

## Client Information Form

Today's date: \_\_\_\_\_

### A. Identification

Your name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Home street address: \_\_\_\_\_ Apt.: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home/evening phone: \_\_\_\_\_ e-mail: \_\_\_\_\_

Cell phone: \_\_\_\_\_ I prefer to get calls  at home  at work  on my cellphone

Calls or e-mail will be discreet, but please indicate any restrictions: \_\_\_\_\_

### B. Referral: Who gave you my name to call?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

If a healthcare professional, may I have your permission to thank this person for the referral?

Yes \_\_\_\_\_ (please initial)  No

How did this person explain how I might be of help to you? \_\_\_\_\_

### C. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

### D. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last physical/medical exam: \_\_\_\_\_

If you enter treatment with me, would you like me to contact your medical doctor so that s/he can be fully informed and we can coordinate your treatment?  Yes (complete ROI)  No

### E. Your current employer

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work phone: \_\_\_\_\_ or other means of communication \_\_\_\_\_

Calls will be discreet, but please indicate any restrictions: \_\_\_\_\_

**F. Educational History**

High School (Name and City): \_\_\_\_\_ Graduate?  No  Yes \_\_\_\_\_ (year)  
Vocational Training (if applicable): \_\_\_\_\_ Graduate?  No  Yes \_\_\_\_\_ (year)  
College (if applicable): \_\_\_\_\_ Graduate?  No  Yes \_\_\_\_\_ (year)  
Graduate Studies (if applicable): \_\_\_\_\_ Graduate?  No  Yes \_\_\_\_\_ (year)

Did you ever have any significant educational concerns or support, such reading support, speech/language, repeat or skip a grade, or receive gifted services?  
If so, please describe: \_\_\_\_\_  
\_\_\_\_\_

**G. Religious and racial/ethnic identification**

Current religious denomination/affiliation  Protestant  Catholic  Jewish  Islamic  Buddhist  Hindu  
 None  Athesist/Agnostic  Other (specify): \_\_\_\_\_

Involvement:  None  Some/irregular  Active

How important are spiritual concerns in your life? \_\_\_\_\_

Ethnicity/national origin: \_\_\_\_\_ Race: \_\_\_\_\_

or other similar way you identify yourself and consider important: \_\_\_\_\_

**H. Chief concern**

Please describe the main difficulty that has brought you to see me: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Adult Checklist of Concerns

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- |  |   |
|--|---|
| <input type="checkbox"/> I have no problem or concern bringing me here   | <input type="checkbox"/> Loneliness   |
| <input type="checkbox"/> Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals | <input type="checkbox"/> Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments |
| <input type="checkbox"/> Aggression, violence  | <input type="checkbox"/> Memory problems  |
| <input type="checkbox"/> Alcohol use   | <input type="checkbox"/> Menstrual problems, PMS, menopause   |
| <input type="checkbox"/> Anger, hostility, arguing, irritability   | <input type="checkbox"/> Mood swings  |
| <input type="checkbox"/> Anxiety, nervousness  | <input type="checkbox"/> Motivation, laziness   |
| <input type="checkbox"/> Attention, concentration, distractibility   | <input type="checkbox"/> Nervousness, tension   |
| <input type="checkbox"/> Career concerns, goals, and choices   | <input type="checkbox"/> Obsessions, compulsions (thoughts or actions that repeat themselves)   |
| <input type="checkbox"/> Childhood issues (your own childhood)   | <input type="checkbox"/> Oversensitivity to rejection   |
| <input type="checkbox"/> Codependence  | <input type="checkbox"/> Pain, chronic  |
| <input type="checkbox"/> Confusion   | <input type="checkbox"/> Panic or anxiety attacks   |
| <input type="checkbox"/> Compulsions   | <input type="checkbox"/> Parenting, child management, single parenthood   |
| <input type="checkbox"/> Custody of children   | <input type="checkbox"/> Perfectionism  |
| <input type="checkbox"/> Decision making, indecision, mixed feelings, putting off decisions                              | <input type="checkbox"/> Pessimism  |
| <input type="checkbox"/> Delusions (false ideas)   | <input type="checkbox"/> Procrastination, work inhibitions, laziness  |
| <input type="checkbox"/> Dependence  | <input type="checkbox"/> Relationship problems (with friends, with relatives, or at work)   |
| <input type="checkbox"/> Depression, low mood, sadness, crying   | <input type="checkbox"/> School problems (see also "Career concerns ...")   |
| <input type="checkbox"/> Divorce, separation   | <input type="checkbox"/> Self-centeredness  |
| <input type="checkbox"/> Drug use—prescription medications, over-the-counter medications, street drugs                   | <input type="checkbox"/> Self-esteem  |
| <input type="checkbox"/> Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues") | <input type="checkbox"/> Self-neglect, poor self-care   |
| <input type="checkbox"/> Emptiness   | <input type="checkbox"/> Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")                         |
| <input type="checkbox"/> Failure   | <input type="checkbox"/> Shyness, oversensitivity to criticism  |
| <input type="checkbox"/> Fatigue, tiredness, low energy  | <input type="checkbox"/> Sleep problems—too much, too little, insomnia, nightmares  |
| <input type="checkbox"/> Fears, phobias  | <input type="checkbox"/> Smoking and tobacco use  |
| <input type="checkbox"/> Financial or money troubles, debt, impulsive spending, low income                               | <input type="checkbox"/> Spiritual, religious, moral, ethical issues  |
| <input type="checkbox"/> Friendships   | <input type="checkbox"/> Stress, relaxation, stress management, stress disorders, tension   |
| <input type="checkbox"/> Gambling  | <input type="checkbox"/> Suspiciousness, distrust   |
| <input type="checkbox"/> Grieving, mourning, deaths, losses, divorce   | <input type="checkbox"/> Suicidal thoughts  |
| <input type="checkbox"/> Guilt   | <input type="checkbox"/> Temper problems, self-control, low frustration tolerance   |
| <input type="checkbox"/> Headaches, other kinds of pains   | <input type="checkbox"/> Thought disorganization and confusion  |
| <input type="checkbox"/> Health, illness, medical concerns, physical problems  | <input type="checkbox"/> Threats, violence  |
| <input type="checkbox"/> Housework/chores—quality, schedules, sharing duties   | <input type="checkbox"/> Weight and diet issues   |
| <input type="checkbox"/> Inferiority feelings  | <input type="checkbox"/> Withdrawal, isolating  |
| <input type="checkbox"/> Interpersonal conflicts   | <input type="checkbox"/> Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition              |
| <input type="checkbox"/> Impulsiveness, loss of control, outbursts   |   |
| <input type="checkbox"/> Irresponsibility  |   |
| <input type="checkbox"/> Judgment problems, risk taking  |   |
| <input type="checkbox"/> Legal matters, charges, suits   |   |

Other concerns or issues: \_\_\_\_\_

Please look back over the concerns you have checked off and choose the one that you most want help with. It is: \_\_\_\_\_

## Notice Of Privacy Practices

*Effective March 1, 2009*

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**This notice describes how health information about you may be used and disclosed and how you can get access to your individually identifiable health information.**

**Please review this notice carefully.**

### **A. My commitment to your privacy:**

My practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *Protected Health Information*, or PHI). In conducting my business, I will create records regarding you and the treatment and services I provide to you. I am required by law to maintain the confidentiality of health information that identifies you. I am also required by law to provide you with this notice of my legal duties and the privacy practices that I maintain in my practice concerning your PHI. By federal and state law, I must follow the terms of the Notice of Privacy Practices that I have in effect at the time.

I realize that these laws are complicated, but I must provide you with the following important information:

- How I may use and disclose your PHI,
- Your privacy rights in your PHI,
- My obligations concerning the use and disclosure of your PHI.

**The terms of this notice apply to all records containing your PHI that are created or retained by my practice. I reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that my practice has created or maintained in the past, and for any of your records that I may create or maintain in the future. My practice will post a copy of my current Notice in my offices in a visible location at all times, and you may request a copy of my most current Notice at any time.**

**B. If you have questions about this information, please discuss it further with me. If you feel your privacy rights have been violated by me, please contact:**

Office of Civil Rights  
Us Department of Health and Human Services  
1961 Stout Street, Room 1426  
Denver, CO 80294  
303-844-2024  
303-844-20225-Fax

### **C. I may use and disclose your PHI in the following ways:**

The following categories describe the different ways in which I may use and disclose your PHI.

**1. Treatment.** Treatment refers to the provision, coordination, or management of healthcare including mental health related to one or more providers. The information provided to insurance and other third party payers may include information that identifies you, as well as your diagnosis, type of service, date of service, provider name/identifier, and other information about your condition and treatment.

**2. Payment.** My practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, I may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and I may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. I also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, I may use your PHI to bill you directly for services and items. I may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

**3. Contacting the Client.** I may contact you to remind you of appointments and to tell you about treatments or other services which may be of benefit to you.

**4. Health Care Operations.** My practice may use and disclose your PHI to operate my business. As examples of the ways in which I may use and disclose your information for my operations, my practice may use your PHI to evaluate the quality of care you received from me, or to conduct cost-management and business planning activities for my practice. I may disclose your PHI to other health care providers and entities to assist in their health care operations.

**8. Disclosures required by law.** My practice will use and disclose your PHI when I am required to do so by federal, state or local law. This includes but is not limited to: reporting child abuse or neglect, when court ordered to release information, when there is a legal duty to warn or take action regarding imminent danger to others, when the client is a danger to self or others or is gravely disabled, when required to report certain communicable diseases and certain injuries; and when a Coroner is investigating a client's death.

**9. Health Oversight Activities.** My practice may disclose your PHI to a health oversight agency for activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, and regulatory programs or determining compliance with program standards.

**10. Crimes on the Premises or Observed by me:** Crimes that are observed by me or directed at me or occur at my business location will be reported to law enforcement.

**11. Involuntary Clients:** Information regarding clients who are being treated involuntarily pursuant to law, will be shared with other treatment providers legal entities, third party payers and others, as necessary to provide the care and management coordination needed.

**12. Family Members:** Except for certain minors, incompetent clients or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of that discussion. However, you object, PHI will not be disclosed.

**13. Emergencies:** In life threatening emergencies, I will disclose information necessary to avoid serious harm or death.

**14. Client Authorization to Release of Information:** I may not use or disclose PHI in any other way without a signed Authorization or Consent to Release Information. When you sign a consent to release information, it may later be revoked, provided that the revocation is in writing. The revocation will apply, except to the extent I have already taken action in reliance thereon.

#### **D. Your Rights as a Client:**

**1. Access to Protected Health Information (PHI):** You have the right to inspect and obtain a copy of the PHI information that I have regarding you and the record. There are some limitations to this right, which will be explained to you at the time of your request, if such a limitation applies. To make such a request, please talk to me.

**2. Amendment of Your Record:** You have the right to request that I amend your PHI. I am not required to amend the record if it is determined that the record is accurate and complete. When there are other exceptions, which will be provided to you at the time of your request, along with an appeal process.

**3. Accounting of Disclosures: You have the right to receive an accounting of certain disclosures that I have made** regarding your protected health information. That accounting does not include disclosures that were made for the purpose of treatment, payment, or healthcare operations. There are other exceptions that will be provided to you, should you request an accounting.

**4. Alternative Means of Receiving Confidential Communications.** You have the right to request that you receive communications of PHI from me by alternative means or locations. For example, if you do not want bills sent to your home, you may request a different address. There are limits to such requests that will be provided to you.

**5. Copy of the Notice:** You have the right to obtain another copy of this Notice upon request.

#### **E. Additional Information:**

**1. Privacy Laws:** I am required by State and Federal Law to maintain the privacy of PHI. In addition, I am required by law to provide clients with notice of its legal duties and privacy practices with respect to PHI. That is the purpose of this notice.

**2. Terms of Notice and Changes to the Notice:** I am required to abide by the terms of this Notice and any amended notice that may follow. I reserve the right to change the terms of this notice and to make new Notice provisions for all PHI that it maintains.

**3. Additional Information:** If you desire additional information about your privacy rights, please contact me.

**Jennifer Harned Adams, Ph.D.**  
**Licensed Clinical Psychologist**

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360 South Monroe, Ste 390  
Denver, CO 80209  
303-325-1633  
303-316-3050 (fax)  
jenniferharnedadams@me.com  
www.jenniferharnedadamsphd.com

I have received the Notice of Privacy Rights and Policies Documentation as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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Client Name (Printed)

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Client Signature

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Date

## **Disclosure Statement**

### Degrees, Licenses & Experience:

B.A. Franklin and Marshall College, Psychology  
M.A. University of Houston, Psychology  
Ph.D. University of Houston, Clinical Psychology

### Clinical Psychology Internship:

University of Texas Houston Health Sciences Center  
Department of Psychiatry and Behavioral Sciences

### Postdoctoral Training:

Postdoctoral Fellowship in Cancer Prevention  
University of Texas M.D. Anderson Cancer Center

License: Colorado, Psychologist, #3123

I maintain a general practice that includes treatment of adults seen as individuals, couples and in groups. My scope of practice encompasses a wide variety of difficulties and disorders including relationships, phase-of-life concerns, mood disorders, loss, trauma, and parenting and women's health issues. I will provide you with additional information about my past experience and areas of practice upon request.

I am a licensed psychologist in the State of Colorado, and the practice of both licensed and unlicensed persons in the field of psychotherapy is regulated by the Colorado Department of Regulatory Agencies. The Psychologist Examiners Board is located at 1560 Broadway #1550, Denver, CO 80202, and may be reached by telephone at 303-894-7800. In a professional relationship, sexual intimacy between a therapist and client is never appropriate and its occurrence should be reported to the Board of Psychologist Examiners.

### Confidentiality

Information provided by you to a psychologist in the course of an evaluation or treatment is privileged communication, which means it is legally confidential. In most cases information can be released to another individual only by written permission from you. However, there are certain exceptions to the confidentiality law (CRS 12-43-218). For example, if you become suicidal, or unable to care for yourself, I am legally required to ensure that you are safe and receive the care that you need. If I believe that you seriously intend to harm someone else, I am required to warn that person, and the appropriate authorities, to ensure that individual's safety (CRS 21-10-101 & 13-21-117). If a child or elderly person is suspected of being abused, I am required to report the abuse to the Department of Social Services (CRS 19-3-301).

I share office space with other mental health professionals, but my practice is entirely independent. I will not discuss your case with them, and they are neither responsible nor liable for my work with you. At some points in your treatment I may discuss your case with a consultant, but your name or information which could specifically identify you will not be used. Another mental health professional may provide emergency coverage for me when I am out of town; however, I will not share information with them about you unless there is a specific need which I have already addressed with you.

#### Therapy: Methods, Duration, & Cost

Psychotherapy requires a commitment of time, emotional energy and money, and it is most likely to be helpful to you when you are ready to investment yourself in these ways. Psychotherapy may arouse painful feelings, and at times you may temporarily feel worse rather than better. The process may also assist you to make meaningful changes in your feelings, behavior, relationships and understanding of yourself and others.

The methods of therapy I utilize depend upon the problems, strengths, needs and style of the individual(s) seeking my professional assistance. In general, I utilize a cognitive-behavioral approach to psychotherapy, and employ empirically supported methods when appropriate and available.

At the end of our initial one to two sessions, I will discuss my recommendations for treatment with you, and together we will decide how to proceed. I expect that questions about the methods, effectiveness, and duration of therapy will be raised by both of us at regular intervals during the course of treatment in order to evaluate progress, make adjustments, and to decide when to end your therapy. You are encouraged to discuss these topics and are reminded that you may end treatment at any time. You may also seek a second opinion if you wish to do so.

My standard fee is \$125 for a 50-minute session. Fees are payable at the end of each session. You will be charged for all missed or canceled sessions unless 24 hours advance notice is given. In case of accident or illness which onset less than 24 hours before the appointment, call to cancel your session as soon as possible. In general, I do not charge for phone consultation, unless there are unusual circumstances. Should phone charges occur, I will discuss this with you.

If you would like to use insurance coverage to pay for your therapy, you will be provided with a superbill. This superbill can then be submitted to your insurance company for reimbursement. Please be aware that if you choose to provide this receipt for services to your insurance company, it must include a psychiatric diagnosis. In that event, I will inform you about the diagnosis that I plan to render before it is given. Any diagnosis that is made will become part of your permanent insurance records. A superbill is no guarantee of reimbursement. Even if you do not pursue reimbursement through your insurance company, a superbill may be useful for tax purposes or for utilizing funds set aside in an employer-based health savings account.

#### Electronic Communication

My email address is : jenniferharnedadams@me.com. Feel free to email me regarding administrative concerns, such as cancellations and scheduling changes. Please do not discuss confidential information in email, as email is not a secure method for private communication. Please do not use email as a method of contacting me in the event of an emergency.

#### Emergency Contact Options

You can reach me by my cell phone at 303-325-1633. I will return all voice mail messages as soon as possible. If you are in emergent need and unable to reach me, call 911, or go to the nearest hospital emergency room

Termination of services

Termination of psychotherapy may occur at any time and may be initiated by either you or your therapist. Please contact me if you decide to discontinue your psychotherapy so that we can schedule for a final session. Termination itself can be a very constructive process, and I encourage you to discuss any plans to end your treatment as soon as is necessary. If any referrals are needed, I can provide those when we meet.

Your rights

At any time, you may question and/or refuse therapeutic or diagnostic procedures or methods or request additional information regarding procedures. Please do not hesitate to discuss any concerns and/or complaints with me so that we can work toward a resolution. Concerns can also be brought to the attention of the Colorado Department of Regulatory Agencies.

Consent to Treatment

I consent to participation in psychotherapy services with Jennifer Harned Adams, Ph.D. and I agree to the policies of her practice as detailed in the above paragraphs. I have had the opportunity to ask questions and clarify my understanding of these policies and there are no misunderstandings or disagreements. I have been given a copy of this document for my own records.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

I have reviewed the above policies and informed consent with the patient and there is no misunderstanding or disagreement.

\_\_\_\_\_  
Jennifer Harned Adams, Ph.D.

\_\_\_\_\_  
Date

### **Sliding Scale for Psychotherapy Services**

In order to qualify for fee adjustment, please provide the front page of your 1040 Tax form for the past two years. If you have significant expenses that seriously impact your ability to afford services that are not reflected in the table below (ie, child support), please provide supporting documentation.

Annual Household Income	Number of people in your household					
	1	2	3	4	5	6
<\$30,000	\$75	\$75	\$75	\$75	\$75	\$75
\$30,000-\$44,000	\$90	\$90	\$90	\$75	\$75	\$75
\$45,000-\$59,000	\$125	\$110	\$110	\$110	\$90	\$90
\$60,000-\$74,000	\$125	\$125	\$125	\$110	\$110	\$100
\$75,000+	\$125	\$125	\$125	\$125	\$125	\$125

**Credit Card Guaranty of Payment**

I authorize Jennifer Harned Adams, Ph.D. charge my credit card to pay balances over \$150 and/or over 60 days overdue. Alternatively and if desired, I authorize a one- time payment of \$\_\_\_\_\_ to pay the remaining overdue balance on my account.

The name and billing address for this credit card is:

Client Name \_\_\_\_\_

Cardholder name \_\_\_\_\_

Cardholder Billing Address \_\_\_\_\_  
\_\_\_\_\_

Card Type                      Visa          MasterCard

Credit Card Number \_\_\_\_\_

Expiration Date \_\_\_\_\_

I understand that these balances may include charges for missed visits ("no-shows") and for late cancellations. I understand that I will be held responsible for any charges or fees if authorization is declined.

I will provide notice immediately if I close this account. I understand that Dr. Adams is relying on this information in continuing to provide services to me.

\_\_\_\_\_  
Client Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client Signature