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 ❑ United/Optum ❑ Medicaid-Co Access ❑ 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.

DART Center LLC

CLIENT INTAKE FORM

(Continuation)

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. _____ will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

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.

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

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. 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 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:

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 in writing.
Unless otherwise arranged, psychotherapy sessions will be conducted face-to-face (not via phone or other media) and will last 55-60 minutes. The standard fee per session is $120, and is due at the time of service. In certain cases, a reduced fee may agreed upon via a written Fee Adjustment Agreement. Sessions lasting over 60 minutes in length may be subject to additional service fees. Additionally, phone calls lasting over 15 minutes may incur charges. If a report, letter, or consultation with an outside party is requested, you may be billed for any time needed to prepare documentation or conduct an in-person or phone consultation. The standard service fee will apply.

Late Charges / No Show Charges
I understand that unplanned circumstances can occur and you may need to cancel an appointment.
To help with efficient and responsible use of time, please provide notice via phone within 24 hours of your scheduled appointment time. Any changes or cancellations received less than 24 hours in advance may be charged the standard fee. Any missed appointment with no notice given will be charged the standard service fee as agreed upon in this disclosure.

Financial Information
If paid by Insurance, co-payment is required at the time of services. If a co-payment is not paid at the time of service, the therapist does have the right to refuse care.
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: _____

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		