Collaborative
Counseling of Colorado

2100 S. Corona St.
Denver, CO 80210

MEN'S GROUP INTAKE PACKET

Dear Prospective Group Member,

Welcome to Collaborative Counseling of Colorado! We are honored that you are interested in participating in this group experience and we are committed to providing you with a meaningful and professional therapeutic experience.
As our name implies, our treatment philosophy is based on collaboration: We will meet you as a whole person and work with you to deepen understandings, unravel dilemmas and move towards the goals and changes that you seek. Your feedback is an invaluable part of honing and improving our work together.

To get started, please review and complete the following documents:

(1) ***Disclosure and Informed Consent for Treatment*** – outlines the group's policies, fees and the therapy agreement. Please read this closely and bring any questions you have to our first meeting.

(2) ***Client Information Form and Billing Form*** – provides us with important information about you that will help with planning your treatment.

(3) (Optional) ***Release and Retrieve of Mental Health Information*** – if you are in individual or couples therapy, it is extremely helpful for your group therapists to coordinate care with your other providers.

You are embarking on a powerful enterprise as you join the group. It is normal to feel both excitement and apprehension. Fortunately, most people begin to feel comfortable with the process in just a few sessions. As you prepare to start the group it might be helpful to think about how you can best 'show up' in the group: your strengths, your growth edges, your values and your goals.

We look forward to working with you. If you have questions or need additional information please let us know.

Sincerely,

Jim Kemp, PsyD
Clinical Psychologist

Neal Brugman, PsyD
Clinical Psychologist

Disclosure and Informed Consent

Service Providers:

Jim Kemp, PsyD – Licensed Clinical Psychologist, Colorado license #3884

Doctor of Psychology – Clinical Psychology
University of Denver, Graduate School of Professional Psychology, 2010
Master of Arts – Clinical Psychology
University of Denver, Graduate School of Professional Psychology, 2008
Bachelor of Science – Business Administration (Psychology Minor)
Boston College, 2001

Neal Brugman, PsyD - Licensed Clinical Psychologist, Colorado license #3786

Doctor of Psychology – Clinical Psychology
University of Denver, Graduate School of Professional Psychology, 2011
Master of Arts – Clinical Psychology
University of Denver, Graduate School of Professional Psychology, 2008
Bachelor of Arts – English Literature
University of Dallas, 2002

Understanding our Qualifications:

There is a large, and sometimes confusing, range of titles a therapist can hold in Colorado. We encourage you to investigate what each qualification means. In a nutshell therapists/counsellors can range from zero educational requirements (e.g. registered psychotherapist), to master's degree level (i.e. Licensed Professional Counselors, most Social Workers) to doctoral level (e.g. Psychologists). As to the regulatory requirements applicable to psychologists: *A Licensed Psychologist must hold a doctorate degree in psychology and have completed 1500 hours of post-doctoral supervision (Please note this is our level of training)*.

The Colorado Mental Health Licensing Section of the Division of Registrations has the general responsibility of regulating the practice psychotherapy. If you feel you cannot safely address concerns about your care with your provider please address them to:

The Board of Psychology Examiners
1560 Broadway, Suite 1350
Denver, Colorado 80202
303-894-7800

Client Rights and Important Information:

As a client seeking mental health services, you have certain rights. These include your right to seek a second opinion from another therapist or your right to terminate this therapy at any time. You are also entitled to receive information regarding the methods of therapy, techniques used, the duration of therapy (if known), and the fees. Please ask me if you would like to receive this information.

In a professional relationship (such as ours) sexual intimacy between a therapist and client is never appropriate. Any circumstances of sexual intimacy within a therapeutic relationship should be reported to the Board of Psychology Examiners listed above.

Generally speaking, the information provided by and to a client during therapy sessions is legally confidential. This means that we may not disclose the information without your consent. There are exceptions to the general rule of legal confidentiality, which are listed in the Colorado Statutes (C.R.S. 12-43-218). Examples of such exceptions include but are not limited to a client who is an imminent danger to self or others and report or evidence of

elder/child abuse or neglect. You should 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. We will identify any exceptions to you if any arise while we are working together, or if they come up after we terminate our therapeutic relationship.

The standards of our profession dictate that we maintain clinical documentation of the group. If you have any questions or would like additional information, please feel free to ask.

Consent for Treatment (check one)

☐ I ____ voluntarily consent to mental health and/or consultative services with Jim Kemp, PsyD and Neal Brugman, PsyD of the Collaborative Counseling Center, LLC.

Financial Agreement

Please review the rates for the group. The rates listed below are based on 90 minute group meetings. For new members to the group, a 12-week commitment is required with group members paying for the 12 weeks up front or in installments. After the initial 12 week commitment, group members transition to ongoing member status and pay monthly group dues which will be collected at the first group of each month.

*** Please Note: Your initial 40-45 minute intake session is FREE OF CHARGE.**

Group fees:

- Initial 12 weeks: $800 for 12-week commitment to be collected prior to the start of the group. No refunds will be given for missed groups or terminating from the group before the 12-week commitment is fulfilled. If you would like to pay the amount in installments please inquire with us.
- Ongoing members: after the initial 12-week commitment, membership will transition to monthly dues of $260 to be collected at the first group of each month. Dues will be prorated for those who transition to Ongoing Member status during the middle of a month.
- Phone/email consults (over 15 minutes in length): $150/ hour
- After-Hours Consultations: $175/hour

Absence/Cancellation Policy:

A group functions at its best when all members are present consistently. To stress the importance of regular attendance, all sessions will be charged for, regardless of the reason for absence. Group membership continues whether you are present or not, and no one can substitute for you in your absence. If you expect a prolonged absence of a month or more because of work commitments or the like, please let us know.

Forms of Payment & Policies:

We accept the following forms of payment: Visa, MasterCard, Discover, American Express, cash and personal checks. Clients will be responsible for payment of the fees outlined above. Any and all declined payments may be resubmitted at a later date.

Insurance:
You are welcome to pay with a Health Savings Account (HSA). We do not bill directly through any insurance or medical plan; however, upon your request we can provide you with insurance ready statements detailing any direct payments you have made to the practice. These statements can be used to initiate the reimbursement process privately through your insurance company at your discretion.

Policy for Non-Payment:
Returned checks will incur a $50 fee. In the event billing efforts fail, delinquent accounts may be subject to collections. We will make every attempt to develop a payment plan with any client working to pay a past due balance prior to sending a balance to collections.

Additional Information

As professional psychologists, we routinely consult with other professionals in the field regarding ongoing psychotherapy cases. Privacy and confidentiality are always maintained in these consultations.

Required Signatures

Please sign below indicating that you understand and agree to the preceding disclosure statement, consent for treatment, financial agreement and additional information provided above.

______________________________________ ______________

Signature of Client or Legal Guardian **Date**

Client Information Form

General Information:

Name: ______________________________ Date of Birth: ______________

Address: ____

City:______________________ State: _____ Zip Code: _______________

Primary Phone: _________________ Secondary Phone: ________________

Occupation (former, if retired): ____________________________________

Is it ok to leave private/confidential messages at these numbers? Yes No

Email address: ____

Is it ok to have billing statements sent to this email address? Yes No

How did you hear about our practice?

Name: _________________________ May we contact this source to thank them? Yes No

Medical Information:

Primary Care Physician (PCP) name: _____________________ Phone: _______________

Current medical conditions: ____

Current medications (list all):____

Date of last physical examination/PCP visit: _____________

Is it ok for your therapists to contact your PCP to coordinate your care? Yes No

Past/Current Mental Health Treatment:

Name of Provider: _____________________________ Dates of Treatment: ____________

Reason for Treatment: ____

Have you ever been hospitalized for a psychiatric reason? Yes No

Have you ever made a suicide attempt? Yes No

Psychiatric medications (past/current): ___________________________________

Family Mental Health History:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Circle one	*List family member(s)*
Alcohol/Substance Abuse	Yes / No	
Anxiety	Yes / No	
Depression	Yes / No	
Physical Violence	Yes / No	
Domestic Violence	Yes / No	
Schizophrenia/Psychosis	Yes / No	
Suicide Attempt	Yes / No	
Other Mental Illness: ______________________	Yes / No	

Alcohol/Drug Use:

Do you drink alcohol? Yes No

If so, how many nights per week do you drink? ______________

How many drinks per night (on average)? __________________

Do you use any drugs recreationally (including prescription medications)? Yes No

If so, which drugs? ______________________ How often? ______________

Have you ever been treated for substance problems? Yes No

If so, what treatment (i.e. AA/NA, court mandated, rehab)? ____________________

Emergency Contact Information:

Name: ___________________________ Relationship to Client: _____________

Address: ____

City:______________________ State: _____ Zip Code: ______________

Phone: _____________________ email: ____________________________

Billing Information

Responsible party (and/or)
name of parent or legal guardian: ____

Date of Birth: _________________________ Social Security Number*: ____________________

☐ *The below information is the same as client information already provided (if checked proceed to payment type)*

Address: ____

City:__________________________ State: ______ Zip Code: _________________

Home Phone: ____________________ Mobile Phone: ____________________

Work Phone: ____________________ Other Phone: ____________________

For routine messages use Phone: ________________ email: ________________

For private/confidential messages use phone ________________ email: ________________

Occupation (former if retired): ____

Form of Payment
Payment will be made by your preferred method (cash, check, charge) at time of service, however we do ask to keep a Credit or Debit Card on file in order to secure appointment times and bill for missed appointments and/or delinquencies. This information will be securely stored in your clinical file and may be updated upon request at any time. Our billing service does not retain your card information.

Payment Type:
Credit Card: ____ Debit Card: ____ HSA Card: ____

Account Holder Information:

Account Holder Name: ____

Card Type: Visa MasterCard Discover

Card Number: ____

Expiration Date: ________________________ CVV#(the 3 digits on back): _____________

I certify the information provided above is accurate to the best of my knowledge. I authorize any service fees to be deducted from the form of payment designated on this form. Should any of the information provided change, I agree to update my provider as soon as possible.

____ ________________

Signature of Client or Legal Guardian **Date**

* If you have made or plan to make a payment plan arrangement this information is required.

OPTIONAL

Permission to Obtain/Release Confidential Information

Name of Client:____

Date of Birth:___/___/___

I hereby give consent to the Collaborative Counseling Center to exchange pertinent and relevant information with the individual/agency identified below.

Name: ____

Agency: ____

Street: ____

City/State/Zip:____

Phone: ____

Fax: ____

Information obtained may include (check all that apply):

- ☐ Information pertinent to coordination of care
- ☐ Clinical Impressions and Records
- ☐ Academic Records (cumulative records, report cards, test scores, etc.)
- ☐ Health Records
- ☐ Special Education Records/504 Plan Records (IEP, 504 Plans, PPT/Student Study Team minutes, evaluations)
- ☐ Psychiatric Evaluations
- ☐ Psychological Evaluations
- ☐ Social Work Evaluations
- ☐ Educational Evaluations
- ☐ Speech and Language Evaluations
- ☐ Other Evaluations (vocational, occupational, etc.)
- ☐ Other ____________________________________

Client/Parent/Guardian

Signature:____

PrintName:____

Relationship to Client:____

Date: __________________