Couple Information Form

Date _____ Client's Name_____ D.O.B. _____

Client's Name_____ D.O.B. _____

Address _____City _____State _____ Zip _____

Home#_____Work#_____ Cell#_____

Email Address _____

In case of an emergency, whom may we contact? _____

Employer/School _____Who referred you to us? _____

Have you had previous counseling? ___Yes ___No If yes, with whom?_____

What is counseling for? _____

Method of payment: Cash, Credit Card, or Check

Accompanying this informati on form is a Disclosure Statement. Please read and sign below.

I understand that I am fi nancially responsible today for all charges or services provided to me. I realize that if I do not give 24-hour noti ce prior to cancellati on of appointment, I will be fully charged for this appointment. In the event of a balance past due, an outside agency will handle collecti ons. The fee for services is $125 per session.

I want the fee to be charged to my _____card. The number on the card is:_____

Exp. Date_____. The name on the card is:_____ V-code on back of card_____.

Signature_____ Date_____

If an ongoing therapeuti c relati onship is established it is expected a face to face visit would occur. By signing this, I accept full responsibility for future face to face visits. Also, I understand that no recording of sessions is ever permitt ed and is illegal in most cases without consent. I acknowledge I am not recording, in any manner, my sessions with Kim Jaquess.

I understand that in some circumstances that my case may be discussed with other therapists who provide therapeuti c services within the center, in order to provide the best therapeuti c experience for me.

I understand that no materials are required for therapy or ongoing treatment. If I elect to purchase any materials. I do so without infl uence or coercion from Kim Jaquess.

I agree not to record our sessions without your writt en consent; and you agree not to record a session or a conversati on with me without my writt en consent.

I consent to treatment with Kim Jaquess/Heart Quest Counseling

_____ _____

SIGNATURE DATE

_____ _____

SIGNATURE DATE

720 Elkton Drive., Colorado Springs, CO 80907| 719.659.9492 | kim@heartquestcounselingco.com | 719.278.3804(fax)

Disclosure Statement

Kim Jaquess, LPC #5233
720 Elkton Dr. Colorado Springs, CO 80907

Degree/Credentials
M.A. Counseling-Colorado Christian University
Licensed Professional Counselor-State of Colorado

Client's Rights and Important Information required by the Board of Licensing:

a. The practice of licensed or registered person in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The Board of Professional Counselors and the Board of Psychologists Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado, 80202, 303-894-7800. As to regulatory requirements applicable to mental health professionals: (1) 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. (2) Certified Addiction Counselor I (CAC I)must be a high school graduate, complete required training hours and 1,000 hours of supervised experience. (3) Certified Addiction Counselor II (CAC II) must complete additional required training hours and 2,000 hours of supervised experience. (4) Certified Addiction Counselor III (CAC III) must have a bachelor's degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience. (5) Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. (6) Licensed Social Worker must hold a master's degree in social work. (7) 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. (8) Licensed Clinical Social Work, 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. (9) A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.

b. 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.

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

d. 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 State Grievance Board. The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, certified school psychologists, and unlicensed individuals who practice psychotherapy. The agency within the Department that has the responsibility specifically for licensed and unlicensed psychotherapists is the State Grievance Board, 1560 Broadway, Suite #1370, Denver, Colorado, 80202, 303-894-7766.

e. Generally speaking, the information provided by and to a client during therapy session is legally confidential if the therapist is licensed. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent. Information disclosed to me 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. These exceptions are listed in the Colorado statutes. You should be aware that legal confidentiality does not apply in a criminal or delinquency proceeding. There are other exceptions which include: 1) If I am required to report suspected child abuse or neglect to the appropriate law enforcement agency; 2) If I receive information from a client concerning a serious threat in imminent physical violence against a specific person, I must inform that person of the threat, and also notify law enforcement authorities; 3) I am required to initiate a mental health evaluation of a client who is dangerous to self or others, or who is gravely disabled, as a result of mental disorder; and 4) I am required to report any suspected threat to national security to federal officials. 5) When I am concerned about a client's safety, it is my policy to request a Welfare Check through local law enforcement. In doing so , I may disclose to law enforcement officers information concerning my concerns. By signing this Disclosure Statement and agreeing to treat with me, you consent to this practice, if it should become necessary. 6) Under Colorado law, C.R.S 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information. If you request treatment information from me, I may provide you with a treatment summary, in compliance with Colorado law and HIPPA Standards.

f. In order to keep our relationship professional, please do not give me any gifts, however small.

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

g. 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

h. My records regarding the treatment of adults will be kept for 7 years after treatment ends or following our last session, but I may not retain them after 7 years. My records for treatment of minors will be kept for 7 years beginning on the last date of treatment or for 7 beginning on the date the minor turns 18 years of age whichever is later. In no event am I required to keep these records longer than 12 years.

i. I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the client's responsible party. I do hereby accept full responsibility for any and all actions taken by myself and/or my child concerning therapeutic assignments, mind/body work, homeopathic remedies with Kim Jaquess. I understand that mind/body work involves minor touch by the therapist and

I understand that I am not receiving a medical diagnosis, medical treatment or prescriptions, but psychotherapeutic interventions and homeopathic suggestions,

j. If receiving Eye Movement Desensitization and Reprocessing, I have been advised and understand that EMDR is a treatment approach that has been widely validated by research for PTSD. Research on other applications of EMDR is now in progress. I have also been specifically advised of the following: Distressing, unresolved memories may surface through the use of the EMDR procedure. Some clients have experienced reactions during the treatment sessions that neither they nor the administering clinician may have anticipated, including a high level of emotion or physical sensations. Subsequent to the treatment session, the processing of incidents/material may continue, and other dreams, memories, flashbacks, feelings, etc. may surface. Before commencing EMDR treatment, I have thoroughly considered all of the above, I have obtained whatever additional input and/or professional advice I deemed necessary or appropriate to having EMDR treatment, and by my signature below I hereby consent to receiving EMDR treatment. My signature on this Acknowledgement and Consent is free from pressure or influence from any person or entity.

_____	_____	_____
Date	Client Signature	Therapist Signature
_____	_____	_____
Date	Client Signature	Therapist Signature