**Heather LaChance, MFT, PhD**
*Compassion in Practice, LLC*
750 E. 9th Ave, Suite 102
Denver, CO 80203
Email: DrHeatherLaChance@gmail.com
Website: http://heatherlachancephd.com

# Client Information Form

**Today's date**: _____

**A. Identification**

Your name: _____ Date of birth: _____ Age: _____
Street address: _____ Apt.: _____
City: _____ State: _____ Zip: _____

Home/evening phone: _____ e-mail: _____

Cell phone: _____

Do you prefer to get calls ☐ at home ☐ at work ☐ on my cell phone
Calls or e-mail will be discreet, but ***please indicate any restrictions***:
_____

**B. Referral:** How did you find out about my practice?

Name: _____

May I have your permission to thank this person for the referral and disclose your name?

☐ Yes _____ (please initial) Phone: _____ ☐ No: please do not disclose my name.

**C. Emergency Information**

If a medical emergency arises and I need to reach someone close to you, whom should I call?

Name: _____ Phone: _____ Relationship: _____

Do I have your permission to contact this person, only in the event of a medical emergency?

☐ *Yes _____ (please initial) ☐ No **Information regarding the emergency will be released.*

**D. Your Medical Care:** From whom or where do you get your medical or psychiatric care?

Clinic/doctor's name: _____ Phone: _____

Date of last physical or psychiatric exam: _____
Would you like me to contact your doctor to coordinate care or in an emergency?

☐ Yes (we will complete ROI) ☐ No ☐ Not applicable

**Please list ALL medications that you are taking:**

_____
_____
_____

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**E. Your Current Employer or Education**

Employer or School: _____ Occupation: _____

How fulfilling is your work or school? How might your work be impacting your current concerns?

_____

**F. Educational History**

High School (Name and City): _____ Graduate? ☐ No ☐ Yes _____ (year)

College (if applicable): _____ Graduate? ☐ No ☐ Yes _____ (year)

Graduate Studies (if applicable): _____ Graduate? ☐ No ☐ Yes _____ (year)

**G. Spiritual/Ethnic Identification**

Current religious denomination/affiliation: _____

Involvement: ☐ None ☐ Some/irregular ☐ Active

How important are spiritual concerns in your life? _____

Race/Ethnicity: _____

Other ways you identify yourself and/or consider important: _____

**H. Past Experiences with Therapy, Counseling, or Mental Health Hospitalization**

Past therapy or hospitalization: _____ Positive? ☐ No ☐ Yes _____ (date)

Past therapy or hospitalization: _____ Positive? ☐ No ☐ Yes _____ (date)

Past therapy or hospitalization: _____ Positive? ☐ No ☐ Yes _____ (date)

Please explain details regarding your prior therapy or hospitalizations:

_____

Would you like me to contact your prior therapists/counselors?

☐ Yes (we will complete ROI) ☐ No ☐ Not applicable

**I. Chief Concern**

Please describe the main difficulty that has brought you to see me:

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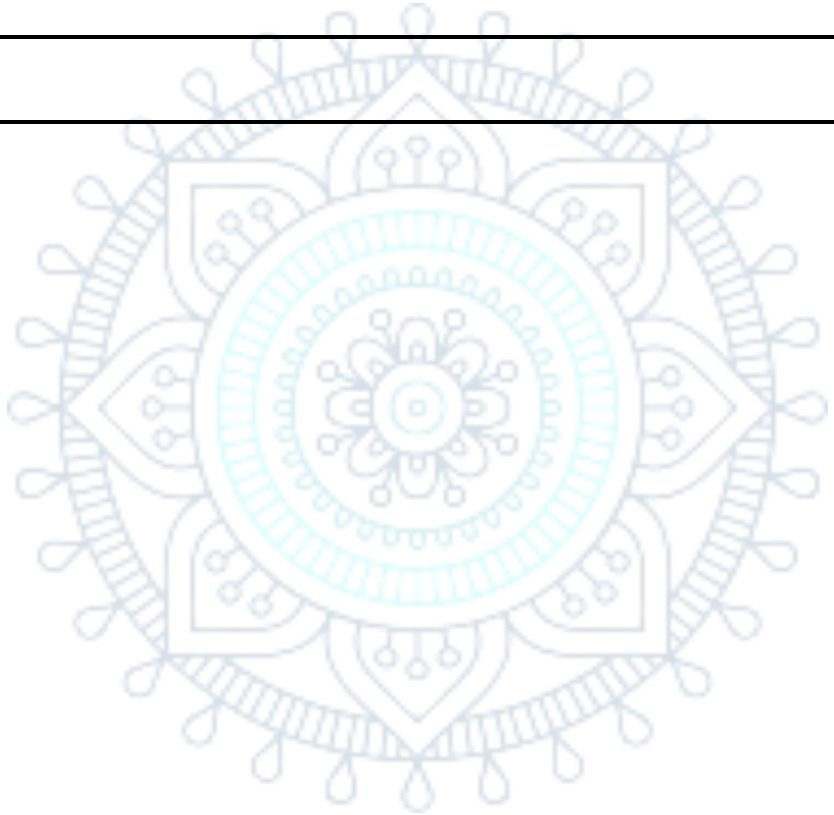

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# Adult Checklist of Concerns

Name: _____

Please mark all of the items below that apply, and feel free to add any others in "Unidentified Concerns" at the bottom of the page. You may add a note or details in the space next to the concerns checked. Thank you! This helps me to any address areas that might be a concern for you!

☐ I have no problem or concern bringing me here
☐ Abuse—physical, sexual, emotional, neglect
☐ Aggression, violence
☐ Alcohol abuse
☐ Anger, hostility, arguing, irritability
☐ Anxiety, nervousness
☐ Attention, concentration, distractibility
☐ Career concerns, goals, and choices
☐ Childhood issues (your own childhood)
☐ Codependence
☐ Confusion
☐ Compulsions
☐ Custody of children
☐ Decision making, indecision, mixed feelings, putting off decisions
☐ Delusions (false ideas)
☐ Dependence
☐ Depression, low mood, sadness, crying
☐ Divorce, separation
☐ Drug use—prescription medications, over-the-counter medications, street drugs
☐ Eating problems—overeating, under-eating, appetite, vomiting (see also "Weight and diet issues")
☐ Emptiness
☐ Fatigue, tiredness, low energy
☐ Financial or money troubles, debt, impulsive spending, low income
☐ Friendships
☐ Gambling
☐ Grieving, mourning, deaths, losses, divorce
☐ Guilt
☐ Headaches, other kinds of pains
☐ Health, illness, medical concerns, physical problems
☐ Housework/chores—quality, schedules, sharing duties
☐ Inferiority feelings
☐ Interpersonal conflicts
☐ Impulsiveness, loss of control, outbursts
☐ Irresponsibility
☐ Judgment problems, risk taking
☐ Legal matters, charges, suits
☐ Loneliness
☐ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
☐ Memory problems

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☐ Failure
☐ Mood swings
☐ Motivation, laziness
☐ Nervousness, tension
☐ Obsessions, compulsions (thoughts or actions that repeat themselves)_____
☐ Oversensitivity to rejection
☐ Pain, chronic
☐ Parenting, child management, single parenthood
☐ Panic attacks: How often?_____
☐ Perfectionism
☐ Pessimism
☐ Phobia/s _____
☐ Procrastination, work inhibitions, laziness
☐ Relationship problems (with friends, with relatives, or at work)
☐ School problems (see also "Career concerns ...")
☐ Self-centeredness
☐ Self-esteem
☐ Self-neglect, poor self-care
☐ Sexual issues, dysfunctions, conflicts, desire differences
☐ Menstrual problems, PMS, menopause
☐ Shyness, oversensitivity to criticism
☐ Sleep problems— Circle: too much, too little, insomnia, nightmares.
Other:_____
☐ Smoking (marijuana or tobacco) use
☐ Spiritual, religious, moral, ethical issues
☐ Stress, relaxation, stress management, stress disorders, tension
☐ Suspiciousness, distrust
☐ Suicidal thoughts: _____
☐ Temper problems, self-control, low frustration tolerance
☐ Thought disorganization and confusion
☐ Threats, violence
☐ Weight and diet issues
☐ Withdrawal, isolating
☐ Work problems, unrewarding employment, unemployment, ambition, lack of purpose
☐ Workaholism, overworking, work-life balance

☐ Unidentified concerns or issues: _____

Please look back over the concerns you have checked off and choose the one that you want the most help with.

Primary concern is: _____
_____
_____

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## CONSENT TO TREAT, POLICIES, AND PROFESSIONAL DISCLOSURE STATEMENT

Welcome! I would like to acquaint you with my credentials, philosophy, policies, and approach to my clinical work. Please read the following carefully. If you have any questions please do not hesitate to ask me. Once you have reviewed the material, I will have you sign below.

Qualifications

I am a Licensed Psychologist (#3068) in the State of Colorado. I received my first Master's in Marriage and Family Therapy (MFT) from University of Connecticut, Storrs in 1998. I received my second M.A. and Ph.D. in Clinical Psychology from University of Colorado, Boulder in 2004. I completed my Post-Doctoral Training at Brown University and my APA-Approved Internship at Harvard University. My specific training is in Clinical Psychology. I have specific training helping people with anxiety/fears, depression, trauma, grief, relationship problems, addictions, codependency, eating/weight management, low self-worth, and spirituality related issues.

Psychological Services, CO requirements:

As to the regulatory requirements applicable to mental health professionals: A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. I hold a doctorate degree in psychology and have completed two years of post-doctoral specialize training.

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 such as ours, sexual intimacy is never appropriate and should be reported to the licensing board.

Expectations

My role as your therapist is as a facilitator and collaborator. During the first few sessions we will be working together to determine whether we can and will work together. If I feel another therapist is better suited for your presenting concern/s, I may refer you to a different therapist. My role is not to solve problems for you but to assist you to recognize and develop internal and external resources available to you. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, worry and anger as part of therapy. However, the goal is to resolve and let go of unhelpful beliefs that trigger these emotions. Change can often happen very quickly. In other instances, change may occur more slowly. There are no guarantees about what you will experience. However, the goal is to resolve the underlying concerns that are causing distress. My approach is to address your concerns with openness, flexibility, and compassion to help you explore your thoughts, beliefs and actions as well as to help you learn new skills, resolve old concerns, and find meaning in personal challenge. This work is in the hope of finding new positive solutions and personal growth.

Values, Philosophy, Treatment Type:

I use a combination of cognitive-behavioral, energy psychology, interpersonal psychology, EMDR, and bibliotherapy with journaling. I may use a variety of techniques, depending on the type of issues or problems we are working on. Nearly all of techniques I use have been supported with research. Of all the tools I use, I find energy psychology (Thought Field Therapy {TFT} and Emotional Freedom Techniques or EFT) to be the most effective. For those who are interested and ask for this approach, I also use meditation and visualization.

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I follow a practical model:

**Insight + Revise Core Beliefs + Compassion + Meaning-Making = *Personal Growth***

Change is about understanding how early experiences can shape the way you see yourself, others, and your world. To grow, we all must let go of old, unhealthy ways of viewing ourselves and others. We must also learn new ways of managing ourselves and life. Of course, this takes practice and commitment. But, with compassion and encouragement, new skills can be mastered and incorporated into your life. Ultimately, finding the meaning in personal challenge facilitates growth, new values, and self-other respect that can bring about a richer, more satisfying life.

Appointments:
The fastest and most effective way to reach me is by email at DrHeatherLaChance@gmail.com. I try to respond to emails within 24-48 hours. I may be unable to respond to voicemails until 36 hours or more, given I am in many appointments during working hours. Appointments are typically 55 minutes in length. However, you and I might modify the session time, if deemed appropriate.

Cancellations:
Please cancel a session within 24-48 hours. Please email in advance to notify me that you are unable to attend. You may be charged the session fee for sessions that are considered "no shows" or are not cancelled with sufficient notice. I try to avoid these fees at all costs, so simply reach out within 24 hour to prevent additional fees.

Fees and Billing:
My fee is $_____ per 55 minute session. This rate is determined based on the general fee for psychologists in our community, and based on my background and extensive training. I have three advanced degrees and specialized additional training from Brown Medical School, in EMDR, and in Energy Psychology methods. Payment is due at each visit. I do not bill insurance companies nor do I contract with managed care. I am willing to provide you with a Superbill so that you can bill your insurance company and they can reimburse you. I will state clearly that payment should be made to the insured (you). Please remember that charges are your responsibility to pay regardless of how the insurer may handle your claim.

Emergencies:
I am **not available to provide crisis or after-hours services**. Please note that I check my voicemail only minimally during business hours. Email is the most effective means to contact me. If you feel you are in an emergency, **please contact 911 or the Denver County Crisis Line: (303) 860-1200,** which is available 24 hours a day/ 7 days per week. You can also call national hotlines: **1-800-SUICIDE** or **1-800-273-TALK.** If you do contact a crisis service, please inform me as soon as possible so I can follow-up with you during business hours. *If you are unable to reach me directly and are in crisis, please call 911 or proceed to your nearest emergency room.* If I will be unavailable for an extended time, I will provide you with a backup number. You may use cellular phones, text or email for communication, but **please initial _____** to indicate you understand and accept the risk that information sent via cellular phone, text, or email may not be a private/reliable means of delivery.

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Confidentiality and Your Records:
With a few exceptions, everything we discuss in our sessions is confidential and will not be disclosed to others without your verbal or written permission. I am required by law to break confidentiality if I receive information or evidence that you might plan to hurt yourself, others, damage property, or when I suspect physical or sexual abuse of a child, elderly, or a dependent person. Other rare exceptions involve HIV status and dangerous sexual activities, pregnancy and dangerous drug use, or issues involving litigation. In almost every instance, I would make every effort to notify you first before breaking confidentiality and/or work with you to resolve an issue rather than having to break confidentiality.

In the context of working with couples or families, statements made by one party to the therapist are not protected when, at a later date, records are demanded by the court. Be advised that I will refuse to submit information during a divorce or custody dispute in order to protect the privacy of all parties. I do not specialize in divorce or custody evaluations and will refer clients to another therapist for such resources. In the context of working with adolescents, there may be circumstances in which I might feel it important to relay information to parents (if I believe an adolescent is engaging in behaviors that might critically harm them). Nevertheless, I will carefully consider any such disclosure with each party's best interest in mind. If you have been sexually abused by a previous therapist, I can, with your permission, make a report on your behalf to the local licensing board.

I keep a record of the health care services that I provide to you. You may request to see a summary statement of this record. You may also ask me to correct any information in that record. I will not disclose your record to others unless you direct me to do so, or unless the law authorizes or compels me to do so. You may request to read and discuss the written information contained in this statement. A copy can be made available to you at your duplicating expense.

Confidentiality and Treatment Session Reminders:
I use a HIPAA compliant software program, ArgonautSoftware.com, that provides auto-reminders of session date and time, 24 hours prior to our meeting. My name is not included in these reminders to protect your privacy. I can arrange these auto-reminders in a number of ways (text, email, voicemail), only with your permission. Do I have your permission and would you like to be contacted via:

Text message to your phone: (  ) _____ Circle: Yes No Initials _____

Who is your mobile carrier company? _____

Voicemail message to your phone: (  ) _____ Circle: Yes No Initials _____

Email message to your computer: _____ Circle: Yes No Initials _____

Proposed Course of Treatment:
Generally, we will discuss the specifics of your treatment plan following the first few sessions. I will attempt to describe the nature and purpose of various aspects of treatment, the risks and benefits of that proposed treatment, and any available alternative treatments that might exist. When an aspect of treatment is not known to be effective based on current research, I will notify you of any possible limitations of treatment. I will also inform you of your possible prognosis with or without treatment, or without various components of treatment. The treatment methods that I use have been significantly researched: Cognitive-Behavioral Therapy (CBT), Eye-

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Movement Desensitization Reprocessing (EMDR), Acceptance and Commitment Therapy (ACT), Thought Field Therapy (TFT) and meditation. From my clinical experience, mind-body techniques such as acupressure stimulation, muscle testing, and TFT are extremely effective and allow me to facilitate change more quickly. I will explain these in more detail in our beginning sessions. However, do not hesitate to ask me any questions about these modalities, or for an article summarizing the research efficacy of Thought Field Therapy and Energy Psychology methods. You can also find more information on the Association for Comprehensive Energy Psychology's website at www.energypsych.org.

I usually use a combination of individual therapy sessions with couple or family sessions, as needed. If I begin working with a couple, I may move to individual sessions. If I begin working with an individual, I find it less effective to then work with a couple. In those instances, I will make a referral. The number of sessions varies, depending on presenting concerns. Optimally, treatment will end at the point in which you feel you have met your goals adequately, or at the point at which you feel that treatment is no longer needed. Treatment can be modified in length, frequency, and content based on your needs. The more you are open about your needs and concerns, the better I will be able to tailor our work to your benefit.

You have the right to refuse treatment at any point during our work together. If you have concerns about the way our work is progressing, I encourage you to bring these concerns up with me directly. If you feel progress is not being made, please discuss this with me so I can either make a change in our treatment plan, or provide you with a referral to another provider or other resources. I want to know how you feel, so please let me know if you have any questions about your therapy or your progress. If you have a formal complaint that you wish to report, you can contact the Colorado Department of Regulatory Agencies, Mental Health Section, 1560 Broadway, Suite 1350, Denver, CO 80202.

Additionally, my office is HIPPA compliant and my filing and billing are in compliance with the federal guidelines for your privacy of medical and personal information. Every effort is made to respect you and your privacy. I use an accounting, records, and scheduling system with Argonautsoftware.com. Data is encrypted with the highest level of security. ArgonautSoftware is fully HIPAA-compliant and qualifies as a HIPAA-covered Business Associate (BA). A copy of Argonaut's HIPAA Compliance Statement is available on request. Argonaut is also fully compliant with the confidentiality guidelines of the American Psychological Association. Clinical notes are not viewable on this system. Any clinical notes or data need to be requested of me in writing.

ACKNOWLEDGEMENT OF POLICIES

I have read and understand the policies set forth by Dr. LaChance in her consent to treat, policy and disclosure statement above. Dr. LaChance has reviewed with me the nature and purpose of her treatment practices, alternative treatments, risks and benefits, and the known effectiveness of her proposed treatments. I understand that I have the right to refuse treatment at any point, and I understand the limitations of confidentiality and how my records will be handled.

X _____ _____
Client Signature Date

X _____ _____
Client Signature Date

_____ _____
Dr. Heather LaChance Date

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## NOTICE OF HIPAA PRIVACY PRACTICES

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
**This notice describes how health information about you may be used and disclosed and how you can get access to your individually identifiable health information.**
**Please review this notice carefully.**

**A. My commitment to your privacy:**
My practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *Protected* Health Information, or PHI). In conducting my business, I will create records regarding you and the treatment and services I provide to you using ArgonautSoftware.com. This is a HIPAA and federally-approved software program for therapists. I am required by law to maintain the confidentiality of health information that identifies you. I am also required by law to provide you with this notice of my legal duties and the privacy practices that I maintain in my practice concerning your PHI. By federal and state law, I must follow the terms of the Notice of Privacy Practices that I have in effect at the time.

I realize that these laws are complicated, but I must provide you with the following important information:
• How I may use and disclose your PHI,
• Your privacy rights in your PHI,
• My obligations concerning the use and disclosure of your PHI.
**The terms of this notice apply to all records containing your PHI that are created or retained by my practice. I reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that my practice has created or maintained in the past, and for any of your records that I may create or maintain in the future. My practice will post a copy of my current Notice in my offices in a visible location at all times, and you may request a copy of my most current Notice at any time.**

**B. If you have questions about this information, please discuss it further with me. If you feel your privacy rights have been violated, please contact:**
Office of Civil Rights
Us Department of Health and Human Services
1961 Stout Street, Room 1426
Denver, CO 80294
303-844-2024
303-844-20225-Fax

**C. I may use and disclose your PHI in the following ways:**
The following categories describe the different ways in which I may use and disclose your PHI.

1. **Treatment**. Treatment refers to the provision, coordination, or management of healthcare including mental health related to one or more providers. The information provided to insurance and other third party payers may include information that identifies you, as well as your diagnosis, type of service, date of service, provider name/identifier, and other information about your condition and treatment.
2. **Payment**. My practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, upon your request, I may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and I may provide your insurer

with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. I also may use and disclose your PHI to obtain payment from third parties for your benefit. I do not negotiate or contract with insurance companies for reimbursement. Clients are responsible for service costs upon beginning or end of appointments. Also, I may use your PHI to bill you directly for services and items, in the event payments were not provided. I may disclose your PHI to other entities to assist in billing and collection efforts.

3. **Contacting the Client.** I may contact you to remind you of appointments and to tell you about treatments or other services which may be of benefit to you.
4. **Health Care Operations**. My practice may use and disclose your PHI to operate my business. As examples of the ways in which I may use and disclose your information for my operations, my practice may use your PHI to evaluate the quality of care you received from me, or to conduct cost-management and business planning activities for my practice.
5. **Disclosures required by law**. My practice will use and disclose your PHI when I am required to do so by federal, state or local law. This includes but is not limited to: reporting child abuse or neglect, when court ordered to release information, when there is a legal duty to warn or take action regarding imminent to danger to others, when the client is a danger to self or others or is gravely disabled, when required to report certain communicable diseases and certain injuries; and when a Coroner is investigating a client's death.
6. **Health Oversight Activities**. My practice may disclose your PHI to a health oversight agency for activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, and regulatory programs or determining compliance with program standards.
7. **Crimes on the Premises or Observed by me:** Crimes that are observed by me or directed at me or occur at my business location will be reported to law enforcement.
8. **Involuntary Clients:** Information regarding clients who are being treated involuntarily pursuant to law, will be shared with other treatment providers legal entities, third party payers and others, as necessary to provide the care and management coordination needed.
9. **Family Members:** Except for certain minors, incompetent clients or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of that discussion. However, if you object, PHI will not be disclosed.
10. **Emergencies:** In life threatening emergencies, I will disclose information necessary to avoid serious harm or death (to you or to others in imminent danger).
11. **Client Authorization to Release of Information:** I may not use or disclose PHI in any other way without a signed Authorization or Consent to Release Information. When you sign a consent to release information, it may later be revoked, provided that the revocation is in writing. The revocation will apply, except to the extent I have already taken action in reliance thereon.

**D. Your Rights under HIPAA:**

1. **Access to Protected Health Information (PHI):** You have the right to inspect and obtain a copy of the PHI information that I have regarding you and the record. There are some limitations to this right, which will be explained to you at the time of your request, if such a limitation applies. To make such a request, please talk to me.
2. **Amendment of Your Record:** You have the right to request that I amend your PHI. I am not required to amend the record if it is determined that the record is accurate and complete. When there are other exceptions, which will be provided to you at the time of your request, along with an appeal process.

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3. **Accounting of Disclosures: You have the right to receive an accounting of certain disclosures that I have made** regarding your protected health information. That accounting does not include disclosures that were made for the purpose of treatment, payment, or healthcare operations. There are other exceptions that will be provided to you, should you request an accounting.
4. **Alternative Means of Receiving Confidential Communications.** You have the right to request that you receive communications of PHI from me by alternative means or locations. For example, if you do not want bills sent to your home, you may request a different address. There are limits to such requests that will be provided to you.
5. **Copy of the Notice:** You have the right to obtain another copy of this Notice upon request.

**E. Additional Information:**

1. **Privacy Laws:** I am required by State and Federal Law to maintain the privacy of PHI. In addition, I am required by law to provide clients with notice of its legal duties and privacy practices with respect to PHI. That is the purpose of this notice.
2. **Terms of Notice and Changes to the Notice:** I am required to abide by the terms of this Notice and any amended notice that may follow. I reserve the right to change the terms of this notice and to make new notice provisions for all PHI that it maintains.
3. **Additional Information:** If you desire additional information about your privacy rights, please contact me at the following:

   **Heather LaChance, MFT, Ph.D.**
   750 East 9th Ave, Suite 102
   Denver, CO 80203
   303-990-8363.
   Email: HeatherLaChance@gmail.com. Web: www.heatherlachancephd.com

**I have received the Notice of Privacy Rights and Policies Documentation as required** by the Health Insurance Portability and Accountability Act of 1996 (HIPAA):

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Dr. Heather LaChance Date

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## CREDIT /DEBIT CARD PAYMENT AUTHORIZATION FORM (OPTIONAL)

Name on Card: _____

**I authorize Dr. Heather LaChance and Argonaut Treatment Services to charge my card for professional services as follows:**

***Please Initial One:***

_____ **This** visit only for the amount of $_____.00 per session hour.

_____ **All visits** scheduled during our treatment for the amount $_____.00 per hour.

_____ Other arrangement: _____

☐ VISA: _____ - _____ - _____ - _____

☐ MASTERCARD: _____ - _____ - _____ - _____

Expiration Date: _____ CVV Code on back of card: _____

**PHONE** number associated with card: _____

**ZIP CODE** associated with card: _____

Charges will appear on your card as Argonaut Treatment Services. This is the billing/accounting program that I use. All data are encrypted and follow HIPAA Federal Guidelines.

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred. I also understand by signing and initialing this form that if no payment has been made, my card may be charged for any outstanding balances.

***Initial*** _____

_____ _____
Card Holder's Signature Date