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

office: 303.756.4924 web: www.craigknippenberg.com fax: 303.758.3515

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** _____

Address _____

Suite/Apt. _____

City _____ **St** _____ **ZIP** _____

Home _____ **Cell** _____

Work _____ **Relation to Client:** _____

Email _____

Check if Financially Responsible for Payment ☐

First _____ **Last** _____

Address _____

Suite/Apt. _____

City _____ **St** _____ **ZIP** _____

Home _____ **Cell** _____

Work _____ **Relation to Client:** _____

Email _____

Check if Financially Responsible for Payment ☐

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.***

www.craigknippenberg.com

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

___Alec Baker, PsyD
- Master's Degree in Clinical Psychology: University of Denver
- Doctorate in Clinical Psychology: University of Denver
- Licensed Psychologist

___Ryan Long, MA, LPC
- Master's Degree in Counseling: University of Colorado Denver
- Licensed Professional Counselor
- Candidate for License in Marriage and Family Therapy

___Julie Miller, MA, LMFTC
- Master's Degree in Couple and Family Therapy: University of Colorado
- Candidate for License in Marriage and Family Therapy

___Rachel Moses, MA, LPC
- Master's Degree in Counseling: Colorado Christian University
- Licensed Professional Counselor

___Michelle De Nooy, LCSW
- Master's Degree in Clinical Social Work: University of Denver
- Licensed Clinical Social Worker

___Timothy Pasternak, PsyD
- Masters Degree in Clinical Psychology: University of Denver
- Doctorate in Clinical Psychology University of Denver

___Angie Rothkamp, MA, LPC
- Master's Degree in Counseling Psychology: Loyola University, Chicago
- Licensed Professional Counselor

___Cindy Souser, LMFT
- Master's Degree in Marriage and Family Therapy: Argosy University
- Licensed Marriage and Family Therapist
- Licensed Teacher

___Mike Villarreal, MA, LPC
- 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

Craig A. Knippenberg, LCSW, M.Div., P.C.
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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

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: _____

Craig A. Knippenberg, LCSW, M.Div., P.C.

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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