



Mark R. LaFleur, MA
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303-475-4603

Client Information Packet

Welcome

I am grateful to have the opportunity to work with you. The following pages contain information and forms that I will need to have on file before I can begin offering services to you.

Guidelines

Please complete these documents and return to my office as soon as possible:

- Client Information Form-to be completed and signed by client
- Office Policy Statement-to be reviewed and signed by client
- Disclosure Statement-to be reviewed and signed by client

Once you have completed all of the forms and signed all relevant documents please return originals to my office. I encourage you to retain a copy of this information for your personal records.

Mark R. LaFleur, M.A.

Client Information Form

Name: _____ Date: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Home phone: _____ Work Phone: _____ Cell: _____

Personal Information

Date of birth: _____ Marital Status: _____

Name of Spouse:

Children (Names/Ages):

Employer:

Occupation:

Emergency Contact: Name: _____ Phone: _____

What way to contact you is: Cell Home Phone Email

Is it acceptable to contact you at home? Y / N

Is it acceptable to leave a message on your home phone? Y / N

Are you currently under medical care? Y/ N

If yes, please explain/describe.

Personal Physician: Name: _____ Phone: _____

Date of last physical:

Are you currently taking prescribed medications? Y / N

If yes, please list medication and explain their use.

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Have you been under the care of a psychiatrist, psychologist, or counselor? Y / N
If yes, please give the name and date of therapy and briefly explain the nature of the problem(s) which required attention.

Do you exercise on a regular basis? Y / N
If yes, please list the activity and how often per week you exercise:

Please circle any of the following you feel pertain to you:

Depression	Anxiety	Fears/Phobias	Eating Disorders
Sexual Problems	Suicidal Thoughts	Separation/Divorce	Relationships
Finances	Drug/Alcohol Use	Career Choices	Anger
Self-Control	Unhappiness	Insomnia	Religious Matters
Work/Stress	Health Problems	Cutting/Self-Mutilation	

*Briefly describe reason(s) you are seeking counseling at this time.

Billing Information

Who is responsible for payment? _____

Name: _____

Relationship to client: _____

Referral

How did you hear of my services?

May I contact this person(s) to thank them for their referral? Y / N

Referrals Contact Info: Phone: _____ Email: _____

By signing below you are allowing me to contact the referral source.

Client Signature (parent or guardian of minor) _____ Date _____

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Disclosure Statement

Ethical Standards

The practice of psychotherapy is regulated by the Department of Regulatory Agencies. The address and telephone number of the Grievance Board is: 1560 Broadway, Suite 1340, Denver, CO 80202. Telephone: (303) 894-7766.

You are entitled to receive information about the following:

- Methods of therapy
- Therapy techniques
- Duration of therapy (if known)
- Fee structure

You may seek a second opinion from another therapist or may terminate therapy at any time (except under special circumstances.) In the case of terminating please give me notice of your leaving. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Grievance Board.

Confidentiality

The confidentiality of your visits and of your discussion with your therapist is protected by the standards of ethical practice and the law. However, there are four important exceptions you should know about:

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 offices.

I am under the supervision of Sharon Hersh, LPC (a licensed professional counselor) therefore, anything you disclose to me may be shared with both privately or during group supervision.

Disclosure of Credentials

You are entitled to the name, business address, business phone number and listing of degrees, credentials and licenses of the therapist providing psychotherapy services to you.

Name: Mark R. LaFleur, MA

Credentials: Registered Counselor, # 8704

Office Address: 7475 W. 5th Ave., Ste. #210

Lakewood, Colorado 80226

Phone: 303-475-4603

Mark R. LaFleur, M.A.

I have been informed of my therapist degrees and credentials. I have also read the preceding information and understand my rights as a client.

Client Signature (parent or guardian of minor)

Date

Office Policies

I am pleased to have the opportunity to serve you and have included some information you may find helpful in your visits.

Messages

You may call (303) 475-4603 regarding any questions you may have (i.e. billing, appointments etc.) and I will get back to you at my earliest availability. (Please note that I use a cell phone for my main means of connection. Cell phones do not guarantee confidentiality. By signing this form you are allowing me to use my cell phone for our out of office communications.) You may also contact me via email at mrlcounseling@comcast.net. (Please note that email does not guarantee confidentiality. By signing this form you are allowing me to use email for our out of office communications.)

*Please note that it is completely acceptable to contact me if there is an emergency, however I do begin to charge all phone calls after 10 minutes (charge is pro-rated).

Appointments

Services are by appointment only and normally scheduled for 50 minutes. As this time is reserved exclusively for you, it is necessary to charge for appointments that are not canceled at least a full 24 hours in advance. In the event of an emergency, special consideration may be given regarding the cancellation policy.

Charges

My fees for psychological services are based on customary and reasonable fee profiles for this area. Payment is due at the time of service. Please have your check ready prior to our session.

Payment is due at the beginning of each session.

Fees are subject to change on an annual or bi-annual basis.

I do not collect insurance for payment. I will, however, give you a printed statement for you to file with your insurance if you so desire.

In order to help you fulfill your financial commitments I will work closely with you to create a payment plan that will fit your needs. However, if your account becomes severely overdue, I reserve the right to resort to the necessary collection procedures. If these procedures become necessary, you will be held accountable to pay all reasonable legal fees toward the collection of your debt.

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I have read and I understand the above information. I agree to pay \$100.00 for individual or \$115 for marital/couples per 50 minute session, and I understand that I am responsible for full payment of these amounts.

Client Signature (parent or guardian of minor)

Date

Final/Ending Session

Within all of therapy there is an ending. When we have successfully completed the therapeutic process it is important to have an "ending/closing" session. The ending/closing session is an important element to a successful counseling experience.

Referrals

Finally, the work that I do is highly based on word of mouth referrals. I am always thankful and appreciative of all referrals from my clients. Please let me know if you would like to have cards/brochures for anyone that you believe could benefit from my services. Thank you.