Tony Petrelli, LPC NCC ACS MA MBA
Equinox Counseling LLC

Phone/Text: 303-569-4588

Email: tony@equinoxcounselingllc.com

Website: www.equinoxcounselingllc.com

Highlands Ranch Medical Plaza II:
9331 South Colorado Blvd., Suite 60
Highlands Ranch, CO 80126

Client Information Packet

Welcome

I am privileged to have the opportunity to serve you with the hope of being helpful as your counselor. This packet contains Information forms that are necessary to provide counseling services for you.

Please print, review, and complete the documents included in this Client Information Packet. The guidelines and instructions below will assist you:

Guidelines

Client Intake Form** - to be completed by client(s). **(Pages 2 & 3).

Disclosure, Policy, and Fee Agreement** - to be reviewed, completed and signed by **client and/or clients. (Page 8).

Once you have reviewed, completed, and signed all relevant documents please return originals to my office at your first appointment.

I encourage you to retain a copy of this information for your records.

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Client Intake Form

Personal Information *Today's Date* _____

Name (Names if Marriage/Couple): _____

Address Street: _____

City: _____ *State:* _____ *Zip:* _____

Email(s): _____ _____

Phone(s) Cell: _____ *Home:* _____ *Work:* _____

In case of emergency, who should we notify?

Name: _____ *Phone:* _____

Who referred you to us? _____

Who is responsible for payment? Please check: Client _____ Other _____ If Other please provide Name:

_____ *Relationship to client:* _____

(Please Note: All Information Below is Optional and at the Client's Discretion.)

Marital Status ***(check one)*** *Single☐ Married_____ Divorced_____ Separated/Widowed_____*

(If applicable)

Name of Spouse, if currently married: _____

First names and ages of children: _____

Current Counseling Desires

What do you see as the primary problem you wish to discuss or resolve with your counselor?

_____

What is it you would like to change? _____

_____

Previous Counseling Experience

Have you ever seen a counselor before? Yes ☐ No ☐ If yes, when? _____
Major problems discussed: _____
How would you describe your prior counseling experience? _____
_____

Medical History

Any medical concerns we should be aware of? _____
Have you struggled with any kind of addiction, either now or in the past? Yes ☐ No ☐ If yes, what?
_____
Have you ever seriously considered or attempted suicide? Yes ☐ No ☐ If yes, please briefly describe: _____
_____
Have you ever been, or are you now, taking any medications we should be aware of? _____
If yes, what medication(s), dosage(s), and for what condition: _____
_____

Spiritual/ Religious (OPTIONAL)

Briefly and in a few words how would you describe your spiritual beliefs, if any? _____
_____
To best serve you, do you consider your spiritual beliefs (if any) something to be considered and/or incorporated into your counseling experience? Yes ☐ No ☐ Not important/Undecided ☐

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Disclosure, Policy, and Fee Agreement

Disclosure of Credentials:
LPC – Licensed Professional Counselor #LPC.0012121
NCC – National Certified Counselor #299807
ACS – Approved Clinical Supervisor #3677

Degrees:
Master of Art in Counseling – Denver Seminary
Master of Business Administration – University of Colorado
Bachelor of Science in Business – University of Colorado

Professional Experience:
Since 2012, I have provided individual, marriage, family, and group mental health counseling services through Equinox Counseling LLC.

Since 2010, I have provided direct mental health counseling services at various times through Cherry Hills Community Church Counseling Center (individual, marriage, couple, and group), National Institute for Change (individual and group), and Shepherd's Gate Counseling Center (individual and marriage). I served as a Member of the Board of Directors for Southwest Counseling Associates from 2013-2018.

Additional Training:
Emotionally Focused Therapy – Externship
Gottman Method Couples Therapy – Levels 1, 2, & 3
Prepare/Enrich by Life Innovations Inc. – Marriage and Premarital assessment and enrichment
Approved Clinical Supervisor Training - University of North Carolina Greensboro

Accreditations:
CACREP - Council for Accreditation of Counseling & Related Education Programs

Member:
American Counseling Association (ACA)
American Association of Christian Counselors (AACC)
Colorado Counseling Association (CCA)

Dear Counselee,

It is my desire to aid and serve you in your counseling needs in the most effective, professional, and ethical manner possible. Counseling services can raise differing expectations, therefore I am providing upfront information and setting clear guidelines for our counseling relationship. You also have certain specific rights which are described herein.

Regulation of Psychotherapists

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 Licensed Professional Counselors Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 864-7800. As to the regulatory requirements applicable for mental health professionals:

Licensed Professional Counselor *(LPC) must hold a master's degree in their profession and have a minimum of two years of post-master's professional experience and supervision.*
Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.
Certified Addiction Counselor I (CAC I) must be a high school graduate, complete required training hours and 1,000 hours of supervised experience.
Certified Addition Counselor II (CAC II) must complete additional required training hours and 2,000 hours of supervised experience.
Certified Addition Counselor III (CAC III) must have a bachelor's degree in behavioral health, complete additional required training hours and 2,000 of supervised experience.
Licensed Addition Counselor must have a clinical master's degree and meet the CAC III requirements.
Licensed Social Worker must hold a master's degree in social work.
Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist.
Unlicensed Psychotherapist is a psychotherapist listed in Colorado data base but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain the registration from the state.

Confidentiality, Ethical Standards, and Counselee's Rights

Generally, information provided by and to a client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality which are listed in section 12-43-218 of the Colorado Revised Statutes, and the HIPAA Notice of Privacy Rights as well as other exceptions in Colorado and Federal law. For example: (1) Your counselor is required to report suspected child abuse or neglect to law enforcement. (2) Your counselor is required to report any threat of imminent physical harm by a client, to law enforcement and to the person(s) threatened, (3) If your counselor receives information concerning a serious physical harm to yourself or others, your counselor will take specific actions which may include calling 911 or another appropriate person to initiate a mental health evaluation. (4) Your counselor is required to report any suspected threat to national security to federal officials; (5) Your counselor may be required by court order to disclose treatment information. If a legal exception arises during therapy, if feasible, you will be informed accordingly. (6) Mental Health Practice Act of Colorado, section 12-43- 224(1)(a) was amended by Colorado's House Bill 17-1011 which requires mental health professionals to provide written notices to clients as follows. Any person who alleges that a mental professional has violated the licensing laws related to the maintenance of records of a client eighteen year of age or older, must file a complaint or other notice with the licensing board within seven years after the person discovered or reasonably should have discovered this. Pursuant to law, this practice will maintain records for a period of seven years commencing on the date of termination of services or on the date of last contact with the client, whichever is later. When the client is a child, the records must be retained for a period of seven years commencing either upon the last day of treatment or when the child reaches eighteen years of age, whichever comes later, but in no event, shall records be kept for more than twelve years. The Colorado Mental Health Practice Act is available at: *https://sehd.ucdenver.edu/cpceinternships/files/2010/08/Statute.pdf.*

Policies

You as the counselee have the right to terminate counseling at any time understanding you are responsible for any unpaid balance for services rendered prior to termination. As the counselor, I also reserve the right to terminate the counseling relationship at any time at my sole discretion including but not limited to my belief it is in the best interest of the counselee. 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. You are entitled to receive information from me about my methods of therapy, the techniques I use, and the duration of your therapy (if known), and the fee structure. You can seek a second opinion from another therapist.

If you are involved or engaged in divorce or custody litigation, my role as a therapist is not to make recommendations to the court concerning custody or parenting issues. By signing this Client Disclosure Statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that I author and/or write any reports to the court or to your attorney and/or make any recommendations concerning custody. The court can appoint professionals, who have no prior relationship with you and/or your family members to conduct an investigation and/or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interest of the family's children.

Equinox Counseling, LLC and Tony Petrelli are not a 24/7 crisis counseling center. Services are by appointment only. We do not provide emergency or 24-hour service coverage. IN CASE OF CRISIS OR SERIOUS EMERGENCY, please dial 911 or go to the nearest emergency room of the nearest hospital.

"No Surprise Act" and Good Faith Fee Estimate:

What is the "No Surprises Act?" The "No Surprises Act" or Consolidated Appropriations Act (hereafter referred to as "the Act") became effective on January 1, 2022. The Act aims to increase price transparency, and reduce the likelihood that clients receive a "surprise" medical bill. Specifically, the Act requires healthcare providers to inform clients or their insurer of a "Good Faith Estimate" ("GFE") of the costs for a scheduled service or upon request before the service is provided. The Act defines "provider" broadly to encompass all healthcare providers practicing within the scope of a state-issued license. Professional counselors working in a clinical setting with a state-issued practitioner license meet this definition and are subject to this law. As part of the Act, you are entitled to receive a "Good Faith Estimate" of what the charges could be for medical services as well as psychotherapy services provided to you. While it is not possible for a psychotherapist to know in advance, the number of psychotherapy sessions may be necessary, appropriate, and/or desired for a given client, the following information provides the method in which to estimate the costs of services provided. The specific fees per session are dependent upon the length of sessions and the cost as described in the next session called Counseling/Psychotherapy Fees." The following example assumes a total cost for psychotherapy fee estimate based on my current Standard Session Fee of $160 per session.

The example assumes you elect to attend 5 Standard Sessions at the current disclosed fee per session. The total cost for psychotherapy in this example would be calculated as follows:

Five Standard Sessions multiplied by $160 equals $800 (5 X $160 = $800).

Thus, the method to estimate Total Fees for psychotherapy is calculated in the following manner:

Estimated # of Sessions ___ multiplied by Session Fee $_____ = Estimated Total Cost $_____

Any variation from the session fees reflected including any potential discounted rates will be agreed upon prior to services being provided. Your total cost of services will be dependent upon the total number of psychotherapy sessions scheduled and attended as well as potential fees for late cancellations and/or "no shows." Any other possible fees and/or charges including assessment and/or psychological tests that may be recommended by your counselor, must be disclosed and agreed upon by the patient and/or responsible party prior to the testing.

Counseling/Psychotherapy Fees:

The objective of this section is to clarify our agreement regarding billing and payment for services provided.

As session time is reserved exclusively for you, it is necessary to charge a cancellation fee for appointments that are not cancelled at least 24 hours in advance. In the event of an emergency, special consideration may be given regarding the cancellation policy. In circumstances where fees may present a serious financial hardship to the client, discounted fees will be considered and discussed in advance of services being rendered. Any discount to the standard fee will be mutually agreed upon prior to services being rendered. I reserve the right to increase fees at any time provided prior notice is given to clients for services rendered and the increased rate.

We do not offer the service of filing insurance claims on behalf of our clients. We will, upon request, issue you a billing statement which you may use to file for reimbursement (if available) from your insurance provider.

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PLEASE CONTINUE TO THE FOLLOWING PAGE

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My standard therapy session fee is $160. Standard therapy sessions are approximately 55 minutes in duration. *Only if desired by the client, extended therapy sessions can be scheduled at a reduced rate reflecting a* ***25% discount*** *applied to the* ***additional*** *session time. A* ***1 ½ -*** *hour (approximately 85 minutes) therapy session fee is $210, and a 2-hour (approximately 110 minutes) therapy session fee is $280. Fees are due at the time of service unless other arrangements are agreed upon in advance. Payments can be made by credit card, check, or cash at the start of the session or on-line at www.equinoxcounselingllc.com.*

It is preferable to have payments made by credit card by providing the necessary information and authorization below.

Credit Card Authorization:

To authorize counseling fees to be charged to your Credit Card, please complete the following information and sign below.

Visa, MC, or Am Express:_____ Card number: _____

CSC Code (back of card): _____ Exp. Date: _____

Name as it appears on the card: _____

Email Address: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

By signing below, I hereby authorize Equinox Counseling LLC/Tony Petrelli to charge to the credit card provided for fees incurred by me or another authorized individual as listed on this form. I understand I am fully responsible for any unpaid balances.

If you have any questions or concerns, please feel free to ask your counselor prior to signing this Client Disclosure, Policies, and Fee Agreement. By signing below, I hereby confirm that I have read and understand this Agreement and the information contained herein. Further, the information has also been presented to me verbally. I hereby agree to the terms and fees as described and agree that I am responsible for payment. I understand my rights as a client or as the client's responsible party receiving counseling from Tony Petrelli and Equinox Counseling, LLC.

_____ _____ _____

Print Client Name ***Client Signature*** ***Date***

_____ _____ _____

Print Spouse or Partner Name ***Client Signature*** ***Date***
(If receiving marriage and/or joint counseling)

_____ _____

Tony Petrelli LPC NCC MBA MA ***Date***
Licensed Professional Counselor
National Certified Counselor