KRYSTEN RUDY | MFT
Individual, Marriage and Family Therapy

CLIENT INFORMATION

Date of 1st Appointment: _____ Referral Source: _____

(Please indicate all those participating):

ADULTS

LAST NAME	FIRST NAME	D.O.B.	AGE	SS#	OCCUPATION	RELATIONSHIP TO CLIENT (or Self ")

CHILDREN

LAST NAME	FIRST NAME	D.O.B.	AGE	SS#	LEGAL GUARDIAN	RELATIONSHIP TO CLIENT (or "Self")

Home Address: _____

City/State/Zip: _____

(OK to contact you here?)

Phone #s: Home: _____ *(Y__ N__)(msg___)*

Work: _____ (Y__ N__)(msg___)

Cell: _____ (Y__ N__)(msg___)

Email: _____ (Y__ N__)(msg___)

Appointment Reminders can be sent via: ____ Text OR ____ E-mail

Emergency Contact Person: _____

Relationship to Client/Family: _____

Contact #: _____

Primary Care Physician: _____

Physician's #: _____

Medications/For What: _____

_____

Person Responsible for Payment: _____

(Continued on next page)

1) Please describe your reasons for seeking therapy at this time. If there is a particular event or situation which triggered your decision, please describe the event:

_____

_____

_____

_____

_____

2) Please rate the severity of the following symptoms over the last month according to the following rating scale:

0-No difficulty

1-Mild

2-Moderate

3-Severe

_____ Decreased appetite

_____ Increased appetite/eating more

_____ Binging and/or purging

_____ Weight change? +/- _____ lbs.

_____ Depressed mood

_____ Decreased energy/fatigue

_____ Sleep changes: trouble falling asleep; trouble staying asleep; trouble waking up (*circle one*)

Avg. # hours sleep _____

_____ Decreased sexual desire

_____ Difficulty with sexual functioning

_____ Loss of interest in activities

_____ Crying

_____ Feelings of hopelessness

_____ Feelings of helplessness

_____ Decreased attention span

_____ Inattentive/Distractible

_____ Memory problems: Long-term; short-term

_____ Self-injurious behavior

_____ Thoughts of suicide

_____ Thoughts of harming others

_____ Impulsivity

_____ Hyperactivity

_____ Anxiety/Nervousness

_____ Worry/Fear

_____ Flashbacks of traumatic event

_____ Difficulties making decisions

_____ Nightmares

_____ Hypervigilance

_____ Obsessive thoughts

_____ Compulsions

_____ Spending sprees

_____ Racing thoughts

_____ Rapid heart beat

_____ Trouble breathing

_____ Sweating

_____ Gambling

_____ Police/Probation involvement

_____ Stealing

_____ Lying

_____ Truancy

_____ Violent behavior towards others

_____ Destruction of property

_____ Harming animals

_____ Fire setting

_____ Opposition

_____ Anger outbursts

_____ Irritability

_____ Substance Abuse

- _____ Alcohol
- _____ Illicit Drugs
- _____ Prescription Drugs

_____ Spending time with others

_____ Self-esteem

_____ Phobia/Fears

3) Please identify any history of abuse/trauma:

_____ Physical Abuse _____ Sexual Trauma _____ Emotional Abuse _____ Witnessed Violence
_____ Combat Trauma

Describe:_____

_____

4) What would you like to see accomplished in therapy?

_____

_____

_____

5) Have you or other members of your family ever received counseling or mental health

services before? If so, please list dates, provider name, the issue for which services were sought, and what you feel was accomplished:

_____

_____

_____

6) Please list any medications and/or other treatments you are receiving at this time (i.e., prescription/over-the-counter medications, medical care, acupuncture, chiropractic care, substance abuse treatment, etc.):

_____

_____

7) Please list any other information not asked specific to why you are seeking therapy :

_____

_____

7) ****<u>EAP Information</u>** *(if applicable)*<u>**:**</u>

Person Responsible for Payment: _____

EAP Insurance company (if applicable):_____

KRYSTEN RUDY | MFT
Individual, Marriage and Family Therapy

INFORMED CONSENT & NOTICE OF PRIVACY PRACTICES

Welcome to my practice. I am a Licensed Marriage and Family Therapists in the state of Colorado (MFT 0001493). I specialize in working with couples, children, adults, and families and offer individual, couples and family therapy.

This packet contains important information about my professional services and business policies. I believe that a person who understands and participates in his or her care can achieve better and quicker results. Please read this carefully and jot down any questions you might have so that we can discuss them at our next meeting.

If you have an emergency

Call 9-1-1 or go to your nearest emergency room. If you have a crisis and you need to speak with someone immediately, call 1-888-493-8255 OR text "TALK" to 38255 and someone will assist you. If you absolutely must speak with me please leave a message on my direct line and your call will be returned as quickly as possible. PLEASE NOTE your call may not be returned for up to 24 business hours. When I am on vacation or out of the office for any reason, my direct line outgoing voicemail will provide instructions on how to deal with urgent matters. Phone calls and emails will not be returned until I return to the office in those cases. **In case of crisis, emergency or urgent matters please call - DO NOT text or email.** Routine (non-emergency/non-urgent) messages will be responded to within 24-48 business hours.

Therapeutic Services

Sessions typically last forty-five to fifty(45-50) minutes. Duration of treatment will depend on your needs, your treatment goals, and other factors related to your treatment responsibilities. As with any type of growth or change process, individual factors can significantly impact the rate and the degree of effectiveness of the therapeutic process. We will discuss your progress throughout treatment, including expected length of therapy. Weekly sessions are generally recommended for the first 4 to 6 visits but may be necessary for longer. If you have any specific scheduling needs, it is strongly recommended that you do this in order to avoid lapses in treatment and to ensure convenient appointment times. Therapy is strictly voluntary in nature. You have the right to terminate therapy at any time. A therapist may also choose to terminate therapy for a variety of reasons. If therapy is terminated by therapist, you will be provided with at least three referrals for alternate therapists.

What to expect in a therapy session

During the first couple of session the therapist will be gathering information and creating treatment goals with you. Therapy works best when you have specific goals you wish to accomplish and you and your therapist work together to develop a treatment plan to achieve your goals. During the time between sessions it is beneficial to think about and work on what was discussed. At times, you may be asked to take certain actions outside of the therapy sessions such as reading a relevant book or keeping records. For therapy to "work," you must be an active participant, both in and outside of the therapy sessions.

Fees

The fee for direct clinical services will be between $155- $175 per session. It is customary to pay for professional services at the time they are rendered. You may pay by cash, check, or credit/debit card made payable directly to Krysten Rudy, MFT. If at any time you experience difficulties making your payment, we will be glad to discuss your concerns with you. In the event your check is returned for non-sufficient funds, you will be expected to pay for services by cash or money order and will also be charged a $35.00 fee for your returned check.

There may be circumstances under which you may be billed for time outside your actual therapy sessions, such as consultation time between your therapist and other professionals working with you, telephone consultations that last more than five (5) minutes, special reports and psychological evaluations, and other services deemed necessary for continuity of your care and effectiveness of treatment. Letters and reports that I complete on your behalf will be billed in half-hour (1/2 hour) increments of my normal hourly fee ($140) for the service. You will be notified of additional charges before they are incurred. These charges are not covered by any EAP/insurance company, and therefore, you are fully responsible for payment.

Cancellation Policy

If you are unable to attend your session for any reason, please notify me at least 24 hours in advance. Failure to do so will result in a full appointment fee and will be expected to be paid at your next session. Insurance companies typically do not reimburse for missed sessions, therefore this will be your responsibility. Appointments may be cancelled by leaving a voice mail on your therapist's direct voicemail 24 hours a day, 7 days a week. If you are cancelling via text or email, please also call if you do not receive confirmation that your therapist received your message.

Confidentiality and Mandated Reporting

All information exchanged between patient and therapist is considered strictly confidential. I will not release any information about your therapy unless permitted by law or:

1. It is agreed upon in writing and complies with State Laws
2. The patient presents an imminent danger to himself or herself or to others
3. There is any reason to suspect the abuse or neglect of a child or elderly person
4. As necessary for continuity of care
5. As required to collect payment for services
6. If a judge determines that our discussions are not confidential, the judge may order that specific information be released
7. As requested by a court appointed attorney for a child involved in court proceedings.
8. If you are bringing in your child for treatment, it is up to the therapist to determine the level of confidentiality he or she will require. As a general rule, children ages 12 and up will retain confidentiality from their parents, prohibiting me from discussing the content of our sessions with parents. (Except in the cases of numbers 2 and 3).

In the cases of numbers 2 and 3, Krysten Rudy, MFT. is mandated by law to inform potential victims and legal authorities so that protective measures can be taken.

9. If you participate in couples counseling as part of your treatment, please be advised that no information will be released without the written consent of both parties. As a standard, I will follow the "minimum necessary" rule for information being released.
10. NO Secrets policy-When working with couples it is essential for the effectiveness of treatment that you know I do not keep secrets between partners in couples. Should I happen to speak with either party individually the content of those conversations will not be kept secret from the partner/spouse. The only exception is if there is an

immediate or ongoing safety issue.

Confidentiality of Records

Please refer to the Federal Health Insurance Portability and Accountability Act (HIPAA) form provided to you with regard to the use and disclosure of your Protected Health Information (PHI). Only the minimum necessary information will be communicated to the carrier. By signing this contract, you are consenting to a release of information about your case to your EAP (if applicable) for claims, certification and case management for the purposed of treatment and payment. Krysten Rudy, MFT. has no control or knowledge over what insurance companies do with the information we submit or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance. Records can also be court ordered by a judge or by a coroner and must be released with a proper legal request.

Electronic Communication

EMAIL

Many people feel comfortable communicating via e-mail. However, there may be risks involved. There is no guarantee that spyware or other such programs will work 100% of the time. All emails will be stored on a password protected account that only your therapist will have access to. Although we have no reason to believe that our email communications will be read by any third party, communication via email is, by nature, impossible to completely secure and it is possible that my email may be accessed by a third-party without the knowledge of Krysten Rudy, MFT. If you agree to email communications, Krysten Rudy, MFT. will not be held liable for breach of confidentiality should these messages be viewed. Should you choose to send an email containing personal/clinical information, you give Krysten Rudy, MFT. permission to respond by referencing the information you have included.

Text Messages

Do not text me if you have an URGENT OR EMERGENT message or situation. If you would like to use texting for appointment changes, please know that if I do not respond within 24 hours then you may need to call. It is not a guarantee that text messages will go through.

Appointment Reminders

You have the option to receive an automated email or text reminder of your appointment. If you have provided a valid cell phone number you will receive a text message reminder. If you prefer an email reminder, please provide a valid email address. If you have not provided a valid email address or cell phone you will not receive an appointment reminder. Reminder messages are a COURTESY only – it is your responsibility to keep track of all appointments. Even if you do not receive a reminder you are still responsible for all late cancelation/no show fees.

Social Networks/Dual Relationships

Please understand that as a matter of policy, I will not accept friend requests or any other request to be added to any social network (including, but not limited to, Facebook, Twitter, LinkedIn and Google+). In addition I. do not engage in friendships and/or business relationships with clients outside of their treatment, even after treatment has terminated.

Consultation

In order to provide you with the best care possible, I will periodically meet with each other and/or other licensed mental health providers to discuss their cases. If your case is discussed, every effort will be made to keep identifying information confidential.

Appeals and Grievances

I acknowledge that I may submit a grievance to Krysten Rudy, MFT. at any time to register a complaint about any aspect of my care. If I am not satisfied with the response I receive, I may submit grievance online to The Department of Regulatory Agencies (DORA) of Colorado at www.colorado.gov under the Professions and Occupations section._____(initial)

AGREEMENT FOR SERVICES

After reading and understanding the information above, please acknowledge your consent to begin services by initialing and signing the following agreement:

I have read, understand, and agree to the policies and procedures described above. _____ (initial)

I have reviewed a copy of HIPAA regulations online at www.hhs.gov (if applicable) _____(initial)

I have read and understand the PHONE, EMAIL and TEXT policies and consent to email or text reminders._____(initial)

I understand that regular attendance will produce the maximum possible benefits but that I am free to discontinue treatment at any time in accordance with the policies of this office. I understand that a 24-hour notice is required for cancellation of my scheduled appointments. I agree to pay the full fee for services for any missed appointments or late cancellations. _____ (initial)

I agree to pay any fees at the beginning of each appointment. I understand that I am solely responsible for payment. ____(initial)

If I am consenting on behalf of a minor child, dependent or beneficiary, I hereby authorize Krysten Rudy, MFT. to deliver mental health services to the patient. I understand that all policies stated in this packet apply to the patient(s). I further accept that although my participation may be required as part of the patient's treatment, the patient's records are confidential, and by law I cannot access these records if Krysten Rudy, MFT. believes such access would be detrimental to the patient. _____(initial

(If using your EAP) I authorize Krysten Rudy, MFT to release medical or other information necessary to process EAP claims for services rendered as part of my treatment. _____(initial)

I have been informed and understand the limits of confidentiality, which include mandated reporting situations. _____ (initial)

By signing below, I consent to psychotherapy with Krysten Rudy, MFT.

Printed Name	D.O.B.	Signature	Date
Printed Name	D.O.B.	Signature	Date

KRYSTEN RUDY | MFT
Individual, Marriage and Family Therapy

Credit Card Information

The undersigned hereby authorize Krysten Rudy, MFT to charge my credit card (provided below) for the amount of the therapy session, or co-pay, if there is an outstanding balance more than 30 days after issuance of an invoice.

I understand that by signing this authorization, I give Krysten Rudy, MFT permission to charge my credit card in the amount of the "full session fee" for a missed appointment without notice or any cancelled appointment that is within 24 hours of the scheduled time. I understand that this amount can be charged on the day of the missed appointment.

A current credit card number must be on file at all times, regardless of your preferred method of payment. Your card will not be charged if you pay by cash or check by the time your payment is due. All paid invoices are emailed to the client at time of charge as requested.

The credit card to remain on file is:

- Please Circle:
  MasterCard Visa Discover
- Card Number: _____
- Expiration Date & Zip Code of card: _____
- Security Code: _____ (3 digits on back of card)
- Name as appears on the card: _____
- Billing address with zipcode:_____
- Signature of card holder:_____

The Undersigned understands and agrees to be bound to such agreements as outlined in this document. Please provide your signature below. If there is more than one adult participating in treatment, both must sign below.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____