Dr. Jeff Caster
& associates

Hello and welcome to Dr. Jeff Caster and Associates!

Thank you for entrusting us with the opportunity to work with you. We want our clinic to be a place of encouragement and effective change. We realize that the investment of your time, energy and resources is valuable, and we are grateful that you have chosen us as the place to begin the process of therapy.

Our mission is to provide a comfortable, respectful, confidential, and professional environment that you can count on for the therapy services you need. We are committed to delivering these services with the utmost privacy and clinical excellence. Our clinic is a place where all are welcome and every patient is important.

We believe that ultimately, the benefit you receive from therapy is directly related to your level of comfort and connection you feel with your therapist. We are committed to helping patients receive the services they need to succeed.

Please take a moment to read the enclosed paperwork and complete the requested information. The entire therapy staff at Dr. Jeff Caster and Associates is committed to the process of helping you grow and succeed.

Please don't hesitate to contact us with any questions or concerns you may have.

Thanks,

Dr. Jeff Caster & Associates

a: 1950 W. Littleton Blvd. Littleton Station - Suite 117
Littleton, CO 80120-2023

p: 303.870.7881 **e:** hello@drjeffcaster.com
w: www.drjeffcaster.com

Dr. Jeff Caster & Associates

NEW CLIENT INFORMATION

Client/s Name: _____ Date of Birth: _____

If minor name of Parent/Guardian: _____ Parent Cell Phone: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

May we contact you and leave messages at these phone numbers? O Yes O No

Home Address: _____

City: _____ State: _____ Zip: _____

May we mail information to this address: O Yes O No

Email: _____ May we email information to you? O Yes O No

Current School Attending (if applicable): _____

CREDIT CARD INFORMATION

Name on Card: _____ Expiration Date: _____

Credit Card Number: _____ Security Code (3 Digits): _____

Billing Address: _____

City: _____ State: _____ Zip: _____

I authorize Dr. Jeff Caster & Associates to keep my credit card information on file and to charge my account for recurring charges, on-going treatment and account balances.

Signature: _____ Date: _____

ADDITIONAL PATIENT INFORMATION

How did you hear about our office? O Internet O Doctor O Other _____

Who may we thank for referring you? _____

Previous Therapy/Counseling: O Yes O No If' 'yes" with whom: _____

Primary Care Physician/Pediatrician: _____

Current Medications (Dose):_____

Emergency Contact: _____

Disclosure Statement

Dr. Jeff Caster & Associates

1950 W. Littleton Blvd ◆ Littleton, CO 80120 ◆ 303-870-7881

Welcome to our practice. This document contains important information about my professional services. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. We know it is lengthy, but we feel it is important that you fully understand the therapeutic process.

Service Provider:

Jesse Andrews

Licensed Professional Counselor

Colorado License Number: 3921

Education/Degrees:

Masters of Arts in Education

The University of Akron - 2002

Bachelor of Arts in Psychology

University of Cincinnati, 1995

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described. It varies depending on the personalities of the therapist and client, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

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 benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Regulation of Mental Health Professionals:

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The Board of Psychologist Examiners can be reached at 1560

Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. As to the regulatory requirements applicable to mental health professionals: a 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. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a master's degree 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 Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelor degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required.

Client Rights and Important Information:

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, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

Generally speaking, the information provided by and to a client during therapy sessions is legally confidential and may not disclosed without the client's consent. There are exceptions to the general rule of legal confidentiality, some of which are listed in the Colorado Revised Statutes (C.R.S. 12-43-218) as well as other exceptions in Colorado and Federal law. Examples of such exceptions include but are not limited to a client who is an imminent danger to self or others and a report or evidence of child abuse or neglect.

If you have any questions or would like additional information, please feel free to ask.

Confidentiality Statement:

All information shared in this treatment is confidential except in circumstances governed by law. If you would like us to confer with another healthcare professional, school, attorney or anyone else pertaining to the client, you will need to sign a "Release of Information" form. Both Parties agree to take all reasonable measure to ensure confidentiality with any communication over the telephone and/or internet.

Financial Agreement:

The fee for your (50 minute) sessions are $ 160. Your regular fee will be charged for any additional professional services rendered at your request, such as phone contact over 5 minutes, consults with other professionals, preparation of special forms, reports, letters, etc. will be billed at your normal hourly rate. Please provide us 5 business days to complete all paperwork requests. If we are involved in any legal endeavors on your behalf and/or are subpoenaed, there will be payment of $300.00 per hour. **Initial:** _____

Forms of Payment & Payment Policies:
This practice accepts the following forms of payment: Visa, MasterCard, American Express, and Discover. Clients will be responsible for payment at the time services are rendered.

No-Show/Late Cancellation Policy:

Your visit has been reserved for you. 24 business hours notice is required to give us ample time to fill your appointment. If you do not cancel prior to 24 business hours there will be a no show/late cancel fee of your full hourly rate per hour. **Initial:** _____

Past Due Balance:

In the event billing efforts fail, delinquent accounts may be subject to collections. This therapist will make every attempt to develop a payment plan with any client struggling to pay a past due balance prior to sending a balance to collections.

Insurance:

This practice does not directly bill through any insurance or medical plan; however, insurance-ready statements will be emailed to you at the end of each month detailing any direct payments you have made to the practice. These statements can be used to initiate the reimbursement process privately through your insurance company if you choose.

Additional Information

Emergency Services:

This practice does not provide 24 hr. emergency service. In the case of a life-threatening emergency, please call 911 or head to the nearest emergency room. Calls placed to the practice and/or to your provider will be returned by the end of the next business day.

Inclement Weather:

On bad weather days please call our phone number and we will provide a message if the office is closed. The office is open unless the message indicates it is closed for the day.

Consent for Treatment

I have read the preceding information and I voluntarily consent to receive mental health and/or consultative services (for myself and/or my dependent).

I understand my rights as a client and/or as the client's responsible party, the financial agreement, and the additional information about emergency services and clinical consultation.

_____ _____

Signature of Client or Legal Guardian **Date**

_____ _____

Signature of Therapist **Date**

RELEASE OF CONFIDENTIAL INFORMATION OR AUTHORIZATION

Client Name (Print): _____ Date of Birth: _____

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I, _____ [ ] client, [ ] parent, [ ] legal guardian do hereby request and authorize Jeff Caster & Associates, and/or their administrative and clinical staff to

[ ] provide information to [ ] obtain information from [ ] exchange information with the below specified

Organization, Agency, or Individual:

NAME:_____

ADDRESS:_____

PHONE:_____ FAX:_____

I authorize release of the following information (please mark all that apply):

[ ] Treatment Summary/Progress/ Recommendations
[ ] Verification of Attendance
[ ] Admission/Discharge Summary
[ ] Psychiatric History/Evaluation
[ ] Psychological Evaluation
[ ] Diagnosis or Diagnostic Impression
[ ] Behavioral Assessment
[ ] Medical History
[ ] Legal/Court Records
[ ] Academic Records

For the Purpose of: _____

I understand that the information to be released includes information regarding the following:
Alcohol and/or Substance Abuse/Dependency, if any
Psychological or Psychiatric Conditions, if any
AIDS-HI V Testing, if any

AUTHORIZATION: I understand and agree that this request and authorization has been made voluntarily and is in effect only for the person, organization or agency specified above. This authorization is valid only for the period of time over which services are provided by Dr. Jeff Caster & Associates but not to exceed 5 years from this date. I understand that I may revoke this authorization, in writing, at any time. There exists the potential for the information disclosed to the above named recipient to be redisclosed by that recipient, and may no longer be protected by the HIPAA Privacy Regulation.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date