laws and statutes of the Mental Health Code of Colorado. If you have any questions regarding this practice you have the right to inquire at any time.

Litigation Limitation

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be confidential and sensitive in nature, it is agreed that should there be any legal proceedings (such as, but not limited to divorce/custody disputes, injuries, lawsuits, etc.), neither you nor your attorney(s), nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of therapy records be requested/released unless otherwise agreed upon. Should I be court ordered as an expert witness to either appear, submit documentation/reports/therapy summaries, and/or consult with other professionals regarding a client's case – fees are $300 per hour, including travel time. Additionally, I will require compensation for having to cancel/reschedule any existing therapy sessions at $150 per 60 min. session. Please initial________

Fees & Payment Policies

In order to determine if my services will be of benefit to you, I offer a 15-minute complimentary phone consultation. Thereafter, my fee is $150 per 60-minute session. I also offer extended appointments: $190 per 75-minute session and $230 per 90-minute session. Regarding payment for any of the above services, cash and checks are accepted prior to our session, or for your convenience, you can pay by credit card or HSA card. Payment is due on the day of your counseling session and credit cards are billed post session. It is the client's responsibility to keep payment information up to date. There will be a $25.00 charge for returned checks. You may contact me with questions about the fee structure and/or recommended duration of therapy sessions.

Regarding health insurance: I am an out-of-network provider, therefore it is your responsibility to file with your insurance company for reimbursement. Should you wish to file for reimbursement, I will provide you with a monthly receipt upon request. All sessions must be paid in full. If insurance does not reimburse as anticipated, it is your responsibility to address the issue with your insurance provider. Please initial _________

Emergency Situations

I can be reached at (303) 495-0317 during the weekdays (Mondays–Thursdays) between the hours of 9:00 a.m.-3:00 p.m. If you do not reach me, please leave a voice mail message, and I will return your call as soon as possible. If your call is after hours or I cannot get in touch with you, please call the closest hospital/crisis center, dial 911, or go straight to a hospital emergency room. If you have left an emergency message on my voicemail and then reach someone else, or have taken other actions, please call me and let me know the status of your emergency situation. Although I hope no unexpected interruptions in our counseling sessions occur, it is possible that an emergency situation could prevent me from attending a session. If this should occur, you will be contacted, informed of the situation, and given instructions as to what to do while I am away from the office. I typically take vacations during the year, but will notify you of my plans in advance, and you will be given the name and phone number of a contact person if you experience difficulty while I am away.

Acknowledgement & Consent

By signing below, you are indicating: 1) I have read this statement; 2) We verbally reviewed the information contained in this statement; 3) Any questions I have about this statement have been answered to my satisfaction; 4) I have voluntarily sought counseling on my own initiative and am under no obligation to apply the counsel that I may receive; 5) I voluntarily accept the help offered by Jana Briggs; 6) I will not hold Jana Briggs liable for my health, behavior, or well-being in any way; 7) I acknowledge my commitment to conform to the specifications of this disclosure statement; 8) I consent to treatment - and/or- give my permission as parent/guardian for a minor in my care to be treated.

Client Signature (Parent/Guardian if client is under age of 18): ____Date:_____________

*If parents are separated or divorced and have joint decision-making authority related to counseling a minor, please add additional signature here:
*(Parent/Guardian if client is under age of 18): ____Date:_____________

If client is a minor between the age of 15-18, please sign here: ____Date:_____________

Jana Briggs, M.A., NCC, LPC #5357______________________________________ **Date verbally reviewed**_______________________

HIPAA - Privacy of Information Policies

This form describes the confidentiality of your records, how the information is used, your rights, and how you may obtain this information. Based on the Health Information Portability and Accountability Act (HIPAA). *Effective 4-14-03*

Legal Duties: State and Federal laws require that I keep your counseling and health records private. Such laws require that I provide you with this notice informing you of the privacy of information policies, your rights, and my duties. I am required to abide these policies until replaced or revised. I have the right to revise the privacy policies for all records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place. The contents of material disclosed in an evaluation, an intake, or a counseling session are covered by the law as private information. I will respect the privacy of the information you provide, and I will abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information: (1) With your written consent, information about you may be used by other professionals for diagnosis, treatment planning, treatment, and continuity of care. I may disclose it to health care providers who provide you with treatment, such as doctors, nurses, and mental health professionals. (2) 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 or personal representative. It is my policy not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements. (3) Regarding insurance companies, managed care, and other third-party payers – I am not responsible for any breach of confidentiality that should occur as a result of your submitting your counseling receipts and the information contained therein to the insurance company or its employees. (4) When using a credit card, although transactions take place on a secured line, your card number, expiration date, and name are included in the transaction, and I am not responsible for any breach of confidentiality that should occur as result of your using a credit card for payment of services rendered.

Duty to Warn and Protect: When a client discloses intentions to harm self or poses danger to self or others, I am required to warn the client and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, I am required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse: If a client states or suggests to me that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, I am required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, I may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

Professional Misconduct: Any information disclosed to me regarding misconduct of a health care professional should be reported, but only with client consent.

Judicial Proceedings: If I am ordered by the judicial system to disclose information for criminal or delinquency proceedings or by law for other reasons, I will do so.

Contact: In the event that I must contact a client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify me in writing where I may reach you by phone and how you would like me to identify myself. For example, you might request that when I phone you at home or work, I do not say the nature of the call, but rather my first and/or last name only. If this information is not provided to me, I will adhere to the following procedure when making phone calls: First I will ask to speak to the client (or guardian) without identifying the name of my office. If the person answering the phone asks for more identifying information I will say that it is a personal call. I will not identify the nature of the call (to protect confidentiality). If I reach an answering machine or voice mail, I will follow the same guidelines.

Your Rights: You have the right to (1) Request to review or receive your files. The procedures for obtaining a copy of your information are as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. There will be a charge for this service per page copied, plus postage; (2) Cancel a release of information by providing a written notice. If you desire to have your information sent to a location different than the address on file, you must provide this information in writing; (3) Restrict which information might be disclosed to others. However, if I do not agree with these restrictions, I am not bound to abide by them; (4) Request that information about you be communicated by other means or to another location. This request must be made in writing; (5) Disagree with the records in your files. You may request that this information be changed. Although I might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file; (6) Know what information in your records has been provided to whom and request this in writing. If you desire a written copy of this notice you may obtain it upon request.

Complaints: You have specific rights under the Privacy Rule. Should you choose to file a complaint, I will not retaliate in any way. If you have any complaints or questions regarding these procedures, please contact me/my office. I will get back to you in a timely manner. You may also submit a complaint to the Office for Civil Rights (address provided upon request) and/or: *Jana Briggs Counseling, LLC - Attn: Records; 8 W. Dry Creek Circle, Suite 207, Littleton, CO 80120---Email: info@janabriggs.com*

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

Client Name	**Parent/Guardian (for Minor) Name**

Client Signature	**Date**	**Parent/Guardian Signature**	**Date**

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Client Contact & Confidential Communication

Email Communication: This means of contact is primarily used for scheduling and brief response. IF a client chooses to send personal information by way of internet, it is the client's responsibility for the security of that information. Jana Briggs uses a secure server, and if necessary will use an encrypted form of transfer for confidential records. Once the communication is transferred to the client's server, the security of that information becomes the client's responsibility. Additionally, it is the client's responsibility to discern what information is sent in an email.

(Initial)__________As client, I will not hold Jana Briggs liable for information put at risk electronically and/or for mishandling once information is on the client's server.

Texting: Occasionally, texting may be appropriate for scheduling or brief messages. This is at the client's discretion. Jana will not text personal information pertaining to the client.

Online Counseling: In some cases, this may be permitted. Please note that e-mail correspondence for this purpose is used only for appropriate situations and must meet ethical codes. Although every precaution will be taken, online communication may not be completely confidential. E-mail response time is typically 12-48 hours. At any point, if the counseling conflicts with ethical standards, Jana Briggs reserves the right to discontinue services. Payment for this type of service is limited to credit cards. Online counseling is not intended for individuals under the age of 18 or for those in crisis. If you are in crisis, feel unsafe, or are actively suicidal, please call your local emergency room, hotline, or 911. ________If applicable, please initial that you understand the above information regarding Online Counseling.

(Initial)_________ As client, I realize that although every precaution will be taken, the above means of communication may not be completely confidential and I authorize the following request(s).

Client's name: ____DOB:_______Relationship to Client (if applicable)__________

Check those that apply:

________ I give consent to be contacted at the phone numbers provided.
________ I give consent to be texted on my mobile device.
Home #________________________________ Cell #_______________________ Work #______________________
________ I give consent to be left a voice mail if needed.
________ I give consent to be contacted by - and/or to receive Email. Email address:______________________________
________ I give consent to receive FAX information/forms if necessary. FAX#____________________________________

Cancellation Policy

Services are by appointment only and are scheduled weeks in advance. As this time is reserved exclusively for you, it is my policy to charge for missed appointments and appointments not cancelled at least 24 hours in advance. If you are unable to keep a scheduled appointment, please notify me at **(303) 495-0317.** If I do not receive such advanced notice, you will be responsible for paying for the missed session fee. Session fee: $150 per 60 min. For appointments scheduled on Mondays, cancellation is necessary by Friday at the scheduled hour. **In the case of an emergency, special consideration may be given regarding the cancellation policy.*

Please initial ________ and complete required information below.

The above-mentioned fee will be charged to the following credit card: □ Visa □ MasterCard □ Amex

Credit Card #: ____ Security Number on back of card __________

Name on Card: ____ Expiration: _______________

I, ____, understand and agree that if I do not show up for my scheduled appointment or if I cancel my scheduled appointment with less than 24-hour notice, the above named credit card will be charged in the amount of $130.00.

(Initial)______I would like to use this billing information for sessions. (Initial)_______I would like to use an alternate form of payment.

Signature ____Phone #_________________ Date ____________