**First-Contact Record**

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

**Identification**

Name of client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:

City: State: Zip Code:

Parent/Guardian: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best Contact #

Parent/Guardian: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best Contact #

Email Address:

Preferred Method of Contact: \_\_\_\_\_\_Phone \_\_\_\_\_\_Text Message \_\_\_\_\_\_Email

**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?**): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**What would you like to get out of therapy?**

**Any questions?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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 Clinical Psychology (Psy.D.): University of Denver, (2012), Masters of Arts in Clinical Psychology: University of Denver (2010). Bachelor of Arts in Psychology: University of Michigan, Ann Arbor (2007). I am a Licensed Psychologist with the Colorado Department of Regulatory Agencies (PSY.0004588).

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.

I never record sessions (video or audio) and ask that you agree to the same courtesy.

Consistent with state laws, I maintain healthcare records for 7 years after the termination of services. If you ever need records, please contact me.

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

Although I share office space with other practitioners, including Dr. Steven A. Lazarus, Psy.D., our practices of psychotherapy are separate and independent. Our practices are not connected, we are not in partnership together, and we are not practicing in association with one another. By signing this disclosure statement, you agree to not hold any other party liable for your treatment that is not associated with your case.

My fee for a forty-five-minute session is One Hundred Twenty Dollars ($120). An hour-long initial intake session is One Hundred Fifty Dollars ($150). 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. Emergency cancellations due to illness or injury may be excused. In the case of inclement weather, appointments may be canceled by the therapist or client on a case-by-case basis. 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. Psychological assessment and report writing services are charged at $150/hour. An estimate of the total cost will be provided to you prior to completing any assessment services.

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 psychotherapeutic 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.

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 hereby acknowledge that I have read the above information and understand my rights as a client. I understand and agree to all the terms discussed above.

Client/ (Parent) Signature Date

Client/ (Parent) Signature Date

Alicia Gauthier, Psy.D. Date