INTENSIVE OUTPATIENT PROGRAM

6700 West 44th Avenue, Wheat Ridge, CO 80033
303-420-8080 303-420-9299 Fax

INTAKE INFORMATION

Client Name:________________________ Gender:________ Entry Date:__________
Address: ________________________ Home Phone:________________
________________________ **Social Security #:**________________
D.O.B.:____________ Ethnicity:__________ County of Residence:______________
Other Contact Numbers (Cell, Work, Pager, e-mail etc.):______________________________
____

Responsible Parties

☐Check here if Client is responsible party

SPOUSE:________________________ **GUARDIAN:**________________________
Address:________________________ Address:________________________
Phone:________________________ Phone:________________________
Alt Phone:________________________ Alt Phone:________________________
INDICATE THE PHONE NUMBER WHERE IT IS OKAY TO LEAVE MESSAGE: ________________________
EMAIL : ________________________ **EMAIL:** ________________________
OCCUPATION:________________________ **OCCUPATION:**________________________
SSN#: ______________ **DOB** __________ **SSN#** ______________ **DOB:**__________

FATHER:________________________ **MOTHER:**________________________
Address:________________________ Address:________________________
________________________ ________________________
Home Phone:________________________ Home Phone:________________________
Work Phone:________________________ Work Phone:________________________
OCCUPATION: ________________________ **OCCUPATION:**________________________
SSN#: ________________________ **SSN#** ________________________
EMAIL : ________________________ **EMAIL:** ________________________

A COPY OF CURRENT ID MUST ACCOMPANY THIS FORM: COPY MADE **YES NO** BY: ________________

Emergency contact: (please list at least one name and phone number)________________________
Religious Preference:____
Church/Pastor Name & Contact Information:____
____

CASE WORKER:________________________ **PROBATION OFFICER:**________________________
County:________________________ Address:________________________
Address:________________________ Phone:________________________
Phone:________________________ **ATTORNEY:**________________________
GAL:________________________ Address:________________________
Address:________________________ Phone:________________________
Phone:________________________

Emergency contact: (please list DHS hotline/crisis phone number)________________________
Previous Placements:

Name of Facility	Date/Duration	Contact:

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INSURANCE INFORMATION

Name of Insured:______________________________ Employer:______________________________________
Insured's ID #:_______________________________ Address:_______________________________________
Insurance Company:____________________________ Phone:____
Address:______________________________________ Policy #:______________________________________
____ Plan/Group #:__________________________________
Contact Person:_______________________________ Phone:____

Other Insurance: (Victim's Comp. Workman's Comp. Social Services, etc.)

Name of Carrier:________________________________ Contact:______________________________________
Address:____ Phone:____

INSURANCE BILLING INFORMATION **Payment by insurance companies requires pre-authorization. Please get pre-authorization and document below. Please attach a copy of all insurance cards to this form.**

Name of Patient:____ D.O.B.:____________
Address:__________________________________ Diagnosis Code and CPT Code:______________________
Pre-authorization date:_______________ Obtained by:____
Victims Compensation is to be billed for services: ☐Yes ☐No
Address of Victim's Compensation office:____

PLACE COPY OF VALID ID AND INSURANCE CARD HERE

(Place this form face down in bypass tray. Place cards below the 5 ½ line [side by side] on the glass and copy.
For multiple cards use a separate sheet)

Client Name:____________________________________ Interviewer: ______________________

Lost and Found Inc
Hope, healing, a place to grow

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PAYMENT IS EXPECTED AT THE TIME OF SERVICE

CLIENT NAME:	ALL FEES FOR SERVICE ARE THE RESPONSIBILITY OF THE INDIVIDUAL NOTED IN THIS FORM AS "RESPONSIBLE PARTY". ANY FEES NOT COVERED OR PAID BY INSURANCE ARE THE RESPONSIBILITY OF THE RESPONSIBLE PARTY
BILL TO	
ADDRESS	
PHONE:	

PRIVATE PAY SESSION RATES

SESSION	STANDARD CHARGE	CLIENT CHARGE / CO-PAY AS AGREED TO WITH THERAPIST
INTAKE FEE	$20.00	OUT–OF-POCKET________INITIAL
INTAKE	$165.00	OUT-OF POCKET _____INITIAL
CASE MANAGEMENT/PROF. CONSULTATION *PER HOUR*.	$55.00	
CRISIS MANAGEMENT PER HOUR.		_____INITIAL
1.0 HR. A/ WK IS INCLUDED FOR IOP & DAY TX		
INTENSIVE OUTPATIENT DAY 3.0 HRS.	$165.00	_____INITIAL
IOP NO SHOW	$165.00	_____INITIAL
EMERGENCY PAGER	$120.00	$30.00 EACH 15 MINUTES FIRM _____INITIAL
URINE SCREENS/ANALYSIS	$35.00	OUT-OF-POCKET _____INITIAL
REQUEST THAT LETTER BE WRITTEN	$100.00 PER HOUR/SHEET/LETTER	

CASH PAYMENTS

We accept cash, checks, or credit card payments. Payment is required before session. If no one is available at that time, your therapist will take payment and write you a receipt. For IOP, weekly payments are accepted and appreciated.
*Cash required for all future payments following a returned check: (initial/date here) _________________________.

INSURANCE PAYMENTS

We bill insurance as a convenience to you; however, you are ultimately responsible for payment: (initial/date)___________

EMERGENCIES

We recognize that sometimes emergencies arise, and are able to accommodate an occasional emergency situation.

I attest by my signature below that I understand that I am responsible for payment for all services provided as agreed to in this contract including any charges not covered or paid for by my insurance company.

____
SIGNATURE OF RESPONSIBLE PARTY **SOCIAL SECURITY # / DOB** DATE

____
SIGNATURE OF THERAPIST DATE

Client Name:_____________________________ Interviewer: ____________________

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POLICIES AND ACKNOWLEDGEMENTS

(All lines/questions must be filled out. If it does not apply indicate by writing: N/A)

FEE RELATED POLICIES

Initial on the line provided for each statement. If client is a minor both Client and Guardian initial and sign.

1. ______ I understand that all individual, family, and group sessions are scheduled for a 50 minute hour.

2. ______ **I am aware that 24-hour notice is required for cancellation of appointments.**
   a. ________ **appointments not cancelled with a 24-hour notice will be billed in full.**
   b. ________ **additionally, I agree to provide at least 24-hour notice of intent to terminate therapy to avoid being subject to the no show/cancellation fee.**

3. ______ I understand that payment is expected at the time of service, that Lost and Found, Inc., will seek payment for my therapy session(s) from 3rd party payors (Insurance, Victim's Comp, etc.) at my request. Ultimately:
   a. ________ I am responsible for resolving any problems with 3rd party payors.
   b. ________ I am responsible for maintaining clear communication with Lost and Found, Inc, re: solutions to missed/late payments.
   c. _______ I am solely responsible for all indebtedness incurred at LNF.

4. ______ **I understand that my treatment may be interrupted/terminated for lack of commitment to the therapeutic process for the following**:
   a. _______ **after 3 unpaid NO SHOWS**.
   b. _______ **due to 3 consecutive cancellations**
   c. _______ unresolved debt of 3 sessions or more.

5. ______ Phone calls in excess of 5 minutes will be billed to the client's account in 15 minute increments at a rate of $30.00.

6. ______ Calls to the emergency/after-hours pager will be billed at the rate of $30.00 for each 15-minute increment.

7. ______ Clients are not to be in possession of alcohol, drugs, paraphernalia or weapons at any time while on Lost and Found property. Individuals who come to their session under the influence of alcohol or drugs will be:
   a. ________ asked to leave the premises
   b. ________ cancelled for session time and held responsible for re-scheduling.
   c. ________ billed for cancelled time at full session rate.

______________________	______________________	__________
Client/Guardian Print	Signature	Date

Jeannine Anderson, MA, LPC	______________________	__________
Therapist Signature Print	Signature	Date

Client Name:______________________ Interviewer: ______________________

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FACILITY RELATED POLICIES

Initial on the line provided for each statement. If client is a minor both Client and Guardian initial and sign.

1. ______ I understand that Lost and Found, Inc., is a faith-based counseling center, that faith principles may be used and referred to appropriately in the context of the therapy session. I understand that I have the freedom and right to ask for prayer with my counselor. I have the right to refuse prayer/spiritual guidance.

2. ______ I understand that I am responsible for my children's behavior. I agree not to leave children unattended at this facility for any reason. I understand that supervision for children is not provided before, after, or during my therapy session. I agree to pick up my children immediately after their session.

3. ______ I understand that Lost and Found, Inc., is a smoke-free environment and that smoking is prohibited on facility grounds.

4. ______ I understand that all pets are prohibited. The exception is for service animals which must have papers with them at all times and be clearly designated.

5. _______I am aware that while on Lost and Found property I will not be allowed to harm myself, others, or any property. If I become a threat of harm to any of these, the authorities will be notified immediately and I will be held responsible for any damages incurred.

6. ______ I am aware that Lost and Found, Inc., is not responsible for items left in the facility during or after sessions. An unclaimed item box is provided in the reception area.

7. ______ I understand that Lost and Found, Inc., is not responsible for damage to vehicles in or around the facility.

8. ______ I understand that Lost and Found, Inc., is a training clinic, and as such:

   a. _____ therapy sessions may include co-facilitation or sole-facilitation by a qualified Masters level intern from an accredited university, requiring supervision by a licensed psychotherapist.

   b. ______ supervision may include:
      - 15 minutes or more of direct supervision by the supervisor during the therapy session;
      - audio/videotaping of the session as a standard tool for supervision or for other therapeutic reasons. Prior disclosure of the intent to tape a session will be made by the therapist and all rules governing client confidentiality will be strictly enforced.

9. ______ I agree to give Lost and Found, Inc., and/or The Family Counseling Center permission to correspond with me by letter, telephone, or by other means necessary to check on my progress after discharge.

10. ______ I understand that my records are protected by HIPPA regulation. I have read and understood the Lost and Found, Inc., privacy protection notice.

11. ______ I understand that I must fill out a specific Authorization for Release of Information form indicating to whom and for what reason(s) records are being requested per HIPPA standard.

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12. ______ I understand that recommendations for nutrition, supplements, exercise, and other healthcare suggestions, are not intended to replace medical advice and treatment from your primary care physician.

13. ______ I understand that occasionally Lost and Found, Inc. sends newsletters and other information to clients and other interested parties unless otherwise personally directed/requested in writing.

14. ______I/We have willingly placed my/ourselves in the program of Lost and Found, Inc., and do authorize Lost and Found, Inc., to act in my best interests and to perform any treatment that is deemed proper and fit by the agency.

15. _______I give Lost and Found Inc. consent to treat myself and/or my family member(s). In addition I give consent for Lost and Found Inc. staff to contact me after my discharge for follow-up information.

16. ______By means of my/our signature, I/we hereby release Lost and Found, Inc., it's staff and directors from all suit, libel, damages or legal litigation of any kind that could be brought against them for any reason by us on our behalf.

17. ______I/we do also hereby state that this agreement and contract is to be in effect for the life of my/ourselves and that even after death this contract shall stay in effect.

18. _____I/we give permission for Lost and Found Inc. to contact me/us for follow-up information within 12 months of my/our discharge from the program.

I attest that I have read, reviewed, understood and agreed to abide by all the above-initialed policies, disclosures, and acknowledgments:

________________________________ ________________________________
Client Name (**Please PRINT**) Guardian Name (**Please PRINT**)

________________________________ ________________
Signature of Client Date

________________________________ ________________
Signature of Guardian Date

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1. Whose idea was it for you to come today?
2. What concern has led you seek counseling? What would you like help with?
3. List any current or past drug use:
4. Is domestic violence a part of your concern? ☐ Yes ☐ No If yes please describe:
5. Describe any sexual problems or concerns:
6. Describe any mental or emotional health concerns:
7. Describe any behaviors that seem out of control:
8. Describe any history of suicidal thoughts or attempts:
9. Describe any history of thoughts or attempts to hurt others:
10. Describe any marital concerns:
11. Describe any parenting issues:
12. Describe any spiritual concerns:
13. Describe any other issues or concerns that you want me to be aware of:
14. List anyone you would like for me to be in contact with regarding your therapy:
    (Please list names, titles and how to contact below)

Client Name:______________________________ Interviewer: ____________________

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SOCIAL HISTORY

(All lines/questions must be filled out for ALL HISTORIES. If it does not apply indicate by writing: N/A)

IMMEDIATE FAMILY:

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Re-married ☐ Other

Name of spouse or partner:______________________________

Names of Children: ages:

______________________________ __________

______________________________ __________

______________________________ __________

______________________________ __________

Who lives in your household, and what is you relation to them?______________________________

____

____

FAMILY OF ORIGIN:

Mother:______________________ Father:______________________

Stepmother:__________________ Stepfather:__________________

Other:_______________________ Other:_______________________

Siblings: (oldest to youngest, include yourself) Ages

______________________________ __________

______________________________ __________

______________________________ __________

______________________________ __________

Other significant people living in the home you were raised in:______________________________

____

Briefly describe yourself:______________________________

____

Briefly describe your family:______________________________

____

Is there any family history of emotional, physical, or sexual abuse?______________________________

If yes, please describe:______________________________

____

Who were you closest to growing up?______________________________

Was school a positive or negative experience for you?______________________________

What level of education have you completed?______________________________

What is you occupation?____________________Are you satisfied in your current occupation?______

What is you sexual orientation?______________________________

Describe your spiritual beliefs or religious preferences:______________________________

____

What types of music do you listen to?______________________________

What activities are you involved in?______________________________

____

Do you have a Guardian ad Litem (G.A.L.) or attorney that you would like us to be in contact with? ☐ Yes ☐ No

If Yes please list name, address, and phone number:______________________________

____

Have you ever been in trouble with the law? ☐ Yes ☐ No

If yes please describe:______________________________

Are you currently facing charges, on probation, on parole? ☐ Yes ☐ No

Please describe:______________________________

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MEDICAL HISTORY

Physician's Name:____ Phone:______________

Address:____

I give my permission for my therapist to contact my PCP (or medical doctor) ☐Yes ☐ No________(Initial)

List current medical conditions:____

____

____

List any physical complaints or health concerns?____________________________________

____

____

Describe your current health:____

____

Describe any recent changes in:

Weight:____

Appetite:____

Sleep:____

Sex drive:____

Have you ever seen a Doctor or Therapist for mental or emotional concerns? ☐Yes ☐ No

If yes, Please list dates and Individuals you have seen:_______________________________

____

____

____

Are you currently pregnant? ☐Yes ☐ No

If yes please list the doctor you are seeing for pre-natal care (include address and phone #):______________

____

____

Please list any drugs or medications you are taking at this time:

Prescription:

Drug name	dosage	frequency	length of time used

Over the counter:

Drug name	dosage	frequency	length of time used

Client Name:________________________________ Interviewer: ____________________

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GENERAL HEALTH CONCERNS

Date:_______________ **Client #:**_______________
Age:_______________ **Gender:**_______________

GENERAL HEALTH HISTORY:

Do you use a seatbelt? ☐ Always ☐ Usually ☐ Sometimes ☐ Never
Do you use a helmet when cycling: ☐ Always ☐ Usually ☐ Sometimes ☐ Never
Do you exercise regularly: ☐ Always ☐ Usually ☐ Sometimes ☐ Never
When was your last physical exam?_______________
Are you pregnant at this time? ☐ Yes ☐ No **Immunizations Current?** ☐ Yes ☐ No
If yes, how many weeks/months are you?_______________
Do you have allergies? ☐ Yes ☐ No **TB Test?** ☐ Yes ☐ No Date_______
If yes, please list:_______________

____

SUBSTANCE ABUSE HISTORY:

What type of drugs are you currently using?_______________

____

Have you used illicit drugs in the past 60 days?_______________
Date of last use:_______________
What form of ingestion do you use?: ☐ Oral ☐ Intravenous ☐ Inhalation ☐ Smoking
Do you presently share needles?:_______________
Do you understand how to use bleach and water?_______ Can you explain how to clean your works?:

____

Are you a tobacco user? ☐ Yes ☐ No
How long have you used tobacco?_______________
How many times have you tried to quit?_______________

SEXUAL HISTORY:

When was your last sexual contact?_______________
How many different sexual partners have you had in the past 12 months?_______________
How many different sexual partners have you had in the past 5 years?_______________
Have you ever had sex with a male? ☐ Yes ☐ No
If yes, did you use a condom? ☐ Yes ☐ No
Do you give or receive ☐ Vaginal sex ☐ Oral sex ☐ Anal sex (check all that apply)
Have you ever been a prostitute? ☐ Yes ☐ No
Have you ever been with a prostitute? ☐ Yes ☐ No When?_______________
Have you ever had a sexually transmitted disease? ☐ Yes ☐ No
If yes, what diseases have you had?_______________

____

Have any of your sexual partners: ☐ Used IV drugs ☐ Prostituted ☐ Tested positive for HIV (Check all that apply)
Have you been tested for HIV? ☐ Yes ☐ No When?_______________
If you were to test positive for HIV, what effect do you feel it would have on you?_______________

____

____

If you were to test negative what, if anything would you do differently?_______________

____

Would you be willing to submit a blood specimen? ☐Yes ☐ No
If no, please explain why you would not wish to have one done:_______________

____

Client Name:_______________ Interviewer: _______________

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SUBSTANCE ABUSE HISTORY

1. How old were you first used alcohol or illicit substances?________________
2. At what age did you start using alcohol/drugs on a regular basis?________________
3. List the substances you have experimented with or used:________________
4. List the drugs you have used or use most frequently:________________
5. Has the use of these substances ever created problem situations for you? ☐ Yes ☐ No
   Describe:________________
6. Have you ever forgotten where you have been or where you were after an extended period of using any of these substances (blackouts)? ☐ Yes ☐ No Describe:________________
7. Have you ever had convulsions, hallucinations or other abnormal experiences while using?☐ Yes ☐ No
   Describe:________________
8. How often do you use substances?________________
9. When did you last use? What and how much did you use?________________
10. How long have you been able to use on a continuous basis?________________
11. When did this kind of continuous use last occur?________________
12. How much and what did you use during this time?________________
13. Describe your substance use pattern and frequency of use:________________
14. Describe the mood you are generally in when you use:________________
15. Describe the benefits you gain from use of substances:________________
16. Describe your substance use preferences (alone, groups, parties etc.):________________
17. Do you occasionally use heavily for periods of time? ☐ Yes ☐ No
18. What is the longest period of time you have gone without using?________________
19. How did you manage to avoid substance use during this time?________________
20. Have you been arrested or cited due to substance use? ☐ Yes ☐ No
21. Have you ever lost a job or time from work due to substance use? ☐ Yes ☐ No
22. Have you ever attended A.A./N.A. or other 12 step meetings? (When and how long?)________________
23. Describe any other programs you have been in for substance use problems:________________
24. What do you need in order to modify, control, change or stop your substance use patterns?________________
25. How does your family or system of influence react to your substance use?________________
26. Describe the patterns of substance use in your family system:________________
27. Do you think you are an addict/alcoholic? ☐ Yes ☐ No

Client Name:________________ Interviewer: ________________