(Pages 1 & 2 are for Colorado residence only)

DEGREE: MASTERS IN COUNSELING PSYCHOLOGY, Naropa University 2008-2011
Title: Breakup Specialist and Medical Medium

About Counseling: You will receive the best care possible when working with me. As your counselor I will support you with practical and spiritual insights that will help you move forward with ease and grace.

Fee Agreement:
Rebekah Freedom LLC is a direct pay practice and does not accept insurance.
Therapy Rights:
The therapeutic relationship is about providing prospective and affirming your life as unique and meaningful. 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.
Therapeutic Relationship:
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. Further, dual relationships are also unethical. Please inquire if you have any questions.
Confidentiality:
Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. If third parties request information, in most cases, it cannot be given without your written consent.
When communicating across digital media such as phone, internet, Skype or social media confidentiality cannot be guaranteed. You are participating in these forms of communication at your own risk and are agreeing to not hold Rebekah Freedom LLC liable for compromised information.
There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes, **and the HIPAA Notice of Privacy Rights which are provided on my website** as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report suspected child abuse to authorities. 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 are:

- Harm to self
- Harm to a child or elder
- Homicidal intent
- Serious and foreseeable harm
- Limits applied to minors under the age of consent

Cancellation Policy:
I require 24 hour notice for session cancellations. If you cancel within the 24 hour period before your scheduled session, payment is required for the missed session**. If you don't pay your bill Karma will hunt you down and eat you alive.** Defaulting on payment can result in additional charges and being perused by a collection agency.

It is suggested to pay your fee at the time of treatment or buy a prepaid package.
I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the client's responsible party.

Agreement

I have read this information fully and completely. I understand there are no guarantees stated or implied. I have familiarized myself with the fees and charges for services provided by Rebekah K McClaskey M.A. as the counselor at Rebekah Freedom LLC, and I consent to the consultation, group, and/or therapy process.

_____ date_____
Print Name

_____date_____
Signature

_____date_____
Therapist/Witness

_____date _____
Client's or Responsible Party's Signature Date
If signed by Responsible Party, please state relationship to client and authority to consent:_____

Contact Information:

Phone Number_____Email_____

Address_____Date of Birth_____

Emergency Contact Phone Number:_____Emergency Contact:_____

Rebekah Freedom LLC
Rebekah McClaskey, MA
Informed Consent to Treatment

Agreements

1. I will be given a clear description from Rebekah McClaskey regarding the problems, diagnosis, personal strengths/limitations and treatment interventions proposed.

2. ALL PURCHASES ARE NON-REFUNDABLE. Terms and conditions are subject to change. See the website for details.

3. I will be given a clear recommendation for the types of treatment recommended, such as individual counseling/therapy, group, counseling/therapy, family/couples counseling/therapy, addictions counseling, and/or psychiatric services. Times, dates, and session length will be discussed with Rebekah McClaskey.
4. I voluntarily agree to undergo mental health treatment and understand that I may end treatment at any time. I understand that Rebekah McClaskey may want to discuss this with me, but that I reserve the right to stop treatment. Furthermore, I understand that Rebekah McClaskey may make diagnostic and treatment recommendations with which I do not agree (e.g. modality of treatment, duration of treatment, frequency of visits, etc.).
5. I understand that Rebekah McClaskey cannot guarantee results (e.g., less depressed, improved marital satisfaction, etc.) of mental health services. However, there will be clearly stated reasons, goals, and objectives for continuing/discontinuing mental health treatment. This will be discussed with Rebekah McClaskey.
6. I understand that there may be some risks in participating in mental health services. These may include, but are not limited to, addressing painful emotional experiences and/or feelings; being challenged or confronted on a particular issue; re-uniting with family members; or being inconvenienced due to costs/fees of counseling. I am aware that I can discuss any unforeseen risks vs. benefits with my Rebekah McClaskey at any time.
7. I understand that I have the right to an interpreter (sign or language) if necessary.
8. I understand that in the case of an emergency, I am to dial 911 or go to my nearest emergency room.
9. I understand that if I have a grievance with Rebekah McClaskey, I will first attempt to communicate this directly to her.
10. I understand that this "Informed Consent/Limits of Confidentiality Form" is not intended to be "all inclusive" of aspects of my mental health treatment. It is only intended to provide some useful information before deciding to engage in mental health treatment.
11. I have read over the Hippa limits of privacy form and agree to the terms.
12. I understand that Rebekah McClaskey may use her **clairvoyant gifts** as part of treatment. I understand entire sessions can take a spiritual and metaphysical undertone, and that I am still responsible for my actions. If I am not comfortable with this I will state as such and seek a different course of treatment.

<u>Limits of Confidentiality</u>

I. The information that you share with Rebekah McClaskey is considered to be confidential. In most cases, information cannot be released to another party without your written consent. However, in certain circumstances, information can be shared legally without your permission. These circumstances include:

1. Suicide: if you are assessed to be a danger to yourself; cannot guarantee your physical safety against the intention of suicide; and/or have immediate suicidal plans, this information is not considered to be "confidential". Actions may be taken to ensure your safety.
2. Homicide: if you are assessed to be a danger to others; cannot guarantee their safety; and have immediate, specific plans to cause fatal injury/harm to another person, this information is not considered to be "confidential". Actions may be taken to protect the safety of others. The police may be notified of your intentions as well as the intended victim.
3. Court order/subpoena: Rebekah McClaskey can be required to relinquish a copy of your written Mental Health Record to the appropriate Courts. Rebekah McClaskey can also be subpoenaed to testify in court without your consent.

4. Child abuse/neglect: Colorado Law requires your Rebekah McClaskey to report to the appropriate authorities (i.e. Child Protective Services) any suspicion or evidence of child abuse or neglect. This law also applies to past incidents of abuse or neglect.
5. Elder abuse/neglect: Colorado Law requires Rebekah McClaskey to report to the appropriate authorities any suspicion or evidence of elder abuse/neglect.
6. Laws regarding minors in mental health services: certain information may be shared with parent/legal guardians at the discretion of Rebekah McClaskey.

II. Mental Health confidential information may also be used within Rebekah Freedom LLC without your written permission for coordinating services and delivering quality care. You may be informed if this is the case. This may include:

1. Consultations and case conference with Supervisor Karen Drucker , Psy D: Licensed Psychologist, License #2625, Boulder Colorado 80301.

III. Company Values
Rebekah Freedom LLC is centered on balance, healing, and growth. Simply, it is the intention of Rebekah Freedom LLC to discuss and agree upon what strategies will be employed to create balance. The relationship between client and therapist will be one that fosters curiosity, confidence, honest interchange, and transformation.
IV. Other Notes on Your Privacy & Billing/Fee Information:
1. Video and audio taping: occasionally, Rebekah McClaskey will want to make an audio/video recording of your sessions. Your written permission in required. YOU HAVE THE RIGHT TO REFUSE THIS.
2. Generally, you will be contacted by phone or mail. Internet email is discouraged unless discussed with your therapist. PLEASE NOTE: PRIVACY AND CONFIDENTIALITY OVER THE INTERNET CANNOT BE GUARANTEED.
3. I have made arrangements with my insurance provider prior to this appointment and understand my insurance benefits as it pertains to receiving counseling. I understand that Rebekah McClaskey does not accept insurance or bill third parties directly. I understand that a diagnosis will have to been given for insurance reimbursement.
4. I understand that it is the policy of Rebekah Freedom LLC to charge the full cost of the session in the event that I do not call to cancel an appointment with 24 hours notice. I understand that fees be paid at the time of service rendered. I understand that in the event that I do not receive a regular invoice of payment from Rebekah Freedom LLC, I am still responsible for the charges incurred. Receipts must be requested at the time of transaction.
5. I understand that in the event spousal parties, estranged partners, or any third-party individuals contact Rebekah McClaskey, all information will be held under the confidentiality agreement unless authorization has been given through Release of Information Form. Further, if communications from third-parties are harassing or threatening towards Rebekah McClaskey she reserves the right to contact the police and make a formal report. I am aware that the course of therapy may be altered by such events in unforeseeable ways that can at any time be discussed with Rebekah McClaskey.
6. If you live outside of Colorado the services provided may be therapeutic but are not intended as therapy; rather as coaching, mentorship or guidance. This intake packet must be **consented to over email with a digital signature.**

I have reviewed this "Informed Consent to Treatment/Limits of Confidentiality" information with Rebekah McClaskey.
I have been given the opportunity to ask questions about this information. A copy of this information is available upon request.
By signing this, I indicate my understanding of this information.

Client Signature _____Date_____Phone#_____

Rebekah McClaskey LLC
CONFIDENTIAL INTAKE FORM

Name: _____ Age:_____
Date of Birth:_____
Gender: Male Female Transgender
Home Address: _____
Mailing Address if different than Home:_____
Email Address:_____ May I email you Yes No
May I follow up with you between sessions? YES NO
Best Contact Phone number: _____
Emergency Contact Name _____ Relationship _____ Phone_____

PROBLEM ANALYSIS:

Briefly describe the problem you most wish help with right now:

In what ways have you attempted to cope with this problem?

We will work together towards your specific outcome. Do you understand that you must commit to at least 1 month of sessions before individual sessions become an option?
Yes
No
What?

How motivated are you to resolve this problem?
Not at all
A little Somewhat
Moderately Extremely
Why have you decided that now is the time in your life to take action to resolve this problem?

How hopeful are you that this problem can be resolved?
Not at all
A little Somewhat
Moderately Extremely
List your strengths and qualities you admire about yourself:
When our work together has been successful, what differences will you notice in yourself?

SOCIOCULTURAL BACKGROUND:

Racial/Ethnic Background:
White/Caucasian African-American Black African Asian-American Asian or Pacific Islander
Hispanic-American Latino/Latin American/Hispanic
Arab-/Middle Eastern-American Arab/Middle
Eastern
Native American/Alaskan Native Multiracial / Other
Specify:_____
Religious preference: _____ Are your currently active in your religion?
Yes Somewhat No
Are you comfortable with and consenting to receive psychic reading from or intuitive information from Rebekah during your sessions?
Yes No IDK
Please list your top three goals for treatment as well as why you have chosen to work with Rebekah.
_____
_____
_____
_____
_____

ACADEMIC/ WORK BACKGROUND:

Place of employment: _____
Hours worked per Week: _____ Years with employer: _____
Position: _____
Are you satisfied with your job? Yes No I Don't Know

Highest Educational Degree: _____
Major: _____
Are you a student? Y N **If yes, where are you studying: _____**

RELATIONAL/ SUPPORT HISTORY:

Please indicate your current relationship status:
Single; In a Committed Relationship; Living with Partner; Married; Separated; Divorced; Widowed
Other: _____
Approximately how many significant romantic relationships have you had? _____
If you are in a romantic relationship, how long have you been in this relationship? _____
Are you satisfied with your current romantic relationship?
Yes No I Don't Know
Do you feel supported by your partner/spouse? Yes No I Don't Know
How would you rate the quality of your friendships?
Very Poor Unsatisfactory About Average Good Excellent
Besides family, how many people can you count on right now for friendship/emotional support? ____

FAMILY BACKGROUND:

Please list the members of your family their occupations and their ages (e.g. father, M, Lawyer, 42; sister, F, teacher 29; son, M, student,12; partner, M, doctor, 35):
Family Members

How much conflict do you currently experience with your family? (Whether living with you or not)
Very little or none Some Moderate Strong Extreme
Who in your family do you currently feel closest to? _____
Most distant from? _____ In most conflict with? _____
PHYSICAL HEALTH:
How is your physical health at present?
Poor Unsatisfactory
Satisfactory
Good
Very good
When was your last physical examination? _____
Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):
Do you have a disability ? No Yes **Specify**
_____
Are you presently taking any prescribed medication ?

Yes No

Please list all medications, the reason for which each is prescribed, name of prescribing physician (ie. Paxil/ social anxiety/Dr. Joseph):

_____

_____

Name of your primary care physician:

_____

Are you having any problems with your sleep habits? No Yes
Are you having any difficulty with appetite or eating habits? No Yes
Have you had a significant weight change in the last 2 months? No Yes
Do you have any problems or worries about sexual functioning?
No
Yes
How many times per week do you exercise? _____ For how long each time? _____

MENTAL HEALTH HISTORY:

Have you ever been a victim of: *(if you do not feel comfortable completing this section, simply leave it blank or write prefer to discuss)*
Emotional abuse as a child Physical abuse as a child Sexual molestation/abuse as a child
Emotional abuse by a partner/spouse Physical abuse/assault by a partner/spouse
Sexual abuse/assault as an adult Other Trauma. **Specify**:_____

Have you received counseling elsewhere before? Yes No

If yes, where: _____
When: _____
Duration: _____
What was the focus of previous counseling?

_____

Are you currently seeing a psychiatrist or have you seen a psychiatrist in that past? Yes No
If yes, where: _____
When: _____
Duration: _____
What was the focus of the psychiatric treatment?

_____ _____

Ire you EVER prescribed psychiatric medications? Yes No
What medications and for what reason?

_____

How often are you having suicidal thoughts presently?
Frequently
Sometimes
Rarely
Never

How often have you had suicidal thoughts in the past?

Frequently
Sometimes
Rarely
Never
When: _____
How often are you having thoughts of harming others presently?
Frequently
Sometimes
Rarely
Never
How often have you had thoughts of harming others in the past?
Frequently
Sometimes
Rarely
Never
When: _____
Have you ever intentionally inflicted any harm upon yourself?
Yes
No
Unsure
When: _____
Have you ever attempted suicide? Yes No
Date(s)

_____
Have you ever been hospitalized for psychological reasons?
Yes
No
Date(s) _____

ALCOHOL AND OTHER DRUG USE:

How often do you drink alcohol?
Daily 3 or more times per Week
1-2 times per Week
Weekly
Monthly
Less than monthly Never
In a typical Week, on how many days do you have 4 or more drinks? _____
How often do you use other drugs (marijuana, cocaine, ecstasy, oxycotin, etc)?
Daily
3 or more times per Week
1-2 times per Week
Weekly
Monthly
Less than monthly Never
Do you or does someone else think that you may need to cut down or stop using other drugs?
Yes
No
Maybe

SIGNATURE:

I verify that the above information is accurate to the best of my knowledge.

_____

Client Name
Client Signature
Date

Accessed January 29, 2009, Google: Intake Form; **www.LifeSkillsResourceGroup.com**
cfabico@LifeSkillsResourceGroup.com

Transform Now Counseling

Closure Statement

Thank you for allowing me to be part of your journey towards health and well-being. We will work together in a variety of ways to achieve your goals as well as bring greater awareness to your circumstances. The duration of time we spend together is depends on a few factors:

1. The goals you have for therapy
2. Environmental influences
3. A good fit

You have the right to end therapy at any time, but I ask that you do so in this manner:

1. Notify me that you suspect our work together is done. No reason needs to be given on why that is the case unless you feel it necessary.
2. Set an appointment for a final session.
3. If you would like to continue your work with a new therapist you are welcome to ask for referrals.

In bringing our work to a close, if any of your hopes were not attended to or you have any complaints feel free to share them in the final session.

Never make your home in a place. Make a home for yourself inside your own head. You'll find what you need to furnish it - memory, friends you can trust, love of learning, and other such things. That way it will go with you wherever you journey.
Tad Williams

Name________________________________Date__________________________________