



**LAVENDER**  
MENTAL HEALTH  
160 E 12th St. Ste 1  
Durango, CO 81301  
970.426.0636

## Lavender Mental Health Intake Form

Name Listed with Insurance/Legal Name \_\_\_\_\_

Date and Place of Birth \_\_\_\_\_

Gender Listed on Insurance \_\_\_\_\_ Relationship Status \_\_\_\_\_

Name/Pronoun Preferences \_\_\_\_\_

Mailing Street Number/Street \_\_\_\_\_

Mailing City, State, Zip \_\_\_\_\_

Email Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Emergency Contact Name, Phone Number, and Relationship to you

\_\_\_\_\_

Insurance Name, Policy Number \_\_\_\_\_

Current Medications \_\_\_\_\_

Medication Prescriber \_\_\_\_\_

Reason(s) for Seeking Therapy \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you previously been in therapy? \_\_\_\_\_



# LAVENDER

MENTAL HEALTH

160 E 12th St. Ste 1

Durango, CO 81301

970.426.0636

## Appointment Cancellation/ No Show Policy

**Canceling and Rescheduling.** Clients may cancel or reschedule without penalty by notifying Lavender Mental Health LLC (LMH) at least 24 hours before their scheduled appointment time. To cancel or reschedule, please contact LMH by phone at 970-426-0636.

**Late Cancellation.** Cancellations are considered late when the client does not cancel or reschedule at least 24 hours prior to the scheduled appointment time. Late cancellations will result in the customer being charged a fee of \$25. LMH will waive this fee in the event of a documented crisis or emergency.

**Missed Appointments.** If a client misses their scheduled appointment without canceling or rescheduling, they will be charged a fee of \$75. LMH will reduce this fee to \$25 in the event of a documented crisis or emergency.

**Provider Cancellation.** If, for any reason, LMH must cancel your scheduled appointment or reservation, we will notify you as soon as possible and will work with you to reschedule.

**Fee Waiver.** LMH reserves the right, at our discretion, to waive any fee or penalty assessed for reasons we deem sufficient and reasonable.

---

Print Name

---

Date of Birth

---

Client Signature/Responsible Party

---

Date



**LAVENDER**  
 MENTAL HEALTH  
 160 E 12th St. Ste 1  
 Durango, CO 81301  
 970.426.0636

## Behavioral Health Provider Disclosure Statement

**Lavender Mental Health**, 160 E 12<sup>th</sup> Street, Ste. 1, Durango, CO 81301, 970-426-0636

### Agency Disclosure Statement

Lavender Mental Health, LLC is a private mental health and clinical social work agency registered with the Colorado Secretary of State.

**Provider Disclosure Statement: Sonya Brophy**, LCSW, completed her master’s degree in social work at Metropolitan State University of Denver in 2015. Sonya has been trained in EMDR (Eye Movement Desensitization and Reprocessing), ACT (Acceptance and Commitment Therapy), DBT (Dialectical Behavioral Therapy, SFBT (Solution Focused Brief Therapy), MI (Motivational Interviewing) and CBT (Cognitive Behavioral Therapy). She customizes her approach to the client. She works with adults and older adults. She worked in crisis intervention and suicide prevention prior to her current position. Currently, Sonya specializes in trauma resolution, depression, suicide prevention, and anxiety.

The practice of registered, certified, or licensed persons in the field of clinical social work and psychotherapy is regulated by the Colorado State Board of Social Work Examiners. Questions and complaints may be addressed to:

Colorado Department of Regulatory Agency  
 Division of Professions and Occupations  
 1560 Broadway, Suite 1300  
 Denver, CO 80202 Phone 303.894.7800

I have read the preceding information, as well as the information on the following page, it has been provided to me verbally, and I understand my rights as a client or as the client’s responsible party.

---

Print Client Name

---

Date of Birth

---

Client Signature/Responsible Party

---

Date

(CONTINUED ON OTHER SIDE)



# LAVENDER

MENTAL HEALTH

160 E 12th St. Ste 1

Durango, CO 81301

970.426.0636

- The regulatory requirements applicable to mental health professionals are as follows:
  - If the professional is a registered psychotherapist, the psychotherapist is 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 registration.
  - Certified Addiction Counselor I (CAC I) must be a high school graduate or the equivalent, complete required training hours and 1000 hours of clinically supervised work experience.
  - Certified Addiction Counselor II (CAC II) must meet the CAC I requirements, complete additional training hours above the CAC I, and 2000 hours of clinically supervised work experience.
  - Certified Addiction Counselor III (CAC III) must have a bachelor's degree in the behavioral health sciences or field; complete additional training above the CAC II, and 2000 hours of clinically supervised work experience.
  - Licensed Addiction Counselor must have a clinical master's degree, meet the CAC III requirements, and pass a national examination in addiction treatment.
  - Licensed Social Worker must hold a master's degree in social work.
  - Psychologist Candidate, Marriage and Family 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.
  - Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's degree in their profession and have two years of post-master's supervision.
  - Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.
- You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy (if known) and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Board that registers, certifies, or licenses the registrant, certificate holder or licensee.
- Most of 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 to confidentiality arises during therapy, if feasible, you will be informed accordingly.



**LAVENDER**  
MENTAL HEALTH  
160 E 12th St. Ste 1  
Durango, CO 81301  
970.426.0636

## **Client Acknowledgement of LMH Privacy Practices**

### Uses and Disclosures Under General Consent to Treatment

Lavender Mental Health (LMH) uses or discloses your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- “General Consent to Treatment” refers to your enrollment with LMH.
- “PHI” refers to information in your health record that could identify you.
- “Treatment” is when LMH provides, coordinates, or manages your mental health care and other services related to your mental health care. An example of treatment would be when LMH consults with another health care provider.
- “Payment” is when LMH submits PHI on your behalf (for example a list of dates and diagnostic codes) to your insurance for your reimbursement, to ease the process with your insurance company. This is a courtesy service.
- “Health Care Operations” are activities that relate to the performance and operation of LMH’s practice. Examples are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “Use” applies only to activities within LMH’s practice.
- “Disclosure” applies to activities outside of LMH such as releasing, transferring, or providing access to information about you to other parties.

### Uses and Disclosures Requiring Authorization

LMH may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when LMH is asked for information for purposes outside of treatment, payment, and health care operations. LMH will obtain an authorization before releasing information.

### Psychotherapy Notes

“Psychotherapy notes” are notes your therapist has made about conversations during a private, group, joint, or family counseling session, which your therapist has kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. LMH will contact you to obtain authorization to release this information.

### Revoking Authorization

You may revoke all authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization for PHI use or disclosure that does not require authorization to disclose.



**LAVENDER**  
MENTAL HEALTH  
160 E 12th St. Ste 1  
Durango, CO 81301  
970.426.0636

Uses and Disclosures with Neither Consent nor Authorization

LMH may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If your therapist has reasonable cause to suspect a child is receiving abuse or maltreatment, whether (or not) the child is present in the office/clinic/lobby, your therapist must report such abuse or maltreatment to the statewide child abuse hotline, or to the county child protective services agency.
- **Elder and At-Risk Adult Abuse:** If your therapist has reasonable cause to suspect an elder or at-risk adult is receiving abuse or maltreatment, whether (or not) the elder or at-risk adult is present in the office/clinic/lobby, your therapist must report such abuse or maltreatment to the county adult protective services agency.
- **Serious Threat to Health or Safety:** LMH may disclose your confidential information to protect you or others from a serious threat of harm or death by you.
- **Oversight:** If there is an inquiry or complaint about your therapist’s professional conduct to the Colorado State Board of Social Work Examiners, LMH may be required to furnish your confidential mental health records relevant to this inquiry.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding, LMH will only release information with your written authorization or a court order. LMH must inform you of the request for information prior to releasing the information.
- **Worker’s Compensation:** If you file a worker’s compensation claim, and LMH is treating you for the issues involved with that complaint, then LMH must furnish to the chairman of the Worker’s Compensation Board the records containing information regarding your condition and treatment.

---

Print Client Name

---

Date of Birth

---

Client Signature/Responsible Party

---

Date



**LAVENDER**  
MENTAL HEALTH  
160 E 12th St. Ste 1  
Durango, CO 81301  
970.426.0636

## **Telemental Health Informed Consent**

I \_\_\_\_\_, hereby consent to participate in telemental health (aka telehealth/virtual therapy) with Lavender Mental Health LLC (LMH) as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are in two separate locations.

### **I understand the following with respect to telemental health:**

- 1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
- 2) I understand that there are risk and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
- 3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
- 4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
- 5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
- 6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call LMH at 970-426-0636 to discuss since we may have to re-schedule.
- 7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

(CONTINUED NEXT PAGE)



LAVENDER

MENTAL HEALTH

160 E 12th St. Ste 1

Durango, CO 81301

970.426.0636

### **Emergency Protocols for Telemental**

LMH needs to know your location during remote sessions in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital or crisis center in the event of an emergency.

In case of an emergency, my location is: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

and my emergency contact person's name, address, phone:

\_\_\_\_\_

\_\_\_\_\_

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all my questions have been answered to my satisfaction.

\_\_\_\_\_

Signature of client

\_\_\_\_\_

Signature of therapist

\_\_\_\_\_

Date

\_\_\_\_\_

Date