



First-Contact Record

Date: _____ Time: _____ A.M./P.M.

Identification

Name of client: _____ Date of Birth: _____

Name of spouse/guardian/other: _____

Client's phone (home/work/day/evening): (H) _____ (W) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Referral source ("How did you get my name?"): _____

Can I contact this referral source and thank them for the referral? Yes / No

Chief complaint (What brings you in today?):

What would you like to get out of therapy? _____

Any questions? _____

Other information

Social Security #: _____ Primary Insured Name: _____ DOB: _____

Insurance Name: _____ Policy #: _____ Co-Pay \$: _____

This is a strictly confidential patient medical record. Rediscovery or transfer is expressly prohibited by law.

STEVEN A. LAZARUS, PSY.D., INC.
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LITTLETON, CO 80120 (303) 267-2194



DISCLOSURE STATEMENT

In seeking the services of a psychologist, you have certain legal rights. This document includes information that I am required to inform you of in advance of treatment. This includes my professional credentials, your rights, and grievance procedures.

Education and training: Doctor of Psychology (Psy.D.): University of Denver, (2002), Masters of Arts in Clinical Psychology: University of Colorado, Denver (1994). Bachelor of Arts in Psychology: University of Colorado, Boulder (1989). I am also a Licensed Psychologist (License # 2932) and a Licensed Professional Counselor (License # 1625). I am a member of the American Psychological Association and the Colorado Psychological Association.

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists and licensed professional counselors who practice psychotherapy. The agency within the Department that has responsibility specifically for licensed psychotherapists is the State Grievance Board. They are located at 1560 Broadway, Suite 1430, Denver, Colorado, 80202. Phone: (303) 894-7766.

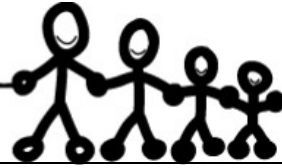
As a client, you are entitled to receive information about my methods of therapy, the techniques I use, the duration of your therapy (if it can be determined), and my fee structure.

You are entitled to seek a second opinion from another therapist or may terminate therapy at any time.

In a professional relationship, sexual intimacy is never appropriate, is illegal, and should be reported to the State Grievance Board at the address and phone number provided above.

The information that you provide during therapy is legally confidential. All information will be kept confidential unless you give me permission in writing to release information about you. However, there are several exceptions that are mandated by law. State law requires that I report to the proper authorities any intent to harm yourself, homicide or threats to the safety of others, or any information regarding child abuse or suspected abuse and /or neglect.

There may be times when I may need to consult with a colleague or another psychologist about issues raised by clients in therapy. Client confidentiality is still protected during consultation by the psychologist or professional consulted.



Steven A. Lazarus, Psy.D., Inc., and his practice has no relationship to other practitioners. By signing this disclosure statement, you agree to not hold any other party liable for your treatment.

The initial intake session is (\$160). Family and Couples therapy is charged at (\$160). Individual 45 minutes sessions are (\$130). Psychological assessment and report writing services are charged at \$160/hour. You are expected to pay your bill and/ or co-pay at the time of service. In the event of a canceled or missed session, you will be charged unless I am notified at least 24 hours in advance of the scheduled session. Insurance companies generally do not reimburse for no-show appointments. Therefore, it is your responsibility to pay for no show appointments out of pocket. Should you utilize third party reimbursement (e.g. Insurance company) and they do not pay for your services, you are responsible for any remaining balance.

Should you require telephone support, you will be charged for any time over five minutes on a prorated basis. I also charge for any written reports or letters that you request I write (for example: for courts, social services, schools, etc.)

I provide non-emergency psychotherapeutic services by scheduled appointment. If I believe your issues are above my level of competence, or outside of my scope of practice, I am legally required to consult, refer, or terminate treatment. If, for any reason, you are unable to contact me by telephone and you are having a true emergency, please call 911, or proceed to the nearest hospital emergency room.

I hereby acknowledge that I have received the provider's *Notice of Privacy Rights*. If you should need additional information or clarification about the information we have just gone over, please feel free to ask me now or at any time in the future.

I have read the above information and understand my rights as a client. By signing this disclosure statement, I understand and agree to all of the terms discussed above.

Client/ (Parent) Signature

Date

Client/ (Parent) Signature

Date

Steven A. Lazarus, Psy.D., Inc.

Date