INTEGRATIVE PSYCHOTHERAPY
Elena Georgouses

Elena Georgouses, LCSW
Integrative Psychotherapy
PO Box 293 Vail, CO 81658
970.471.2297

New Client Form

Todays Date: _____

Name:_____ Birth Date:_____

Pronouns and Preferred Titles

Physical Address:

_____

City: _____ State: _____ Zip: _____ Phone_____

email_____

Cell: Okay to leave a message?

Emergency Contact: Relationship:

Mailing Address:

_____

City: _____ State: _____ Zip: _____

Home Phone: _____

Employer or Educational Institution:

_____

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Client Information/Disclosure

Psychotherapy can be a very effective means for learning about yourself and your relationships, healing, and making changes. This document is designed to inform you of my background and ensure you understand our professional relationship.

You are entitled to ask questions about my approach and methods. I will answer your questions about therapy and our work together. You have a right to seek other opinions and to terminate therapy at any time. Change and growth while rewarding, can be uncomfortable at times. If you have questions or concerns about this, please let me know.

I have a master's degree in social work from Loyola University, Chicago, Illinois. I am a licensed clinical social worker, Colorado license # 991654. I have been in private practice in Colorado since 1992. If you have questions about my on-going training, please inquire. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Mental Health Grievance Board. The practice of psychotherapy in Colorado is regulated by the Department of Regulatory Agencies. Concerns and/or complaints can be reported to the Grievance Board, The Board of Social Work Examiners Broadway, Suite 1370, Denver, CO 80202, (303) 894-7760. Additionally you can fill out a grievance report at their website, https://www.colorado.gov/pacific/dora/DPO_File_Complaint

CONFIDENTIALITY

Most issues discussed during psychotherapy are confidential, and written consent is required before any information can be released. However, there are specific situations in which I am legally required to release information. These instances are when abuse is suspected or reported, when a client is in danger of hurting her/himself, when an individual discussed in therapy is in danger of physical harm, or in the rare instance of a 911 emergency. If any of these exceptions occur, I will inform you before I release any information or make a report. In the case of minor adolescents, I will consult with parents in such a way as to protect the child's privacy while addressing parental concerns and familial issues if indicated.

At times I consult with colleagues about cases. In such circumstances names are not disclosed and the identity of the person is disguised. If you are not comfortable with this, please inform me. I do my very best to protect every client's privacy with the added consideration that we live in a very small community.

My bookkeeper receives payment information and payments.

Please note, email is not a secure form of communication. While you are free to email me for any reason, please exercise caution when sharing anything private in nature. I will ask for your consent before I email you anything private.

Fees

My fee is $130.00/hr. At times I can adjust my fee and offer payment plans in the event of financial challenge. The amount of your fee will be discussed at your initial session.

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Insurance
I do not accept insurance nor am I on any HMO's or PPO's. A few health insurance policies cover out-patient psychotherapy services by a licensed clinical social worker. I will provide you with a statement that will include all the information required by most insurance companies. Your claim form and statement should satisfy your insurance company's requirements. If your insurance company needs more information, I will be happy to provide it at their request with your written consent.

Appointments

Your appointment is reserved for you. I will make every effort to start and end your session on time. Sessions are generally 60-90 minutes. In some instances, it may be necessary to schedule longer sessions. Please notify me as soon as possible if you need to cancel an appointment. Since I am unable to fill a canceled or missed session on short notice, it is important that you notify me at least 24 hrs. in advance. You will be charged for any canceled appointments with less than 24 hrs notice. You will be charged for any missed appointments. You will not be charged for emergency conditions such as ill health, inclement weather, etc. You must discuss this with me to avoid charges.

Phone Calls/Emails/Texts

You may contact me between sessions for any reason. My phone is answered by confidential voice mail when I am not available. Please leave your name and a phone number where you can be reached. I will make every effort to return your call as promptly as possible. I check messages frequently during the day. Messages left after 5:00 pm or on the weekend will be returned next business day.
You may be charged for phone calls longer than 20 minutes on the quarter hour at my hourly rate.

Vacations

I will notify you and arrange for coverage when I leave town.

Emergencies

In the event of an emergency call 911.

I have read the above information and have had the opportunity to ask questions. I have received a copy of this form for my records.

_____ _____

Client, Parent, or Guardian Date

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NOTICE OF PRIVACY PRACTICES
June 2021

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.

Elena Georgouses, LCSW, acts to maintain the privacy of protected health information and provide individuals with notice of the practice's legal duties and privacy practices regarding protected health information as described in this Notice. My computers have passwords to protect our database, only the minimum necessary information is disclosed, and access of your medical information to anyone who works for me is limited to the essentials needed to perform their duties.

Provision of Notice: The practice will provide its Notice of Privacy Practices to every patient with whom it has a direct treatment relationship no later than the date of the first treatment to the client and it will be available in my office. This Notice is available via mail to any member of the public to enable prospective patients to evaluate the practice's privacy practices when making his or her decision regarding seeking treatment from the practice.

Documentation of Provision of Notice: When a client receives the Notice from the practice, the practice will request they sign their "Receipt of Notice of Privacy Practices" form. The form is filed with the patient's medical record. Should the client refuse to sign the form, it will be noted in the record that the client was given the Notice and refused to sign the form.

Effective Date and Changes to Notice: This Notice is effective January 1, 2018. The practice reserves the right to revise this notice whenever there is a material change to the uses or disclosures, the individual's rights, the covered entity's legal duties, or others privacy practices stated in the Notice. If the Notice is revised, it will be available upon request beginning on the revision's effective date. The revised Notice will be posted in the practice's reception area and made available to all patients, including those who had previously received their Notice. The patient will then be asked to acknowledge receipt of the updated Notice.

Complaints: If you believe your privacy rights are being violated, you may file a written complaint, describing the acts or omissions within 180 days of becoming aware of the violation. These letters should be addressed to Elena Georgouses, LCSW. PO Box 293 Vail, CO 81658.the practice will investigate each complaint. The client also has the right to contact,

Secretary
U.S. Department of Health & Human Services,
Office of Civil Rights
200 Independence Avenue, S.W. Washington,
D.C. 20201

The practice will not take any adverse action against any client who files a complaint against the practice.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

My office is permitted by federal law to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing services to you. It may include documenting your symptoms, diagnoses, treatment and recommendations for future care or treatment. It also includes billing documents for those services.

YOUR HEALTH INFORMATION RIGHTS

The health and billing records we maintain are the physical property of this office. The information in it belongs to you. You have the following rights:

- Request a restriction on certain disclosures of your health information (these requests may not always be granted but will be carefully reviewed).
- Request a paper copy of the current Notice of Privacy Practices for Protected Health Information
- Request to inspect and copy your health record and billing record
- Appeal a denial of access to your protected health information, except in certain circumstances
- Request that your health care record be amended to correct incomplete or incorrect information. This request may be denied if the information was not created by us, was not part of the health information kept by the office or is accurate and complete. However, if denied, you will be informed of the reason for the denial and can submit a statement of disagreement to be kept with your record.
- Request that a communication of your health information be made by alternative means or at an alternative location
- Obtain an accounting of disclosures of health information (not including disclosures made at your request or authorization, or for treatment, payment, or operations)
- Revoke authorizations that you made previously to disclose information by writing my office, except to the extent that information or action had already been taken.

If you wish to exercise any of these rights, please contact Elena Georgouses.

Responsibilities of the Therapist

My office is required to maintain the privacy of your health information as required by law. Therefore I am providing you with a Notice of duties and privacy practices regarding the information I collected and maintained about you. I will notify you if I cannot accommodate a requested restriction or request and accommodate your reasonable requests regarding communicating health information.

Uses and Disclosures Not Requiring Authorization

As required by law, disclosure of abuse of a minor, disabled person, or of someone over age 60 is mandatory. Also, a client's relative, emergency room personnel, law enforcement or paramedical personnel may have to be contacted and given information in

the event of an emergency (i.e. a threat to health or safety). I may disclose to the Food and Drug Administration (FDA) heath information related to adverse events related to medications, nutritional supplements, or other products.

Disclosure Requiring Authorization

In Colorado, specific written authorization is required to disclose or release information regarding mental health treatment (except in an emergency), alcoholism or drug abuse treatment, or AIDS (Acquired Immune Deficiency Syndrome). The federal HIPAA laws allow disclosure of necessary information required for purposes of treatment, payment, and health care operations.

_____

Acknowledgement of receipt/Signature

I acknowledge receipt of the Notice of Privacy Practices. The Notice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the therapist has reserved a right to change his or her privacy practices that are described in the Notice. I understand that a copy of any Revised Notice will be provided to me or made available upon written request.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the therapist. I also understand that I will not be able to revoke this consent in cases where the therapist has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the therapist's office.

_____ _____

Signature Date

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Fee Agreement and Office Policy

The information, guidelines, and policies set forth herein are offered so that the client will have a full understanding of office procedures, billing policy and patient payment policy. This will also set forth the fee agreement. Current rates for professional services are as follows:

OUTPATIENT PSYCHOTHERAPY AND CONSULTATIONS $130.00 per 1 hour session
Elena Georgouses' billing cycle is from the 1st through the end of each month. All clients will be sent an account statement itemizing those charges incurred during the billing cycle, plus any accumulated charges from previous month(s).

1. Clients are expected to pay for services at the time of the visit. It is considered the client's responsibility to provide all necessary billing information. The client acknowledges and agrees that it is his/her sole responsibility to pay for services rendered. Elena Georgouses doesn't do insurance billing, and therefore it is up to the client to submit their own claims.

2. Clients will be charged at regular therapy rates for appointments not canceled or canceled less than 24 hours before the scheduled appointment.

3. Monthly statements not paid in full when due will draw interest at the rate of eighteen percent (18%) ANNUAL PERCENTAGE RATE on the unpaid balance, which translates into a periodic INTEREST or FINANCE charge of one- and one-half percent (1.5%) per month. A ten-dollar ($10.00) rebilling fee will be added, at the sole discretion of the provider, to each account showing accumulated charges from the previous month. In addition, if it is necessary to initiate legal proceedings, consultation, or advice to secure payment of the patient's incurred charges, the patient agrees to pay the provider's reasonable collection / attorneys' fees and costs associated therein.

4. Client acknowledges that psychotherapy is not an exact science. Client acknowledges that no guarantees or assurances have been made to him/her, nor will any be made. Client further acknowledges that his/her obligation to pay the provider's charges is not related to the success of the treatment accorded to the patient by the therapist.

5. Joint Custody: If both parents of a minor share fiscal responsibility, one parent must sign the Agreement for Services form give their written consent for the treatment/assessment of their child.

The client, parent/guardian is responsible for payment in full regardless of insurance coverage on the account. The patient's signature below evidences his (her) approval of all terms, conditions, and policies outlined above.

_____

Signature and Date

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Credit Card Authorization

Name on Card

Account Number

Expiration Date

Security Code

Zip Code

I authorize Elena Georgouses, Vail Integrative Psychotherapy to charge my credit card for the agreed upon charges. I understand that my cc information will be saved to file for future transactions on my account.

Signature Date

Attachment Questionnaire

Please use additional paper if needed so you are not limited in your responses.

1) What was it like growing up? Who was in your family? Who lived in your household?

2) If your parents are still living, are they still together? If not how old were you when they divorced?

3) How did you get along with your parents early in your childhood? How did the relationship evolve throughout your youth to present time?

4) How did your relationship with your mother and father differ and how were they similar? Are there ways in which you try to be like or try not to be like each of your parents?

5) Did you ever feel rejected or threatened by your parents? Were there other experiences you had that felt overwhelming or traumatizing during childhood or beyond? Do any of these experiences feel alive today? Do they continue to influence your life?

6) How did your parents discipline you as a child? What impact did they have on your childhood? How did your parents impact your role as a parent?

7) Do you recall your earliest separations from your parents? What was it like? Did you ever have prolonged separations from your parents as a child?

8) Did anyone significant in your life die when you were a child? What was that like for you as a child and how does that affect you now?

9) How did your parents communicate with you when you were happy or excited? Did they join you in your enthusiasm?

10) When you were distressed or unhappy what would happen? Did your mother and father respond differently to you during these times? How?

11) To whom did you go for comfort as a child? Could you always count on that person/those people to comfort you? How did you let them know you wanted comfort or connection?

12) What did you learn about comfort from those who comforted you as child?

13) If you did not turn to another for comfort? How did you comfort yourself?

14) Did you or do you ever turn to alcohol/drugs/sex/shopping/material things for comfort?

15) Was there anyone else in your childhood who took care of you other than your parents?

16) What was the relationship like for you? What happened to this/these individual(s)? Do you let others take care of you now? What is that like for you?

17) If you had difficult times during childhood, were there positive relationships outside of your home that you could depend on during those times? How do you feel those connections benefitted you then and how might they benefit you now?

18) How have your childhood experiences influenced your relationships as an adult? Do you find yourself trying to behave in certain ways because of what happened to you as a child? Do you have patterns or behaviors you would like to alter but have trouble changing?

19) What impact do you think your childhood had on your adult life in general including the ways you relate to yourself and the ways you relate to your children? What would you like to change about the ways you relate you yourself and relate to others?

20) Are there times when you can turn to your partner for comfort? If not, please explain.

21) Have there been traumatic incidences in previous romantic relationships?