Client's Full Name: _____ Client's MCAID #_____

DART Center LLC

Phone: 720.507.6035 E-mail: dartcenterllc@gmail.com

CLIENT INTAKE FORM

(Please Print)

Today's Date _____/_____/_____ **Therapist:** _____

CLIENT INFORMATION

Client's Last Name	First	Middle	❑ Mr. ❑ Ms.	Marital Status (Circle One) Single / Married / Other

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Race/Ethnicity	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Social Security - -	Home Phone No. ( )

P.O. Box	City	State	ZIP Code	Cell Phone No. ( )

Occupation	Employer	Work Phone No. ( )

Referred to Provider by (Please check one box & list) ❑ PCP. _____ ❑ Insurance Plan ❑ Website

❑ Family ❑ Friend ❑ Google Search ❑ Psychology Today ❑ Other _____

Email Address:	List of Medication:

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE OFFICE MANAGER)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Email Address:			Cell Phone No. ( )

Occupation	Employer	Employer Address	Work Phone No. ( )

Is this client covered by insurance? ❑ Yes ❑ No	Military Service:	YES NO

Please Select Your Primary Insurance Provider

❑ Aetna ❑ Cigna ❑ Medicaid-CCHA ❑ Medicaid-ABC ❑ Medicaid-CHP+

❑ Other _____

What is the authorization number? ❑ Self Pay

Insured's Name	Insured's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if any) Insured's Name	Group #	Policy #

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

Client's Full Name: _____ Client's MCAID #_____

DART Center LLC

CLIENT INTAKE FORM

(Continuation)

PLEASE READ THE FOLLOWING CAREFULLY

I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop(If not covered by insurance).

X _____

CLIENT/GUARDIAN SIGNATURE DATE

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

I authorize the payment of medical benefits to the provider of services.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

Client's Full Name: _____ Client's MCAID #_____

Disclosure Statement

Alex Boyko - MA, LPC (LPC. 0012196 exp. 8.31.2023)
Anna Boyko – MA, LPC (LPC.0012241 exp. 8.31.2023)

Phone: **720.507.6035**
Address: **13710 E. Rice Pl. Ste. 220 Aurora, CO 80015**
Website: **www.dartherapy.com**

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed social workers, licensed professional counselors, licensed marriage and family therapists, licensed school psychologists practicing outside the school setting, licensed or certified addiction counselors, and unlicensed individuals who practice psychotherapy.

- A Registered Psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado, but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.
- A Certified Addiction Counselor I (CAC I) must be a high school graduate or equivalent, complete required training hours and 1,000 hours of supervised experience.
- A Certified Addiction Counselor II (CAC II) must be a high school graduate or equivalent, complete the CAC I requirements, and obtain additional required training hours, 2,000 additional hours of supervised experience, and pass a national exam.
- A Certified Addiction Counselor III (CAC III) must have a bachelor's degree in behavioral health, complete CAC II requirements, and complete additional required training hours, 2,000 additional hours of supervised experience, and pass a national exam.
- A Licensed Addiction Counselor must have a clinical master's degree, meet the CAC III requirements, and pass a national exam.
- A Licensed Social Worker must hold a master's degree from a graduate school of social work and pass an examination in social work.
- A Licensed Clinical Social Worker must hold a master's or doctorate degree from a graduate school of social work, practiced as a social worker for at least two years, and pass an examination in social work.
- A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.
- A Licensed Marriage and Family Therapist must hold a master's or doctoral degree in marriage and family counseling, have at least two years post-master's or one year post-doctoral practice, and pass an exam in marriage and family therapy.
- A Licensed Professional Counselor must hold a master's or doctoral degree in professional counseling, have at least two years post-master's or one year postdoctoral practice, and pass an exam in professional counseling.
- A Licensed Psychologist must hold a doctorate degree in psychology, have one year of post-doctoral supervision, and pass an examination in psychology.

The practice of licensed or registered persons in the field of psychotherapy is regulated

Client's Full Name: _____ Client's MCAID #_____

by the Mental Health Licensing Section of the Division of Professions and Occupations. The Board of Psychotherapists can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800.

Client Rights and Important Information:

- You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy (if I can determine it), and my 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 between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Department Of Regulatory Agencies, Mental Health Section.
- 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. 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. The Mental Health Practice Act (CRS 12-43-101, et seq.) is available at: http://www.dora.state.co.us/mental-health/Statute.pdf.
- If you have any questions or would like additional information, please feel free to ask.

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. By signing this document, I voluntarily authorize and consent to mental health and/or consultative services with DART Center in accordance with the information contained within.

_____

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's Full Name: _____ Client's MCAID #_____

DART Center LLC
Phone: (303) 929-2176 E-mail: dartcenterllc@gmail.com

Financial statement

By entering into a professional psychotherapy relationship with DART Center LLC you are also entering into a financial arrangement. Payment for services rendered is the sole responsibility of the client (or responsibility party as signed below), unless otherwise agreed upon by clinician and the client(s).
Medicaid clients with active coverage will NOT be billed directly for services provided.
Unless otherwise arranged, psychotherapy sessions will be conducted face-to-face (not via phone or other media) and will last 53-60 minutes.

Cancellations of appointments/no-show
When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. It is very important that you call within 24 hours in advance to cancel your appointment.
If for any reason you need to cancel an appointment, please notify our office as a soon as possible.

After three no-show occurrences, the practice may elect to terminate our relationship with you.

Financial Information
If paid by Insurance, co-payment is required at the time of services.
Any balances unpaid more than 30 days after service may be subject a late payment fees. In the event billing efforts fail, delinquent accounts may be subject to collections.

Patient / Guardian Name: _____

Signature: _____ Date: _____

Client's Full Name: _____ Client's MCAID #_____

Dear Member,
We would like to give you some information about your services.

Services
Services are available when you need them. Most providers are open from 8am to 5pm Monday through Friday. Providers are in many locations. Many providers are available at least two days a week at some locations. If you have emergency, services are available 24 hours a day/7 days a week. Ask your provider about the hours their services are available.

Access to Care Standards
You should expect to receive services in a timely manner. If you have an emergency, you can talk to someone in person within one hour or by phone within 15 minutes. A first appointment should be scheduled within 7 working days. An urgent appointment should be scheduled within 24 hours.

Grievances and Appeals
If you are unhappy with the care you receive, you can file a grievance. A grievance is also known as a complaint. To file a complaint:
Web Site: coaccess.com/members/services/grievances/
To speak with someone directly, call grievance department at 720-744-5134

Member Appeals Process located on Colorado Access website at coaccess.com/providers/resources/um/

I have read and understand the information provided to me in this letter.

_____	_____	_____
Member Printed Name	Member Signature	Date

Client's Full Name: _____ Client's MCAID #_____

Advance Directives Acknowledgment

What is an Advance Directive?
Advance Directives are written instructions a person completes that tell medical providers what to do if they become incapacitated and can't make those decisions for themselves. For example, a person might not want to be placed on life support if they are in an accident or have a stroke or other serious medical event. Any competent adult in Colorado (age 18+) can obtain an Advance Directive.

Advance directives are acknowledged by DART Center, LLC; however, since we do not provide any life-sustaining care, we do not accept or act on any of the actual instructions about a member's future medical care in the event they become unable to speak for themselves.

Do you have any Advance Directives? ☐YES ☐NO

If so, would you like to provide a copy? ☐YES ☐NO

If not, are you interested in obtaining information regarding Advance Directives?
☐YES ☐NO

Members Signature: Date:

Witness' Signature: Date:

Signature of parent, guardian or authorized person if appropriate: Date:

Client's Full Name: _____ Client's MCAID #_____

Authorization to Release Information

Client Name_____ DOB: _____MCAID ID:_____

I hereby authorize DART Center to release my information to:

CO ACCESS
Phone: 800-511-5010; Address:11100 E Bethany Dr. Aurora, CO 80014

The purpose for the release:
- [x] Continuity of care
- [x] Benefits and Coverage
- [x] Care Coordination/Treatment
- [ ] Other_____

I authorize the following (checked) information to be released from my mental/behavioral health records:

☐ All Health records

OR

☐ History	☐ Psychosocial Assessment	☐ Medications
☐ Psychiatric Eval/Tests	☐ Psychosocial Eval/Tests	☐ Psychological Testing Results
☐ Progress Notes	☐ Physician Orders	☐ Alcohol/Drug Assessments
☐ Discharge Summary	☐ Treatment Plan	☐ Alcohol/Drug Treatment Records
☐ Group Therapy Notes	☐ Psychotherapy Notes	☐ Other (Please Specify):

_____

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon this authorization. If not previously revoked, this authorization will terminate on the following date, event or condition:_____. If no date, event or condition specified, this authorization will expire after two years from the date of my signature.

I understand that no treatment, payment, enrollment or eligibility for benefits may be conditioned on whether I sign this authorization.

The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by federal law(45 CFR Part 164).

I understand that I am entitled to a copy of this authorization.

Signature of Client or Legal Representative: _____Date:_____

Print Name of Legal Representative: _____ Relationship to Patient_____

Client's Full Name: _____ Client's MCAID #_____

DART Center Initial Service Plan

Phone: 720.507. 6035 E-mail: dartcenterllc@gmail.com

Client Name: _____

Presenting Problem	
Current Problem Severity:	☐Very High ☐High ☐Medium ☐Low Minimal
Member's Strengths/Resources to address this problem (check all that apply):	
☐Supportive Family, Friends, etc ☐Attendance to 12 Step Meetings ☐Effective Financial Management Skills ☐Maturity ☐Intelligence ☐Effective Communication Skills ☐Assertive ☐Open Minded ☐Honesty	☐Determination ☐Resiliency ☐Self-Confidence/Good Self-Esteem ☐Patience ☐Strong Religious Connection ☐Hopefulness ☐Stable Employment ☐Effective Coping Skills ☐Other (*please specify*):
Goal #1 (must be written in member's language):	
Office Use Only:	
Diagnostic Impressions:	
Objective #1a (must be concrete, measurable and written with specific functional/behavioral terms)	
Targeted Intervention #1a (specific modality, frequency and method/strategy):	
Target End Date:	

Signatures:		**Date:**
Member Signature (required)		
Clinician Signature		

Client's Full Name: _____ Client's MCAID #_____

Early Periodic Screening, Diagnostic and Treatment (EPSDT)
(For ages 20 years and under)

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children and youth ages 20 and under including adults who are pregnant, who are enrolled in Medicaid.
EPSDT is key to ensuring that children and youth receive appropriate preventive, dental, mental health, developmental and specialty services.

Early: Assessing and identifying problems early
Periodic: Checking children's health at periodic, age-appropriate intervals
Screening: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
Diagnostic: Performing diagnostic tests to follow up when a risk is identified, and
Treatment: Control, correct or ameliorate health problems found

Are you interested in obtaining information regarding EPSDT: ☐YES ☐NO

Do you need help in finding Primary Care Physician(PCP): ☐YES ☐NO

Members Signature: Date:

Signature of parent, guardian or authorized person if appropriate: Date: