Local, National & Global
TRANSFORMED HEARTS
Counseling Center

NEW CLIENT INFORMATION FORM

CLIENT INFORMATION

Today's Date ____ / ____ / ____

Client Name _____ DOB ___ / ___ / ____ (___ ___)
First Name Last Name Age

Address _____ _____ _____ _____
Street City State Zip Code

_____ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___
Email Home Telephone Number

___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___
Work Telephone Number Mobile Telephone Number

PARTNER INFORMATION

Partner Name _____ DOB ___ / ___ / ____ (___ ___)
First Name Last Name Age

Address _____ _____ _____ _____
Street City State Zip Code

_____ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___
Email Home Telephone Number

___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___
Work Telephone Number Mobile Telephone Number

REFERRED BY ❑Church ❑Family ❑Friend ❑Internet ❑Support Group ❑Other _____

RESPONSIBLE PARTY (If different)

Name _____ Relationship to Client _____

Address _____ _____ _____ _____
Street City State Zip Code

_____ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___
Email Home Telephone Number

___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___
Work Telephone Number Mobile Telephone Number

[OVER…]

POLICIES

Please read the following policies.

- **Account Changes:** Any account changes must be received in writing via email to office@transformedhearts.com or fax (719) 488-4454. Verbal notice or requests by clients, parents or spouses will not be accepted. Therapists are not responsible for relaying messages regarding billing.
- **Fees:** The fee for a 45-60-minute therapy session is $140.00. The fee for a 25-30-minute therapy session is $70.00. Group fees are $35.00 per session. If you are participating in a group, you will be given additional information. By consenting to treatment with Cory M. Schortzman, MA, LPC, SRT you acknowledge that you are responsible for the cost of the provided services (to you or to your minor child) at the time the service is rendered. Payment is expected at the beginning of each counseling session. For your convenience, we offer the use of credit cards: Visa, Mastercard and Discover. We do not accept American Express. If you select the debit/credit card method of payment, your card will be charged 24 hours prior to your session.
- **Late Fees:** If payment is not received 3 business days after your scheduled appointment, a $35.00 late fee will be assessed on the unpaid account. Failure to pay and/or update a debit/credit card on file after 5 business days will result in any unpaid balance being assessed an additional 25% late fee on the total amount due. All past due accounts will continue to accrue interest of 25% until paid.
- **Failure to Pay:** Failure to make full payment within 30 days after services are rendered will result in the account being reported to the credit bureau unless special financial arrangements have been approved in writing.
- **Cancellations:** Notification of cancellation of appointments scheduled but not attended must be made 24 hours before the appointment time. If you miss an appointment without notification 24 hours prior to your appointment, you will be charged on the credit or debit card you provide on the New Client Form or on the card provided during your initial appointment.
- **Refunds**
  Once a counseling service has been provided, no refunds will be provided for ANY reason regardless of client dissatisfaction. Transformed Hearts is not responsible for outcome.
- **Mailing List**
  By signing below, you agree to be included on our email list. If you prefer not to be included, check this box. ❑

PAYMENT METHOD

❑ Cash ❑ Check ❑ Credit Card ❑ Other _____

If you will be paying by credit card, please include the information requested below.

Credit Card Number ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___

CVC2 Code ___ ___ ___ ___ Expiration Date ___ ___ /___ ___

(The CVC2 code is a 3 or 4-digit number located on the back of your credit card.)

By signing below, I agree to all the terms listed above.

_____ _____

Client's Printed Name Client's (or Responsible Party's) Signature Date

_____ _____

Partner's Printed Name Partner's Signature Date

_____

Therapist Signature Date

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DISCLOSURE STATEMENT

Welcome to Transformed Hearts Counseling Center. I am pleased you have chosen me as your therapist. ***Please read carefully the following information in regards to ethical, legal and financial issues. If you have questions in regards to anything on this form, please discuss it with me before signing the consent.*** After you have read this disclosure statement thoroughly, please sign and date for Transformed Hearts to retain in your client file.

CREDENTIALS

Cory M. Schortzman, MA, LPC, NCC, SRT's credentials include the following:

B.A, Doane College, Crete, Nebraska, May 1997
Master's in Counseling, Denver Theological Seminary, Denver, Colorado, May 2000
Licensed Professional Counselor, Colorado LPC License #4905, February 2008
Licensed Mental Health Practitioner, Nebraska LMHP License #2424, September 2003
Licensed Independent Mental Health Practitioner, Nebraska LIMHP, License #259, December 2007
National Certified Counselor, License #62817, July 2000
Sexual Recovery Therapist, American Association of Sex Addiction Therapy, #606 February 2009
Certified Recovery Therapist, Founder & Supervisor, Sexual Addiction Recovery Association

STATE REGULATIONS

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 Licensed Professional Counselors 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:

- **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.
- **Certified Addiction Counselor I (CAC I)** must be a high school graduate, complete required training hours and 1,000 hours of supervised experience.
- **Certified Addiction Counselor II (CAC II)** must complete additional required training hours and 2,000 hours of supervised experience.
- **Certified Addiction Counselor III (CAC III)** must have a bachelor's degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience.
- **Licensed Addiction Counselor** must have a clinical master's degree and meet the CAC III requirements.
- **Licensed Social Worker** must hold a masters degree in social work.
- **Psychologist Candidate, 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.
- **Licensed Clinical Social Worker**, **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.
- **Licensed Psychologist** must hold a doctorate degree in psychology and have one year of post-doctoral supervision.

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GENERAL INFORMATION

I am committed to providing high quality services to my clients and providing them with all the information necessary to be informed regarding the treatment process. As a client, you are entitled to receive information from me about the methods of therapy, the techniques used, the duration of your therapy (if known), and the fee structure.

I accept in my private practice only clients whom I believe have the capacity to resolve their own problems with my assistance. Some clients need only a few counseling sessions to achieve their goals, whereas others may require months or even years of counseling. As a client, you are in complete control and may seek a second opinion from another therapist, and/or end our counseling relationship at any time. I, too, have the right to withdraw from your treatment if a conflict arises. In that eventuality, you will be informed and given appropriate referrals.

PROFESSIONAL RELATIONSHIP

Although our session may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a personal one. Our contact will be limited to the paid sessions you have with me. Please do not invite me to social gatherings, offer gifts, or ask me to relate to you in any way other than in the professional context of our counseling sessions. This is a requirement of the ethical guidelines for Licensed Professional Counselors and is in your best interest. You will be best served if our relationship stays professional and if our sessions concentrate exclusively on your concerns. You will learn a great deal about me as we work together during our counseling experience. However, it is important for you to remember that you are experiencing us only in our professional role. Please note that it is impossible to guarantee any specific results regarding your counseling goals, but together we will work to achieve the best possible results for you.

Colorado law requires me to inform you that in our professional relationship physical intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder. If you have a grievance against any professional, the specific agency to notify is The Board of Licensed Professional Counselors Examiners, which can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800.

If at any time for any reason you are dissatisfied with services, please let me know. If I am not able to resolve your concerns, you may report your complaints to the appropriate authorities.

CONFIDENTIALITY

Generally speaking, the information provided by you, the client, and from me, the therapist, is legally confidential, and I cannot be forced to disclose the information without your, the client's, consent. Information disclosed to me is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates. There are exceptions to the general rule of legal confidentiality, which are listed in the Colorado statues (C.R.S. 12-43-218) and Federal law. However, please be aware that provisions concerning disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in section 13-90-107 C.R.S. 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.

Exceptions to confidentiality:

1. Any evidence or disclosure by the client of perpetrating child or elderly abuse (past or present, physical or sexual abuse) must be reported to legal authorities.
2. Any evidence or disclosure by the client of downloading child pornography (past or present) must be reported to legal authorities.
3. Any evidence or disclosure by the client of any suspected threat to national security to federal officials.
4. If an individual intends to take harmful, dangerous or criminal actions against another human being or against him/herself, it is my duty to report such action or intent to medical and legal authorities. In the unlikely event, it is my clinical judgment that you are a danger to yourself or someone else, by signing the consent, you authorize me to contact either the persons listed as your emergency contacts, or someone else to provide assistance through this crisis situation. This would include, at our discretion, contacting an intended victim. By law, your consent is not necessary.

[Continued…]

5. Sexual improprieties by a former therapist are a criminal offense and must be reported.
6. Certain court orders/actions, such as custody cases, malpractice actions, etc., may legally require disclosure of certain material covered in our sessions.
7. Collection of fees may require disclosure that you have been in a counseling process.
8. Consultation and supervision with other professionals to aid in your treatment process.
9. Insurance companies: If you desire to file insurance on your own, you must know that I usually will be required to document your diagnosis and treatment. This may include personal information that you would not want employers to know. I cannot guarantee your confidentiality or that this will not have adverse effects on you personally.

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- **Insurance:** Some insurance companies may cover part of your fees. You will need to determine the reimbursement policies of your insurance company. **Transformed Hearts does NOT file insurance claims.** If you desire to file for insurance reimbursement, **a statement will be provided to you** for all sessions that are paid in full. It is important to remember that if you choose to utilize your insurance, the issues of confidentiality explained previously will need to be considered.

  I understand in marriage counseling sessions, a 3-day, 5-day or 10-day intensive, the marriage is the client. All individual times are collateral sessions intended to facilitate the understanding of the marriage. **Therefore, no insurance can be billed for individual therapy sessions** since the marriage is the client. Any future individual time with Cory M. Schortzman is also understood to be collateral to the marriage and is not considered individual counseling or therapy.

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LEGAL

In the unlikely event of time spent on legal correspondence, record requests, or time away from the office due to court appearances resulting from legal issues, additional hourly fees will be assessed and payable prior to receipt. My fee is $300.00 per hour with a minimum of one hour. If travel is required, the fee begins from the time I leave my office until I return to my office.

If you are involved in a divorce or custody litigation, you need to understand that my role as a therapist is not to make recommendations for the court concerning custody, parenting issues, or to testify in court concerning opinions on issues involved in the litigation. By signing this disclosure statement, you agree not to call me as a witness in any such litigation or subpoena for summons or records. Experience has shown that testimony by therapists in domestic cases causes damage to the clinical relationship between a therapist and client. Only court-appointed experts, investigators or evaluators can make recommendations to the court on disputed issues concerning parental responsibilities and parenting plans.

I understand notes may be taken during the course of therapy and ongoing treatment. Written notes are not intended to be, nor are they part of, a "medical" record. They are intended solely for therapist use, to assist in determining the course of therapy. There is no presumption that any third party reading such notes would, in any way, be able to interpret or infer anything whatsoever about the client's mental health state or treatment. Notes will be properly destroyed when they are no longer appropriate for treatment. If you complete a *Release of Information Form* to request information to be released or transmitted to another mental health professional in written form, a summary can be provided for a fee. I am not required to comply with any request for counseling notes. You will not have a right to review or appeal any such denial.

I understand that no material is required for therapy or ongoing treatment. If I elect to purchase any materials I do so without influence or coercion from Cory M. Schortzman or anyone employed by Transformed Hearts Counseling Center.

If an ongoing therapeutic relationship is established, it is expected a face-to-face visit would occur. By signing this, I accept full responsibility for future face-to-face visits. Also, I understand no recording of sessions is ever permitted and is illegal in most cases without consent. I acknowledge I am not recording, in any manner, my sessions with Cory M. Schortzman, MA, LPC, SRT.

By signing below you agree that you have read and understood the preceding information, which has also been provided verbally. You understand your rights as a client or as the client's responsible party and are consenting to treatment with Transformed Hearts Counseling Center, Inc., Cory M. Schortzman, MA, LPC, SRT. The signed copy of this document will become part of your file at Transformed Hearts. If you have any questions, please address them during our initial session.

_____	_____
Client's Printed Name	Client's (or Responsible Party's) Signature Date
_____	_____
Partner's Printed Name	Partner's Signature Date
_____	
Therapist Signature Date	