

Driving Lessons For Life, LLC

10259 Ouray Street, Commerce City, CO 80022, 303-288-2660,
drivinglessonsforlife@gmail.com

Disclosure Statement: The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The Board of Social Work Examiners can be reached at 1560 Broadway, Suite 350, Denver, Colorado 80202, (303) 894-7800. As to the regulatory requirements applicable to mental health professions, a Licensed Clinical Social Worker must hold a masters degree in social work and have two years of post-masters supervision.

Clinical Rights and Important Information:

- You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy, if known, and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time.
- In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant, or certificate holder.
- Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 and the Notice of Privacy Rights you were provided as well as other exceptions in Colorado and Federal law. For example, a mental health professional is required to report child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be advised accordingly.

Jim R. Jacobs, LCSW, Licensed Clinical Social Worker, Colorado License #890.
Graduated 2000, MSW Brigham Young University.

I have read the preceding information, it has been provided verbally, and I understand my rights as a client or as the client's responsible party.

Signature

Date

Relationship

Print Name of Client

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Description of Services

Driving Lessons For Life, LLC provides professional, licensed counseling services to individuals, couples, families, and groups. Please review the following carefully, ask questions of your therapist, and carefully consider these items as you participate in treatment. Your active involvement in your treatment is important.

Therapeutic Goals, Opportunities, Benefits, Risks, and More

Therapy is dynamic process involving professional assistance to overcome obstacles, remove barriers to change, resolve emotional challenges, and seek greater degrees of personal happiness and well-being. It is important that you understand the nature and limitations of counseling when it comes to resolving your particular challenges and achieving your specific goals. Many people resolve their challenges through and/or with the assistance of counseling. Some challenges may remain even after counseling. Positive outcomes are often connected to your participation in and out of session in the work that you are asked to do and the goals you set for yourself. Your personal commitment to working through your specific challenges greatly determines the success of counseling. At times, counseling may involve uncomfortable feelings and experiences. Your counselor will work with you to understand and hopefully resolve those feelings. Every effort will be made to assist you to achieve your goals and feel better. Counseling is normally short-term, with a focus on helping you to accomplish your goals or feel better prepared to accomplish them. Some conditions warrant longer term counseling. Please discuss length of treatment with your counselor.

Confidentiality

Please see Mandatory Disclosure and Notification of Privacy Practices received with this form. If you did not receive these items, please contact the agency. In general, all communications with counselor and client are maintained in strict confidence. Abuse, violence, illegal activity, or other circumstances may warrant a change in this rule. Client's may consent to release of their information in writing, and preferably, after discussion with your counselor.

Payment

Sessions are billed in 60 minute increments for a fee of \$100 due at the time of service. Extra time is billed in 15 minute increments. Initial assessments and marital and family sessions are scheduled for 90 minutes for a fee of \$150. Driving Lessons For Life, LLC accepts cash or check payments only, due at the time of service. We are unable to bill insurance or other third-parties. Driving Lessons For Life, LLC, does not work with LDS

Bishops and cannot receive payment from fast offering funds. Individuals eligible for services at LDS Family Services are not eligible for services from Driving Lessons For Life, LLC. Services are not billed and payment is accepted at time of service. Please talk to your counselor if you have difficulty with payment. Referrals can be made to other providers who work with sliding scales, insurance, Medicaid, etc. Additional appointments will not be scheduled until fees are paid in full.

Cancellations/No Shows

If you need to change or cancel your appointment, please contact Driving Lessons For Life, LLC at least 24 hours in advance. You may make this contact via telephone or e-mail. You may be billed \$50 for late cancellations or no-shows.

Other considerations:

Clients with small children should make other arrangements for the care of their children prior to the appointment. Clients who bring young children to the appointment will have their appointment cancelled and be expected to reschedule to another time. Counseling sessions often involve sensitive emotions and content may not be appropriate and/or harmful to young children. Every effort is made to keep appointments to their allotted times. You are responsible for helping end sessions in the scheduled time. Please be sensitive to other clients who also have challenges and issues to discuss. Occasionally, sessions may go longer due to critical issues and items. You are responsible for the cost of these extended times even if your counselor did not discuss it with you in the moment of crisis. Please be sensitive to delays if prior sessions are extended. Every effort will be made to stay on schedule, but sensitivity to client needs and issues is always a priority.

Evaluation and Feedback

Your progress, growth, and satisfaction are important to us. We welcome feedback at any time in the treatment process. In fact, treatment will progress much quicker if you provide feedback on activities, assignments, homework, etc. You will not offend your counselor if you provide helpful and corrective feedback. Please be a good customer and advocate for what you need and what works for you. In most cases, the counselor can adjust to accommodate your needs and preferences. Most clients report greater progress and quicker growth when they provide feedback to their counselor about what helps most. Clients are also encouraged to give feedback in other forums including websites such as www.healthgrades.com. If you have a complaint or grievance, please send a written grievance or complain attn.: Manager, Driving Lessons For Life, LLC detailing your concern and complaint. The manager will respond within 30 days. If you are not satisfied with the resolution of your complaint or grievance, you may contact the Board of Examiners for Social Workers. We take your concerns seriously and will seek a resolution to any and all concerns. Most concerns can be avoided by active participation in treatment and providing feedback (as stated above) throughout the entire therapeutic process.

Acknowledgement of Description of Services

I have read and understand the information contained in the Description of Services. I also understand that if I do not understand any part of this document now or at any time in the course of services that it is my responsibility to seek clarification. I acknowledge that I have received in writing and verbally a description of services including my understanding of the fee for services rendered. I have also received a notification of privacy practices.

Signature

Date

Relationship

Print Name of Client

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INTAKE AND APPLICATION FOR SERVICES

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ May we call you at this number? _____

May we leave a message? _____ May we text you? _____

E-mail address: _____ May we contact you via this? _____

PERSONAL INFORMATION

Birthdate: _____ Marital Status: _____ Years Married? _____

Name of Spouse: _____ Emergency Contact? _____

Emergency Contact (if not spouse): _____ Number: _____

Names and Ages of Children (Oldest to youngest):

_____ Age _____ Lives with you? _____ Adopted? _____

_____ Age _____ Lives with you? _____ Adopted? _____

_____ Age _____ Lives with you? _____ Adopted? _____

_____ Age _____ Lives with you? _____ Adopted? _____

Health Concerns Past and Present (Please include surgeries, illnesses, hospitalizations, etc.): _____

Please list any and all medications you are taking (including OTC, herbal, etc.): _____

When is the last time you saw your PCP? _____ Reason? _____

Doctor: _____ Phone #: _____

Please list any other care you are receiving (massage, chiropractic, counseling, acupuncture, etc.): _____

How important is spirituality in your life? _____

How would you like to include your spiritual beliefs in counseling: _____

What do you hope to change, resolve, or accomplish in counseling? _____

How optimistic are you about counseling being able to help you? _____

Have you ever had counseling before? _____ When? _____

What was previous counseling for? _____

What did you like about your previous counseling? _____

What was the most helpful? _____

What was the least helpful? _____

Would you like us to speak to your previous counselor? _____

Names of Previous Counselors, treatment agencies, etc. _____

What other challenges or obstacles are you facing in your life that may be affecting the reason for seeking counseling? _____

Are you presently or have you ever been a victim of abuse or violence? _____

Are you presently or have you ever been involved with the court or legal system? _____

The information I have provided above is true and correct.

Signature Date Relationship

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name: _____ (Please Print)

I have received and reviewed a notification of privacy practices. I understand that by signing this authorization I am authorizing Driving Lessons For Life, LLC and its staff to disclose my personal health information to persons and entities listed below.

Additionally, I authorize persons and entities below to disclose health information which may be in their possession to Driving Lessons For Life, LLC. Personal health information may include, without limitation, any records, reports, assessments, test results, lab reports, opinions, and any and all other items relating to medical, social, marital, emotional, educational, employment, or psychological conditions. Disclosure may also be made to describe my condition and progress, seek further assessment, and to discuss future treatment. I understand that Driving Lessons For Life, LLC., does not work with LDS Bishops.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to Driving Lessons For Life, LLC, attn.: Manager. I understand that revoking this authorization will not affect disclosures already made under this authorization. Further, I understand that disclosures already made under this authorization may be subject to re-disclosure by persons or entities authorized prior to revocation and is no longer protected by practices of Driving Lessons For Life, LLC.

I authorize Driving Lessons For Life, LLC and the persons or entities listed below, or their representatives, to mutually release and disclose my personal health information. I waive my rights of privacy that I have in connection with these authorized disclosures. I fully understand the provisions of this release of information and my duty to seek further clarification now and throughout the course of treatment. This authorization is valid until _____ (date) or until 3 months after my file is closed.

Name: _____ Title: _____ Initials: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Name: _____ Title: _____ Initials: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Name: _____ Title: _____ Initials: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Name: _____ Title: _____ Initials: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Signature Date Relationship

Print name of Client

Signature of Witness Date Relationship

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Consent to Counseling and Services via Electronic Means

At Driving Lessons For Life, LLC., we recognize that electronic communication is part of our everyday lives and can help facilitate communication and interactions with others. Counselors are willing to engage in electronic communication to help support treatment, facilitate skill-building and goal-achievement between sessions, and to supplement counseling goals. While counselors are willing to engage in counseling via electronic means, counselors maintain boundaries in terms of social media sites (Face Book, Twitter, LinkedIn, etc.) and do not accept friend or connection requests. Counselors will engage in contact via agency numbers and e-mail addresses. Personal information is not exchanged.

Acknowledgement: I understand that in the course of treatment there is a possibility of receiving services via electronic means including, but not limited to telephone, texting, e-mail, video conferencing, and/or the internet. I understand that there are limitations to the use of electronic means to provide counseling services and supports. These limitations may include, but are not limited to, compromised privacy, electronic equipment failures, miscommunications, etc. Further, I understand that use of electronic means may help to facilitate communication and progress in treatment goals, but is not a good replacement for face-to-face services. I acknowledge that should I choose to engage in electronic communication as part of treatment that I accept the limitations and risks of said electronic media.

I have discussed the use of electronic means as part of my counseling, carefully considered how I may receive counseling services, and I consent to counseling services via electronic means from Driving Lessons For Life, LLC.

Signature

Date

Relationship

Print Client Name

Witness

Date

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PRIVACY PRACTICES NOTICE

Driving Lessons For Life, LLC., is required by the Health Insurance Portability and Accountability Act (HIPAA) to give you this notice. This notice will inform you of the various ways in which your personal health information may be used and/or disclosed. Please review this notice carefully as it will describe your rights and obligations regarding the use and disclosure of your health information and how to access that information. This notice applies to the information and records we have about your health and the care you have received from Driving Lessons For Life, LLC..

How your personal health information may be disclosed

Your personal health information may be disclosed to facilitate **your treatment**. For example, your counselor may discuss your care with another staff member to determine the most appropriate care for you. Your health information may be disclosed in order to facilitate **payment** for your treatment. You have the right to request that your health information from treatment not be disclosed to your health insurance provider when you pay out of pocket. Your personal health information may be used and disclosed to facilitate **agency operations**. Your information may be used to more efficiently manage our operations, evaluate performance of staff, and/or to contact you to remind you of your appointments. Please notify us in writing at any time should you not wish to be reminded of your appointments. We may also release your personal health information in **special circumstances** including, but not limited to, situations where disclosure is deemed necessary to prevent a serious threat to your health and safety or the health and safety of another individual; when it is required by applicable local, state, or federal laws; when disclosure is required by law in cases of abuse or neglect or in preventing injury; when disclosure is in response to a court order, subpoena, warrant, summons, or other legal process.

Except where otherwise required or authorized by law, we will not use or disclose your personal health information for any purpose without your express written authorization. We will not use or disclose your health information from psychotherapy notes or in any other manner which constitutes a sale without your written authorization. You may opt out of any fund raising activities or communications. We will not release or disclose your health information for any fund raising activities without your written consent. If at any time you authorize the release of your personal health information, you may revoke the authorization, in writing, at any time. If the authorization is revoked, we will no longer release your personal health information. However, we cannot undo or take back any disclosures made during the authorized period of time. We have an obligation

to notify you if and of your health information is used or disclosed in a way contrary to law.

Your rights regarding your personal health care information

In regard to your personal health information, you have the following rights:

- You may, with a few certain exceptions, inspect and copy your health information
- If you believe information about you is incorrect or incomplete, you may ask us to amend the health information.
- You may obtain a record of our disclosures of your personal health information. This is a list of all disclosures of your information for purposes other than treatment, payment, and agency operations.
- You have the right to request that we restrict or limit the use or disclosure of your personal health information to only treatment, payment, and agency operations. We are not required to comply with your request.
- You have the right to request where and when we communicate with you about your health care. For example, you may request that we only contact you at home or mail.
- You have a right to receive a paper copy of this privacy practices notice.

If you desire to exercise any of these rights, please contact the agency manager, in writing.

Changes to This Notice

We are required to abide by the most current notice that is in effect. As such, we have the right to change this notice and apply it to the information we already have about you as well as future information we may obtain. Should said notice change, you will be provided with a copy of the new privacy practices.

Complaints

If you believe your privacy rights have been violated, you may file a written complaint with our office or with the Secretary of the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint. This notice is effective January 2, 2015.