A.V.O.S Counseling Center & Training Institute, LLC

8795 Ralston Rd. Suite 200A • Arvada, CO 80002 • (716) 260-5443

Client Information

Date:

Name:

Address:

City State Zip code Client date of birth: / /

Contact Information

Please know that email and texting are not HIPPA protected forms of communication.
I will make every reasonable attempt to maintain confidentiality.

Client phone number: ( ) Cell Phone: ☐ Yes ☐ No

I give Kimberly Davis permission to text me: ☐ Yes ☐ No (Initial)

Email Address:

I give Kimberly Davis Permission to email me: ☐ Yes ☐ No (Initial)

Emergency Contact Information

In case of Emergency, I give Kimberly Davis permission to contact:

Name:

Relationship: Phone number: ( )

Does this person know you are in therapy? ☐ Yes ☐ No

Client Intake Form

Are you currently taking any medications? ☐ Yes ☐ No If so, please list below:

Have you ever been on psychotropic medications in the past? ☐ Yes ☐ No

If so, please list below:

What is the primary reason you are seeking therapy?

Are there important cultural considerations surrounding your race, ethnicity, sexual orientation, gender identity, age, gender, sex, ability, religious affiliation or other cultural factors that you think are important for me to know or that may impact your healing?

Why did you choose to work with A.V.O.S. Counseling?

Client Signature *Date*

A.V.O.S Counseling Center & Training Institute, LLC

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Clinician Name:	Kimberly Davis, MA
Degrees, Credentials, Licenses:	M.A. Clinical Mental Health Counseling; Transpersonal Art Therapy
Business Address:	8795 Ralston Rd. Suite 200A. Arvada, CO. 80002
Business Phone:	716-260-5443

Kimberly Davis is a Registered Psychotherapist in the state of Colorado working towards her license. She earned her Master of Arts in Clinical Mental Health Counseling: Transpersonal Art Therapy from Naropa University in 2017. Her internship was with Children's Hospital Colorado in which she completed 1000 hours of therapy. She conducted individual sessions with children and adolescents in the psychiatric unit for various mental/emotional disorders including depression, anxiety, trauma, eating disorders, substance use, suicide attempts, self-harm as well as working in the medical unit with children and adolescents with physical illness and disease. She also led and co-facilitated multi-family counseling groups with parents and children. Prior to her internship she worked with Family Hospice, counseling those experiencing immanent death as well as grief and loss for family members.

She also holds a certificate of completion in Traditional Native American Self-Healing techniques received from the Spiritual Advisor to the Six Nations of Western New York and Ontario, Canada.

She has over 10 years experience as a qigong practitioner and recently received a scholarship for further training.

She is actively working toward her license to practice psychotherapy in the state of Colorado. She is registered with the Department of Regulatory Agencies as a Psychotherapist No. NLC.0108115.

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Kimberly's direct clinical supervisor is Erica Bonham, LPC, License number 0011279

A.V.O.S. Counseling Center and Training Institute; 8795 Ralston Rd. suite 200A; (303) 880-7793

Kim's Therapeutic Approach

My approach to the therapy process recognizes each individual's unique culture and way of life. My education and clinical experiences have given me the opportunity to grasp a whole body perspective on the impact of trauma and how symptoms have the ability to manifest mentally, emotionally and physically. I draw from both traditional and non-traditional therapeutic models to make the process as meaningful and individualized as possible. As a trauma-informed, mind-body, strength-based counselor, my primary focus is on post traumatic growth and resiliency development. I utilize a combination of modalities including art therapy, meditation and qigong.

Art therapy is a mental health profession in which clients use art media, the creative process, and the resulting artwork to explore their feelings, reconcile emotional conflicts, foster self-awareness, manage impulsive behavior, develop social skills, improve reality orientation, reduce anxiety and increase self-esteem.

I also share my intensive training in Native American self- healing techniques and qigong for each session as I see fit. I have spent 15 years cultivating various self-healing meditations that I personally practice and received from the Spiritual Advisor to the Six Nations. I am also a practitioner of Taoist and Buddhist Qigong for over 10 years. Qigong is an ancient form of movement and breath work that stems from the science of Energy Medicine as understood through the complexity of Traditional Chinese Medicine. The purpose of both meditation and qigong is to cultivate and harmonize our innate and vital life force energy. Simple movements, in combination with breath, aid in shifting mental and emotional perspectives as well as provide insight into resolving body sensations.

Through this collaborative process, I aim to create a safe, empathic environment in which we can gain self-awareness and seek out solutions that are going to work for you.

If, for any reason, you feel that my approach is not a good fit for you, please let me know and I can collaborate with you to find a more appropriate counselor. You should feel empowered, safe, comfortable and informed with your counselor and I am honored to be a part of your process in any way that I can.

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The practice of both licensed and unlicensed persons in the field of psychotherapy is regulated by the Department of Regulatory Agencies, Mental Health Section. Questions and complaints may be addressed to:

Department of Regulatory Agencies, Mental Health Section
1560 Broadway, Room 1350
Denver, Colorado 80202
(303) 894-7800

Client Rights

• You are entitled to receive information about the methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure.

• You may seek a second opinion from another therapist or may terminate therapy at any time.

• In a professional relationship, sexual intimacy is never appropriate and is illegal in Colorado. It should be reported to the Department Of Regulatory Agencies, Mental Health Section.

• The information provided by you during therapy is legally confidential except as required by law.

• If you participate in group therapy, it is necessary for you to agree to protect and respect the privacy of other group members. You need to agree not to share personal information, including the names of other group members, with people outside of the group. You may expect other group members to show the same respect for your confidentiality.

Confidentiality

I understand that my records and information will be held in confidence according to the policy of the Network as defined by the Division of Mental Health pursuant to Colorado Revised Statutes (CRS 27-10-101 et.seq. & Standard CF.1 et.seq.) and the Division of Alcohol and Drug Abuse pursuant to code of Federal Regulations (42 C.F.R. Part 2). Everything that we talk about in counseling is confidential and private. There are exceptions to the

rule of confidentiality that require me to break confidentiality. These exceptions include a "threat of serious harm to yourself or others" as in the case of child abuse, elder abuse, suicide, grave disability, or serious plans to harm or kill someone else. If, for any reason, I am under a court order; or in response to any legal action taken by you against this agency, I will also be required to break confidentiality.

Destruction of Records

I understand that the clinical records from this treatment episode may be destroyed if no further treatment is rendered within ten years of the date of termination of this episode (or ten years from the date client reaches age eighteen, if client is a minor).

As a client, you have the following rights:

- You have the right to revoke this consent at any time.
- To receive treatment only if you or your legal guardian gives permission in writing.
- To be treated with respect and recognition of your need for dignity.
- To receive services based on your individual needs, in a setting which supports your individual freedoms.
- To actively participate with your provider in creating a plan for your care. To include other people you think would be helpful to you in creating your care plan.
- To confidentiality, and to expect that none of the information about your treatment will be given to anyone without your permission except as required by law.
- To request a change in the person or persons providing your care.
- To refuse treatment unless you are court ordered to receive services and to be informed of the consequence of your refusal.
- To have your family members involved in your care, at your request. To be represented by your guardian in the case that you are unable to full participate in your treatment decisions.
- To inspect your records, or have them shown to anyone designated by you in writing. If you are denied access to records, to know why and how to appeal.
- To receive written notification and request a second opinion if you disagree with your provider's decision to reduce or discontinue your services, or deny you inpatient services.
- To receive written information about BHI's services, providers and clinical guidelines.
- To not be discriminated against due to race or ethnicity, sex, age, disability, sexual orientation, gender identity, genetic information, source of payment or any other reason.
- To be informed of the rights in a way you understand.
- To complain about my services at any time without retaliation.
- To receive assistance from a consumer representative in making a complaint and to receive copies of the complaint/grievance procedure.

Treatment Agreement

I have voluntarily requested services from A.V.O.S. Counseling and agree to pay fees on time and at every session. If I cannot make my appointment, I will give 24 hours advanced notice, or I will be responsible for the full cost of the session. If it is an emergency, I will let Kimberly Davis know as soon as possible. I understand that the fee for the session are due at the time of service.

I fully understand that I have the right and opportunity to file a complaint if I choose to do so. Further, I fully understand that by exercising that right and proceeding with filing a complaint, that any and all information contained in the complaint, in any related written documents or in oral communications, or revealed in any follow-up investigations, may be shared without any limitation or restriction with staff of Behavioral Healthcare, Inc. (BHI) and with staff of Division of Mental Health of the State of Colorado (DMH), for purposes of BHI and State reporting, monitoring, and quality improvement activities. All information contained in the complaint, related written documents, oral communications, or follow-up will remain confidential with BHI and DMH, and will not be shared with other parties without the written consent of the consumer or complainant.

I have been informed of my counselor's degrees, credentials and licenses. I have also read and received a copy of the information on both sides of this page. I understand my rights as a client. I hereby acknowledge that I have been provided a copy of the Notice of Privacy Rights.

Client Name (please print)

Client Signature *Date*

Clinician's Signature *Date*

Policy Statement

I am honored you have chosen to work with me for therapy. I always want to be open with you and for you to feel free to ask any questions. This policy statement will give some basic information about what to expect from our professional relationship. Please read thoroughly and remember that you have the right to terminate therapy at any time, seek a second opinion, receive information about my methods of therapy, techniques I use, fee structure, and duration if I can determine it.

Confidentiality

I understand and respect your need for privacy. To prevent any unauthorized disclosure of any kind, all private communications in therapy will remain private except as required by law and discussed more fully in my disclosure statement. Some exceptions to confidentiality include when one is considered to be a danger to self or another or in the case of child or elder physical, sexual or emotional abuse or neglect. I will identify these exceptions should the situation arise during treatment or in our professional relationship. In the event information about your care is discussed with another person supervising the treatment, the supervisor will abide by the same confidentiality agreement. Different guidelines apply to couples, family, and adolescent therapy. Please inquire if you have questions. You will also be required to sign a HIPAA policy statement. By signing this policy statement, you understand that if you send a text or an email this presumes that this form of communication cannot be guaranteed to be confidential and you are releasing Kimberly Davis from any unintentional liability this may incur. I will have due diligence to keep all of your information confidential.

Fees

Full payment for each session is expected after the therapy session unless other arrangements have been previously arranged. The cost for a 50 minute session is $90. I do not accept insurance. Therapy fees and treatment are based on a clinical hour so that I may review my notes and/or assessment on your behalf. Any paperwork including letters, treatment plans, speaking with outside parties or phone calls over 10 minutes are pro-rated at $1.50 per minute. Payment will be made using an app called IVY; after our initial consultation, you will receive instructions on how to set it up via text message.

When you terminate therapy, you will need to make arrangements to pay off the bill, should there be one. Please be aware that if you do not pay for three months, according to our plan, I may turn you over to a collection agency or seek collection with a civil court action. Should this occur, I will provide the collection agency or Court with your Name, Address, Phone Number, and any other directory information, including dates of service or any other information requested by the collection agency or Court deemed necessary to collect the past due account. You will be charged 18% interest per year on your unpaid balance and any other appropriate fees such as collections or attorney's fees, should you default on your account. This often amounts to more than 50% of the original account. If your check bounces, an additional $35.00 fee will be applied to your account. I cannot allow your balance to exceed $200. If you have questions about your situation, please feel free to ask.

Late or Cancelled Appointments

Please understand that if I reserve a time slot, I am taking away that slot from other clients. Please give AT LEAST 24 hours notice of your scheduled appointment or you will be charged the full amount for your session. Emergency situations will certainly be considered. I will wait 10 minutes if you are late, unless you call to tell me you are on the way. If you are more than 10 minutes late, I may not be able to see you for the full scheduled appointment. If that situation arises, you will still be billed the full fee for the session. In the event of inclement weather, I will do everything in my power to make it to the office. If I am able to come in, I expect that you will also be able to make your appointment. I also offer internet-based therapy as an alternative in case of illness.

Termination

Should you discontinue therapy for more than 60 days, your treatment will be considered "terminated", unless other arrangements have been made in writing. You may resume therapy at anytime. However, you may be required to sign another disclosure statement and policy statement and/or provide additional information to update your client records. You should also know that I may not have availability and that fees may increase. Terminating therapy can also be a great celebration of the progress and work that you have done. I recommend having at least one termination session to have good closure, to practice saying healthy goodbyes and to celebrate all of the victories you have had in therapy.

Telephone Consultations

To be more available to you, we can set up phone or internet sessions through Zoom. These are conversations that last for more than 10 minutes and will be billed at your regular fee based on the quarter hour.

Court Appearances

On occasion I am requested to appear in court on behalf of my clients. The fee for this service is based on an hourly rate of $90 per hour and includes, but is not limited to testimony, case research, report writing, depositions, actual testimony, cross examination time, courtroom time, and other necessary preparation. Travel time is charged at half of your regular fee.

Document Writing

Writing of reports and other documents are charged at $1.50 per minute.

Telephone Calls and Emergencies

I have a voice messaging system and check it frequently. Occasionally, there are unavoidable delays in returning your call due to the nature of my work and hours, however, I will strive to return calls as soon as possible during normal business hours. If I am out of town, I will have another provider on call for emergencies only. Remember, if you need to, you can always call 911 for immediate help. I will try and return all calls within 24 hours of the next business day. Should you need emergency care, please review my disclosure statement.

Email List and Blog

Please note that as a new client of *A.V.O.S Counseling Center,* your email will automatically be added to our email list. This can be a way for you to have resources while not in therapy and stay abreast of any changes or

updates here at A.V.O.S. You can unsubscribe at any time. You may also chose to join our Facebook group for daily inspirations and resources.

Philosophy of Therapy

Working on your mental well-being may be the most important project you can undertake. I believe it takes time and focus to make the best use of the opportunity. Although therapy can be challenging at times, its rewards are great and worth the time, effort and money that you expend.

Please understand that therapy is a voluntary process and can produce changes in your life, some unexpected. However, no guarantee of results is possible, since you, the client, are in charge of your well-being and life choices. My goal is to help you. I am willing to work as quickly or slowly as you like. Please let me know if you require a change of pace.

Please reach out and ask any questions regarding my therapeutic style, our process or any other concerns. We are a team! Let's get to work!

I have read and understand this statement of policy and agree to all contents. If I am under the age of fifteen, my parent and/or legal guardian is signing this policy statement on my behalf.

Client Signature	*Date*
Parent and/or Legal Guardian Signature (required if minor client)	*Date*
Kimberly Davis, MA	*Date*

Consent for Release of Confidential Information

Please fill this form and include any family members, previous therapists, your primary care physician and/or anyone else you would like me to speak with about your case. If this does not apply to you, you may leave this form blank.

Date: _____

Client Name(s): _____

Address: _____

Phone number: ( ) _____

I, _____ , ( ) client, ( ) parent, ( ) guardian, hereby authorize

Kimberly Davis, MA to release or exchange information concerning my psychological or medical history/treatment.

Authorization is granted to:

Person/Agency _____

Phone ( ) _____ Fax ( ) _____

Address _____

City _____ State _____ Zip _____

I authorize the release of the following information:

- ☐ Psychological or psychiatric evaluation
- ☐ Psycho-diagnostic assessment results (testing)
- ☐ Treatment plan/summary
- ☐ Social History
- ☐ Medical history and information
- ☐ As needed for treatment
- ☐ For scheduling only
- ☐ For Financial Purposes Only
- ☐ Other (specify)

I understand that I may withdraw this authorization in writing at any time.

Signature of Client/Parent/Guardian

Please Print Name

Date:

A copy of this release shall be as valid as the original.