

**Knippenberg, Patterson, Langley & Associates**  
Group, Family and Individual Counseling

Specializing in Child & Adolescent Neurobehavioral Disorders

2650 S. Eudora St.  
Denver, CO 80222

Dear Client:

We would like to take this opportunity to thank you for choosing our practice for the treatment needs of your family. Our goal is to provide client-centered services to you and your family with the highest professional standards. It is of great importance to us that our clients are truly appreciated and valued throughout their treatment process. If at any time during the treatment process you have any questions or concerns, we urge you to address these promptly with your therapist. We also welcome your feedback personally as we continue to strive to provide the highest level of care.

Our practice is designed to run efficiently and economically to meet the needs of our clients. If you have any questions regarding our fee structure or policies, please do not hesitate to ask your therapist or any of us. These policies are designed to give the most flexibility possible to our clients.

It is our sincere hope that you will benefit greatly from our services and experience growth for yourself and/or your family.

Sincerely,

Craig A. Knippenberg, LCSW, M.Div.  
Lisa M. Patterson, MA, LPC  
Jimmy Langley, PsyD

Craig A. Knippenberg, LCSW, M.Div., P.C.  
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**Client Information Form**

Start Date \_\_\_\_\_ Client DOB \_\_\_\_\_  
Client First \_\_\_\_\_ Last \_\_\_\_\_  
Address \_\_\_\_\_  
Suite/Apt. \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Home Phone \_\_\_\_\_ Mobile/Cell \_\_\_\_\_  
Work Phone \_\_\_\_\_ Email \_\_\_\_\_

**For Office Use Only**  
Therapist \_\_\_\_\_  
CPT \_\_\_\_\_  
Diag Code \_\_\_\_\_  
Session Length \_\_\_\_\_  
Fee \_\_\_\_\_

**Parent/Guardian Information (if client is a minor):**

First _____ Last _____	First _____ Last _____
Address _____	Address _____
Suite/Apt. _____	Suite/Apt. _____
City _____ St _____ ZIP _____	City _____ St _____ ZIP _____
Home _____ Cell _____	Home _____ Cell _____
Work _____ Relation to Client: _____	Work _____ Relation to Client: _____
Email _____	Email _____
Check if Financially Responsible for Payment <input type="checkbox"/>	Check if Financially Responsible for Payment <input type="checkbox"/>

**Please list all current household members and their ages:**

**Household Members**

Age					
-----	--	--	--	--	--

**Party to notify in case of an emergency:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation to Client: \_\_\_\_\_

**Referral Information (Please list all known information for us to send our thanks):**

Name: \_\_\_\_\_ Referral Source: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ St \_\_\_\_\_ ZIP \_\_\_\_\_

\*\*\* Would you like a diagnosis listed on your billing statement:  Yes  No

\*\*\* As a fee-for-service private practice, we do not bill insurance companies for our treatment services.

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**CREDENTIALS**

Please indicate therapist & obtain appropriate signatures

\_\_\_ **Craig A. Knippenberg, LCSW, M.Div.**

- Master's Degree in Clinical Social Work: University of Denver
- Master's Degree of Divinity with Focus in Pastoral Counseling: Iliff School of Theology
- Licensed Clinical Social Worker

\_\_\_ **Lisa M. Patterson, MA, LPC**

- Master's Degree in Clinical Counseling: University of Colorado
- Master Teacher: Jefferson County Public Schools
- Licensed Professional Counselor

\_\_\_ **Jimmy Langley, Psy.D.**

- Master's Degree in Clinical Psychology: University of Denver
- Doctorate in Clinical Psychology: University of Denver
- Licensed Psychologist

\_\_\_ **Alec Baker, Psy.D.**

- Master's Degree in Clinical Psychology:  
University of Denver
- Doctorate in Clinical Psychology: University of Denver
- Licensed Psychologist

\_\_\_ **Ryan Long, MA, LPC**

- Bachelor's Degree in Business Management:  
Metropolitan State University of Denver
- Master's Degree in Counseling:  
University of Colorado Denver
- Licensed Professional Counselor
- Candidate for License in Marriage and Family Therapy

\_\_\_ **Julie Miller, MA, LMFTC**

- Bachelor's Degree in English:  
Gustavus Adolphus College
- Master's Degree in Couple and Family Therapy:  
University of Colorado
- Candidate for License in Marriage and Family Therapy

\_\_\_ **Rachel Moses, MA, LPC**

- Bachelor's Degree in Communications:  
Truman State University
- Master's Degree in Counseling:  
Colorado Christian University

\_\_\_ **Michelle De Nooy, LCSW**

- Bachelor's Degree in Psychology: Calvin College
- Master's Degree in Clinical Social Work:  
University of Denver
- Licensed Social Worker

\_\_\_ **Timothy Pasternak, Psy D.**

- Masters Degree in Clinical Psychology:  
University of Denver
- Doctorate in Clinical Psychology  
University of Denver

\_\_\_ **Angie Rothkamp, MA, LPC**

- Bachelor's Degree in Psychology:  
St. Cloud State University, Minnesota
- Master's Degree in Counseling Psychology:  
Loyola University, Chicago
- Licensed Professional Counselor

\_\_\_ **Cindy Souser, LMFT**

- Bachelor's Degree in Music Education:  
University of Colorado Boulder
- Master's Degree in Marriage and Family Therapy:  
Argosy University
- Licensed Marriage and Family Therapist;  
Licensed Teacher

\_\_\_ **Mike Villarreal, MA, LPC**

- Bachelor's Degree in Business Administration:  
Regis University
- Master's Degree in Clinical Mental Health:  
Adams State University
- Licensed Professional Counselor

**Student Associate/Other Name:** \_\_\_\_\_

**Credentials & Current Status:** \_\_\_\_\_

**I have been informed of the degrees, credentials, and licenses of my therapist.**

\_\_\_\_\_  
**Client's Name (Please Print)**

\_\_\_\_\_  
**Client's Signature or Guardian's Signature**

\_\_\_\_\_  
**Date**

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**DISCLOSURE STATEMENT AND FINANCIAL AGREEMENT**

Colorado law requires that the following information be provided to all clients.

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 \_\_\_\_\_ 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 masters 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 masters 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 1,000 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's 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 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.

A separate addendum to this disclosure, which identifies your therapist's degrees, credentials and licenses, will be provided to you.

You are entitled to receive information about your therapist's methods of therapy, techniques used, the duration of therapy (if known), and fee structure. You may seek a second opinion from another therapist or terminate this 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 the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado revised statutes, as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly.

You should know that Craig A. Knippenberg, LCSW, and/or \_\_\_\_\_ will provide your therapist with \_\_\_\_\_ supervision or \_\_\_\_\_ consultation. As such, information regarding your case will be available to him/her. Information regarding your case will also be provided to other staff members of Knippenberg, Patterson and Associates for administrative and/or clinical care coordination purposes.

**Mailing:**

2650 S. Eudora St. Denver, CO 80222  
Voice Messaging: 303-756-4924  
Fax: 303-758-3515

**Clinical:**

12325W. Bowles Ave. Littleton, CO 80127  
2650 S. Eudora St. Denver, CO 80222  
9094 E. Mineral Ave. #100, Centennial, CO 80112

[www.craigknippenberg.com](http://www.craigknippenberg.com)

You will be billed at the time services are rendered. Any balance not paid after thirty days will be assessed a service charge at the rate of 1.5% per month. In the event our billing efforts fail, we will send delinquent accounts to a collection agency, with instructions to follow their usual course of action. By signing this agreement you are agreeing to this procedure.

Sessions are generally 45 to 50 minutes, for individual/family sessions and 90 to 150 (in summer) minutes for group sessions. This time is reserved for you. Missed appointments with less than 24-hour notice will be charged at the therapy session rate.

Telephone calls will be returned as promptly as possible. If your call is an emergency, please state this when you are calling. Telephone consultations lasting more than 10 minutes will be charged at therapy session rate.

Our standard and customary fees are \$175.00 per individual/family session; \$85.00 per 90-minute group session; and \$125.00 per 150-minute group session. Fees for other services and out of office procedures may vary. I understand that the fee for my service is \$\_\_\_\_\_ per \_\_\_\_\_\*

I/We will receive counseling beginning \_\_\_\_\_.

I understand that payment is due at the time of service unless other arrangements have been made.

SpecialArrangements: \_\_\_\_\_

Any person who alleges that a mental professional has violated the licensing laws related to the maintenance of records of a client eighteen years of age or older, must file a complaint or other notice with the licensing board within seven years after the person discovered or reasonably should have discovered this. Pursuant to law, this practice will maintain records for a period of seven years commencing on the date of termination of services or on the date of last contact with the client, whichever is later. When the client is a child, the records will be retained for a period of seven years commencing either upon the last day of treatment or when the child reaches eighteen years of age, whichever comes later, but in no event shall records be kept for more than twelve years.

I have been informed of my therapist's degrees, credentials and licenses. I have also read the preceding information and I understand my rights as a client or as the client's responsible party. I agree that I am financially responsible for all services received. In the event I am seeking services for a child, I also hereby attest that I have the authority to consent for such services for said child.

\_\_\_\_\_  
Responsible Party (Printed Name)      Date

\_\_\_\_\_  
Therapist

\_\_\_\_\_  
Responsible Party (Signature)      Date

\_\_\_\_\_  
Credentials

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Licensure

\_\_\_\_\_  
Address

\_\_\_\_\_  
Supervisor

Contact Numbers:

\_\_\_\_\_  
Home

\_\_\_\_\_  
Work

\_\_\_\_\_  
Cell

\*Rates may periodically be subject to change

## ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the card you wish to use for all services rendered through this practice. Charges for services rendered will be deducted from the card designated below at the time services are rendered. We accept: Visa, MC and Discover.

### Client Information:

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Number: \_\_\_\_\_ Mobile Number: \_\_\_\_\_ SSN: \_\_\_\_\_

Email: \_\_\_\_\_

### Billing Information:

Please indicate the information associated with the debit card you wish to use.  I prefer to use a credit card.

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

I authorize all service fees to be deducted from the card ending in \_\_\_\_\_ (last four digits of the card)

Please enter the CVV code \_\_\_\_\_ (last three digits on back of card)

I authorize the use of this card for all services and fees at the time they are rendered for the following parties:

Full Name(s) \_\_\_\_\_

I understand that this form authorizes my provider to charge this card for varying session types, across multiple dates of service. \*By authorizing use of this card, and signing this electronic payment authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.

\_\_\_\_\_  
**Cardholder Signature**

\_\_\_\_\_  
**Date**

Payments are processed by Therapy Partner.  
Therapy Partner is a registered ISO/MSP of Fifth Third Bank, Cincinnati, OH and HSBC Bank USA National Association, Buffalo, NY.

**Debit Card Information:**  I prefer to use a credit card.

Please provide your payment information below. The card information you provide on this form will be destroyed once your information has been securely encrypted and stored.

Card (circle one):    Visa    MasterCard    Discover

Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

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**AUTHORIZATION TO RELEASE/RETRIEVE MENTAL HEALTH INFORMATION**

I hereby consent to Craig A. Knippenberg, LCSW, M.Div., P.C. & Knippenberg, Patterson, Langley & Associates, including the therapist listed below, to Release information to the following parties. This includes written and verbal transfer of history, mental health, and treatment information, for the purposes of consultation and coordination with relevant professionals.

These Individuals Are As Follows:

Name	Address	Phone Number
_____	_____	_____
_____	_____	_____

I hereby consent to Craig A. Knippenberg, LCSW, M.Div., P.C. & Knippenberg, Patterson, Langley & Associates, including the therapist listed below, to Retrieve information from the following parties. This includes written and verbal transfer of history, mental health, and treatment information, for the purposes of consultation and coordination with relevant professionals.

These Individuals Are As Follows:

Name	Address	Phone Number
_____	_____	_____
_____	_____	_____

**AUTHORIZATION:** I certify that this release has been made voluntarily. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it.

**THIS authorization should be valid for:**

- \_\_\_\_\_ 12 Months from the date of my signature;
- \_\_\_\_\_ Months from the date of my signature ; Or
- \_\_\_\_\_ Until thirty (30) days after the termination of treatment with Craig A. Knippenberg, LCSW, M.Div., P.C. (& Knippenberg, Patterson, Langley & Associates), including the therapist listed below.

A facsimile or copy of this release shall be treated as an original.

\_\_\_\_\_  
Client's Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client/Parent/Guardian Signature

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Therapist's Signature & Credentials