



*Academy of Creative Living*

SHARON M. BARNES, MSSW, LCSW

THERAPIST FOR SENSITIVE AND GIFTED



*Those who come to psychotherapy  
are the wisest and most courageous among us.  
Everyone has problems, but what they often do  
is try to pretend that those problems don't exist,  
or they run away from those problems,  
or drink them down,  
or ignore them in some other way.  
It's only the wiser and braver among us  
who are willing to submit themselves  
to the difficult process of self-examination  
that happens in a psychotherapist's office.  
- M. Scott Peck, M.D.*



**CLIENT INFORMATION**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Street: \_\_\_\_\_ City, Zip \_\_\_\_\_  
 Best Phone Number: \_\_\_\_\_ OK to leave a message? Y N Birth Date: \_\_\_\_\_  
 Other Phone Number: \_\_\_\_\_ OK to call? \_\_\_\_ Employer: \_\_\_\_\_  
 Email Address: \_\_\_\_\_ OK to send you our email newsletter? Yes No  
 Please indicate how best to contact you: \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

If you searched online, how did you find us? (Circle All) Bing Google Yahoo Facebook Twitter  
 LinkedIn Psychology Today Denver Therapists Network GoodTherapy.org YourTango YouTube  
 Other \_\_\_\_\_

If were you referred, by whom?: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Reason for Referral : \_\_\_\_\_ May I send them a Thank-you note? Yes?

*In Case of Emergency Contact:*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Street, City, Zip: \_\_\_\_\_ Phone : \_\_\_\_\_

*Person Responsible for the Bill:*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Street, City, Zip: \_\_\_\_\_  
 Week Day Phone: \_\_\_\_\_ Week End/Night Phone: \_\_\_\_\_

You may release information necessary for billing to this person: \_\_\_\_\_

*Please list all people living in your household:*

Name	age	Relationship to you	Occupation/School grade
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



# Academy of Creative Living

SHARON M. BARNES, MSSW, LCSW

THERAPIST FOR SENSITIVE AND GIFTED



8089 South Lincoln Street, Suite 203, Littleton, Colorado 80122

Phone: (303) 987-0346 Fax: (303) 989-0099

www.TherapistForSensitiveAndGifted.com

## Online and Phone "Distance Consultation" Consent

**What is Distance Consultation?** Distance Consultation is working with a psychotherapist via video or audio communications.

In the state of Colorado, USA, where I am licensed, psychotherapy is recognized as happening only on an in-person basis, where we are both in the same room face-to-face. For people at a distance who wish to work with me, *and for whom it appears that distance consultation is appropriate and could be helpful*, I also offer Distance Consultations. For video consultations, I use a free video-conferencing program through [Vsee.com](http://Vsee.com) which is easy to use and is available for all types of computers. In order to use it you must have a "web cam" and a high-speed Internet connection. Vsee states that their services are HIPAA compliant, which means that confidentiality is protected and others online are unable to listen to or watch our session.

**My fees for Distance Consultation are the same as for in-person therapy. Payment must be made through a Credit Card or via PayPal before or at the time of the appointment.**

**Why would you choose Distance Consultation?** Some of the common reasons include....

- You cannot find a therapist appropriate to your needs in your local area (this is the most common reason)
- You don't have to travel anywhere; you save travel time and expenses
- To supplement your in-person therapy sessions

**Why would you not choose Distance consultation?**

- It can be harder to establish a personal connection and relationship when we are not in the same room at the same time.
- There may not be the same sense of safety and security when we are not in the same room at the same time. It may therefore be harder to deal with sensitive and difficult things.
- Nuances of communication on both sides may be harder to perceive; misunderstandings and missed communication can more easily happen when meeting by phone or online.

**Is Distance Consultation as effective as in-person therapy?** Distance Consultation may be, but is not always as effective as in-person therapy. In some cases it is best to combine online therapy with some in-person sessions. Other problems are helped very effectively with Distance Consultation alone.

**I have read the above information and has asked any questions I have about it. I understand the issues involved and I request to have online counseling with Sharon M. Barnes, MSSW, LCSW, PLLC.**

Client Signature

Date

# Amen Clinics, Inc. Adult Intake Questionnaire

Used by permission

In order to able to fully evaluate your needs, please fill out the following intake form and questionnaires to the best of your ability. We realize there is a lot of information and you may not remember or have access to all of it; please do the best you can. If there is any information that you do not want in your chart it is ok to refrain from putting in this information and we will discuss it. Thank you!

## CLIENT IDENTIFICATION

Name _____	First Appointment Date _____
Birth Date _____	Age _____ Gender _____
Religion _____	Marital Status _____
Race _____	Children _____
Address _____	City _____
State/Province _____	Country _____
Best phone _____	Other phone _____

Who are you currently living with? \_\_\_\_\_

## MAIN PURPOSE OF THE CONSULTATION (Please give a brief summary of the main problems)

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## WHY DID YOU SEEK THE CONSULTATION AT THIS TIME? What are your goals in being here?

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## PRIOR ATTEMPTS TO CORRECT THE PROBLEMS/MENTAL HEALTH HISTORY

(Please include contact with other professionals, medications, types of treatment, etc.)

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Name: \_\_\_\_\_

## MEDICAL HISTORY:

Current medical problems/medications: \_\_\_\_\_

Current supplements/herbs: \_\_\_\_\_

Past medical problems/medications: \_\_\_\_\_

Other medical/mental health professionals seen regularly: \_\_\_\_\_  
Any history of head trauma? (describe) \_\_\_\_\_  
Ever any seizures or seizure-like activity? \_\_\_\_\_  
Prior hospitalizations (place, cause, date, outcome) \_\_\_\_\_  
Prior abnormal lab tests, X-rays, EEG, etc: \_\_\_\_\_  
Allergies/drug intolerances (describe) \_\_\_\_\_  
Present Height \_\_\_\_\_ Present Weight \_\_\_\_\_ Any changes in weight: \_\_\_\_\_

**CURRENT LIFE STRESSES** (include anything that is currently stressful for you, examples include relationships, job, school, finances, children, etc.) \_\_\_\_\_  
\_\_\_\_\_

**Prenatal and birth events:** Your parents' attitude toward their pregnancy with you: \_\_\_\_\_  
Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc. \_\_\_\_\_  
Any birth problems, trauma, forceps or complications? \_\_\_\_\_

**Sleep Behavior:** sleepwalking, nightmares, recurrent dreams, current problems ( getting up, going to bed, etc.) \_\_\_\_\_  
\_\_\_\_\_

**School History:** Last grade completed \_\_\_\_\_ Last school attended \_\_\_\_\_  
Average grades received \_\_\_\_\_ Specific learning disabilities \_\_\_\_\_  
Learning strengths \_\_\_\_\_  
Any behavior problems in school? \_\_\_\_\_  
What have teachers said about you? \_\_\_\_\_  
*Please bring school report cards and any state, national or special testing that has been performed.*

**Employment History:** (Summarize jobs you've had, list most favorite and least favorite) \_\_\_\_\_  
\_\_\_\_\_

Any work related problems? \_\_\_\_\_  
What would your employers or supervisors say about you? \_\_\_\_\_

**Military History?** \_\_\_\_\_

**Ever Any Legal Problems?** \_\_\_\_\_

**Sexual History:** (answer only as much as you feel comfortable)  
Age at the time of first sexual experience: \_\_\_\_\_ Number of sexual partners: \_\_\_\_\_  
Any history of sexually transmitted disease? \_\_\_\_\_ History of abortion? \_\_\_\_\_  
History of sexual abuse, molestation or rape? \_\_\_\_\_  
Current sexual problems? \_\_\_\_\_

**Alcohol and Drug History** (Please list age started and types of substances used through the years and any or current usage. Also, describe how each of these substances makes/made you feel, what benefit you get/got from them). These include alcohol, (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc.), cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms), PCP. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever experienced withdrawan symptoms from alcohol or drugs? \_\_\_\_\_

Has anyone told you they thought you had a problem with drugs or alcohol? \_\_\_\_\_

Have you ever felt guilty about your drug or alcohol use? \_\_\_\_\_

Have you ever used drugs or alcohol first thing in the morning? \_\_\_\_\_

What is your caffeine use per day? (Caffeine is in coffee, tea, sodas, chocolate) \_\_\_\_\_

What is your nicotine use per day? (Nicotine is in cigarettes, tobacco chew) \_\_\_\_\_

**FAMILY HISTORY**Family Structure : (Who lives in your current household, please give relationship to each) \_\_\_\_\_  
\_\_\_\_\_

**Current Marital or Relationship Satisfaction** \_\_\_\_\_

**Significant Developmental Events** (Include marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**History of Past Marriages** \_\_\_\_\_

**Birth Mother History:** age: \_\_\_\_\_ outside work: \_\_\_\_\_

School, highest grade completed \_\_\_\_\_

Learning problems: \_\_\_\_\_ Behavior Problems: \_\_\_\_\_

Marriages \_\_\_\_\_

Medical Problems: \_\_\_\_\_

Childhood atmosphere (family position, abuse, illnesses, etc) \_\_\_\_\_

Has mother ever had any psychiatric treatment? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, for what purpose? \_\_\_\_\_

Mother's alcohol/drug use history? \_\_\_\_\_

Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (Specify) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Birth Father History:** age: \_\_\_\_\_ outside work: \_\_\_\_\_

School, highest grade completed \_\_\_\_\_

Learning problems: \_\_\_\_\_ Behavior Problems: \_\_\_\_\_

Marriages \_\_\_\_\_

Medical Problems: \_\_\_\_\_

Childhood atmosphere (family position, abuse, illnesses, etc) \_\_\_\_\_

Has father ever had any psychiatric treatment? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, for what purpose? \_\_\_\_\_

Father's alcohol/drug use history? \_\_\_\_\_

Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (Specify)

**Siblings** (names, ages, problems, strengths, relationship to client) \_\_\_\_\_

**Children** (names, ages, problems, strengths, with whom they live) \_\_\_\_\_

**Cultural/Ethnic Background** \_\_\_\_\_

**Describe your relationships with friends** \_\_\_\_\_

**Describe Yourself** \_\_\_\_\_

**Describe your strengths** \_\_\_\_\_

## Sharon Barnes' CASIGY Characteristics Questionnaire

**Please indicate HOW OFTEN the following statements are true by circling the answer which is most correct.**

- |  |           |       |  |
|--|-----------|-------|--|
| NEVER  | SOMETIMES | OFTEN | I have an insatiable curiosity.                                      |
| NEVER  | SOMETIMES | OFTEN | I set very high standards for myself.                                |
| NEVER  | SOMETIMES | OFTEN | I can be my own worst critic.  |
| NEVER  | SOMETIMES | OFTEN | I have a powerful need to know things.                               |
| NEVER  | SOMETIMES | OFTEN | I am a seeker of ultimate truths.                                    |
| NEVER  | SOMETIMES | OFTEN | I have been criticized for being “too much” of everything.           |
| NEVER  | SOMETIMES | OFTEN | I feel deeply wounded by injustice and human suffering.              |
| NEVER  | SOMETIMES | OFTEN | I can see many sides to nearly every issue.                          |
| NEVER  | SOMETIMES | OFTEN | I love a good debate.  |
| NEVER  | SOMETIMES | OFTEN | I have a lot of energy.  |
| NEVER  | SOMETIMES | OFTEN | I often feel driven by my own creativity.                            |
| NEVER  | SOMETIMES | OFTEN | I love puzzles, mazes, paradoxes, complex ideas, and words. (If      |
| more than one, circle the ones which apply)  |           |       |  |
| NEVER  | SOMETIMES | OFTEN | I often feel responsible for problems that don't belong to me.       |
| NEVER  | SOMETIMES | OFTEN | Many times I have felt ‘different’ from most other people.           |
| NEVER  | SOMETIMES | OFTEN | I often feel like a minority of one.                                 |
| NEVER  | SOMETIMES | OFTEN | I am a dyed-in-the-wool perfectionist.                               |
| NEVER  | SOMETIMES | OFTEN | I have been criticized for not “sticking with one thing.”            |
| NEVER  | SOMETIMES | OFTEN | Honesty, integrity, and authenticity are very important to me.       |
| NEVER  | SOMETIMES | OFTEN | Frustration builds up in me when I don't engage in activities that   |
| involve creative self-expression.  |           |       |  |
| NEVER  | SOMETIMES | OFTEN | I have a history of questioning rules and challenging authority.     |
| NEVER  | SOMETIMES | OFTEN | I have heightened senses: taste, touch, smell hearing, sight, and/or |
| seem to be bothered by bright lights, aromas, or noises that others don't even notice (If yes, circle the ones |           |       |  |
| which apply).  |           |       |  |
| NEVER  | SOMETIMES | OFTEN | I have a well-developed sense of humor that is somewhat offbeat.     |
| NEVER  | SOMETIMES | OFTEN | I often have a childlike sense of playfulness and wonder.            |
| NEVER  | SOMETIMES | OFTEN | Stress seems to have more impact on me than it does on others.       |

**Please add up your score: NEVER \_\_\_\_\_ SOMETIMES \_\_\_\_\_ OFTEN \_\_\_\_\_**



## Amen Brain System Checklist (Used by permission)

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person who knows you well (such as a spouse, partner or parent) rate you as well. Name other: \_\_\_\_\_

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>NA</b>
Never	Rarely	Occasionally	Frequently	Very Frequently	Not applicable/Not Known

Other    Self Rating

- |       |       |   |
|-------|-------|---|
| _____ | _____ | 1. Fails to give close attention to details or makes careless mistakes  |
| _____ | _____ | 2. Trouble sustaining attention in routine situations (i.e., homework, chores, paperwork)                     |
| _____ | _____ | 3. Trouble listening  |
| _____ | _____ | 4. Fails to finish things   |
| _____ | _____ | 5. Poor organization for time or space (such as backpack, room, desk, paperwork)                              |
| _____ | _____ | 6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort.                 |
| _____ | _____ | 7. Loses things   |
| _____ | _____ | 8. Easily distracted  |
| _____ | _____ | 9. Forgetful  |
| _____ | _____ | 10. Poor planning skills  |
| _____ | _____ | 11. Lack clear goals or forward thinking  |
| _____ | _____ | 12. Difficulty expressing feelings  |
| _____ | _____ | 13. Difficulty expressing empathy for others  |
| _____ | _____ | 14. Excessive daydreaming   |
| _____ | _____ | 15. Feeling bored   |
| _____ | _____ | 16. Feeling apathetic or unmotivated  |
| _____ | _____ | 17. Feeling tired, sluggish, or slow moving   |
| _____ | _____ | 18. Feeling spacey, or “in a fog”   |
| _____ | _____ | 19. Fidgety, restless or trouble sitting still  |
| _____ | _____ | 20. Difficulty remaining seated in situations where remaining seated is expected                              |
| _____ | _____ | 21. Runs about or climbs excessively in situations in which it is appropriate (or wants to-restrains oneself) |
| _____ | _____ | 22. Difficulty playing/working quietly  |
| _____ | _____ | 23. “On the go” or acts as if “driven by a motor”   |
| _____ | _____ | 24. Talks excessively   |
| _____ | _____ | 25. Blurts out answers before questions have been completed (or has to restrain oneself from doing so)        |
| _____ | _____ | 26. Difficulty waiting turn   |
| _____ | _____ | 27. Interrupts or intrudes on others (e.g., butts into conversations or games)                                |
| _____ | _____ | 28. Impulsive (saying or doing things without thinking first)   |
| _____ | _____ | 29. Excessive or senseless worrying   |
| _____ | _____ | 30. Upset when things do not go your way  |
| _____ | _____ | 31. Upset when things are out of place  |
| _____ | _____ | 32. Tendency to be oppositional or argumentative  |
| _____ | _____ | 33. Tendency to have repetitive negative thoughts   |
| _____ | _____ | 34. Tendency toward compulsive behaviors  |
| _____ | _____ | 35. Intense dislike for change  |
| _____ | _____ | 36. Tendency to hold grudges  |
| _____ | _____ | 37. Trouble shifting attention from subject to subject  |
| _____ | _____ | 38. Trouble shifting behavior from task to task   |
| _____ | _____ | 39. Difficulties seeing options in situations   |
| _____ | _____ | 40. Tendency to hold on to own opinion and not listen to others   |
| _____ | _____ | 41. Tendency to get locked into a course of action, whether or not it is good                                 |
| _____ | _____ | 42. Needing to have things done a certain way or you become very upset  |
| _____ | _____ | 43. Others complain that you worry too much   |
| _____ | _____ | 44. Tend to say no without first thinking about question  |
| _____ | _____ | 45. Tendency to predict fear  |
| _____ | _____ | 46. Frequent feelings of sadness  |
| _____ | _____ | 47. Moodiness   |

- \_\_\_\_\_ 48. Negativity
- \_\_\_\_\_ 49. Low energy
- \_\_\_\_\_ 50. Irritability
- \_\_\_\_\_ 51. Decreased interest in others
- \_\_\_\_\_ 52. Decreased interest in things that re usually fun or pleasurable
- \_\_\_\_\_ 53. Feelings of hopelessness about the future
- \_\_\_\_\_ 54. Feelings of helplessness or powerlessness
- \_\_\_\_\_ 55. Feeling dissatisfied or bored
- \_\_\_\_\_ 56. Excessive guilt
- \_\_\_\_\_ 57. Suicidal feelings
- \_\_\_\_\_ 58. Crying spells
- \_\_\_\_\_ 59. Lowered interest in things usually considered fun
- \_\_\_\_\_ 60. Sleep changes (too much or too little)
- \_\_\_\_\_ 61. Appetite changes (too much or too little)
- \_\_\_\_\_ 62. Chronic low self-esteem
- \_\_\_\_\_ 63. Negative sensitivity to smells/odors
- \_\_\_\_\_ 64. Frequent feelings of nervousness or anxiety
- \_\_\_\_\_ 65. Panic Attacks
- \_\_\_\_\_ 66. Symptoms of heightened muscle tension (headaches, sore muscles, hand tremor)
- \_\_\_\_\_ 67. Periods of heart pounding, rapid heart rate or chest pain
- \_\_\_\_\_ 68. Periods of trouble breathing or feeling smothered
- \_\_\_\_\_ 69. Periods of feeling dizzy, faint or unsteady on your feet
- \_\_\_\_\_ 70. Periods of nausea of abdominal upset
- \_\_\_\_\_ 71. Periods of sweating, hot or cold flashes
- \_\_\_\_\_ 72. Tendency to predict the worst
- \_\_\_\_\_ 73. Fear of dying or doing something crazy
- \_\_\_\_\_ 74. Avoiding places for fear of having an anxiety attack
- \_\_\_\_\_ 75. Conflict avoidance
- \_\_\_\_\_ 76. Excessive fear of being judged or scrutinized by others
- \_\_\_\_\_ 77. Persistent phobias
- \_\_\_\_\_ 78. Low motivation
- \_\_\_\_\_ 79. Excessive motivation
- \_\_\_\_\_ 80. Tics (motor or vocal)
- \_\_\_\_\_ 81. Poor handwriting
- \_\_\_\_\_ 82. Quick startle
- \_\_\_\_\_ 83. Tendency to 'freeze' in anxiety provoking situations
- \_\_\_\_\_ 84. Lacks confidence in their abilities
- \_\_\_\_\_ 85. Seems shy or timid
- \_\_\_\_\_ 86. Easily embarrassed
- \_\_\_\_\_ 87. Sensitive to criticism
- \_\_\_\_\_ 88. Bites fingernails or picks skin
- \_\_\_\_\_ 89. Short fuse or periods of extreme irritability
- \_\_\_\_\_ 90. Periods of rage with little provocation
- \_\_\_\_\_ 91. Often misinterprets comments as negative when they are not
- \_\_\_\_\_ 92. Irritability tends to build, then explodes, then recedes, often tired after a rage
- \_\_\_\_\_ 93. Periods of spaciness or confusion
- \_\_\_\_\_ 94. Periods of panic and/or fear for no specific reason
- \_\_\_\_\_ 95. Visual of auditory changes,, such as seeing shadows or hearing muffled sounds
- \_\_\_\_\_ 96. Frequent periods of déjà vu (feelings of being somewhere you have never actually been)
- \_\_\_\_\_ 97 Sensitivity or mild paranoia
- \_\_\_\_\_ 98. Headaches or abdominal pain of uncertain origin
- \_\_\_\_\_ 99. History of a head injury or family history of violence or explosiveness
- \_\_\_\_\_ 100. Dark thoughts, may involve suicidal or homicidal thoughts
- \_\_\_\_\_ 101. Periods of forgetfulness or memory problems

# Sharon M. Barnes, LCSW, PLLC

## Fee Schedule and Agreement

Sharon Barnes' fee per 50 minute session is \$140.00.

\* \_\_\_\_\_ The amount I agree to pay for counseling services is \$140.00 per 50/minute session.

\* \_\_\_\_\_ I understand that any time under or over 50 minutes will be pro-rated accordingly.

**INSURANCE BILLING:** I understand that the fee for each counseling session is due and payable at the time of service. I also understand I am responsible for finding out what my insurance will cover (if anything) and for filing my own insurance claims. At my request, Sharon Barnes will provide me with a statement containing all the information necessary for me to file a claim with my insurance carrier so that I may receive insurance reimbursement. I understand that there will be a fee for this.

\* \_\_\_\_\_ **APPOINTMENT CANCELLATION POLICY:** I understand that I am responsible to keep my therapy appointments, and that I am to notify the office at least 24 hours in advance of any appointments which cannot be kept. If I provide less than 24 hours' notice, I agree that I will be charged the regular rate for my usual appointment.

\* \_\_\_\_\_ **CREDIT CARD AUTHORIZATION:** I hereby authorize Sharon M. Barnes, LCSW, PLLC to charge my credit card for missed sessions, as agreed. I understand that Sharon Barnes will keep my Credit Card Information confidential, with my client record. I understand that my credit card statements will show charges as coming from "Sharon M. Barnes, MSSW, PLLC".

Name as it appears on the Card: _____	Type of Card: _____
Card Number / _____ / _____ / _____ / _____ / _____	Authorization Code: _____
Exp Date: _____	Address: _____
City _____	State ____ Zip _____ Home Phone: _____
Daytime Phone: _____	Email Address _____

\*Please read each section & get clarification on any questions you may have before initialing each one.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_



## Colorado Mandatory Disclosure Statement

**The following disclosure is made in accordance with Colorado Law:**

**DEGREES AND CREDENTIALS:**

Bachelor of Science Degree; Major in Social Service: Loma Linda University, 1974  
Master of Science in Social Work Degree: San Diego State University, 1976  
Licensed Clinical Social Worker in California, #6986, initiated: 1979. No longer active.  
Licensed Clinical Social Worker in Colorado, #991263, Active since 1994

The practice of both licensed and unlicensed psychotherapists is regulated by the Department of Regulatory Agencies under **12.43.214 (1) (C)**. Questions or complaints may be addressed to:

Colorado State Grievance Board  
1560 Broadway, Suite 1340  
Denver, Colorado 80202  
(303) 894-7760

Under this statute, **12.43.214 (1)(d) CRS** you are entitled to receive information about the methods of therapy; the techniques used; the duration of therapy (if known) and the fee structure. You may seek a second opinion from another therapist or may terminate therapy at any time. In a professional relationship sexual intimacy is inappropriate and should be reported to the Grievance Board.

**12.43.214 (1)(d) CRS:** states that information provided by a client during therapy sessions is legally confidential in the case of licensed clinical social workers, except as provided in Section 12.43.218 and except for certain legal exceptions which will be identified by the licensee should any such situation arise during therapy.

**Practice Information:** Sharon M. Barnes, MSSW, LCSW is incorporated in the state of Colorado as Sharon M. Barnes, LCSW, PLLC and is in independent practice. She is not in partnership with any other professional or therapist who uses the same office suite.

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

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**Client Signature**

**Date**

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**Therapist Signature**

**Date**

## **Sharon M. Barnes, LCSW, PLLC Business Practices Descriptions and Disclosures**

**Welcome to my counseling, psychotherapy and consultation practice. I look forward to working with you.** I see women, men, teens and some children. I use individual, group, couple, and family sessions and a combination of these. The problems I most frequently work with include coping & thriving as a creative, highly sensitive, and/or gifted person, parenting creative, highly sensitive, and/or gifted children; coping & thriving with ADD or AD/HD; relationship concerns, self-esteem issues, grief issues, coping with chronic or life-threatening illness, parenting concerns; personal and spiritual growth, life passages and transitions, creativity recovery and development, trauma recovery and resolution, and adoption issues.

My gentle, supportive approach focuses on guiding people through the Wilderness of Inner Territory to Destinations of Delight. The healing, change and growth that people seek when they come to work with me takes place within the context of our therapeutic relationship. This enables people to find their way through anxieties, depression, fears, confusion, abuse, loss, relationship and life changes. I help people learn how to discover their own pathways to healing, joy and fulfillment. In this inner journey, many discover metaphorical personal treasure which had been hidden in life's deep dark woods. It is my privilege to accompany many people on this inner quest, and to help them create better self-esteem; be centered and find their voice; be empowered to understand themselves better and form more fulfilling relationships; as well as to be more able to know who they are, what they want in life, and how to craft a life they love to live.

Most clients come on a regular basis, weekly or every other week, and often for six months to a year or more. Sessions usually last 50 minutes, but may be extended to 75 minutes for couples, families, or whenever indicated. Fees are adjusted according to the length of the session. See my Fee Agreement for more details on my fee structure.

### **FOLLOWING IS SOME INFORMATION ABOUT MY POLICIES AND PROCEDURES:**

#### **Confidentiality**

The information you discuss during a psychotherapy is protected as confidential under law (CRS 12,43,214 (1)(d)), with certain limitations.

- In most situations, your written consent is required before any information can be released. However, there are specific situations in which I am legally required to release information without your consent.
- It is my legal responsibility and my policy to report suspected child abuse without an investigation to the proper authorities who may then investigate.
- I may take some action without your consent if I assess you to be a serious harm to yourself or another. Any action I take without your consent will be discussed with you.
- If I am unable to collect my agreed upon fee, I may send your name and address to a collection agency.
- If you file a complaint or a lawsuit against me, according to Colorado law, your right to confidentiality will be waived.
- If you choose to use your health benefit plan, you will have given your insurance or managed care company consent to obtain required confidential information for the purpose of determining eligibility for reimbursement. This normally requires diagnosis and procedure code information.
- If I seek consultation from another mental health professional, your privacy will be protected by that professional, and I will reveal only the necessary private information for the purpose of the consultation.
- If another mental health professional is involved in your mental health treatment and I determine that it is important for your treatment, I may collaborate in order to coordinate care. Your authorization may not be obtained, but you will be advised of this situation.
- Clerical and/or billing persons contracted by me may have access to limited confidential information, for example, your name, address, diagnosis, dates and procedure codes. This information is protected from further disclosure and is used solely for administrative purposes.
- When I am away from my office for a few days, we will discuss how to handle any emergent need which may arise. If we decide to ask another licensed therapist to cover emergencies for me, I will disclose to this therapist only what he or she needs to know to assist you in an emergency.

### **Availability**

I answer my phone directly when I am able. At other times, it is forwarded to my confidential voicemail. I am notified of every message that is left for me. You may leave a voicemail message 24 hours a day at 303-987-0346, and I or a designated backup therapist will attempt to return your call within 24 hours during the weekdays or on the first working day following a weekend or holiday. I do not provide routine 24 hour emergency coverage. In the event of a psychiatric emergency, you will need to call 9-1-1 or go to your nearest emergency room. When, in our work together, we are able to anticipate the potential of such emergencies, we will make plans together for how to handle the emergency.

### **Health Care Benefits**

\_\_\_\_\_ As stated in the Fee Agreement, with the exception of Medicare, I do not accept insurance benefits. In the event that you choose to use your health care benefits, and my services are reimbursable under your insurance plan, you are responsible to file your own insurance claims. You will also need to give me written authorization to release any required information. Confidential information required by your insurance company may range from identifying information, diagnosis, dates and types of sessions and charges to a written assessment with treatment goals and progress reports, when your benefits come under managed care. My policy is to provide the least amount of information necessary for the purpose of authorizing benefits. However, I can no longer be in control of the storage or access to your confidential information when it is given to a third party. The insurance company will determine benefit coverage and the kind of service for which they will reimburse. I charge for report writing time at the same rate as therapy time.

### **Records**

\_\_\_\_\_ Records may include identifying information, dates and types of sessions, an assessment and diagnosis, a treatment plan, progress notes, and any reports, consultations or collateral contacts made, and informed consent disclosures. My private psychotherapy notes are kept separate, and are not a part of the record. These psychotherapy notes are further protected from subpoena and unauthorized access by HIPAA. Your records will be stored safely with attention to your privacy for at least 7 years as required by Colorado Statute. In the event that I am no longer able to secure and monitor access to your record, another mental health professional will act as my professional representative. That professional representative will contact you regarding the location of your record. Your records are protected by Colorado Statute, HIPAA regulations, and Professional Ethics. Records can only be released with your written permission and direction. It is my policy not to release an entire record, even with your authorization. Instead, I will summarize the content related to the request. Colorado Statute, CRS 25-1-803, limits release to a summary after termination. If you were seen in couple or family sessions, all adults present would have to sign the release. You will be granted reasonable access to your record, but no copy of the record. If you choose to read your record, it is my policy to be present in order to respond to any questions or confusion you have about the recordings. You may request, in writing, an amendment or addition to your record. My time in dealing with any request for records is reimbursable at the rate agreed upon in the fee agreement.

### **Termination**

\_\_\_\_\_ Termination will usually be agreed upon mutually, but you are free to terminate at any time. Ending treatment by reviewing our work together and summarize what you are taking with you is much more helpful to you than ending treatment without the benefit of this wrap-up review. Even though planned endings and spoken goodbyes can be difficult, they are well worth the effort and I highly recommend it, especially in our work together. In a few rare and special instances I may decide to stop working with you even though you wish to continue. The reason for this may include a need for special services outside of the area of my competency, a failure to meet the terms of our fee agreement, or and/or prolonged failure to make progress in our work together. Should any of these occur, I will discuss the reason for termination with you, and you will be helped to make different plans for yourself, including a referral to a more appropriate resource.

### **CLIENT AGREEMENT**

\_\_\_\_\_ I consent to becoming a client of Sharon M. Barnes, LCSW, PLLC. I have been informed of her degrees, credentials and licenses. I have read the above information. I have clarified all areas about which I have had questions. I understand and agree to my rights and responsibilities as a psychotherapy or consultation client.

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Client Signature

Date

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Therapist Signature

Date





## Acknowledgement of Receipt of Notice of Privacy Rights

I, \_\_\_\_\_, acknowledge that I have received access to a copy  
Please Print Client Name

of the Notice of Privacy Practices for *Sharon M. Barnes, LCSW, PLLC*.

I acknowledge that these Privacy Practices are posted on her website and available to me at my convenience in this location: <http://therapistforsensitiveandgifted.com/counseling/notice-privacy-practices/>

\_\_\_\_\_  
Signature of Client or Personal Representative

\_\_\_\_\_  
Date