STEFANIE RACCUGLIA
EMBODIED HEALING

910 Santa Fe Dr. Unit 11, Denver, CO 80204
720-626-0274, stefanie@stefanieraccuglia.com

I am thrilled to be exploring our future work together and feeling the excitement of helping you see and be the magnificence of who you already are! This document is a quick overview of my practice policies that may help answer some more of your logistical questions about our work together! Please feel free to ask any/all questions you may have via email, phone, or in our initial consultation!

Quick Guide to Policies

Electronic Health Records

I use a HIPPA compliant cloud-based service called *TherapyNotes* to store all of your Protected Health Information (PHI) including (but not limited to) treatment plan, diagnosis, progress notes, and paperwork. Once we have scheduled our first appointment, you will receive an email invitation to create a login to the Client Portal- here you will download, upload, and electronically sign all documents.

Scheduling

Generally, we will schedule appointments at the end of sessions if we do not have standing appointments. Otherwise, you are welcome to email me at stefanie@stefanieraccuglia.com to schedule an appointment. I cannot guarantee availability within the same week you request.

Cancellations

If you need to cancel or reschedule an appointment, please give notice within 48 hours. If I do not receive at least 48hrs notice, you will be automatically charged for the full session rate.

Rescheduling

If you wish to reschedule your appointment within the same week, as mentioned you must give at least 48 hrs notice. I cannot guarantee openings for rescheduling. If I do not receive notice by 48 hrs, and we cannot reschedule to a time (either in-person or teletherapy) within the same business week, it is considered a cancellation and you will be responsible for paying the full session fee.

Lateness

If you are more than 15 minutes late to your appointment **AND** you have not been in communication with me via phone, text or email; your appointment will be considered cancelled. I will not be available should you arrive after the 15 minute mark, and it will be considered a cancellation. If you are running late, please let me know. I will not contact you to remind you of your appointment. Session rates will not be adjusted due to lateness.

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Missed appointments

If you do not attend your appointment at all without any communication this will be considered a "No Call/ No Show" (NCNS). Our work together will be terminated after one NCNS. Emergencies and extenuating circumstances should be communicated as promptly as possible.

Generally speaking, I understand that things come up that may be outside of your control including illnesses and other emergencies. Please value your own therapeutic work and time and be in as much communication as you can/need to be.

Phone and Email Communication

Email Security

I do use a secure and encrypted email service to make sure your electronic communications are protected as best as possible. This is not a flawless system, so please be mindful of what you are communicating and documenting electronically. You will be required to sign a consent to electronic communications.

Communication in between sessions

If you need or would like to be in communication with me in between sessions, that is very welcome. Please know that for emails and phone calls that go beyond 15 minutes, I will charge a prorated fee based on the amount of time spent on the call or email. I will do my best to respond within 72 hours to your email/call.

Emergencies should not be communicated in this way. If you are experiencing an emergency you should first call 911 or visit your nearest emergency room or mental health crisis walk-in center. I do not provide emergency services, and I am not available 24/7.

Investment

Individual sessions

50- minute session costs $150
(Session length may range from 50-55 minutes depending on individual client needs that day)
90- Minute session $270

Packages- save 20%
Buy 10- 50 minute sessions for $1200 ($120 per session)
Buy 10- 90 minute sessions for $2160 ($216 per session)
*Packages must be purchased at time of first session

Family Therapy

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75 minutes- $225

Please note that rates are subject to change over time, and I will notify you at least 3 weeks in advance before implementing the new change.

Direct Payment

Payment will be collected at the end of each session (unless you are using a package)
I accept cash, check, or credit card*

*I use a HIPAA compliant secure service called IVY Pay- before our first session you will receive a text message with a link to enter your information. You will not have to enter this information again unless your credit card information has changed or your card has been declined. I will charge your card at the end of each session.

Insurance

I accept the following insurances:

- Cigna
- Medicaid- CO Access only.

It is your responsibility to be aware of your copays, and I will confirm before our first session. I will bill the insurance companies directly, and you will be responsible for a direct payment of your co-pay (if applicable) at time of session.

If you have another insurance provider, you will have to communicate with them about reimbursement. I am happy to provide a super bill at your request.

Social Media

I **do not accept friend or contact requests** from current or former clients on social networking sites such as Facebook or LinkedIn.

I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and my respective privacy. It is important to me to maintain clear professional boundaries which, ultimately, support the important work we are doing in session.

You are welcome and encouraged to follow my business page, Stefanie Raccuglia PC on any social media site!

If you choose to put complaints/ reviews/ testimonials on social media/google/ LinkedIn, you are welcome to do so, but please know that I cannot and will not respond in protection of your confidentiality.

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Disclosure Statement and Policies

This is a lengthy document and contains specific requirements as outlined by the State of Colorado. Please read carefully, and never hesitate to ask me any questions about this, or any other document!

Practice Information

Stefanie Raccuglia PC ("SR") is located at:
910 Santa Fe Dr. Unit 11, Denver, CO 80204
720-626-0274, stefanie@stefanieraccuglia.com
Website: stefanieraccuglia.com

*The mental health professional located at SR is Stefanie Raccuglia, LPC, R-DMT:

Stefanie Raccuglia obtained her Master of Arts in Somatic Counseling Psychology with a Dual Concentration in Dance/Movement Therapy and Body Psychotherapy from Naropa University in 2016. Stefanie Raccuglia is a Licensed Professional Counselor in the State of Colorado, License No. 14919. Stefanie Raccuglia is a Registered Dance/ Movement Therapist through the American Dance Therapy Association.

Stefanie Raccuglia, LPC seeks supervision as needed from:

Brie Anderson Feldman, LPC, BC-DMT
709 Kimbark St.
Longmont, CO 80501
720-289-2835
Licensed Professional Counselor, Board Certified Dance/Movement Therapist

Regulation of Mental Health Professionals in Colorado

The Colorado Department of Regulatory Agencies ("DORA"), Division of Professions and Occupations ("DOPO") has the general responsibility of regulating the practice of Licensed Psychologists, Licensed Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified and Licensed Addiction Counselors, and registered individuals who practice psychotherapy. The agency within DORA that specifically has responsibility is the Mental Health Section, 1560 Broadway, Suite #1350, Denver, CO 80202, (303) 894-2291 or (303) 894-7800; DORA_MentalHealthBoard@state.co.us. The State Board of Licensed Professional Counselor Examiners regulates Licensed Professional Counselors, and can be reached at the address listed above. Clients are encouraged, but not required, to resolve any grievances through SR's internal process.

You, as a client, may revoke your consent to treatment or the release or disclosure of confidential information at any time in writing and given to your therapist.

Levels of Psychotherapy Regulation in Colorado include Licensing (requires minimum education, experience, and examination qualifications), Certification (requires minimum training, experience, and for certain levels, examination qualifications). All levels of regulation require passing a jurisprudence take-home examination.

910 Santa Fe Dr. Unit 11, Denver, CO 80204
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A licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a masters degree in his or her profession and have two years of post-masters supervision.

Everyone fifteen (15) years and older must sign this disclosure statement. A parent or legal guardian with the authority to consent to mental health services for a minor child/ren in their custody must sign this disclosure statement on behalf of their minor child under the age of fifteen (15) years old.

This disclosure statement contains the policies and procedures of SR and is HIPAA compliant. No medical or psychotherapeutic information, or any other information related to your privacy, will be revealed without your permission unless mandated by Colorado law and Federal regulations (42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164).

Client Rights and Important Information

As a client you are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy (if I can determine it) and my fee structure. Please ask if you would like to receive this information.

Fees:

a. My fee structure, services, and fee policy are outlined as follows:

Standard Individual sessions
50- minute session costs $150
(Session length may range from 50-55 minutes depending on individual client needs that session)
90- Minute session $270

Family Therapy
75 minutes- $225

Please note that rates are subject to change over time, and I will notify you at least 3 weeks in advance before implementing the new change. I will occasionally offer packages or specials.

b. It is the policy of my practice to collect all fees at the time of service, unless predetermined and agreed upon arrangements are made.
c. Therapy fees and treatment are based on a 50-55 minute clinical hour instead of a 60 minute clock hour so that I may review my notes and assessments on your behalf.
d. I am a Medicaid provider. If you have Medicaid- Colorado Access coverage that includes mental health services, I am able to offer mental health services to you.
e. I have limited spaces for reduced fee sessions and am a provider through the Open Path Collective, a membership-based service for clients seeking affordable counseling. Should you select me as an Open Path therapist, you will be required to pay fees associated with their service, in addition to your session cost to me. Additional paperwork will be provided.
f. I accept private insurance of: **Cigna**

910 Santa Fe Dr. Unit 11, Denver, CO 80204
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g. To collect fees through a Credit Card, I use "IVY Pay", a HIPPA Compliant credit card processor.
h. Legal Services incurred on your behalf are charged at a higher rate including but not limited to: attorney fees I may incur in preparing for or complying with the requested legal services, testimony related matters like case research, report writing, travel, depositions, actual testimony, cross examination time, and courtroom waiting time. The higher fee is $375.00 per hour.

In addition, I request that you fill out a "Credit Card Authorization" form to keep in my file, in addition to the information required for the credit card processing service. All accounts that are not paid within thirty (30) days from the date of service shall be considered past due. If your account is past due, please be advised that I may be obligated to turn past due accounts over to a collection agency or seek collection with a civil court action.

By signing this document, you agree that I may seek payment for your unpaid bill(s) with the assistance of a collections agency. 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. I will not disclose more information than necessary to collect the past due account. I will notify you of my intention to turn your account over to a collection agency or the Court by sending such notice to your last known address.

Restrictions on Uses:
You are entitled to request restrictions on certain uses and disclosures of protected health information as provided by 45 CFR 164.522(a), however SR is not required to agree to a restriction request. Please review SR's Notice of Privacy Policies for more information.

Second Opinion and Termination:
You are entitled to seek a second opinion from another therapist or terminate therapy at any time.

Sexual Intimacy:
In a professional relationship (such as psychotherapy), sexual intimacy between a psychotherapist and a client is never appropriate. If sexual intimacy occurs it should be reported to DORA at (303) 894-2291, Mental Health Section, 1560 Broadway, Suite 1350, Denver, Colorado 80202; State Board of Licensed Professional Counselor Examiners.

Confidentiality:
Generally speaking, the information provided by and to a client during therapy sessions is legally confidential. Therefore, SR cannot be forced to disclose the information without the client's consent or in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

There are exceptions to this general rule of legal confidentiality. These exceptions are listed in the Colorado statutes, C.R.S. §12-43-218. You should be aware that provisions concerning disclosure of confidential communications does not apply to any delinquency or criminal proceedings, except as provided in C.R.S § 13-90-107. There are additional exceptions that I will identify to you as the situations arise during treatment or in our professional relationship.

Examples of situations that will require me to break confidentiality:
- I am required to report child abuse or neglect situations
- I am required to report the abuse or exploitation of an at-risk adult or elder or the imminent risk of abuse or exploitation

910 Santa Fe Dr. Unit 11, Denver, CO 80204
720-626-0274, stefanie@stefanieraccuglia.com

- If I determine that you are a danger to yourself or others, including those identifiable by their association with a specific location or entity, I am required to disclose such information to the appropriate authorities or to warn the party, location, or entity you have threatened
- If you become gravely disabled, I am required to report this to the appropriate authorities.
- I may also disclose confidential information in the course of supervision or consultation in accordance with my policies and procedures,
- In the investigation of a complaint or civil suit filed against me
- If I am ordered by a court of competent jurisdiction to disclose such information.
- You should also be aware that if you should communicate any information involving a threat to yourself or to others, I may be required to take immediate action to protect you or others from harm.

In addition, there may be other exceptions to confidentiality as provided by HIPAA regulations and other Federal and/or Colorado laws and regulations that may apply.

Although confidentiality extends to communications by text, email, telephone, and/or other electronic means, I cannot guarantee that those communications will be kept confidential and/or that a third-party may not access our communications. Even though I utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by a third-party.

Please review and fill out SR's Consent for Communication of Protected Health Information by Unsecure Transmissions.

"No Secrets" Policy:
When treating a couple or a family, the couple or family is considered to be the client. At times, it may be necessary to have a private session with an individual member of that couple or family. There may also be times when an individual member of the couple or family chooses to share information in a different manner that does not include other members of the couple or family (i.e. on a telephone call, via email, or via private conversation).

In general, what is said in these individual conversations is considered confidential and will not be disclosed to any third party unless your therapist is required to do so by law. However, in the event that you disclose information that is directly related to the treatment of the couple or family it may be necessary to share that information with the other members of the couple or the family in order to facilitate the therapeutic process.

SR will use her best judgment as to whether, when, and to what extent such disclosures will be made. If appropriate, your therapist will first give the individual the opportunity to make the disclosure themselves.

This "no secrets" policy is intended to allow this therapist to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the couple or the family being treated.

If you feel it necessary to talk about matters that you do not wish to have disclosed, you should consult with a separate therapist who can treat you individually.

Extraordinary Events:

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In the case that this therapist becomes disabled, dies, or away on an extended leave of absence (hereinafter "extraordinary event,") the following Mental Health Professional Designee will have access to my client files. If I am unable to contact you prior to the extraordinary event occurring, the Mental Health Professional Designee will contact you. Please let me know if you are not comfortable with the below listed Mental Health Professional Designee and we will discuss possible alternatives at this time.

NAME: Brie Anderson-Feldman, LP, BC-DMT
ADDRESS: 709 Kimbark St., Longmont, CO 80501
TEL: 720-289-2835
CREDENTIALS: Licensed Professional Counselor, Board Certified Dance/ Movement Therapist

The purpose of the Mental Health Professional Designee is to continue your care and treatment with the least amount of disruption as possible. You are not required to use the Mental Health Professional Designee for therapy services, but the Mental Health Professional Designee can offer you referrals and transfer your client record, if requested.

Maintenance of Client Records:
As a client, you may request a copy of your Client Record at any time. In accordance with the Rules and Regulations of the State Board of Licensed Professional Counselor Examiners, SR will maintain your client record (consisting of disclosure statement, contact information, reasons for therapy, notes, etc.) for a period of seven (7) years after the termination of therapy or the date of our last contact, whichever is later. SR cannot guarantee a copy of your Client Record will exist after this seven-year period.

Electronic Records:
SR may keep and store client information electronically on SR's laptop or desktop computers, and/or some mobile devices. In order to maintain security and protect this information, SR may employ the use of firewalls, antivirus software, changing passwords regularly, and encryption methods to protect computers and/or mobile devices from unauthorized access. SR may also remotely wipe out data on mobile devices if the mobile device is lost, stolen, or damaged.

SR may use electronic backup systems such as external hard drives, thumb drives, or similar methods. If such backup methods are used, reasonable precautions will be taken to ensure the security of this equipment and it will be locked up for storage. SR uses a cloud-based service for storing or backing up information. The cloud-based backup system SR uses is: TherapyNotes and the email service provider SR uses is: GSuite and Paubox for encryption. SR may maintain the security of the electronically stored information through encryption and passwords. In addition, in order to maintain security of the electronically stored information SR has employed the following security measures:

- Entered into a HIPAA Business Associates Agreement with the cloud-based company and email service provider. Because of this Agreement, the cloud-based company and email service provider are obligated by federal law to protect the electronically stored information from unauthorized use or disclosure.
- The computers that store the electronically stored information are kept in secure data centers, where various security measures are used to maintain the protection of the computers from physical access by unauthorized persons.

910 Santa Fe Dr. Unit 11, Denver, CO 80204
720-626-0274, stefanie@stefanieraccuglia.com

- The cloud-based company and email service provider employ various security measures to maintain the protection of these backups from unauthorized use or disclosure.

It may be necessary for other individuals to have access to the electronically stored information, such as the cloud-based company or email service provider's workforce members, in order to maintain the system itself. Federal law protecting the electronically stored information extends to these workforce members. If you have any questions about the security measures SR employs, please ask.

Therapeutic Use of Touch:
Therapeutic touch may be utilized during sessions determined by both client and therapist. In addition to present-moment verbal consent, a separate consent agreement must be signed prior to services.

Client Agreements

You as a Client agree and understand the following (please initial after each):

1. I understand that SR may contact me to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to me in accordance with SR's Consent for Communication of Protected Health Information by Unsecure Transmissions.

Initials:_____

2. I understand that if I initiate communication via electronic means that I have not automatically consented to in SR's Consent for Communication of Protected Health Information by Unsecure Transmissions, I will need to sign or amend the consent form so that my therapist may communicate with me via this method.

Initials:_____

3. I understand that there may be times when my therapist may need to consult with a colleague or another professional, such as an attorney or supervisor, about issues raised by me in therapy. My confidentiality is still protected during consultation by my therapist and the professional consulted. Only the minimum amount of information necessary to consult will be disclosed. Signing this disclosure statement gives my therapist permission to consult as needed to provide professional services to me as a client.

Initials:_____

I understand that I will need to sign a separate Authorization for Release of Information for any discussion or disclosure of my protected health information to another professional besides a colleague, supervisor or attorney retained by my therapist.

Initials:_____

910 Santa Fe Dr. Unit 11, Denver, CO 80204
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4. I understand that my therapist does not accept personal Facebook, LinkedIn, Twitter, Instagram, and/or other friend/connection/follow requests via any Social Media. Any such request will be denied in order to maintain professional boundaries. I understand that SR has, or may have, a business social media account page. I understand that there is no requirement that I "like" or "follow" this page. I understand that should I "like" or choose to "follow" SR's business social media page that others will see my name associated with "liking" or "following" that page. I understand that this applies to any comments that I post on SR's page/wall as well. I understand that any comments I post regarding therapeutic work between my therapist and I will be deleted as soon as possible. I agree that I will refrain from discussing, commenting, and/or asking therapeutic questions via any social media platform. I agree that if I have a therapeutic comment and/or question that I will contact my therapist through the mode I consented to and not through social media.
Initials:_____

6. I understand that if I have any questions regarding social media, review websites, or search engines in connection to my therapeutic relationship, I will immediately contact my therapist and address those questions.

Initials:_____

7. I understand my therapist provides non-emergency therapeutic services by scheduled appointment only. If, for any reason, I am unable to contact my therapist by the telephone number provided to me, 720-626-0274, and I am having a true emergency, I will call 911, check myself into the nearest hospital emergency room or mental health crisis center, or call Colorado's Crisis Hotline (844) 493-8255. SR does not provide after-hours service without an appointment. If I must seek after-hours treatment from any counseling agency or center, I understand that I will be solely responsible for any fees due. I understand that if I leave a voicemail for my therapist on the phone number provided, my therapist will return my call within 48 hours, excluding holidays and weekends.

Initials:_____

8. If my therapist believes my therapeutic issues are above her level of competence or outside of her scope of practice, my therapist is legally required to refer, terminate, or consult.

Initials:_____

9. I understand that I am legally responsible for payment for my therapy services. If for any reason, my insurance company, HMO, third-party payer, etc. does not compensate my therapist, I understand that I remain solely responsible for payment. I also understand that signing this form gives permission to my therapist to communicate with my insurance company, HMO, third-party payer, collections agency or anyone connected to my therapy funding source regarding payment. I understand that my insurance company may request information from my therapist about the therapy services I received which may include but is not limited to: a diagnosis or service code, description of services or symptoms, treatment plans/summary, and in some cases my therapist's entire client file. I understand that once my insurance company receives the information I or my therapist has no control of the security measures the insurance company takes or whether the insurance company shares the required information. I understand that I may request from my therapist a copy of any report SR submits to my insurance company on my behalf. Failure to pay will be a cause for termination of therapy services.

910 Santa Fe Dr. Unit 11, Denver, CO 80204
720-626-0274, stefanie@stefanieraccuglia.com

Initials:_____

For Medicaid Clients/Providers only

10. Health First Colorado Member Billing Providers agree to accept the Health First Colorado payment as payment in full for benefits. Colorado law (C. R. S. 25.5-4-301 (II)) provides that no Health First Colorado member shall be liable for the cost, or the cost remaining after payment by Health First Colorado, Medicare or a private insurer, of medical benefits authorized under Title XIX of the Social Security Act. This law applies whether or not Health First Colorado has reimbursed the provider, whether claims are rejected or denied by Health First Colorado due to provider error, and whether or not the provider is enrolled in the Health First Colorado. This law applies even if a Health First Colorado member agrees to pay for part or all of a covered service. This law also prohibits providers from billing Health First Colorado members for the estates of deceased Health First Colorado members for Health First Colorado benefits. As such, Health First Colorado members are not responsible for payment for late cancellations or failure to show for an appointment.

Initials:_____

11. I understand that this form is compliant with HIPAA regulations and no medical or therapeutic information or other information related to my privacy, will be released without permission unless mandated by Colorado law as described in this form and the Notice of Privacy Policies and Practices. By signing this form, I agree and acknowledge I have received a copy of the Notice or declined a copy at this time. I understand that I may request a copy of the Notice at any time.

Initials:_____

12. I understand that if I have any questions about my therapist's methods, techniques, or duration of therapy, fee structure, or would like additional information, I may ask at any time during the therapy process. By signing this disclosure statement I also give permission for the inclusion of my partners, spouses, significant others, parents, legal guardians, or other family members in therapy when deemed necessary by myself or my therapist. I agree that these parties will have to sign a separate Consent for Third-Party Participation Agreement or may have to sign a separate disclosure statement in order to participate in therapy.

Initials:_____

13. I understand that should I choose to discontinue therapy for more than sixty (60) days by not communicating with SR or my therapist, my treatment will be considered "terminated." I may be able to resume therapy after the sixty (60) day period by discussing my decision to resume therapy services with SR. Ability to resume therapy after sixty (60) days will depend upon my therapist's availability and will be within her sole discretion. This disclosure statement will remain in effect should I resume therapy if one (1) year has not elapsed since my last session. However, I may be asked to provide additional information to update my client record. I understand "discontinuing therapy" means that I have not had a session with my therapist for at least sixty (60) days, unless otherwise agreed to in writing.

Initials:_____

910 Santa Fe Dr. Unit 11, Denver, CO 80204
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14. There is no guarantee that psychotherapy will yield positive or intended results. Although every effort will be made to provide a positive and healing experience, every therapeutic experience is unique and varies from person to person. Results achieved in a therapeutic relationship with one person are not a guarantee of similar results with all clients.

Initials:_____

15. Because of the nature of therapy, I understand that my therapeutic relationship has to be different from most other relationships. In order to protect the integrity of the counseling process the therapeutic relationship must remain solely that of therapist and client. This means that my therapist cannot be my friend, cannot have any type of business relationship with me other than the counseling relationship (i.e. cannot hire me, lend to or borrow from me; or trade or barter for services in exchange for counseling); cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client, and cannot hold the role of counselor to her relatives, friends, the relatives of friends, people known socially, or business contacts.

Initials:_____

16. I understand that should I cancel within 48 hours of my appointment or fail to show up for my scheduled appointment without notice ("no-show"), excluding emergency situations, my therapist has a right to charge my credit card on file, or my account, for the full amount of my session.

Initials:_____

17. I also affirm, by signing this form, I am at least fifteen (15) years old and consent to treatment and therapy services here at SR or that I am the legal guardian and/or custodial parent with the legal right to consent to treatment for any minor child/ren who is under the age of fifteen (15), for whom I am requesting therapy services here at SR

Initials:_____

18. I understand that if I am consenting to treatment and therapy services for my minor child/ren that my therapist will request that I produce, in advance of commencing services with SR, the Court Order Custody Agreement and/or Parenting Plan that grants me the authority to consent to mental health services for my minor child and make therapeutic decisions on behalf of my minor child/ren. Further, I understand and agree to keep my therapist informed of any proceedings or supplemental court orders that affect my parenting rights, custody arrangements, and decision-making authority. I understand that failing to provide the Court Order Custody Agreement and/or Parenting Plan will prohibit my therapist from providing therapy to my minor child/ren. I understand that it is beyond the scope of my therapist's practice to provide custody recommendations. Any request for custody recommendations will be denied. A Court is able to appoint professionals with the expertise to make such recommendations.

Initials:_____

By signing this form, I affirm that I am fully informed of the therapy services I am requesting and that SR is providing, and grant my consent to receive such therapy services. Initials:

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Signature Page

My signature below affirms that the preceding information has been provided to me in writing by my primary therapist, or if I am unable to read or have no written language, an oral explanation accompanied the written copy. I understand my rights as a client/patient and should I have any questions, I will ask my therapist.

Client Name/Signature DATE

Parent/Legal Guardian Signature (Please specify Relationship to Client) DATE

Parent/Legal Guardian Signature (Please specify Relationship to Client) DATE

Stefanie Raccuglia, LPC, R-DMT (Therapist Signature) DATE

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NOTICE OF PRIVACY POLICIES AND PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL AND MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Stefanie Raccuglia PLLC ("SR") believes it may be a covered entity under the Health Insurance Portability and Accountability Act (HIPAA) and thus provides its clients with this Notice of Privacy Policies & Practices and complies with the procedures and protocols listed herein. If SR is determined not to be a covered entity under HIPAA, it will still follow this Notice of Privacy Policies & Practices regarding use and disclosure of PHI; however, the client may not be entitled to the rights set forth in the "Your Rights as a Client" section.

Given the nature of SR's work, it is imperative that it maintains the confidence of client information that it receives in the course of its work. SR is a mental health practice that provides mental health services. SR's practice works solely to provide the best counseling treatment options to its clients. SR is prohibited from releasing any client information to anyone outside immediate staff, employees, interns, and/or volunteers except in limited circumstances in accordance with this Notice of Privacy Policies and Practices. Discussions or disclosures of protected health information ("PHI") within the practice are limited to the minimum necessary that is needed for the recipient of the information to perform his/her job. Please review this Notice of Privacy Policies and Practices ("Notice of Privacy Policies"). It is my policy to:

1. fully comply with the requirements of the HIPAA General Administrative Requirements, the Privacy and Security Rules;
2. provide every client who receives services with a copy of this Notice of Privacy Policies;
3. ask the client to acknowledge receipt when given a copy of this Notice of Privacy Policies;
4. ensure the confidentiality of all client records transmitted by facsimile;
5. obtain from each client an informed Authorization for Release of Protected Health Information form when required.

SR is required to follow all state and federal statutes and regulations including Federal Regulation 42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164, governing testing for and reporting of TB, HIV AIDS, Hepatitis, and other infectious diseases, and maintaining the confidentiality of PHI.

PHI refers to any information that I create or receive, and relates to an individual's past, present, or future physical or mental health or conditions and related care services or the past, present, or future payment for the provision of health care to an individual; and identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual.PHI includes any such information described above that I transmit or maintain in any form, this includes Psychotherapy Notes. HIPAA and federal law regulate the use and disclosure of PHI when transmitted electronically.

YOUR RIGHTS AS A CLIENT:

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your mental health record

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- You can ask to see or get an electronic or paper copy of your mental health record and other health information I have about you. Ask me how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee to fulfill your request.
- If I deny your request, in whole or in part, I will let you know why in writing and whether you have the option of having the decision reviewed by an independent third-party.

Ask me to correct your mental health record

- You can ask me to correct health information about you that you think is incorrect or incomplete. Ask me how to do this.
- I may say "no" to your request, but I'll tell you why in writing within 60 days.

Request confidential communications

- You can ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.
- Please review the Consent For Communication Of Protected Health Information By Non-Secure Transmissions
- You are required to "opt-in" to receive communications electronically as set-forth in the Consent for Communication of Protected Health Information by Non-Secure Transmissions. If you choose not to "opt-in" to receive electronic communications, I will not communicate with you via electronic means.

Ask me to limit what I use or share

- You can ask me not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and I may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask me not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires me to share that information.

Additional Restrictions

- You have the right to request additional restrictions on the use or disclosure of your mental health information. However, I do not have to agree to that request, and there are certain limits to any restriction. Ask me if you would like to make a request for any restriction(s).

Get a list of those with whom I've shared information

- You can ask for a list (accounting) of the times I've shared your health information for six years prior to the date you ask, who I shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked me to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before I take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel I have violated your rights by contacting me using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.
- You may also file a complaint with the Colorado Department of Regulatory Agencies, Division of Professions and Occupations, Mental Health Section; 1560 Broadway, Suite 1350, Denver, Colorado, 80202, 303-894-2291; DORA_Mentalhealthboard@state.co.me. Please note that the Department of Regulatory Agencies

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may direct you to file your complaint with the U.S. Department of Health and Human Services Office for Civil Rights listed above and may not be able to take any action on your behalf.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A use of PHI occurs *within* a covered entity (i.e., discussions among staff regarding treatment). A disclosure of PHI occurs when SR reveal PHI to an outside party (i.e., SR provides another
treatment provider with PHI, or shares PHI with a third party pursuant to a client's valid written authorization).

SR may use and disclose PHI, without an individual's written authorization, for the following purposes:

1. Treatment: disclosing and using your PHI by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members and for coverage arrangements during your therapist's absence, and for sending appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
2. Payment: disclosing and using your PHI so that SR can receive payment for the treatment services provided to you, such as: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization of review activities.
3. Health Care Operations: disclosing and using your PHI to support SR's business operations which may include but not be limited to: quality assessment activities, licensing, audits, and other business activities.

Uses and disclosures for payment and health care operations purposes are subject to the minimum necessary requirement. This means that SR may only use or disclose the minimum amount of PHI necessary for the purpose of the use or disclosure (i.e., for billing purposes SR would not need to disclose a client's entire medical record in order to receive reimbursement. SR would likely only need to include a service code and/or diagnosis etc.). Uses and disclosures for treatment purposes are not subject to the minimum necessary requirement.

SR is required to promptly notify you of any breach that may have occurred and/or that may have compromised the privacy or security of your PHI.

Confidentiality of client records and substance abuse client records maintained are protected by federal law and regulations. It is SR's policy that a client must complete an Authorization for Release of Protected Health Information it provides prior to disclosing health information to another individual and/or entity for any purpose, except for treatment, payment, or health care operations in accordance with this Notice of Privacy Policies.

Absent the above referenced form, other than for treatment, payment, or health care operations purposes, SR is prohibited from disclosing or using any PHI outside of or within the

organization, including disclosing that the client is in treatment without written authorization, unless one of the following exceptions arises:

1. Responding to lawsuit and legal actions (Disclosure by a court order, in response to a complaint filed against SR, etc. This does not include a request by you or another party for your records).
2. Disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation.
3. Help with public health and safety issues (Client commits or threatens to commit a crime either at SR's office or against any person who works for SR; A minor or elderly client reports having been abused or there is reasonable suspicion that abuse has or will take place; Client is planning to harm another

910 Santa Fe Dr. Unit 11 Denver, CO 80204
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person, including but not limited to the harm of a child or at-risk elder; Client is imminently dangerous to self or others).

4. Address workers' compensation, law enforcement, and other government requests.
5. Respond to organ and tissue donation requests.
6. Business Associates: SR may enter into contracts with business associates to provide billing, legal, auditing, and practice management services that are outside entities. In those situations, protected health information will be provided to those contractors as is needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.
7. In compliance with other state and/or federal laws and regulations.

The above exceptions are subject to several requirements under the Privacy Rule, including the minimum necessary requirement and applicable federal and state laws and regulations. See 45 C.F.R. § 164.512. Before using or disclosing PHI for one of the above exceptions, SR's staff must consult its Privacy Office (Stefanie Raccuglia, LPC, R-DMT, 720-626-0274, stefanie@stefanieraccuglia.com) to ensure compliance with the Privacy Rule. Violation of these federal and state guidelines is a crime carrying both criminal and monetary penalties. Suspected violations may be reported to appropriate authorities, as listed above in the "Client Rights" section, in accordance with federal and state regulations. Know that SR will never market or sell your personal information without your permission.

SPECIAL AUTHORIZATIONS

Certain categories of information have extra protections by law, and thus require special written authorizations for disclosures.

Psychotherapy Notes: SR may keep and maintain "Psychotherapy Notes", which may include but are not limited to notes SR makes about your conversation during a private, group, joint, or family counseling session, which is kept separately from the rest of your record. These notes are given a greater degree of protection than PHI. These are not considered part of your "client record." SR will obtain a special authorization before releasing your Psychotherapy Notes.

HIV Information: Special legal protections apply to HIV/AIDS related information. SR will obtain a special written authorization from you before releasing information related to HIV/AIDS.

Alcohol and Drug Use Information: Special legal protections apply to information related to alcohol and drug use and treatment. SR will obtain a special written authorization from you before releasing information related to alcohol and/or drug use/treatment.

You may revoke all such authorizations to release information (PHI, Psychotherapy Notes, HIV information, and/or Alcohol and Drug Use Information) at any time, provided each revocation is in writing, signed by you, and signed by a witness. You may not revoke an authorization to the extent that (1) SR has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, the law provides the insurer the right to contest the claim under the policy.

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As a covered entity under the Privacy and Security Rules, SR is required to reasonably safeguard PHI from impermissible uses and disclosures. Safeguards may include, but are not limited to the following:

1. Not leaving test results unattended where third parties without a need to know can view them.
2. Any PHI received as an employee, intern, or volunteer about a client or potential client, may not be used or disclosed for non-work purposes or with unauthorized individuals. SR may only use and disclose such PHI as described above.
3. When speaking with a client about his or her PHI where third parties could possibly overhear, the conversation will be moved to a private area.
4. Seeking legal counsel in uncertain situations and/or incidences.
5. Obtaining a Business Associates Agreement with those third-parties that have access to and/or store client information. Some of the functions of the practice may be provided by contracts with business associates. For example, some of the billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services.
6. Implementing FAX security measures
7. Obtaining your consent prior to sending any PHI by unsecure electronic transmissions
8. Providing information on my electronic record-keeping.

YOUR CHOICES:

For certain health information, you can tell SR (verbal authorization) your choices about what it shares. If you have a clear preference for how SR shares your information in the situations described below, talk to SR. Tell SR what you want it to do, and it will follow your instructions. SR may request you sign a separate document if you authorize it to share certain PHI. You may revoke that authorization at anytime for future disclosure.

In these cases, you have both the right and choice to tell SR to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell SR your preference, for example if you are unconscious, SR may go ahead and share your information if SR believes it is in your best interest and for your care/treatment. SR may also share your information when needed to lessen a serious and imminent threat to public health or safety.

In these cases I never share your information unless you give me written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Changes to the Terms of this Notice

910 Santa Fe Dr. Unit 11 Denver, CO 80204
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SR can change the terms of this notice, and the changes will apply to all information SR has about you. The new notice will be available upon request, in SR's office, and on its web site.

This notice is effective:

Client Signature Date

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

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Authorization To Release of Protected Health Information (aka "ROI")

I, _____, authorize Stefanie Raccuglia, LPC, R-DMT, to exchange and release the information specified below with the following person/class of persons :

Name/Group: _____
Telephone Number: _____
Address: _____
Relationship to Client: _____

CLIENT NAME: _____ CLIENT DATE OF BIRTH: _____

PARENT/LEGAL GUARDIAN (if applicable): _____

ADDRESS: _____

INFORMATION REQUESTED

I request and authorize Stefanie Raccuglia to exchange and release the information specified below to the above named person (or class of persons)

Please check all that apply:
_____ Evaluations/Testing/Assessments
_____Psychotherapy Notes
_____Complete Medical/Mental Health Records
_____Treatment Summary
_____Medications prescribed
_____Diagnosis/Psychiatric Conditions
_____Drug/Alcohol Abuse Information
_____HIV/AIDs Information
_____Treatment Plan
_____Other:

Type/Form of Information Requested (check all that apply):
_____Records
_____Verbal Communications
_____Electronic Communications such as texts or emails

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I understand that the information to be released includes information for the following **purpose:**

_____ **Insurance Claims/Billing/ Coverage**

_____ **Psychiatric Condition, Psychological Testing/Assessment**

_____**Treatment Planning**

_____**Rehabilitation program, development, or services**

_____**Legal Issues**

_____ **Coordination of Care**

_____ **Consultation/Supervision**

_____ **Education**

_____ **Drug/Alcohol Abuse**

_____**HIV/AIDS**

_____**Medical Care**

_____**Other:** _____

The information sought in this request is the minimum necessary to accomplish the intended purpose of the request. 45 C.F.R. 164.502(b)(2)(v). (See 65 FED. Reg. 82530). Information may be released verbally, in writing, photocopy, by fax or mail unless client indicates otherwise.

I understand that the information to be disclosed may include any or all information involving psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism, and/or information involving communicable and/or venereal diseases such as HIV/AIDS.

I understand that this authorization will expire in one (1) year from the date of signing, unless otherwise specified here:

AUTHORIZATION: I understand that the disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or eligibility to obtain benefits, unless specified in this form. I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by sending a letter to the facility Privacy Officer at the contact information above, or their designee. I understand my revocation will not be effective to the extent

910 Santa Fe Dr. Unit 11 Denver, CO 80204
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that action has already been taken in reliance on it. I understand and I authorize the disclosure of my mental health information to someone who may or may not be legally required to keep it confidential, and understand that it may be re-disclosed and may no longer be protected by the

Standards for Privacy of Individually Identifiable Health Information, set forth at 45 CFR Parts 160 and 164. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a reasonable fee will be charged for copies of my mental health record. I understand the facility will provide me a copy of the signed authorization form upon my request. If I have questions about disclosure of my mental health information, I can contact the facility Privacy Officer or their designee. I understand that treatment may not be denied if I refuse to sign this authorization, except: 1) If the authorization is the very reason for seeking the health care (e.g., a pre-employment physical), health care may be denied; or 2) If the authorization is for disclosure to a research study, I may be denied the treatment that is part of the study. In addition, the following consequences might occur if I refuse to sign the authorization: 1) If the authorization is to demonstrate to a health plan that a service should be paid for, the health plan may refuse to pay for it, and 2) If the authorizing is sought by an insurer because I am seeking enrollment or eligibility, the insurer may deny me the coverage I am seeking. I understand that a health plan may not refuse payment or benefits if I refuse to authorize disclosure of certain psychotherapy notes. I understand and affirm, by my signature below, that the benefits and disadvantages of releasing the above information, if known, have been explained to me. **A copy or telefax of this authorization will be as valid as the original.**

Client Signature Printed Name Date

Parent/ Guardian Signature(if applicable)

****The information disclosed to you may be from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.**

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Consent for Communication of Protected Health Information
VIA UNSECURE TRANSMISSIONS

This consent form is for the communication of Protected Health Information ("PHI") that Stefanie Raccuglia PC ("SR") may transmit without the written authorization of the client as described in the Uses and Disclosure section of SR's Notice of Privacy Policies.

I, _____, hereby consent and authorize SR to communicate my PHI through the following unsecure transmissions (please initial all your choices):

_____ Cellular/Mobile Phone this includes text messaging & voicemails
Please Insert Cell Phone Number:
_____ Unsecured Email
Client's Email: _____ ___Send ___Receive
Please Check One: ___Work ___Personal
Therapist's Email: stefanie@stefanieraccuglia.com ___ Send ___Receive
_____ Appointment/Scheduling Reminder System (Simple Practice)
_____Other Media:
Please describe:

OR

_____ I do not wish to have my protected health information transmitted electronically

Should we agree to communicate by the approved communications listed above, i.e. text, email, telephone, or any other electronic method of communication, confidentiality extends to those communications. However, SR cannot guarantee that those communications will remain confidential. Even though SR may utilize state of the art encryption methods, firewalls, and/or back-up systems to help secure our communication, there is a risk that the electronic or telephone communications may be compromised, unsecured, and/or accessed by an unintended third-party. There is never a 100% guarantee information will remain confidential when transmitted electronically.

I, _____, consent to SR transmitting the following PHI by the above selected electronic communications (please initial all your choices):

_____ Information related to scheduling/appointments
_____ Information related to billing and payments
_____ Information related to your mental health treatment (this may contain personal materials, forms, suggested articles, homework, etc.)
_____ Information related to SR's operations
_____ Other Information; Please Describe:

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I further understand that if I initiate communication via electronic means that I have not specifically consented to in this form, I will need to amend this consent form so that my therapist may communicate with me via that method.

Signature of Client/Parent/Legal Guardian DATE

STEFANIE RACCUGLIA
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Credit Card/Payment Authorization Form

Stefanie Raccuglia PC ("SR") uses **IVY Pay**, a HIPPA compliant secure application to charge and process credit card payments.

I also request that you provide your credit card information below. If you choose to pay by credit card your credit card will be charged the agreed upon session rate **(rate)** here after each session on the day the session occurs.

**If you choose to pay by cash or check, your credit card will only be charged if your account is past due and/or for any additional fees you and/or your minor child/ren incur such as late cancellation or no-shows fees.

☐ I do not authorize SR to charge my credit card after each session but only for additional fees I and/or my minor child/ren incur as set forth in SR's disclosure statement and policies. I will be notified of the type of additional fees I and/or my minor child/ren incur.

__ I authorize SR to charge my credit card $_____ after each session and for any and all additional fees I and/or my minor child/ren incur.

If your credit card does not go through, you do not have a credit card, or you do not wish to provide your credit card information, in the event your account remains past due for sixty (60) days, your account may be sent to collections. SR reserves the right to send your account to collections, in accordance with SR's policies and procedures; at any time after your account is considered past due.

By signing this authorization form, you agree to notify SR of any changes to your credit card information such as a new expiration date or when your credit card has been cancelled, lost, stolen, or revoked. A new form must be submitted if information such as the list of authorized users and the credit card account's expiration date is amended.

Name on Credit Card: _____

Type of Credit Card: __Visa __MasterCard __Discover __American Express

Credit Card Number: _____

CCV Code: _____ Expiration Date : _____

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Card Holder's Full Address, including zip code (the mailing address for your Credit Card statements):

This credit card authorization form will remain in effect and on file at SR unless revoked in writing or until the therapeutic relationship is terminated, at which time, authorization to charge your credit card will be revoked, unless an outstanding balance remains on your account after termination. SR will not share your credit card information with any third-party without your consent. Your credit card information will be kept confidential.

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Signature Page – Please check one:

___Card Holder is the client (or parent/legal guardian) receiving services from SR.

I hereby authorize SR to charge the above credit card number for payment of the counseling fees I or my minor child/ren incurs, which shall include late or past due fees or fees related to cancellations or no-shows. I understand that my credit card will be billed in accordance with the authorizations listed above.

_____

Client/Parent/Legal Guardian Signature DATE

OR

___Card Holder is a third-party payer for the client receiving services from SR.

I, _____ hereby authorize SR to charge the above credit card number for payment of the counseling fees (Client) incurs, which shall include late or past due fees or fees related to cancellations or no-shows. I understand that my credit card will be billed in accordance with the authorizations listed above. I understand as a third-party payer that I am only entitled to receive information concerning payment and that this Credit Card Authorization Form does not authorize me to receive any confidential and protected information about Client beyond payment.

_____

Third-Party Payer's Signature DATE

I, _____ authorize SR to communicate with the above Third-Party Payer solely as it may relate to payment for services I receive from SR.

_____

Client's Signature DATE

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CLIENT INTAKE FORM

Providing this information will accelerate the process of our work and will also help us to identify areas of your life that need special attention. ***Please leave blank any question you would rather not answer.*** *Information you provide here is held to the same standards of confidentiality as our therapy.*

IDENTIFYING INFORMATION

Today's date:

Name (legal): Birthday:

Age: Marital/Partnership Status:

Mailing Address:

Phone Number(s):

Email:

How do you prefer to be contacted by me? (e.g., phone, mail, email):

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Current situation

Presenting Challenges that have brought you to therapy:

Duration of Challenges:

Events that Led to Your Seeking Help:

Recent Life Changes or Stressors:

Intentions/Goals for therapy:

YOUR BACKGROUND

Developmental History:

What do you know (if anything) about your birth?

Did you nurse? How long?

What is your earliest significant memory?

How would you describe your childhood/middle-school/adolescent years?

Tell me about the family system in which you were raised? (e.g. with parents, married or divorced, siblings, extended family, etc?)

910 Santa Fe Dr. Unit 11 Denver, CO 80204
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How would you describe the family environment in which you grew-up? (e.g. peaceful, loving, supportive, hostile, chaotic, violent, etc)

Medical History:

Please list any current or past medical conditions:

Please list any current medications:

Please describe any history of head injuries:

Have you ever had your thyroid checked? When/how often?

Do you currently use alcohol or drugs?
If so, how much and how often?

If so, how long have you used these substances?

If so, have you ever been in treatment for substance use?

Do you have any history of compulsive behaviors, such as sexual addiction, gambling, shopping, exercise addiction, over-eating, etc? If so, please explain.

Are there any medical conditions/concerns that you have which would be helpful for me to know about? Please explain:

Family/Personal Mental Health History:

Have you have been hospitalized for psychiatric reasons? (If yes, please explain: when, how long, reason, treatment, outcome, follow-up):

Have you ever been in counseling?
If so, when, and for how long?

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If so, what brought you to counseling?

If so, how was your experience(s) with counseling? What worked? Did not?

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Trauma History:

I have experienced**:**
(Please circle any that apply and indicate how old you were at time)

Event:	**Your age at time (best estimate):**
a physical assault	yes/no
verbal abuse	yes/no
emotional abuse	yes/no
molestation	yes/no
unwanted sexual attention	yes/no
sexual harassment	yes/no
gender discrimination	yes/no
a hate crime	yes/no
other:	yes/no

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty	**Family Member**
Depression	yes/no
Bipolar Disorder	yes/no
Anxiety Disorders	yes/no
Panic Attacks	yes/no
Schizophrenia	yes/no
Alcohol/Substance Abuse	yes/no
Eating Disorders	yes/no
Learning Disabilities	yes/no
Trauma History	yes/no
Suicide Attempts	yes/no

Have you ever experienced:

Extreme depressed mood	yes/no
Wild Mood Swings	yes/no
Extreme Anxiety	yes/no
Panic Attacks	yes/no
Phobias	yes/no

910 Santa Fe Dr. Unit 11 Denver, CO 80204
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Sleep Disturbances yes/no
Hallucinations yes/no
Unexplained losses of time yes/no
Unexplained memory lapses yes/no
Alcohol/Substance Abuse yes/no
Frequent Body Complaints yes/no
Eating Disorder/ Disordered Eating yes/no Body Image Problems yes/no
Repetitive Thoughts (e.g., Obsessions) yes/no
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing) yes/no
Homicidal Thoughts yes/no
Suicide Attempt yes/no

Are you currently feeling suicidal yes/no

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Educational History:

At what age did you begin school?

Did you enjoy school? Why or why not?

What were/are your favorite subjects?

Was there anything "atypical" in your educational experience, e.g., were you in gifted or talented classes, or were you diagnosed with a learning disability?

Occupational History:

Are you currently employed?
If so, how do you feel about your current position?

Please list any work-related stressors, if any:

Do you prefer job tasks where you work individually, or with groups?

Spiritual History and Orientation:

Were you raised with a religious/spiritual orientation? If so, please describe:

Do you consider yourself to be a spiritual/religious person?

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If yes, what is/are your faith(s)?

Do you have a consistent spiritual practice and if so, please share:

What role (if any) does spirituality or religion play in your life?

Social History:

To whom were you closest as a child?

Did you have a mentor or mentors as a child (e.g., parent, teacher, coach, friend's parent, etc.)?

Were you shy or outgoing as a child? How are you as an adult?

Please describe your current friendships (anything you want to say here is fine):

How do you feel about the quality of your friendships?

Are you happy with the size of your current network of friends and acquaintances?

How do you typically meet friends?

Have you experienced any significant losses (e.g., death of loved one)?

Are you currently in a romantic relationship?
If so, how long have you been in this relationship?
On a scale of 1-10, how would you rate the quality of your current relationship?

910 Santa Fe Dr. Unit 11 Denver, CO 80204
stefanei@stefanieraccuglia.com/ 720-626-0274

Please list previous significant relationships and durations:

How do you typically meet your romantic partners?

Treatment Modalities:

Have you ever experienced body-centered psychotherapies?

Are you interested in exploring body-centered psychotherapy?

Sometimes, body-centered psychotherapy involves the use of non-sexual touch by me. Please tell me how this sounds to you:

Are you interested in exploring your challenges through art and other creative processes?

Do you have any sensory (tactile) challenges? If so, please explain.

Other Information that Will Assist Us in Your Therapy:

What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies that you've learned?

What do you do for fun and self-care?

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What else would be helpful for me to know about you?

STEFANIE RACCUGLIA
EMBODIED HEALING

Intake Form (12-17)

This questionnaire is a chance for you to share a little bit about yourself and anything else that you think might be helpful for our work together. Therapy and counseling is a relationship that involves trust that builds over time. It's perfectly ok if you don't wish to share certain experiences or feelings just yet. And because this is a helpful tool for me, so I ask that you do share what you are comfortable with.

This should be filled out by you as my client, but you can certainly ask your parent or legal guardian for help or input if, and only if, YOU want to.

I will not share the information you put in this form with anyone (including your parents) unless I determine that it is in your best interest and/or required by certain laws to do so. These circumstances include if you are in danger, or a danger to yourself, or to others. In our first session, we will discuss more about confidentiality, and what circumstances would require me to break confidentiality.

Any request or authorization in this form to contact a Third Party, such as a medical doctor, will require a separate Authorization for Release of Information (aka "ROI").

Client Information:
Name:
Birthdate:
Gender:
Address (please include city, state and zip):

May I send mail to you at this address: ___ YES ___ NO

Preferred Telephone/ Type (Cell, home):

Secondary Telephone/Type:

May I contact you at all the above telephone numbers provided:
___ YES___NO

May I leave a voice message at all the above telephone numbers provided:
___ YES ___NO

May I send text messages to the above telephone numbers provided:
___ YES ___NO

Email Address:

Do you share this email address with anyone else? If so please list who else shares the email address:

May I contact you at the above email address: ___YES ___NO

****Please be aware there is a risk that an unintended third-party may access information shared by electronic transmissions such as email and/or cell phones. By allowing Stefanie Raccuglia to contact you by email you are consenting to receive electronic communications and understand the risks involved. Stefanie Raccuglia cannot guarantee that confidential information shared using electronic communications will remain confidential.**

What is your preferred method of communication (email, text, phone call):

Emergency Contact Information:
In case of an emergency, I may be required to contact someone on your behalf. Please list your emergency contact below, which I may contact on your behalf. I will share the minimum amount of information necessary with your emergency contact should he or she need to be contacted.

Name:
Relationship:
Telephone Number:

Family Information:
Are your parents: ___Married or Civil Union ___ Separated ___Divorced ___Living Together

If your parents are no longer together, are either of your parents remarried:
___YES ___ NO
Please list your Stepmother and/or Stepfather's Name and telephone number:

May I contact any Stepmother and/or Stepfather: ___ YES ___ NO

Mother's Name:
Mother's Telephone:
Mother's Address (if different than yours listed above):
Mother's Occupation:
Do you live with your Mother: ___YES ___NO
If yes, do you live with her ___ Full-Time ___ Part-Time
May I contact your Mother: ___YES ___NO

Father's Name:

Father's Telephone:
Father's Address (if different than yours listed above):
Father's Occupation:
Do you live with your Father: ___ YES ___ NO
If yes, do you live with him___Full-Time ___Part-Time
May I contact your Father: ___ YES ___ NO

Do you have any siblings: ___ YES ___ NO
How many? Ages:
Do you live with all your siblings: ___YES ___NO
If no, who do your other siblings live with:

Are there any other persons that live in your home with you: ___ YES ___ NO
If yes, please list their names and ages, and any relationship to you:

Health History

Primary Care Physician Information:

In order to provide you with continuous and congruent care, I may need to contact your primary care physician. Any contact that I may have with your Primary Care Physician will require you to sign an Authorization for Release of Protected Health Information and Confidential Information (also called an "ROI").

Name:

Telephone Number: Fax:

Address:
Please Provide the Date of Your Last Physical:

May I contact your physician:___YES ___NO

Please list any medication you are currently taking (including birth control)
(if you are not currently taking any medications, please state that you are not currently taking any medications):

Please list any current physical illnesses, issues, and/or ailments you have (if you do not currently have any physical illnesses, issues, and/or ailments, please state so):

Mental Health History:

Have you ever received therapy, counseling, or any other psychiatric service?

___YES ___ NO

If yes, please share a little bit more about why?:

If yes, please share what was successful about that treatment?

Date of your Last Session:

In your own words, share with me a little bit about why you are seeking counseling?

How have you dealt with these issues/problems in the past___YES ___ NO

If yes, please describe

Please list any past or current issues that may affect your mental health:

Have you ever been, or are you currently, suicidal ___ YES ___ NO:

Have you ever attempted to commit suicide ___YES ___NO:

Has anyone in your family ever attempted or committed suicide ___ YES ___NO

Have you used, or do you currently use, alcohol, inhalants, nicotine products, marijuana, or any illegal drugs: ___YES ___ NO

If so, please indicate which ones:

Does your family have a history of mental illness such as depression, anxiety, drug/alcohol abuse, addictions, eating disorders (if yes, please indicate): ___YES ___ NO

Have you ever gotten in trouble at school? ___YES ___ NO

If so, please describe the circumstances and what happened afterwards:

Are you currently involved in any civil or criminal legal proceedings: ___YES ___ NO

If yes, please state the circumstance(s):

Are there any weapons available or unlocked in your home: ___YES ___ NO ___ Prefer not to Answer

If yes, please list the weapon, where it is located, and who it belongs to:

Do you have a preoccupation with weapons, violence, killing, or fire: ___YES ___ NO ___ Prefer not to Answer

If yes, please describe:

Social History, Hobbies and Interests:

Do you work: ___YES ___ NO ___ Prefer not to Answer
If yes, please state where you are employed:

Do you play any sports or musical instruments: ___YES ___ NO ___ Prefer not to Answer
If yes, please list what sports and/or musical instruments you play:

Please list any other hobbies or interests that you have:

How do you normally spend your day? / What does a typical day look like for you?

What school do you attend and what grade are you in:

Share with me what you enjoy about school, and what's challenging:

Do you have a favorite subject taught in school:

Are you currently happy with your network of friends?

Have you started dating? ___YES ___ NO ___ Prefer not to Answer
If not, would you like to?
If yes, are you happy with your relationship?

Is there anything else you would like me to know?

If you could wave a magic wand and give yourself or change 3 things, what would they be?

1.
2.
3.

Client Affirmation:

By signing this Intake Form, I certify that all the information I provided is true and accurate to the best of my knowledge.

Client Signature Date

Printed Name