CRAIG DAVID LOUNSBROUGH, M.DIV., LPC

19284 Cottonwood Drive, Suite 202
Parker, Colorado 80138
(303) 593-0575

Welcome to my practice. I appreciate the fact that you have selected me for your counseling needs. I will strive to provide you with the best care possible. To help me more effectively meet your needs, please fill out this form completely in ink. If you have any questions or need assistance, please feel free to ask me as our first session begins.

Date _____

Patient's Name _____ SS# _____ DOB _____

Gender: Male _____ Female _____ Marital Status _____

Street Address _____

City, State and Zip _____

Home Phone Number _____ Referred by _____

Occupation _____

Employer _____ Phone Number _____

Employer's Address _____

City, State and Zip _____

Church _____ Member _____ Attender _____

Denomination _____ Pastor _____

Do you wish to sign a release of information allowing me to include your Pastor/Priest as a part of your treatment team? If you check the "Yes" box, please fill out the attached "Release of Information" form so that I can contact them. Yes _____ No _____ N/A _____

Please take time to complete the following *if the responsible party is someone other than the person listed above*. If you plan to submit your claims for insurance reimbursement, the following information must be complete about the insured.

Name _____ SS# _____ DOB _____

Gender: Male _____ Female _____ Marital Status _____

Occupation _____

Employer _____ Phone Number _____

Employer's Address _____

PLEASE COMPLETE BOTH SIDES OF THE PATIENT DATA SHEET

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City, State and Zip _____

In Case of Emergency Contact _____

Their Home Phone # _____ Work # _____

Name of Your Physician _____ Phone # _____

Do you wish to sign a release of information allowing me to include your Physician as a part of your treatment team? If you check the "Yes" box, please fill out the attached "Release of Information" form so that I can contact them. Yes _____ No _____ N/A _____

Briefly explain your reason for seeking therapy: _____

_____

_____

What do you hope to accomplish from therapy: _____

_____

_____

Please list all previous therapist(s) and counseling experience(s): _____

_____

Have you formally terminated therapy with your previous therapist? *Yes _____ No _____ N/A ____

*If you have terminated with your previous therapist, do you wish to sign a "Release of Information" form so that I can receive copies of your records? Yes _____ No _____ N/A ____

If you would like to be added to our email list to receive helpful information and tips on a wide variety of mental health issues, please print your email address here: _____

_____ _____
Signature Date

_____ _____
Signature of Partner (If seeking conjoint/marital therapy) Date

PLEASE COMPLETE BOTH SIDES OF THE PATIENT DATA SHEET

Craig D. Lounsbrough, M.Div., LPC
Licensed Professional Counselor
19284 Cottonwood Drive, Suite 202
Parker, Colorado 80138
(303) 593-0575

DISCLOSURE AND CONSENT FORM

Welcome to my practice. Thank you for deciding to seek counseling with me. The following information will help you understand many of the details about your therapy here. My primary commitment is to provide quality treatment to individuals, couples and families regardless of age, race, gender, or religious affiliation. Professional Christian counseling and the use of spiritual resources are available for patients who request it. I am further committed to the patient's rights of information regarding office policy, non-discrimination, confidentiality, consent and competent service. In keeping with this policy, I have listed below several regulations, client rights, divorce, custody, professional and my office policies for your information. Please read through these, ask any questions you may have. Also, please read through and sign the other forms provided along with this disclosure form. Please ask me any questions you have regarding these forms or their content during our session (s).

Many of my patients have already seen my website, www.craiglpc.com and read my biography regarding my professional experience and credentials. I have also included a copy in your intake packet. Please initial here that you are aware of this information and _____/_____please ask me any questions or concerns you may have during our session (s).

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The regulatory boards can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. The regulatory requirements for mental health professionals provide that a Licensed Clinical Social Worker, a 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. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a master's degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelor's degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. A Registered Psychotherapist is listed in the State's Database and is authorized by law to practice psychotherapy in Colorado, but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.

CLIENT RIGHTS AND IMPORTANT INFORMATION

1. You are entitled to receive information from me about my methods of therapy, the techniques I use, and the duration of your therapy, and my fee. Please ask if you would like to receive this information.
2. You can seek a second opinion from another therapist or terminate therapy at any time.
3. Consistent with my established moral and ethical position, in a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Board that licenses, certifies or registers the therapist.

4. Generally speaking, information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and the therapist cannot disclose the information without the client's consent. There are several exceptions to confidentiality which include: (1) I am required to report any suspected incident of child abuse or neglect to law enforcement; (2) I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (3) I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental disorder; (4) I am required to report any suspected threat to national security to federal officials; (5) I am required to report abuse of a senior, who is 70 years of age or older, which I believe has probably occurred, including institutional neglect, physical injury, financial exploitation, or unreasonable restraint; and (6) I may be required by Court Order to disclose treatment information.
5. When I am concerned about a client's safety, it is my policy to request a Welfare Check through local law enforcement. In doing so, I may disclose to law enforcement officers information concerning my concerns. By signing this Disclosure Statement and agreeing to treat with me, you consent to this practice, if it should become necessary.
6. Under Colorado law, C.R.S. § 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information. If you request treatment information from me, I may provide you with a treatment summary, in compliance with Colorado law and HIPAA Standards.
7. I agree not to record our sessions without your written consent; and you agree not to record a session or a conversation with me either through voice or video recording without my written consent.
8. Have you ever filed a grievance on a mental health, medical or dental professional? Yes / No If yes, please explain the situation and outcome to Mr. Lounsbrough during your initial session.

DISCLOSURE REGARDING DIVORCE AND CUSTODY LITIGATION

If you are involved in divorce or custody litigation, my role as a therapist is not to make recommendations to the court concerning custody or parenting issues. By signing this Disclosure Statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that I write any reports to the court or to your attorney, making recommendations concerning custody. The court can appoint professionals, who have no prior relationship with family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interests of the family's children.

PAYMENT POLICY

My policy is for each person receiving counseling or testing services to pay for such service **at the time the professional services are rendered**. Payment can be made using cash, checks, or Visa/MasterCard. Any other arrangements **must be made in advance**. **A $35 administrative fee will be charged on all checks that are returned for non-sufficient funds.**

My per-session fee is **$140** and is based on a fifty (50) minute session. Weekend appointment fees are **$140** per each fifty (50) minute session. Patient telephone calls, consultations with other professionals, and report preparation less than 5 minutes are without charge; those 5 minutes or more are billed at the per session rate in 15 minute increments.

Please note: Charges for testing services are in addition to the regular per-session fee. Please refer to the assessment policy sheet for further information.

INSURANCE

Many insurance policies provide partial to total coverage for mental health services. Your insurance (personal, group, private, governmental, partial payment or full payment type) is a contract between you and your insurance company; it is not an agreement between the insurer and my practice. This means that your account with me is **your responsibility** regardless of insurance coverage which may exist. It is agreed that payments will not be delayed or withheld because of any insurance coverage or dependency upon those payments. It is also understood that Craig D. Lounsbrough, LPC will not assume responsibility for the collection of insurance payments. I (we) authorize the release of my DSM-V (or ICD-10) diagnosis to be printed on my (our) HCFA (Health Claim Form) in order for me (us) to obtain any and all ***out of network*** insurance benefits.

CANCELLATIONS/MISSED APPOINTMENT

I understand that it may, at times, be necessary to cancel an appointment. To help me be most efficient and responsible in the use of my time, I require that **any changes or cancellations be made at least 24 hours in advance any workday, Monday through Friday**. If there is a need to cancel a Monday appointment, that cancellation would need to be made **by the Friday before the appointment**. If you have scheduled two fifty-minute sessions on the same day and need to cancel, I will need **48 hours advance notice**. **Any changes or cancellations received less than 24/48 hours in advance will be charged the regular per-session rate. Any missed appointment with no call received will be charged the regular per-session rate**.

EMERGENCIES

If a life threatening emergency arises, please call 911 or go to your nearest hospital emergency room. Please let them know you are one of my patients and ask them to call me. I would also ask that you call me as soon as you are able.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of the person named below and agree to pay all fees for such treatment. I agree to pay all charges for me and members of my family shown by statements promptly, upon presentment thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days of billing date. Accounts with no financial activity for 30 days may be sent to a professional collection agency, including potential court costs, attorney fees, and other costs of collection.

I attest that I have read this information sheet and that it has been presented to me verbally. I have seen Craig Lounsbrough's biography, am aware of his degrees, and credentials, professional experience and certifications. I understand the disclosures that have been presented to me. I further agree to receive counseling under these conditions and that I have received a copy of this Disclosure Statement.

_____	_____
Signature of Patient or Legal Guardian	Signature of Spouse (when in Couples Therapy)
Print Client's Name _____	Print Client's Name _____
Date: _____	Date: _____

THE IMPORTANCE AND VALUE OF PERSONALITY TESTING

Welcome to the office of Craig D. Lounsbrough, Licensed Professional Counselor. I appreciate that you have selected my office for your counseling needs. When a person comes to therapy, they can be experiencing a wide variety of concerns. An important part of my treatment program involves clarifying what the problems are and the kinds of resources the person has to deal with those problems. At times the presenting problems, the ones that led the individual to seek help, are symptoms of deeper issues. There are a variety of levels to all relational, emotional, and psychological problems and in order to maximize the therapy process it is valuable to determine as soon as possible the various factors that may be contributing to the problems.

In order to provide you with the most focused and short-term treatment possible, it is my policy that all new patients take the Myers-Briggs Type Indicator. The Myers-Briggs Type Indicator (MBTI) is one of the most popular and useful tools to understand your strengths and how you relate to others. It is a valuable and effective resource in working with individuals, marriages and families.

I have used the MBTI for over twenty years. There is no cost for the initial MBTI. The initial MBTI includes a detailed interpretative report that allows you to become more familiar with your personality and relationship styles as well as assist you and I in the development of your specific treatment plan. This tool is given to you to take at home between sessions and returned at the next appointment for scoring and report generation.

Additionally, during our first session, your situation will be assessed and a recommendation will be made to you regarding the potential use of any additional testing and assessment tools. ***Recommendations will only be made if it appears that testing and/or assessment will effectively provide the information and resources necessary to maximize counseling outcomes.*** Should it be determined that additional testing would be of value in assisting you in achieving your goals for therapy, those instruments will be reviewed at that time. The most frequently utilized tests that we provide are the MCMI-3 at $200.00, the MMPI-2 at $200.00 and the TJTA at $60.00. Types of testing, the rationale for testing, how a particular test would assist you in achieving your goals, as well as any costs will be reviewed should additional testing be recommended. It is within the patient's right to accept or decline any testing recommendations.

If you have any questions, please do not hesitate to ask. My primary concern is to provide you with the most time-effective/cost-effective care possible. Your insurance company may/or may not reimburse you for personality assessment/psychological testing; therefore, I am notifying you in advance. I appreciate your cooperation and look forward to working with you.

_____ _____

Signature of Patient Signature of Partner (if in couple therapy)

Date_____ Date_____

PATIENT/THERAPIST GUIDELINES

Craig D. Lounsbrough, M.Div., LPC

1. Therapy with Craig Lounsbrough is a collaborative process between him and his patient(s). This means that Mr. Lounsbrough does what he commits himself to do and the patient does the same. An example of this is reflected in the homework assignments, reading, behavioral assignments, charting, and assessments, etc., are to be completed in the agreed upon time.

2. Successful treatment starts with and builds on a good rapport between patient and therapist; however, this is based on appropriate professional boundaries. Mr. Lounsbrough treats patients with respect, dignity and care. He anticipates that patients will treat him in a similar manner. Mr. Lounsbrough does not allow sessions to be recorded.

3. Mr. Lounsbrough has been practicing as a mental health provider for over twenty-nine years. He is only licensed as a Licensed Professional Counselor in Colorado. People residing in other states or within the State of Colorado who request to be his patients will need to be prepared to come to his Parker office for initial sessions to include a clinical intake, personality assessments, initial therapy sessions and treatment planning. If Mr. Lounsbrough's clinical assessment is that the patient's presenting issues and diagnosis are of the nature that they cannot be managed by an in office and telephone regimen, then he will only provide transition assistance until a local provider can be secured for the patient. Please be advised that your insurance provider may not reimburse you for his services.

4. Mr. Lounsbrough is committed to his patient's well-being. He may request a collateral session(s) with a patient's family member, MD, another therapist, a pastor or priest, etc. to receive other's perspective on the patient. If this is needed, Mr. Lounsbrough will discuss this with the patient and obtain their signed permission to allow him to speak to them. The patient will be responsible for the payment of that session(s).

5. All new patient forms will need to be filled out and supplied to Mr. Lounsbrough's office at the person's first visit. Out of State or local patients will be emailed these forms in advance.

6. Mr. Lounsbrough's agreed upon fees are to be paid at the time of the session. He asks for a patient's credit card to be on file to be run remotely for any in-office, telephone sessions, case management and assessment costs.

7. Mr. Lounsbrough maintains a full patient schedule. He asks that you would respect his time boundaries as he seeks to do the same for his patients. When patient emergencies arise in his day, he will contact you as soon as possible and reschedule if the need arises. Although Craig returns calls the same business day, if you are calling him on the weekend, he may not return your call until the following Monday.

8. If you have any other questions or concerns, please talk to Mr. Lounsbrough during your initial session.

9. I consent to have read these guidelines and commit myself to follow them as Mr. Lounsbrough's patient.

Patient's Signature_____ Date_____

Patient's Partner or Parent_____ Date_____

Electronic Payment Communications Disclosure

Payments for Craig D. Lounsbrough, LPC services via credit card include the following cards:

- Visa
- MasterCard

Please Be Aware of the Following:

We have the duty to uphold your confidentiality, and thus we wish to make sure that your use of the above payment services is done as securely and privately as possible.

After using either of these cards to pay your fees, that service may send you receipts for payment by email or text message. These receipts will include our business name, and would indicate that you have paid for a therapy session.

It is possible the receipt may be sent automatically, without first asking if you wish to receive the receipt. We are unable to control this and we are likewise unable to control which email address or phone number your receipt is sent to. These factors are determined by your credit card company as part of your agreement with them.

So before using one of the above services to pay for your session(s), please think about these questions:

- At which email address or phone numbers have I received these kinds of receipts before?
- Are any of those addresses or phone numbers provided by my employer or school? If so, the employer or school will most likely be able to view the receipts that are sent to you.
- Are there any other parties with access to these addresses or phone numbers that should not be seeing these receipts? Would there be any danger if such a person discovered them?

In addition to these possible emails or text messages, payments made by credit card will appear on your credit card statement as being made to Craig D. Lounsbrough, LPC. Therefore, you may wish to consider who might have access to your statements before making payments by credit card.

Health Savings Account and Flexible Spending Accounts

If you are using a Health Savings Account (HSA) or Flexible Spending Account (FSA) payment card, please be aware that even if your payment goes through and is authorized at the time that we run your card, there is the possibility that your payment could later be denied. In the event of this happening, you are responsible for ensuring that full payment is made by other means.

I acknowledge receipt of this notice and that I have read it and consent to it.

Patient Name : _____ Date: _____

Signature: _____

Patient Name : _____ Date: _____

Signature: _____

Craig D. Lounsbrough, M.Div., LPC

Licensed Professional Counselor
Colorado

19284 Cottonwood Drive, Suite 202
Parker, Colorado 80138
TEL: 303-593-0575, extension 2
FAX: 303-840-0902

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____(DOB)_____, hereby authorize Craig D. Lounsbrough, M.Div., LPC to release to and/or receive from: (Example: a former therapist, your current Medical Doctor or psychiatrist), my confidential medical and psychological information and records. Information relative to my counseling and/or psychological evaluation, including: psychological test reports, social history summary, medical records, including medications received, counseling records, or other. Information and records released to Craig D. Lounsbrough are for the purpose of: _____.

Information released includes but is not limited to: dates of contact, reasons for treatment, issues around fitness to parent, relationships with any and all significant others, diagnosis, and treatment progress and outcome. Please list the following information regarding who you are releasing me to contact.

Name: _____

Address: _____

Phone #: _____

I understand that disclosure of this confidential medical record information is protected by HIPAA Federal Regulation 42 CFR, Part 2, and Colorado Revised Statutes 25-1-802 and federal law protects that further disclosure and no further disclosure will be made without my specific and written permission. I further understand that my information may not be protected from re-disclosure by the recipient of this information. The recipient (s) may not re-disclose any information without my further written authorization unless otherwise provided for by state or federal law.

I understand that a copy or facsimile of this authorization is to be considered as valid as the original and that with this authorization I give permission for this information to be sent, either by FAX 303-840-0902 or by regular surface mail. I understand that I may withdraw this authorization, in writing, at any time and that any action taken on this authorization prior to the rescinded date is legal and binding.

_____ _____
Signature of Patient (or parents/guardian if minor) Please Print Your Name Here/ Date

_____ _____
Signature of Partner (If in conjoint therapy) Please Print Your Name Here/ Date

_____ _____
Witness Date

01/10/2019

CRAIG DAVID LOUNSBROUGH, M.DIV., LPC

19284 Cottonwood Drive, Suite 202
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(303) 593-0575

THERAPIST BIOGRAPHY

Welcome to my practice. As we begin our therapy relationship, I will have the opportunity to learn about you. Therefore, it is important that you learn some essentials about me as we begin. If you have any questions about my training or professional credentials, please do not hesitate to ask them during our initial session.

Craig Lounsbrough earned an Associate of Science Degree from Hocking Technical College, a Bachelor of Arts degree in Religion with an emphasis in Christian Education from Azusa Pacific University, and a Master of Divinity degree in Family Pastoral Care and Counseling from Fuller Theological Seminary. He is presently completing his Doctor of Ministry degree in Marriage and Family Counseling from Denver Seminary. Craig is a Licensed Professional Counselor in the State of Colorado, is a Certified Professional Life Coach and is ordained by the Evangelical Church Alliance.

Craig has over thirty years of counseling experience with a wide range of patients in a variety of treatment settings. These have included providing counseling in two psychiatric hospitals, a residential and day treatment program, a facility for the mentally retarded and the physically handicapped, an outpatient clinic and a program for blind developmentally disabled patients. He has also provided counseling services in a variety of church and parachurch ministries.

Craig has a broad and unique base of experience counseling children and adolescents. Areas of emphasis with children include mood disorders, posttraumatic stress disorder, conduct disorder, attention deficit hyperactive disorder, schizophrenia and psychosis. Craig also has significant experience working with children and adolescents who have experienced developmental delays, varying degrees of trauma, various types of physical and/or sexual abuse, abandonment and/or neglect, dysfunctional family systems, as well as issues related to mental retardation and physical handicaps.

Craig also has a strong base of counseling experience working with adults in a variety of settings. Specialty areas include, depression, bipolar disorder, general mood disorders posttraumatic stress disorder, borderline personality disorder, paranoid personality disorder, and attention deficit hyperactive disorder. He is also experienced in the areas of premarital, marital and family therapy. Craig also provides personal and professional life coaching and is a Certified Professional Life Coach.

In addition, Craig has over ten years experience in pastoral ministry. He has served as youth pastor, associate pastor and senior pastor in churches both in Colorado and California. In these positions he has also provided leadership in both state and national denominational ministries. Furthermore, he has published five books to date, has published numerous articles in various Christian publications, and he hosted a Christian radio ministry for two years. He is a member of the American Association of Christian Counselors and is an ordained minister