TEOCALLI TREATMENT OPTIONS, LLC

123 W. Tomichi Ave., Suite 6, Gunnison, CO 81230

Heather C. Peterson, MA, LAC

CLIENT INFORMATION

Name: _____ Sex: M/F Age: ____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____ Years at position: ____

Home phone _____ok to leave message? Y/N

Work phone _____ok to leave message? Y/N

Cell phone _____ok to leave message? Y/N

In case of an emergency, contact _____ Relationship to you _____
Phone number_____

Relationship Status: (circle one)
Single Committed Relationship Married Separated Divorced Widowed

Education: (Circle highest level completed)
GED High School Vocational School Bachelors Masters Doctorate

Do you have children? No/Yes, How many? _____
If yes, what are their names and ages
_____
_____

Please circle if you have ever had a problem with the following:

Memory Special Education classes Poor attention span Hyperactivity Stealing

Depressed for several days at a time Loss of interest Irritability

Suicidal thoughts Suicide plan Attempted suicide (how many times? _____)

Periods of excessive energy Excessive spending spree Financial

Heard or seen things that no one else could hear/see Too much / too little sleep

Trouble with persons in authority Excessive Anger Hurting animals

Experienced child abuse or sexual abuse Witnessed/victim of domestic violence

Sudden panic, nervousness, or strong fear for no particular reason

Family relationships Distress about the loss of a loved one, job, separation, etc.

Work relationships Marital conflict Unemployment Worthlessness

Anxious, tense, or worried about things for several days at a time off and on for months

Appetite Change Unintentional weight gain/loss Feeling slowed down

Headaches Fatigue / loss of energy Illness Disability Restlessness

When did these symptoms start?

_____

_____

_____

Previous mental health or substance use treatment:

Name of Provider/Agency: Dates of treatment:

_____ _____

_____ _____

_____ _____

Current / Ongoing medical issues?

_____

Current medications (include all names & doses):

_____

_____

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Exercise regimen: Y/N Days per week: ____ Type of exercise: _____
Caffeine intake per day: _____
Regular sleep schedule: Y/N Hours per night: ____ Sleep Disturbances: Y/N

Please circle if you have ever had a problem with the following:
Alcohol Illegal drugs Prescription medication Legal Trouble

Please identify any family history of substance abuse/dependence or mental health issues:_____
_____

Please fill out the table below regarding your substance use:

SUBSTANCE	HOW MUCH?	HOW OFTEN?	HOW LONG?	FIRST USE	LAST USE

Have you ever felt like you should cut down on your drinking/use? YES/NO
Have you ever felt annoyed by people criticizing your drinking/use? YES/NO
Have you ever felt bad or guilty about your drinking/use? YES/NO
Have you ever had a drink or use drugs in the morning to steady your nerves or get rid of a hangover? YES/NO
Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember? YES/NO
How many drinks does it take to make you feel "buzzed" or "high?" _____

Last use of prescription medication (type and date)?

_____
_____

Have you ever tried to cut down or quit your use of alcohol/illegal drugs/prescription pain meds? Y/N How many times? _____

Have you ever experienced any withdrawals symptoms? Y/N How many times? _____

For which substance(s)? _____
_____
_____

Reason(s) for seeking treatment at this time?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Desired outcome of treatment: _____
_____
_____

What changes are in interested in making?

_____
_____
_____
_____

Thank you, please return this to your counselor.

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BILLING FORM

Responsible Party:

If you are the parent or legal guardian of a client/patient who is under the age of 18, or if you are a third party agreeing to pay for services, please complete the following with your information. If you are over the age of 18, please continue to the next section.

Name of Parent/Legal Guardian: _____

Date of Birth: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Employer/Employer Address: _____

Form of Payment:

Please indicate the form of payment you wish to use for any services rendered through Teocalli Treatment Options, LLC. PayPal and all major credit cards are accepted, as well as cash and personal checks. Applicable fees will be deducted from the designated account at the time services are rendered. This information will be securely stored in your clinical file and may be updated upon request at any time.

Payment Type: Credit/Debit Card: _____ PayPal: _____ Cash: _____ Check: _____

Account Holder Information:

Account Holder Name: _____

Account Holder Address: _____

Card Type: Visa MasterCard Discover American Express PayPal Account

Card Number: _____ Expiration Date: _____

I certify the information provided above is accurate to the best of my knowledge. I authorize any service fees to be deducted from the form of payment designated on this form. Should any of the information provided change, I agree to update Teocalli Treatment Options, LLC as soon as possible.

_____ _____

Signature of Client or Legal Guardian **Date**

(970)641-3711 Heather@TeocalliTreatmentOptions.com www.TeocalliTreatmentOptions.com

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FINANCIAL AGREEMENT

The following policies are provided for our mutual understanding and agreement. These policies protect both the client and therapist from any misunderstanding and/or false expectations. If you have questions or concerns about these policies, please discuss them with me before signing the contract.

Standard Service Fees:

_____ Initial Consultation, 30 minutes: FREE

_____ Substance Abuse/Mental Health Diagnostic Intake Assessment: $150

_____ Substance Abuse/Mental Health Diagnostic Assessment with Report: $175

_____ Individual Adult/Adolescent Counseling, 50 minutes: $100

_____ Couples/Families Counseling, 60 minutes: $125

_____ Case Management & Consultation, 15 minute increments: $25

DUI/DWAI Service Fees:

_____ Initial Consultation, 30 minutes: FREE

_____ Level I Education, 12 hours (two, 6hr sessions): $180

_____ Level II DUI/DWAI Diagnostic Intake Assessment: $75

_____ Level II Education, 2hr group session: $30

_____ Level II Therapy, 2hr group session: $30

_____ Interlock Enhancement Counseling, 2hr group session: $30

_____ Interlock Enhancement Counseling, 30 minute individual session: $30

_____ Level II DUI/DWAI Diagnostic Assessment with Report: $100

Skype, Phone, and Email Policies:

Sometimes meeting in person is not possible and we need to communicate in other ways. Skype and phone sessions are scheduled the same way that an in-person session would be and the fee is the same. (Excluding Diagnostic Assessments, which must be conducted in-person.)

If you are interested in communicating with your therapist between sessions, over the phone or by email, you will be billed in 15 minute increments for this Consultation. Short emails regarding scheduling will not be charged but if you would like me to read a longer email and respond as I would in a therapy session, you will be charged based on the time spent to do so.

You may call my confidential voicemail at (970) 641-3711 and leave a message or you may email me at Heather@TeocalliTreatmentOptions.com. I try my best to return messages within 24hrs during the business week, unless otherwise communicated. **I do not provide 24-hour phone or email coverage. Contact 911 if you need emergency services.**

Discount Rates:

If you are currently receiving a rate reduction, which has been previously arranged by your therapist, please enter this rate here: _____. This corresponds to a _____% discount.
Initials: _____

Forms of Payment & Payment Policies:

Teocalli Treatment Options, LLC accepts cash, check, PayPal, and all major credit cards (Visa, MasterCard, American Express, Discover) as methods of payment.

Payment is due at the time of each appointment. Please have your cash or pre-written check ready prior to the beginning of each session. If you pay by cash or check, a receipt will be provided. A $25 administrative fee will be charged on all checks that are returned for non-sufficient funds.

You may pay via PayPal on my website at: www.TeocalliTreatmentOptions.com by clicking on the "Make a Payment" button. An email confirmation of your payment and the amount paid will be sent to both parties.

Cancellations:

In the event you need to cancel an appointment, please provide notice within 24 hours of your scheduled appointment time. If sufficient notice of a cancellation is not provided, or no notice is given at all, your service fee as agreed upon in this disclosure will be assessed for that session.
Initials: _____

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Insurance:

Many insurance plans reimburse for some portion of psychotherapy. Please direct questions about reimbursement amounts and timeliness to your insurance company. Teocalli Treatment Options, LLC is not contracted (in network, preferred provider) with any insurer. I will provide you with a receipt for the counseling service at your appointment that may be used to submit for reimbursements if you choose. Please note that Teocalli Treatment Options, LLC does not complete any insurance paperwork.

By signing below, I am indicating that I have read, understood, and agree to abide by the terms and conditions set forth in this contract.

_____ _____

Person responsible for payment (Client or Parent/Guardian (if applicable)) Date

_____ _____

Heather C. Peterson, MA, LAC Teocalli Treatment Options, LLC Date