Todd Owen, Ph.D, LPC
Intake Forms

Welcome. This packet contains important information about my professional services and business policies. Please read it carefully and write down any questions you have so we can discuss them.

Counseling Services

I offer a variety of services including counseling/therapy for individuals and couples, stress management, and Employee Assistance Program consultation. The term "therapy" (or counseling) is not easily described and can vary depending on the personality of both the therapist and client, and particular types of problems or issues presented.

When I work with people one of my goals is to help them identify the underlying thinking that is associated with undesirable feelings, actions and behaviors. One potential benefit of therapy is the ability to detect, challenge, and change those beliefs and attitudes that create, maintain and worsen feelings such as depression, anxiety, fear, panic, anger, etc. Therapy can also help us gain new understanding about our problems and learn new ways of coping and solving problems. With new skills, people often report a significant reduction in their feelings of distress, improved general functioning, and improved relationships.

Overcoming problems and building emotional muscle takes hard work. I believe in a team approach to change, and as a member of the team, I will work diligently to provide my professional skills, knowledge and services. I will regularly review with you your goals and progress and want you to be open and honest in providing input, feedback and suggestions.

At any time during our work together, you have the right to decide to end treatment, and there is no moral, legal, or financial obligation other than to pay for services already rendered.

CONSENT TO TELEHEALTH SERVICES INTRODUCTION

"Telehealth" (also known as "Video Therapy" and "Telephone Counseling") involves the delivery of psychotherapy counseling services using electronic communications, information technology or other means between a mental health clinician and a client who are not in the same physical location. Telehealth may be used for diagnosis, treatment, follow-up and/or education, and may include, but is not limited to:
• Video Therapy: counseling sessions provided via video conferencing
• Telephone Counseling: counseling sessions provided via telephone
• Electronic transmission of clinical records, photo images, personal health information or other data between a client and a Provider (Dr. Owen).
• Interactions between a client and Provider via audio, video and/or data communications; and • Use of output data from clinical devices, sound and video files. The vendor of the electronic systems used in the provision of Video Therapy Services (Doxy.me) has represented that it incorporates industry standard network and software security protocols to protect the privacy and security of health information. Doxy.me is HIPAA compliant.

STATEMENT OF POTENTIAL RISKS AND BENEFITS
Potential Benefits of Telehealth Services
• Can be easier and more efficient for you to access clinical care and treatment from a Provider.
• You can obtain clinical care and treatment at times that are convenient for you.
• You can interact with a Provider without the necessity of an in-office appointment.

Potential Risks of Telehealth Services
• Information transmitted to your Provider may not be sufficient to allow for appropriate clinical decision making by the Provider.
• The inability of your Provider to conduct certain tests or assessments in-person may in some cases prevent the Provider from providing a diagnosis or treatment or from identifying the need for emergency clinical care or treatment for you.
• Your Provider may not able to provide clinical treatment for your particular condition via Video Therapy or Telephone Counseling. You may be required to seek alternative care. In this case, your Provider would offer you referral suggestions and resources to the best of her/his ability.
• Delays in clinical evaluation/treatment could occur due to failures of the technology.

• Security protocols or safeguards could fail causing a breach of privacy. If this were to occur, I would notify you promptly.

By accepting this Consent to Telehealth Services, you acknowledge your understanding and agreement to the following:

1. I understand that the delivery of health care services via Telehealth is an evolving field and that the use of Video Therapy or Telephone Counseling in my clinical care and treatment may include uses of technology not specifically described in this consent.
2. I understand that while the use of Telehealth Services may provide potential benefits to me, as with any clinical care service no such benefits or specific results can be guaranteed. My condition may not be cured or improved, and in some cases, may get worse.
3. It is my duty to inform my Provider of other in-person or electronic interactions regarding my care that I may have with other health care providers.
4. I understand that my Provider may determine in his or her sole discretion that my condition is not suitable for treatment using Telehealth Services, and that I may need to seek clinical care and treatment in-person or from an alternative source.
5. A variety of alternative methods of mental health care may be available to me, and that I may choose one or more of these at any time. My Provider has explained the alternatives to my satisfaction.
6. I understand that the same confidentiality and privacy protections that apply to my other health care services also apply to these Telehealth services. My Provider cannot ensure my privacy at my location.
7. I agree and authorize my Provider and Center to share information regarding my Telehealth treatment with other individuals for treatment, payment and health care operations purposes as allowed by law.
9. I agree and authorize Dr. Owen provide me with technical support if I request it.
10. I understand that I can withhold or withdraw my consent at any time by emailing or providing other such written notification to my Provider with such instruction, without affecting my right to future care or treatment.
11. If my health insurance provider does not reimburse for provision of Telehealth Services, I may be solely responsible for covering the costs of my Video Therapy or Telephone Counseling.
12. I understand that my Provider may only utilize Video Therapy for my treatment when I am located in the state of my residence and/or in which the Provider has authorization or licensure to practice. As such, my Provider will ask to verify my location at the beginning of sessions.
13. I understand the need to participate in Telehealth Services from a secure, private location to the best of my ability. I will communicate any privacy limitations to my Provider at the beginning of the session.

CLIENT CONSENT TO THE USE OF VIDEO THERAPY

By signing below, I indicate agreement to the following:

• I have read this Consent to Telehealth Services form and Client Guide to Telehealth carefully and understand the risks and benefits of the use of Video Therapy and/or Telephone Counseling in the course of my treatment.
• I hereby give my informed consent for the use of Video Therapy and/or Telephone Counseling in my mental health care.
• I hereby authorize my Provider to use Video Therapy and/or Telephone Counseling in the course of my diagnosis and/or treatment. THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

_____/_____ _____

Signed Date

Confidentiality

I will need to know a good deal about you in order to effectively help you with your concerns. You can be assured that I will keep all information about you confidential.

You should know that insurance companies and EAPs almost always require outpatient treatment plans or reports, as a condition for certifying or recertifying treatment. Information requested may be a simple as a diagnosis and type of treatment, but also may be of a personal nature requiring more detailed information.

Information revealed in couple's therapy is protected by privileged communication Colorado and requires permission of both to waive. When working with couples, I adopt a "no secrets" rule. That is, should I speak with individually with either party (e.g., via telephone), I reserve the right to disclose any information to the other party if I believe such information is relevant to the therapy process.

In order to provide clinical coverage for me when I am out of town, it may be necessary for me to release general information to the licensed provider who is covering for me. If I am going to be out of the office, I

will make every effort to inform you who is covering for me, and let you know the type of information that I may need to share with him/her. However, if an emergency required me to be out of the office suddenly, I would be guided by the American Psychological Association Ethical Principles of Code of Conduct regarding the type of information disclosed

Returned Telephone Calls/Texts/Emails

I strive to return calls, texts and emails between each session (which is one of the reasons my sessions are 50-60 minutes). I am not interrupted during sessions for incoming calls. In the event of a life-threatening emergency you should contact 911 or go to the nearest Emergency Room. My on-call phone is (303-321-1808).

Private Pay

All sessions are 45-55 minutes in length. A credit, debit or HSA card are necessary at our first session to proceed with the intake.

My fee is 95.00 for each cash-pay session. I offer an adjusted fee based on your situation, so please request this change if you need.

Insurances and EAPs

All sessions are 45-55 minutes in length. A credit, debit or HSA card is necessary at our first session to proceed with the intake.

Insurance deductibles and co-pays are paid prior to each session. I accept credit, debit and HSA cards only.

In the cases where insurance copays and deductibles apply, I may bill your credit card for the balance due to you._____(Please Initial).

EAP clients *do not* pay any fee for counseling services.

Appointment Cancellations

Unless ***1 Day*** notice is given, you will be expected to pay for the ***late cancellation/no-show*** at the rate of 50.00, unless we both agree that you were unable to attend due to circumstance beyond your control. A late cancellation or no-show has an impact. If I have enough notice of a cancellation, I can provide help to someone else. A late cancellation or no-show means that I am unable to serve another person. **Note**: Insurance companies and EAPs do not pay for late cancellations or no-shows.

Note: I do not complete disability forms or evaluations, nor requests for job accommodations. If you need these please make an appointment with your MD.

Agreement

I have read this information fully and completely. I understand there are no guarantees stated or implied. I have familiarized myself with the fees and charges for services provided by Todd Owen, LPC.

_____ _____

Client Signature Date Partner/Other Signature Date

_____

Todd Owen, Ph.D., LPC Date

Contact Information

Name:_____Date: _____

Address:_____

City:_____State:_____Zip:_____Date of Birth: _____

Email Address:_____

Insurance Information

Primary Health Insurance:_____Subscriber Name: _____

Relationship to Subscriber:_____Subscriber Date of Birth:_____

ID number:_____ Group/Policy #: _____

Employment Status

Are you employed? ☐ Yes ☐ No Are you using your EAP? ☐ Yes ☐ No

Employer Name: _____

Contact Telephone Numbers

		Phone/Text Messages OK? Yes	Phone/Text Messages OK? No	Primary Contact number?
HOME:	( ) _____	☐	☐	☐
WORK:	( ) _____	☐	☐	☐
CELL:	( ) _____	☐	☐	☐

Marital Status

☐ Single ☐ Divorced (_____years) ☐ Living as Married (_____years)
☐ Married (_ years) ☐ Separated (_____years) ☐ Widowed (years)

Emergency Contact Information

Name: _____

Phone: ( )_____Relationship to you: _____

Primary Care Physician

Current Physician: _____
Phone Number:

State of Colorado Mandatory Disclosure

Except in an emergency situation or where psychotherapy is being administered pursuant t o a court order, every unlicensed psychotherapist, or licensee shall provide the information below in writing to each client during the initial client contact.

Name:	Todd Owen		
Address:	539 S. Grant St. Denver, Co 80209		
Phone:	(303)-321-1808		
Degrees:	Bachelor of Arts, Psychology	University of Colorado	(1988)
	Master of Arts, Psychology	Regis University	(1997)
	Doctor of Philosophy, Psychology	Saybrook Institute	(2003)
License:	Colorado Licensed Professional Counselor # 2242		

The Department of Regulatory Agencies regulates the practice of both licensed and unlicensed persons in the field of psychotherapy. Questions or complaints may be addressed to:

Department of Regulatory Agencies 1560
Broadway, Suite 1340 Denver, CO. 80202
(303)-894-7766

A client is entitled to receive information about methods of therapy: the techniques used: the duration of therapy (if known); and the fee structure. A client may seek a second opinion from another therapist or may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the State Grievance Board.

Information provided by and to a client during therapy sessions is legally confidential if the therapist is a certified school psychologist, a licensed clinical social worker, a licensed marriage and family therapist, a licensed professional counselor, a licensed psychologist, or an unlicensed psychotherapist practicing under the supervision of a licensed psychotherapist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent.

There are exceptions to the general rule of legal confidentiality. These exceptions are listed in the Colorado statutes (see section 12-43-218, C.R. S., in particular). These include: reports of child abuse, intent to harm oneself or someone else, or a court order.

_____ _____

Client Signature Date Partner/Other Signature Date

_____

Todd Owen, Ph.D., LPC Date

Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Thank You.

1. Statement of Our Duties

   We are required by law to maintain the privacy of your personal health information and to provide you with this notice of our privacy practices and legal duties. We are required to follow the terms of this notice. We reserve the right to change the terms of this notice based on the Denver Counseling Affiliates' needs and changes in state and federal law. If we change this notice, we will provide you with a revised notice in writing.

2. Statement of Your Rights

   You have the right to know how we may use or disclose your Protected Health Information (PHI). In addition, you have the following rights:

- The right to request that we place additional restrictions on our uses and disclosures of your PHI. However, we are not obligated to agree to impose any such additional restrictions.
- The right to access, inspect and to receive a copy of the protected health information that we maintain in our files about you. Recipient will be charged a fee for copying and postage of PHI.
- The right to have us correct or amend any information that we create in error. Requests to access or amend your health information should be sent to the contact person and address provided in Section 4 of this notice.
- The right to receive an accounting of the disclosures of your PHI that we make for purposes other than activities related to your treatment, our payment functions, or other health care operations.
- The right to receive communications of PHI in a confidential manner.
- The right to release your records to others, for any purpose you choose. Such a request must be in writing and may be revoked at any time in writing.

3. Use and Disclosure of Protected Health Information (PHI)

   Denver Counseling Affiliates adheres to Colorado Law and requires written authorization in order to disclose any PHI outside of Denver Counseling Affiliates. The use and disclosure of PHI typically occurs on the following occasions:

- Treatment. We may use or disclose your health information to provide, coordinate or manage your treatment including others outside our practice with whom we are consulting or to whom we are referring you.
- Payment. Information will be used to obtain and facilitate payment for treatment and services provided. This will include verification of benefit eligibility and coverage, determination of payment status and utilization review activities.
- Healthcare Operations. We may also use or disclose your protected health information to perform administrative, financial, legal and quality improvement activities necessary, to run the business and support the core functions of treatment and payment.

4. Information Disclosed Without Your Consent. Under Colorado and federal law, information about you may be disclosed without your consent in the following circumstances:

- Emergencies. Sufficient information may be shared to address the immediate emergency you are facing.
- As Required by Law. This would include situations where we have a subpoena, court order, or are mandated to provide public health information such as suspected child, elder or institutional abuse or neglect.
- Governmental Requirements. We may disclose information to a health oversight agency for activities authorized by law such as audits, investigations, inspections and licensure. We are also required to share information, if requested, with the Department of Health and Human Services to determine our compliance with federal laws related to health care.

- Criminal Activity or Danger to Others. If a crime is committed on our premises or against our personnel, we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement when we believe an immediate danger may occur to someone else.

5. Contact Person for Complaints or Further Information

To request more information about this notice, you may contact the persons listed below. You may complain either directly to us or to the Secretary of Health and Human Services if you believe that we have not properly protected your health information. You will not be retaliated against in any way for filing a complaint.

Office for Civil Rights (OCR)
U.S. Department of Health and Human Services
Atlanta Federal Center, Suite 3B70
61 Forsyth St. SW, Atlanta, GA 30303-8909

To file a complaint with us, you may submit one in writing that includes as many details as possible to:

Todd L. Owen, Ph.D., LPC
Denver Counseling Affiliates
539 S. Grant St.
Denver, CO. 80209

6. Our practices regarding confidentiality and security

We restrict access to your protected health information to those contract employees of Denver Counseling Affiliates who need to know that information in order to provide services to you. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your private information.

_____ _____

Client Signature Date

_____ _____

Child/Spouse/Partner Signature Date

Client Concerns

Please check the items you would like to address in counseling

Career/work

__ Career choice
__ Financial concerns
__ Difficulties at work
__ Problems making decisions
__ Personality conflicts
__ Overwork/stress
__ *Other*:_____

Health concerns

__ Weight change
__ Eating pattern disorder
__ Tired all the time
__ Concerns about drugs
__ Bingeing
__ Difficulty sleeping
__ Headaches
__ Concerns about alcohol
__ Purging
__ Lack of energy
__ Dizziness
__ Nightmares
__ *Other*:_____

Personal concerns

__ Suicidal thoughts
__ Anxious
__ Unhappy
__ No self-confidence
__ Feeling anger
__ Dealing with loss
__ Trouble concentrating
__ Feeling panicky
__ Sensitive
__ Worried
__ Not feeling at all
__ *Other:*_____
__ Depressed
__ Feeling inferior
__ Feelings easily hurt
__ Fearful
__ Dealing with death

Social relationships

__ Shy with people
__ Difficulty making friends
__ *Other:*_____
__ Problems maintaining a relationship
__ Feeling lonely
__ Difficulty relating to people
__ Fighting in personal relationships

Family relations/spouse

__ Sexual concerns
__ Verbal abuse
__ *Other:*_____
__ Marital concerns
__ Physical abuse
__ Fighting
__ Financial stress

Family relations/parents

__ Care-giver stress
__ Conflict over child raising
__ *Other:*_____
__ Financial concerns
__ Impending loss of loved one
__ Fighting

Personal goals

__ Develop assertiveness skills
__ Develop clearer personal identity
__ *Other:*_____
__ Develop more realistic self-expectations
__ Increase awareness of emotional response
__ Accept personal limitations
__ Develop coping skills
__ Clarify personal goals and values

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? □ Yes □ No

Have you had previous psychotherapy? □No □Yes

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
□Yes □No If Yes, please list: _____

If no, have you been previously prescribed psychiatric medication?
□Yes □No
If Yes, please list: _____

General Health Information

1. How is your physical health at present? (please circle)

   Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):
   _____
   _____

3. Are you having any problems with your sleep habits? □ No □ Yes
   If yes, check where applicable:

   □ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams

4. How many times per week do you exercise? _____
   Approximately how long each time? _____

5. Are you having any difficulty with appetite or eating habits? □ No □ Yes

   If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting
   Have you experienced significant weight change in the last 2 months? □ No □ Yes

6. Do you regularly use alcohol? □ No □ Yes

   In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____