386 W. Main Street, Unit 102, New Castle, CO 81647
Phone: (970) 388-1903 Email: ashley@newawarenesscounseling.com

PERSONAL INFORMATION

Date: ____/____/____ Referred by:________________

First Name: __________________________ Last Name: _________________

Date of Birth ________________________

Address ____________________________ Apt # _________

City ________________________________ State _________ Zip _________

Primary Phone *______________________ Work Phone *: _______________

Cell Phone *__________________________ Email Address *: ______________

Employer ___________________________

*By providing these numbers, you are giving me permission to call and leave messages. Please omit any numbers you do not want me to call.

Primary reason(s) for seeking therapeutic services:

____

____

____

Have you had any previous counseling experience?
❒ Yes ❒ No
If yes, please provide details (when, where, how long, provider name, medications, etc.):

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____

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Are you currently (or recently) taking any prescription or over the counter medications?
❒ Yes ❒ No
If yes, please provide details:

Has anyone in your family been diagnosed with a mental illness?
❒ Yes ❒ No
If yes, please provide details:

Do you drink alcohol?
❒ Yes ❒ No
If yes, please provide details (how much, how often, any blackouts, etc.):

Do you use any other recreational drugs?
❒ Yes ❒ No
If yes, please provide details (what drugs, how often, last use etc.):

Have you ever attempted suicide or thought about harming yourself?
❒ Yes ❒ No
If yes, please provide details:

Have you ever been charged with a crime, arrested or convicted?
❒ Yes ❒ No
If yes, please provide details:

Do you have any work-related problems or difficulties in school?
❒ Yes ❒ No
If yes, please provide details:

Do you have a history of trauma (i.e. abuse, neglect, victim of a disaster)?
❒ Yes ❒ No
If yes, please provide details:

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OFFICE POLICIES

Messages
You may call (970) 388-1903 regarding any questions you may have. After hours, leave a voice mail message with your contact information and you will be contacted the next business day. New Awareness Counseling, LLC is not a 24-hour counseling center. In cases of emergency, please call 911.

Scheduling
Services are by appointment only and normally scheduled weeks in advance. As this time is reserved exclusively for you, it is necessary to charge for appointments that are not canceled at least 24 hours in advance. In the event of an emergency, special consideration may be given regarding the cancellation policy.

Sessions
Sessions are typically scheduled for 60 minutes, though they may be longer as necessary. Frequency of appointments is typically once a week, but may vary depending on a variety of factors. A plan will be developed and discussed during your first session.

Billing
The regular fee is $180.00 per 60-minute session. Payment is due at the time of each session. Cash, checks, and credit card payments are accepted. Therapeutic phone calls longer than ten minutes, consultations and other auxiliary services requested will also be prorated accordingly. Additional traveling fees may be charged for out of office services. If you have an unpaid balance for more than six months, your account may be turned over to a collection agency or small claims court.

Insurance
If you have a health insurance plan, your visits may be partially paid for by your insurance company. Billing statements will be available the first week of each month for the previous month's services. Statements will contain all pertinent information required by the insurance company for reimbursement.

I have read and I understand the above information. I agree to the session fees and understand that I am responsible for full payment of this amount. My signature indicates my understanding and agreement to these policies and procedures.

____
Client Signature (parent or guardian for minor)   Date

____
Counselor Signature   Date

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ATTENDANCE AND PAYMENT CONTRACT

For services with Ashley Mauldin, MA, LPC, EMDR

I acknowledge the following expectations regarding my attendance and payment in therapy:

- I need to give 24-hour notice for any cancelled appointments. If I do not, I understand that the session will be billed for.
- I understand that **all** no-shows will be billed for in full.
- I understand that if I have any combination of 2 no-shows or cancellations without 24-hour notice I will need to develop a plan for improving my attendance before another session will be scheduled.
- I understand that if I chose to have my debit or credit card billed that I will be billed the Friday following my session. If I pay with check or cash payment will be due at time of service.
- I understand that if I have a session on a Friday that my card will be billed that evening.
- I understand that my information will be sent to Premier Collection Agency of Grand Junction if I am delinquent on my account for longer than two months or have not set up a payment plan with Ashley Mauldin. Only demographic and payment information will be shared – no treatment information will be disclosed.

Client Signature *(parent or guardian for minor)* Date

Counselor Signature Date

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DISCLOSURE STATEMENT

Ashley Mauldin, MA, LPC
401 27th Street, Suite 115
Glenwood Springs, CO 81601
(970) 388-1903

- Licensed Profession Counselor, State of Colorado
  License Number: LPC-5960
- University of Northern Colorado Master of Arts, Clinical Counseling with Emphasis in Marriage and Family Therapy
- University of Northern Colorado
- Bachelor of Arts, Psychology and Sociology with Family Studies Emphasis
- Trained in EMDR therapy, Eye Movement Desensitization and Reprocessing

Dear Counselee:

My desire is to help you in the best possible fashion while always being upstanding and above reproach legally and ethically. Since counseling can raise differing expectations, it is my desire to give you some upfront information and set some clear guidelines for our counseling relationship.

I offer comprehensive mental health services including: individual, couples, family, and adolescent counseling. Payment for services is expected at the time the service is rendered unless an agreement has been made as an exception.

Counselee's Rights
I strive to maintain the highest quality of service. I follow ethical guidelines set by various organizations including the American Counseling Association. You are entitled to receive information about methods of therapy, techniques, duration of therapy (if determinable), and fee structure. Please ask if you would like to receive this information. You may accept or reject any suggested counseling intervention. You can also seek a second opinion from another therapist or terminate therapy at any time.

As to the regulatory requirements applicable to mental health professionals: 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 two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a master's 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 1,000 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 bachelor's 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 master's degree and meet the CAC III requirements.

Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required.

In a professional relationship, 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, Mental Health Section.

Generally speaking, the information provided by and to a client during therapy sessions is legally confidential. I cannot be forced to disclose the information without the client's consent. Information disclosed 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.

There are exceptions to the general rule of legal confidentiality as noted in the Colorado State Mental Health Code CRS 12-43-218. Exceptions are as follows:

- If you sign a release of information form that allows me to disclose information to individuals or institutions specified by you.
- If you are using insurance benefits, I may disclose relevant information regarding diagnosis and treatment if requested by your insurance company.
- If you feel that you are in danger of causing immediate harm to yourself of an-other person, I am required by law to report this to appropriate authorities.
- If I am ordered by a court of law to disclose information about you, I am required in some cases to respond to that order.
- If you reveal information concerning physical or sexual abuse of a child, I required by law to report this knowledge to the appropriate authorities.
- If you are in therapy by order of a court of law.
- If you are involved in a criminal or delinquency proceeding.
- If I need to provide another therapist with pertinent information when that therapist is on-call for my practice in my absence, or if, on rare occasion, I consult with another colleague about your treatment.

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of individuals who practice psychotherapy. The agency with-in the Department that has responsibility specifically for licensed and unlicensed psychotherapists is the Department of Regulatory Agencies, Mental Health Section, 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone: (303) 894-7766. If you have any questions or would like additional information, please feel free to ask.

I have read the preceding information and understand my rights as a client.

____

Client Signature *(parent or guardian for minor)* Date

____

Counselor Signature Date

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COLORADO NOTICE OF HIPAA PRIVACY PRACTICES

The federal government requires all medical offices to make patients aware that they have rights regarding the use of their personal health information. An expanded version of the Notice of Privacy Practices is available for your review at the office or via email.

HIPAA PATIENT CONSENT FORM

By signing this form, you consent to our use and disclosure of protected health information according to the Notice of Privacy Practices available to you at the office. You have the right to revoke this consent at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. New Awareness Counseling, LLC provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

You have the right to request a restriction or limitations on the medical information we use or disclose about you for treatment, payment or healthcare services. This request must be done in writing. Whenever possible, we will honor your request.

The patient understands that:

- We will not release information to any future doctor, attorney, life insurance company, or miscellaneous companies without your written consent.
- Protected health information may be used for treatment through on of your current doctors (Such as your primary care physician or a specialist referral), payment with your insurance company, or healthcare services within our office.
- New Awareness Counseling, LLC has a Notice of Privacy Practices that is available for review.
- New Awareness Counseling, LLC reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information, but New Awareness Counseling, LLC does not have to agree to these restrictions if, for example, it interferes with payment, daily services, providing quality health care, or harm to the counselee's life/persons involved in counselee's life.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- New Awareness Counseling, LLC may condition treatment upon the execution of this consent (for example, you may be required to pay for your visit at the time of service).

I hereby acknowledge that I have reviewed the Notice of Privacy Practices statement and that I had the opportunity to read the expanded version provided by New Awareness Counseling, LLC.

Client Name (please print)   Parent or Guardian *(for Minor)* Name

Client Signature   Parent or Guardian Signature   Date

Counselor Signature   Date

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DEBIT AND CREDIT CARD AUTHORIZATION

All clients must complete this form and have a current credit or debit card on file, even if they prefer to pay with cash or check.

I authorize New Awareness Counseling, LLC to keep my signature on file and to charge fees, or partial fees, to my credit, charge or debit card account for services provided to:

____

Client Name
(please print)

I understand that this authorization is valid until canceled in writing. I understand that charges for ongoing services will normally be posted to my credit card account within a day of each service date. I agree that if I have any concerns, problems, or questions regarding charges to my account, I will contact Ashley Mauldin for assistance. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Ashley Mauldin and those attempts have failed.

Cardholder Name (please print):

____

Billing Address (where statements are mailed):

_____________________________________ City: ________________ State: ____

Zip: __________

Card Type (circle one): Debit Credit

Card (circle one): Visa MasterCard

Acct No.: _____________________________________ Exp. Date: ____________

V-Code: ______

If you are unable to pay with cash or check, your card will be billed the Friday following your session. If your session is on a Friday, you will be billed that evening.

Cardholder Signature: _____________________________ Date: _______________