Client:
I.D.
ICD 10:

Joseph Librizzi LCSW
License number 1519
808 Mathews St. Fort Collins, CO 80524
970-492-5309
JL@JosephLibrizzi.com
JosephLibrizzi.com
CO License #1519

CLIENT REGISTRATION

Place of service: 808 Mathews St. Fort Collins, CO 80524

Please fill out this form and bring it to your first session. Please note that the information you provide here is protected as confidential information.

Client Name:_____ Date:

Address: _____ Zip code _____

Birth Date: _____ Age: _____ Gender: ▫ Male ▫ Female

Home Phone: (_____) _____ May I leave a message?

Cell/Other Phone: (_____) _____ May I leave a message?

Work Phone: (_____) _____ May I leave a message?

E-mail: _____ May I email you? *Please note: Email correspondence is not considered to be a confidential medium of communication.

Medicaid ID /Insurance Name and ID # K 100 351

Social Security Number _____(Required for Medicaid billing)

Marital Status: ▫ Never Married ▫ Domestic Partnership ▫ Married ▫ Separated ▫ Divorced ▫ Widowed
School Status: ▫ Full Time ▫ Part Time ▫ High School ▫ College ▫ Trade School ▫ Other

Please list children/age _____

Religious/spiritual affiliation or support: _____

PROBLEM AND SYMPTOMS: Please describe the problem you are experiencing, and the degree of any symptoms (mild, moderate, severe), and when the problems/symptoms began.
_____
_____
_____
_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? No__Yes___, previous therapist/practitioner: _____

Last Physical Exam (Date) ____/____/____ Note: If you have not had a physical exam more than 1 year prior to this intake, or if the client is a minor and they have not had a recent Well Child exam, I am recommending that you contact: Associates in Family Medicine 970-204-0300 for an appointment. Initial _____

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Name of PCP_____
Please list any prescription medication and dosage you are currently taking?
_____

Medications, continued:_____
_____

Have you ever been prescribed psychiatric medications ▫ Yes ▫ No Please list and provide dates:
_____
_____

General Consent for Child, or Dependent, Treatment
Name of parent (if client is under 18 years old):
_____ Birth Date: _____ /_____ /_____
Age: ____ Gender: ▫ Male ▫ Female

I am the legal guardian or legal representative of the client, and on the client's behalf I Legally authorize Joseph Librizzi, LCSW to deliver mental health care services to the client. I also understand that all policies described in this statement apply to the client I represent.

Signature of parent/ guardian/legal representative:
_____ Birth Date: ___ /____ /_____

If a Child is under Conjoint Legal Custody then both Parents need to consent to treatment: Name of guardian/legal representative: _____
Birth Date: _____ /_____ /_____ Age: ____ Gender: ▫ Male ▫ Female Phone #: _____
Address: _____

Signature of Guardian/Legal Representative _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION
1. How would you rate your current physical health? (Please circle) Poor Unsatisfactory Satisfactory GoodVery good
Please list any specific health problems you are currently experiencing:
_____
_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good. Please list any specific sleep problems you are currently experiencing: _____

3. What types of exercise do you participate in and how many times per week:
_____

4. Please list any difficulties you experience with your appetite or eating patterns.
_____

5. Are you currently experiencing sadness, grief, or depression? ▫ No ▫ Yes
If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias? ▫ No ▫ Yes
If yes, when did this begin? _____

7. Are you currently experiencing any chronic pain? ▫ No ▫ Yes
If yes, please describe: _____

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7. Do you drink alcohol more than once a week? ▫ No ▫ Yes, About how much? _____

8. How often do you engage recreational drug use? ▫ Daily Monthly ▫ Infrequently ▫ Never

9. Are you currently in a romantic relationship? ▫ No ▫ Yes
   If yes, for how long? _____

10. On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:
    _____
    _____
    _____
    _____

12. Do you have special transportation needs?_____ Do you need a referral for transportation assistance? _____

FAMILY MENTAL HEALTH HISTORY

In the section identify if there is a family history of any of the following. Please indicate if you or a family member:

Alcohol/Substance Abuse _____ Anxiety_____ADD or ADHD_____
Bipolar_____Depression_____Domestic Violence_____Eating Disorder_____
Obesity_____Obsessive Compulsive Disorder _____ Schizophrenia_____
Suicide Attempt/completed suicide _____Suicidal thoughts/plan_____Other_____

ADDITIONAL INFORMATION
Are you currently employed? ▫ No ▫ Yes If yes, where are you employed:
_____ If yes, what is your current employment: ▫ Full Time ▫ Part Time ▫
Laid Off ▫ Medical Leave (Stress or Injured) ▫ Other (explain):
_____

Do you enjoy your work? ▫ No ▫ Yes
Is there anything stressful about your current work?
_____
_____
What would you like to accomplish in therapy? My Goals are:

1._____

2._____

3._____

4._____

PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT
This document provides important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides increased privacy protections and expanded patient rights with regard to the use and disclosure of your Protected Health Information (PHI). HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of personal health information for treatment, payment and health care operations. The Notice, which is attached to this document explains HIPPA and its application to you personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session.

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You may find more detailed information on HIPAA and the privacy of your health information than is contained below by visiting the following website:

http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html

Please read and sign at the bottom to indicate that you reviewed and understand this information.

COUNSELING SERVICES
Services provided include clinical assessments, psychotherapy, consultation, education and crisis intervention.
Psychotherapy is not easily described in general statements. It varies considerably depending on presenting concerns and individual styles. One of the primary goals of therapy is to help a person achieve a more fulfilling life. The process of psychotherapy involves talking about ongoing problems with a professionally trained, licensed provider in an attempt to better understand and respond to all that contributes to ongoing difficulties.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have significant benefits. Therapy often leads to better relationships, solutions to specific problems, and noticeable reductions in feelings of distress. But there are no guarantees of what you will experience.
The first few sessions will consist of collecting information from you in an attempt to assess various needs and concerns. During this assessment period, we will both decide if I am the best person to provide the services you need in order to meet your treatment goals. If you have any questions about the process, guidelines, or anything we talk about we can discuss them at any point. It is important to emphasize that you may withdraw from treatment at any time.

CONFIDENTIALITY
Psychotherapy necessarily involves the sharing of sensitive, personal, and private information with your therapist. As a result, the information you share is kept strictly confidential, and is not disclosed without your written permission. There are, however, a few carefully agreed upon exceptions to the protection of confidentiality which you should know about prior to beginning therapy. These exceptions are listed as follows:

1. Supervision or Consultation: At times, I find it helpful to consult or receive supervision from other health and mental health professionals about a case. During consultation or supervision, I make every effort to avoid revealing a patient's identity. The other professionals are legally bound to keep the information confidential. I will note all consultations in your Clinical Record (which is called PHI in my notice of therapist's policies and practices to protect the Privacy of your health information). 2. Abuse of a Child or Elderly or Disabled Person: If I have reason to believe that a child under the age of eighteen (18), an elderly, or disabled person is being abused or neglected, I am obligated by law to report this situation to the appropriate state agency.

2. Imminent Harm to Self: If I have reason to believe that you are threatening immediate physical harm to yourself, and if you are unwilling or unable to follow treatment recommendations, I may have to contact a family member or another person who may be able to help to ensure your safety.

3. Imminent harm to others: If I have reason to believe that you are actually threatening physical violence against another person, or if you are an actual threat to the safety of another person, I am required by law to take some action to ensure that the other person is protected (such as contacting the police, notifying the other person, seeking hospitalization, or a combination of these alternatives).

4. Court Related Proceedings: In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

5. Lawsuit: If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding the case in order to defend myself. The above situations have rarely occurred in my practice. If an event does occur which may necessitate breaching confidentiality, I will make every effort to fully discuss it with you before taking any action.

This written summary of exceptions to confidentiality should help to inform you about potential problems. If at any time you have questions or concerns regarding confidentiality and exceptions to it, please raise them with me. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

SESSIONS
Therapy sessions are 1 hour, once a week, but may vary according to your needs and situation.Once an appointment is scheduled you are responsible for payment of that session unless you provide 24 hours advance notice of cancellation excluding circumstances beyond your control.

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PROFESSIONAL FEES
My hourly fee is $110.00. (The initial intake session is billed at a rate of $130. Many health insurance policies cover all or part of the initial intake, please check your coverage).

In addition to weekly appointments, I charge this amount for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party.

BILLING AND PAYMENTS
You will be expected to pay for each session at the time it is held. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment.
If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. Please note: 1. that insurance companies do not reimburse for missed or cancelled sessions. 2. *You are responsible for your health insurance being current, i.e., active; if it lapses during psychotherapy treatment you will be responsible for payment of sessions that are not covered by your health insurance.*

INSURANCE REIMBURSEMENT
I participate on some insurance panels, and am in the process of joining others. If you use your health coverage to help pay for your treatment you will be expected to pay for treatment first, and then submit a claim directly to your insurance company for reimbursement. I will be happy to provide you with an insurance form at the end of each month in an attempt to help in this process.

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. To help determine your mental health coverage I will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions.

It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by contract.]

CONTACTING ME
I am often not immediately available by telephone. When I am unavailable, my office cell phone is answered by voice mail that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the mental health counselor on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, (Health Insurance Portability & Accountability Act of 1996) I keep Protect Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, the goals we set

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for treatment, your progress towards these goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations or supervision, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others (for which I will provide you with an accurate and representative summary of your Record), you may examine and/or receive a copy of your Clinical Record, if you request it in writing.

Because these are professional records, they can be misinterpreted and/ or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents.

In addition, I also keep a set of Psychotherapy Notes. These notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your signed, written Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your Psychotherapy Notes unless I determine that such disclosure would be injurious to you.

Patient Rights. HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS
If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

CLIENT REGISTRATION FORM
Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Client Name:_____

Client Signature:_____ Date:_____

Witness Signature:_____Date:_____

Your signature below serves as an acknowledgment that you have 1. received the HIPPA notice form described above, 2. that I have asked if you have an 'Advanced Medical Directive' and 3. have offered you an educational brochure or information for online resources.

Client Name:_____

Client Signature:_____Date:_____

Witness Signature:_____Date:_____

If the patient is a minor, have they had a 'Well-Child Exam' within the past year?_____; if they haven't, please schedule this exam with your family physician.

Cancellation policy: An appointments made is time set aside for you. I cannot bill your insurance for missed or cancelled appointments. Except for emergencies, missed appointments, or appointments not cancelled with 24hr. prior notice, will be billed at a rate of $50.00, or a rate agreed to by us.

By signing you agree to this cancellation policy: _____ Date:

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DISCLOSURE STATEMENT

To Prospective Clients:

I am a licensed clinical social worker, CO license #1519. I hold a masters in Social, completed at Marywood University, 2300 Adams Ave, Scranton, PA 18509, in 1989. I have background training as a clinical psychiatric social worker and received psychotherapy and substance abuse training as part of my education. I have practiced in outpatient mental health clinics, I formed and participated in a group psychotherapy practice in Upstate NY from 1990 to 2004 and have also conducted a private practice since 1990.

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Professions and Occupations. The Social Work Examiners Board, which regulates social work practice, can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800.

As to the regulatory requirements applicable to mental health professionals **:**

Licensed Social Worker must hold a master's degree in social work.

Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's degree in their profession and have two years of post-masters supervision.

1. 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.

2. 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.

3. Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes, and the HIPAA Notice of Privacy Rights you were provided, as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report suspected child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly.

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

Print Client's Name_____

Client's or Responsible Party's Signature_____ Date _____

If signed by Responsible Party, please state relationship to client and authority to consent:

_____

_____

Client:
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RELEASE OF INFORMATION OR AUTHORIZATION FORM

I authorize Joseph Librizzi LCSW to **release _X_ or receive_X_** the in formation indicated to/from the agency or persons listed below for purposes of service coordination, continuity of care and case management.

The authorization pertains to:
(Please print) _____

Client Name Date of Birth

Information to be released or requested: (Check every box applicable.)

( ) **All medical and mental health treatment records which includes mental health condition and treatment, for all dates of treatment:** Including, but not limited to clinical charts, office notes, test reports, test data, physician notes, notes of Progress-to-Date, consultation reports and notes, outpatient records, and correspondence related to clinical matters.

( ) **Verbal Communications:** Including communication either verbally or in writing with the person(s) or entity(ies) listed below, regarding all the released information available, including information contained in treatment records as described above, an d is to give opinions and answer questions.

( ) **Drug abuse or alcohol abuse, which includes, if any, alcohol and substance abuse condition and treatment information.** Includes all information regarding any assessment, diagnosis, referral, history, or discussion of drug abuse or alcohol abuse.

( ) **Other:** Department of Social Services records, including information regarding the pending dependency and neglect action and treatment plan compliance.

( ) **Other:** Attendance, progress, participation, and recommendations

Other: _____. Information to be released to or received from:
Name of agency or person Address/Telephone:
_____
_____
_____

• I understand that my records and/or those of any individual(s) listed above are protected under federal and state confidentiality regulations. I understand that if I have authorized the release of drug abuse and/or alcohol abuse information that the confidentiality of this information is protected by Federal Law [42 CFR, Part 2]. This information cannot be disclosed without my written consent, unless otherwise specifically provided for in the regulations. I understand that I may revoke this consent at any time. Copies of this form may be used in lieu of the original. I understand and agree that this release form may be sent to the agencies and persons identified above.

• This disclosure is at the request of the individual or legal authority or _____n/a_____. This disclosure is for the purpose of **Treatment**, **Payment**, **Operations**, or **Other**. If "Other" is checked, regardless of whether additional purposes are also checked, this form is a HIPAA compliant Authorization. As such, the Center may not condition treatment, payment, enrollment, or eligibility for benefits on your signing this Authorization. Also, if this is an Authorization, the Center must provide you with a copy.

• I understand that there is a potential for information disclosed as a result of this release/authorization to be re-disclosed by the recipient and therefore no longer protected by the HIPAA Privacy regulations.

• This consent expires and cannot be used past the following date (Not to exceed one (1) year): _____

Signature / Date _____

If not the client, please print and state your legal authority to sign for client / Date
_____

Witness Signature Date _____

I hereby revoke this consent to Release/Authorization for Information.

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Mental Status Exam

Client Name	Date

OBSERVATIONS

Appearance	□ Neat	□ Disheveled	□ Inappropriate	□ Bizarre	□ Other
Speech	□ Normal	□ Tangential	□ Pressured	□ Impoverished	□ Other
Eye Contact	□ Normal	□ Intense	□ Avoidant	□ Other	
Motor Activity	□ Normal	□ Restless	□ Tics	□ Slowed	□ Other
Affect	□ Full	□ Constricted	□ Flat	□ Labile	□ Other
Comments:					

MOOD

□ Euthymic	□ Anxious	□ Angry	□ Depressed	□ Euphoric	□ Irritable	□ Other
Comments:						

COGNITION

Orientation Impairment	□ None	□ Place	□ Object	□ Person	□ Time
Memory Impairment	□ None	□ Short-Term	□ Long-Term	□ Other	
Attention	□ Normal	□ Distracted	□ Other		
Comments:					

PERCEPTION

Hallucinations	□ None	□ Auditory	□ Visual	□ Other
Other	□ None	□ Derealization	□ Depersonalization	
Comments:				

THOUGHTS

Suicidality	□ None	□ Ideation	□ Plan	□ Intent	□ Self-Harm
Homicidality	□ None	□ Aggressive	□ Intent	□ Plan	
Delusions	□ None	□ Grandiose	□ Paranoid	□ Religious	□ Other
Comments:					

BEHAVIOR

□ Cooperative	□ Guarded	□ Hyperactive	□ Agitated	□ Paranoid
□ Stereotyped	□ Aggressive	□ Bizarre	□ Withdrawn	□ Other
Comments:				

INSIGHT	□ Good	□ Fair	□ Poor	Comments:
JUDGMENT	□ Good	□ Fair	□ Poor	Comments:

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Treatment Plan

Place of service: 808 Mathews St. Fort Collins, CO 80524

-Target problem or symptom :

Planned interventions: CBT, Inquiry, Problem Solving Therapy, Community and other resources, 1-4 times a month.

Strengths and supportive resources:

60% problem or symptom reduction sought by

-Target problem or symptom:

Planned interventions: CBT, Inquiry, Problem Solving Therapy, Community and other resources, 1-4 times a month.
60% problem or symptom reduction sought by 5/1/2020

Strengths and supportive resources:

Agencies / other providers involved in client care and type of intervention:

Pt.will be referred to other providers/other health care professionals as needed.

This treatment plan is designed to address your problems/concerns through the achieving of objective measurable goals within a specified period of time. Goals may be modified in the course of treatment as progress occurs. Treatment plan will refer to a 'Client Resources List' that will be reviewed in session. Discharge criteria may be modified as a Member's circumstances change; modifications will be documented in the Member's treatment plan.

Client Name: _____

Client signature: _____ Date: 2/24/20

Therapist: _____ Date: 2/24/20

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HISTORY / ASSESSMENT

CHIEF COMPLAINT:

HISTORY :

PREVIOUS PSYCHIATRIC HISTORY:

ALCOHOL AND SUBSTANCE ABUSE HISTORY:

DEVELOPMENTAL HISTORY:

MEDICAL HISTORY:

MENTAL STATUS:

RISK ASSESSMENT:

DSM-IV DIAGNOSIS:

AXIS I: _____
AXIS II:_____
AXIS III:_____
AXIS IV:_____
AXIS V:_____

PLAN:

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