Denver Counseling Solutions LLC
New Client Information Form

Client Information

Date: _________________

Last Name: _________________________________ First Name: _________________________________ MI: __________

Client is: __Self __Couple __Family __Minor Gender: __________________

Marital Status: __Single __Married __Divorced __Separated __Widowed __Domestic Partnership

Date of Birth: __________________ Age: ________

Address: ____

City, State, Zip Code: ____

Cell Phone: ____________________ Home Phone: ____________________ May we contact you at these numbers? __Yes __No

Email address: ________________________________ May we contact you by email? __Yes __ No

Will you be filing a claim with your insurance (if yes, then you must provide an email address)? __Yes __No

May we use your contact information to inform you of changes and new services at our practice as well as to share resources and support in the mental health community? __Yes __No

Parent/Guardian Information (If client is under 18)

Last Name: ____________________________________ First Name: __________________________________

Relationship to Client: ____

Address: ____

City, State, Zip: ____

Cell Phone: ____________________ Home Phone: ____________________ May we contact you at these numbers? __Yes __No

Email address: ________________________________ May we contact you by email? __Yes __ No

Permission for Treatment

In presenting myself (or my child) for diagnosis and treatment, I voluntarily consent to the rendering of counseling services provided by Denver Counseling Solutions LLC. I acknowledge no guarantees have been made to me as to the effect of treatment on my (or my child's) condition. I acknowledge I am responsible for all reasonable charges in connection with care and treatment. I have read this statement and acknowledge that I understand it.

This disclosure is for: Family Therapy (including child/adolescent therapy) Individual Therapy Couples Therapy

____ ____________________________________

Client Signature (or Parent/Guardian) **Date**

____ ____________________________________

Client Signature (or Parent/Guardian) **Date**

____ ____________________________________

Client Signature (or Parent/Guardian) **Date**

Self –Assessment

Client Name: ____ Date of Assessment: _____________________________

In filling out this form, you are encouraged to provide as much information as possible.

If you find a question that you desire to leave blank, you are welcome to do so for any reason.

Your therapist will review this form and if they have any questions regarding your answers, they will follow up with you in session.

Section A: Client Information

1. Are there cultural or heritage influences that are important to you, which your counselor should be aware? Yes or No

   If yes, please explain: ____

2. Ethnicity: ____

3. Are there religious or spiritual beliefs that are important to you, which your counselor should be aware? Yes or No

   If yes, please explain: ____

   ____

   ____

Section B: Presenting Problem

1. Briefly describe the problem or concern you're hoping to address?

   ____

   ____

   ____

2. How would you rate the intensity of the problem or concern that led you to seek professional services?

   (Please circle your selection)

   Extreme Moderate Mild

   5 4 3 2 1

3. Approximately how long have you had the current problem or concern? ______________________________

4. In what ways have you attempted to cope with this problem or concern?

   ____

   ____

   ____

Section C: Family Background

1. Please list the members of your family:
   a. Father Age: Occupation: Education:
   b. Mother Age: Occupation: Education:
      c. Sibling Age: Occupation: Education:
      d. Sibling Age: Occupation: Education:
      e. Sibling Age: Occupation: Education:
      f. Sibling Age: Occupation: Education:
2. Is your father deceased? Y or N Year? ____________________
   Mother deceased? Y or N Year? ____________________
3. What is/was your parents' marital status? ____
4. Please list your stepfamily members. (Please circle "step" or "half")
   a. Step-father Age: Occupation: Education:
   b. Step-mother Age: Occupation: Education:
      c. Step/half sib Age: Occupation: Education:
      d. Step/half sib Age: Occupation: Education:
      e. Step/half sib Age: Occupation: Education:
      f. Step/half sib Age: Occupation: Education:
5. In what city were you raised? ____
6. Please list all cities you have lived in: ____
   ____
7. What is your spouse's/partner's name? ________________________ Age: __________
   Occupation: _____________________________ Education: _____________________________
   How long have you been together/married? ______________________
   Deceased? Y or N Year: ________________
8. Please list your children:
   a. Child Name____________________ Age_______ Gender: M or F
      Circle: Biological Stepchild Adopted Foster
   b. Child Name____________________ Age_______ Gender: M or F
      Circle: Biological Stepchild Adopted Foster

c. Child Name____________________ Age_______ Gender: M or F

Circle: Biological Stepchild Adopted Foster

d. Child Name____________________ Age_______ Gender: M or F

Circle: Biological Stepchild Adopted Foster

e. Child Name____________________ Age_______ Gender: M or F

Circle: Biological Stepchild Adopted Foster

9. Have you personally experienced significant abuse?

   None Unsure Emotional Physical Sexual

10. In general, how happy or adjusted were you growing up?

   Poor Unsatisfactory Average Substantial Completely

11. How much is your immediate family a source of emotional support for you?

   None Little Somewhat Substantial Always

12. How much conflict in values do you currently experience with your parents?

   None Little Somewhat Substantial Always

   Who in your family do you currently feel closest to? ____

   Most distant from? __________________________ In most conflict with? ______________________________

Section D: Education and Work Information

1. What is your highest education level? ____

2. What was your major/minor area of concentration? ____

3. Did you experience any learning problems in school?

   None Little Some Substantial Always

   Please explain: ____

   ____

4. How satisfied are you with your academic progress so far? (Please circle a number)

   5 4 3 2 1

5. What barriers, if any, are impeding your academic progress? _______________________________

6. What is your current job and/or occupation? ____

7. Where are you currently employed? ____

8. How satisfied are you with you current job and/or occupation? (Please circle)

   Very Satisfied Satisfied Dissatisfied Very Dissatisfied

9. Please list past significant employment history:

____

____

Section E: Health and Social Issues

1. How is your physical health at present?

   Poor Fair Satisfactory Good Excellent

2. Please list any persistent physical symptoms or health concerns (e.g., chronic pain, headaches, diabetes, etc.)

   ____

   ____

3. Please list any prescribed medications you are presently taking, including dosage and frequency

   ____

   ____

4. Are you having any problems with your sleep habits? Yes or No

   If yes, circle where applicable:

   Sleeping too little Sleeping too much Poor quality of sleep

   Disturbing dreams Other: ____________________________

5. How many times per week do you exercise? __________ For how long? ____________________

6. Are you having any difficulty with appetite or eating habits? Yes or No

   If yes, circle where applicable: Eating less Eating more Binge eating Restricting calories

7. Have you had a significant weight change in the past two months? Yes or No

8. Do you regularly use alcohol? Yes or No

   In a typical month, how often do you have four or more drinks in a 24-hour period? ____________________

9. Have you ever tried to cut down on the amount of alcohol you consume? Yes or No

10. Has anyone close to you ever been annoyed by your drinking? Yes or No

11. Do you consider your alcohol consumption to be a problem? Yes or No

12. How often do you engage in recreational drug use? ______________________________

13. Do you consider this drug use to be a problem? Yes or No

14. Have you ever experienced any legal problems? Yes or No

    Nature of problem: ____

    ____

15. In the past, how would you rate the quality of your peer relationships?

    Very Poor   Unsatisfactory   Average   Good   Excellent

16. Approximately how many significant intimate relationships, lasting six months or more, have you had? ________________

    Are you currently in one?   Yes or No

17. Have you been married previously?   Yes or No   When? ____________________   Duration: ____________________

18. Do you have any problems or worries about sexual functioning?   Yes or No

    If yes, circle where applicable:

    Performance Problem   Sexual Impulsiveness   Lack of Desire

    Difficulty Maintaining Arousal   Worry about STD(s)

19. What is your sexual orientation?   Heterosexual   Gay/Lesbian   Bisexual   Transgender   Unsure

20. Besides family members, who are the people you can really count on currently for emotional support?

    ____

    ____

Section F: Mental Health History

1. Are you currently receiving psychiatric services, professional counseling or therapy elsewhere?   Yes or No

   If yes, by whom? ______________________________________

2. Have you ever had previous counseling or psychotherapy?   Yes or No   If yes, please specify the following:

   Reason for counseling: ____

   ____

   ____

   Counseling location: ____

   Counseling dates: ____

   Counseling duration: ____

3. Have you ever been hospitalized for psychiatric reasons?   Yes or No   If yes, please specify the following:

   Reason for hospitalization: ____

   ____

   ____

   Hospital location: ____

   Dates of hospitalization: ____

   Duration of hospitalization: ____

4. Have you ever been prescribed medication for psychiatric reasons? Yes or No If yes, please specify the following:

   Name/dose of medication: ____________________

   Date of prescription: ____________________

   Duration of medication: ____________________

   Prescribing doctor: ____________________

5. Is there a family history of mental illness? Yes or No

   If yes, please specify relation and diagnosis: ____________________

   ____

6. Do you own or have access to weapons? Are there any weapons in the home? Yes or No

7. Have you had suicidal thoughts recently? Yes or No If yes, how often? ____________________

   Have you had them in the past? Yes or No If yes, how often? ____________________

8. Have you ever intentionally inflicted harm upon yourself? Yes or No

   If yes, how often? ____________________ Nature of harm: ____________________

   ____

9. Have you ever intentionally hurt someone else? Yes or No

   If yes, when? ____________________ Nature of experience: ____________________

   ____

10. Have you ever experienced any form of traumatic experience? Yes or No

    If yes, when? ____________________ Nature of experience: ____________________

    ____

    Please circle any past, present, or impending problems/issues in your family:

    a. physical/sexual abuse b. deaths c. financial/unemployment

    d. frequent relocations e. divorce f. legal problems

    g. injuries/disabilities

    Please specify family member(s), which problem/issue, and approximate year of occurrence:

    ____

    ____

    ____

11. Have you ever experienced sexual assault, unwanted sex or uncomfortable touching?

    Frequently A Few Times Once Never Unsure

12. How does the future look to you? Poor Fair Neutral Good Excellent

13. Please describe your future plans.

____

____

____

14. What do you hope to accomplish through counseling?

____

____

____

15. Is there anything else you would like your counselor to know about you?

____

____

____

~Thank you for your valuable time and effort~

Denver Counseling Solutions LLC
Policy Statement

- The full cost of each session will be billed directly to the client.

- Payment is due at the end of each session. A receipt will be provided for the client to make their own insurance claim.

- Clients will be charged $35 for returned checks. Upon the occurrence of a returned check the client will be required to pay by cash or credit card for future sessions.

- Sessions begin at the designated appointment time. Standard sessions are 53 minutes with direct client contact and 60 minutes for billable time in length. Clients arriving late after their designated appointment time will still be charged the full fee.

- Cancellations must be made 48 hours prior to appointment. Any cancellations made less than 48 hours in advance will be charged the full fee. Missing an appointment without prior notice is considered a No Call / No Show. All No Call / No Show's will be billed directly to the client for the full amount of the scheduled session. Clients that accumulate three late cancellations or No Call / No Show's in any combination may be referred out to another counseling service.

- Time spent preparing letters, misc. paperwork, etc. on behalf of a client will be billed directly to the client at the rate of the clinician's current fee schedule.

- If you become involved in legal proceedings, we charge $300 per hour for services related to your legal matter. You will be responsible for paying for any professional time we spend on your legal matter, even if the request comes from another party. Professional time spent on your legal matter includes, but is not limited to: attorney fees that we may incur in preparing for or complying with the requested legal services; communication with your attorneys or our attorneys by phone, text, email, in person, or any other types of communication, testimony related matters such as case research, report writing, travel, depositions, actual testimony, cross examination, courtroom waiting time, and travel related to such matters (portal to portal, from office to court and back).

- Time spent on the phone or in correspondence over 15 minutes and consultations with third parties for a client will be billed directly to the client according to the clinician's current fee schedule.

- If a client is not seen for three consecutive weeks, unless other arrangements have been made in advance, your case is considered closed and can be reopened if agreed upon in the future.

- Clients may not bring weapons onto the office premises. Denver Counseling Solutions is a professional environment. Clients shall conduct themselves in an orderly, safe, and respectful manner while in the office.

  By signing below, I signify that I have read and fully understand this Policy Statement, and that I agree to pay any charges that may be applied to my account as a result of these policies.

________________________________ ________________________________
Client Signature (or Parent/Guardian) **Date**

________________________________ ________________________________
Client Signature (or Parent/Guardian) **Date**

________________________________ ________________________________
Client Signature (or Parent/Guardian) **Date**

Denver Counseling Solutions LLC
Credit Card Authorization Form

I, ____, hereby authorize Denver Counseling Solutions LLC to charge my credit card account according to the following fee schedule:

- ☐ Licensed Therapist Rate: ______________
- ☐ EMDR Rate: ______________
- ☐ MFTC/LPCC/Registered Psychotherapist Rate: ______________
- ☐ Intern Rate: ______________
- ☐ Reduced Fee Rate: ______________
- ☐ Group Rate: ______________
- ☐ Supervision: ______________

( ) VISA ( ) MasterCard ( ) American Express ( ) Discover

Credit Card Number: ____

Expiration Date: _____ /_____ Security Code: ___________

Credit Card Billing Address:

Name as it appears on card: ____

Street: ____

City:____ State: ___________

Zip Code: __________ - ________ Telephone: (_____) ______- ___________

Email: ____

By signing below, I authorize the charges specified above.

____ _____/_____/_______
Cardholder's Signature Date

____ _____/_____/_______
Client's Signature (if different than cardholder) Date

____ _____/_____/_______
Client's Signature (if different than cardholder) Date

If cardholder is different from client, then client will need to complete a release of information as well.

Your completion of this authorization form helps us to protect you from credit card fraud. Denver Counseling Solutions LLC will attempt to keep all information entered on this form strictly confidential and in a secure location.

DISCLOSURE STATEMENT

____

(Clinician's Name, Degree, Credentials, and License Number)

Denver Counseling Solutions LLC
Office Phone: (720) 608-0379

Parker Office Location
12760 Stroh Ranch Way, Ste 103
Parker, CO 80134

Castle Rock Office Location
753 Maleta Lane, Suite 204
Castle Rock, CO 80108

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed social workers, licensed professional counselors, licensed marriage and family therapists, licensed school psychologists practicing outside the school setting, licensed or certified addiction counselors, and unlicensed individuals who practice psychotherapy. The agency within the Department that has responsibility specifically for licensed and registered Psychotherapists is the Department of Regulatory Agencies, Mental Health Section, 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7766.

Client Rights and Important Information:

1. 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.
2. Treatment records are confidential. If you request treatment information, it must be done in writing and we may provide you with a treatment summary in compliance with Colorado law. This is considered a release of information and must be consented to by all members of the treatment unit.
3. Client records will be maintained for a period of seven years from the date of last contact with the client. A minor's record will also be maintained for seven years or until the child turns age 18, whichever comes later. However, a minor's record will not be maintained for longer than 12 years. Any person who alleges that a mental health professional has violated the licensing laws related to the maintenance of records of a client eighteen years of age or older, must file a complaint or other notice with the licensing board within seven years after the person discovered or reasonably should have discovered this.
4. You can seek a second opinion from another therapist or terminate therapy at any time.
5. 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 Department of Regulatory Agencies, Mental Health Section.
6. Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the therapist is a licensed psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, licensed or certified addiction counselor, or a Registered Psychotherapist. If the information is legally confidential, in most cases, the therapist cannot be forced to disclose the information without the client's consent. Information disclosed to a licensed psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, licensed or certified addiction counselor, or an Registered Psychotherapist is privileged communication and cannot be disclosed 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 the general rule of legal confidentiality. These exceptions are listed in the Colorado statutes (C.R.S. 12-43-218). I am required to disclose information under the following circumstances:
    - Situations of suspected or confirmed child abuse or neglect;
    - Abuse or exploitation of an at-risk adult or elder, including imminent risk of such abuse;
    - Threats of harm to others, including people identifiable by their association with a specific location or entity;
    - Threats against a school or the occupants of a school;
    - Threats of harm to yourself.

Please be advised that there is no time limit on the mandatory reporting of child abuse. This means that even adult clients who experienced childhood abuse (no matter how long ago) might disclose in therapy past abuse incidents that still fall under the mandatory reporting requirements. The law requires that if there is reasonable cause to know or suspect that the perpetrator has subjected any other child currently under eighteen years of age to abuse or neglect or to circumstances or conditions that would likely result in abuse or neglect and/or is in any "position of trust" with children today then past abuse disclosed by an adult client is required to be reported. If you have questions or concerns about these requirements, please discuss further with your therapist.

In such situations, I may be required to take protective actions which may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If such a situation arises during our work together, I will make every attempt to discuss it fully with you before taking necessary action. You should be aware that provisions concerning disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in C.R.S. 13-90-107. There are exceptions that I will identify to you as the situations arise during therapy.

7. 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 reasonable security measures, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by a third-party. By initialing below, you consent and authorize me to communicate Protected Health Information ("PHI") through the following unsecure transmissions (please initial all of your choices):

   _____ Cellular/Mobile phone, including text messages and voicemails

   _____ Unsecured email: Client's Email, Therapist's Email, and any email communications from Denver Counseling Solutions or its staff

   All written forms of communication may be documented in your file. Therapists and clients are ethically prohibited from personal communication via social media. However, engaging in communication on the business social media outlets is on your own accord and is not private or confidential. I understand that my therapist cannot guarantee confidentiality when using tools of technology such as phone, email, text messaging, video conferencing or video chat apps, etc. When you communicate via any certain technology, it implies consent for our practice to reciprocate communication via the same or similar methodology and/or technology.

8. The use of recording devices is strictly prohibited without written consent. Neither the client nor the therapist can audio-record or video record sessions unless agreed upon beforehand with written permission.

9. I understand that my therapist provides non-emergency therapeutic services by scheduled appointment. Should a crisis arise, I take the responsibility to notify proper authorities, call 911, or take myself to an emergency room for immediate support. I understand that if my therapeutic needs are outside of the skill set of my therapist, he or she is required to refer, terminate, or consult regarding my case.

10. If I am involved in divorce or custody litigation, I understand that my therapist's role is not to make recommendations to the court concerning parenting or custody matters.

11. I agree not to subpoena my therapist for testimony or for disclosure of treatment information.

12. I understand that in the course of couples and family work it is sometimes necessary to utilize work done in individual sessions in joint sessions. I give permission for my therapist to use his or her discretion in discussing information from my individual sessions with partner and/or my family and myself. I understand that my therapist does not hold secrets in therapy or keep information from family members that may hinder therapeutic progress/treatment.

13. In the state of Colorado, minors over the age of 12 years old may consent to their own therapy, but are not required to do so. I give my therapist permission to use their discretion when treating minors as to when and what information is necessary to disclose in an effort to uphold the therapeutic ethical standard of confidentiality and maintain the relationship between the child and parent/guardian. If you are consenting to the treatment of a minor child, you will be required to provide a copy of the most recent Court Order Custody Agreement and/or Parenting Plan, if applicable, that gives you the authority to consent to the treatment of the child. By signing this form, you agree to keep me informed of any supplemental court orders or other proceedings that impact your parental rights, custody arrangements, or decision-making authority. Failure to produce the Court Order will prohibit me from seeing the

minor child. If there is joint medical decision-making authority for your child, I will require both parents to consent to treatment and will not proceed until such consent is obtained.

It is beyond the scope of my practice to provide custody recommendations, and any such request will be denied. The Court can appoint professionals who have the expertise to make such recommendations. By signing below, you agree not to subpoena my records or ask me to testify in court or to provide letters or documentation expressing my opinion about custody or visitation. Despite this, a Court may still require me to testify or to provide treatment information to an evaluator. I will comply with these requests as legally required and you will be required to compensate me for time spent providing these services as indicated in the "Policy Statement" section above.

In the course of treatment with your child, I may involve other family members in your child's treatment. However, please remember that my client is your child, not the other family members of the child. Any meetings with you or other family members will be documented in your child's record. These notes will be available to anyone who has legal access to your child's treatment record. Therapy is most effective when there is a trusting relationship between the therapist and client. Privacy is important in establishing trust, and as a result, it is often important for child or adolescent clients to have a level of privacy around the therapy. It is my policy to provide parents with general information about their child's treatment, but not to share specific information disclosed during therapy. This includes behaviors that you may not approve of but which do not place your child at imminent risk or danger. If I ever feel that your child is in danger, I will communicate this information to you. By way of example, if your child tells me that s/he has tried alcohol a few times at parties, I will not generally share this with you. If your child shares that s/he has been drinking and driving or riding with a drunk driver, I would share this information with you. If you have questions about the types of information I will share, you can feel free to ask me hypothetical questions about situations that I would or would not disclose to you. Although you may have the legal right to access any written record I keep, by signing this agreement you are agreeing that your child or adolescent should have privacy around their therapy and you agree not to request access to your child's full record.

14. It is our practice's policy to have all person(s) having medical and/or mental health decision making authority for a minor sign consent for treatment for the children in therapy whenever possible. Legal documentation of medical and/or mental health decision making authority must be provided at the beginning of treatment.

15. Supervision and Consultation Disclosure**:** To assure the quality of care, I understand my therapist may regularly consult with individual and group supervisors regarding treatment. Supervisors and other mental health professionals are bound by the legal confidentiality standards outlined in this disclosure statement and explained in the Colorado statutes concerning the information you disclose in therapy. Case consultation and presentation may also be used for the purposes of teaching or enhancing learning in the field. If your therapist presents or consults with supervisors, colleagues or field experts regarding issues pertinent to your therapy, your circumstances will be generalized and all identifying information will be concealed. Client consent is required for release of any identifying information. Additionally, supervisees may observe sessions for training purposes and/or supervisors may observe sessions for educational purposes.

    Supervisor's Name /Credentials/License #: ____

16. Levels of regulation of mental health professionals in Colorado include licensing (requires minimum education, experience, and examination qualifications), certification (requires minimum training, experience, and for certain levels, examination qualifications), and registration (does not require minimum education, experience, or training.) All levels of regulation require passing a jurisprudence take-home examination. Denver Counseling Solutions contracts with clinicians under various licensures. Below is an explanation of many of the different licensure requirements.

    a. Registered Psychotherapist is a psychotherapist listed in the state's database and is authorized by law to practice psychotherapy in Colorado. However, they not licensed by the state and are not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.

    b. Certified Addiction Counselor I (CAC I) must be a high school graduate, complete required training hours and 1,000 hours of supervised experience.

    c. Certified Addiction Counselor II (CAC II) must complete additional required training hours and 2,000 hours of supervised experience.

    d. Certified Addiction Counselor III (CAC III) must have a bachelor's degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience.

e. Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements.
f. Licensed Social Worker must hold a master's degree in social work.
g. Psychologist Candidate, Marriage and Family Therapist Candidate (MFTC) and a Licensed Professional Counselor Candidate (LPCC) must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.
h. Licensed Clinical Social Worker (LCSW), a Licensed Marriage and Family Therapist (LMFT), and a Licensed Professional Counselor (LPC) must hold a master's degree in their profession and have two years of post-masters supervision.
i. Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.
j. Psychiatric Mental Health Nurse Practitioner (PMHNP) must hold a master's degree in nursing and is certified by the Colorado State Board of Nursing, and board certified through the ANCC.

Therapist/Clinician Information (Office Use Only)

Name of Clinician: ____

Degree/Institution/Date When Conferred: ____

License & License Number/Date Obtained: ____

Additional Certifications & Training: ____

If you have any questions or would like additional information, please feel free to ask.

____________________________________ ____________________________________
Client Signature (or Parent/Guardian) **Date**

____________________________________ ____________________________________
Client Signature (or Parent/Guardian) **Date**

____________________________________ ____________________________________
Client Signature (or Parent/Guardian) **Date**

Emergency Contact:
I give Denver Counseling Solutions permission to contact this person in case of an emergency. I am aware that under such circumstances, limitations of confidentiality do not apply.

Name: ______________________________ Phone Number: ______________________________

Client Signature
I have read the above terms and understand them as stated. I have been informed of my therapist's policies and practices to protect the privacy of my health information and understand my rights as a client/patient.

______________________	______________________	__________
Client Name (PRINT)	**Client Signature**	**Date**
Client Name (PRINT)	**Client Signature**	**Date**
Client Name (PRINT)	**Client Signature**	**Date**
Parent / Guardian Name (PRINT)	Parent / Guardian Signature	Date
Therapist Name/Credentials (PRINT)	**Therapist Signature**	**Date**

Denver Counseling Solutions, LLC
NOTICE OF PRIVACY PRACTICES

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

In the course of providing services to you, Denver Counseling Solutions, LLC will obtain, record, and use mental health and medical information about you that is considered Protected Health Information, or "PHI." PHI is defined as "individually identifiable health information" that is created or received by a healthcare provider and which relates to past, present, or future health, provision of healthcare, or payment for provision of healthcare and that either identifies the individual or could be used to identify the individual. HIPAA and other laws regulate the use and disclosure of PHI when it is transmitted electronically. This Notice describes Denver Counseling Solution, LLC's policies related to the use and disclosure of your PHI.

Uses and Disclosures Not Requiring Consent.

Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow me to use and disclose your health information for these purposes. In most cases, I am limited to disclosing the minimum information necessary to accomplish these purposes. To help clarify these terms, here are some examples:

- *Treatment* is when I use and disclose health information to provide, coordinate or manage your health care and other services related to your health care. If I decide to consult with another licensed health care provider about your condition, I would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist me in the diagnosis or treatment of your mental health condition.
- Disclosures for treatment purposes are not limited to the minimum necessary standard, because physicians and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care among health care providers or by a health care provider with a third party, consultations between health care providers, and referrals of a patient for health care from one health care provider to another.
- *Payment* is when I use and disclose health information to obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- *Health Care Operations* refers to the use and disclosure of health information for activities that relate to the performance and operation of my practice. Examples of health care operations are review of treatment procedures or business operations, calendar and appointment software and apps, quality assessment and improvement activities, and staff training.
- PLEASE NOTE: I, or someone from Denver Counseling Solutions, LLC, acting with my authority, may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your prior written authorization is not required for such contact.

Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. I will also obtain an authorization from you before using or disclosing PHI in a way that is not described in this Notice. You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in certain circumstances, including, but not limited to:

- *Child or At-Risk Adult Abuse: If I have reasonable cause to know or suspect that a child has been subjected to abuse or neglect or an at-risk adult has been mistreated, self-neglected, or financially exploited or is at imminent risk of mistreatment, self-neglect, or financial exploitation, then I must report this to the appropriate authorities.*
- *Health Oversight Activities: If the Colorado state licensing board or an authorized professional review committee is reviewing my services, I may disclose PHI to that board or committee.*
- *Judicial and Administrative Proceedings: If you are involved in a court proceeding where you are being evaluated for a third party or where the evaluation is court ordered, I may disclose PHI to the court. You will be informed in advance if this is the case.*
- *Serious Threat to Health or Safety: If you communicate to me a serious threat of imminent physical violence against a specific person or persons, including those identifiable by association with a specific place, I have a duty to notify any person or persons specifically threatened, as well as a duty to protect by taking other appropriate action. If I believe that you are at imminent risk of inflicting serious harm on yourself, I may disclose information necessary to protect you. In either case, I may disclose information in order to initiate hospitalization.*
- *Business Associates: Denver Counseling Solutions, LLC, 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.*
- *In Compliance with Other State/Federal Laws and Regulations: PHI may be disclosed when the use and disclosure is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS), to a medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions (fitness for military duties, eligibility for VA benefits, etc.)*

Client Rights

When it comes to your PHI, you have certain rights. This section explains your rights and some of Denver Counseling Solutions, LLC's responsibilities to help you.

- *Right to Request Restrictions*: You have the right to request restrictions on certain uses and disclosures of protected health information regarding you. The request must be in writing, and I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- *Right to Inspect and Copy*: You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend*: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting*: You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy*: You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.
- *Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket*: You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

Provider's Duties

As a mental health provider, I have certain duties to you related to your PHI. These are described below.

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I am required to notify you if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will send a revised Notice of Privacy Practices by mail or email to the address I have in your record.

Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Sarah Spurlock, MA, LMFT, at 720-608-0379, sarah@denvercounselingsolutions.com.

If you believe that your privacy rights have been violated and wish to file a complaint with my office, you may send your written complaint to Sarah Spurlock, MA, LMFT, at sarah@denvercounselingsolutions.com. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201, or email to OCRComplaint@hhs.gov. Denver Counseling Solutions, LLC, will not retaliate against you for exercising your right to file a complaint.

This Notice is effective January 2020.

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

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices for Denver Counseling Solutions, LLC, effective January 2020.

Name (please print): ____
Signature: ____________________________________ Date:__________________________

I am a parent or legal guardian of _________________________________ (client name). I have received a copy of the Denver Counseling Solutions, LLC Notice of Privacy Practices effective January 2020.

Name (please print): ____
Relationship to Patient: ☐ Parent ☐ Legal Guardian
Signature: ___________________________________ Date:_____________________________

For Office Use Only:

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective January 2020 given to individual on _________________ (date)

☐ In Person ☐ Mailing ☐ Email ☐ Other _______________________________________

Reason individual or parent/legal guardian did not sign this form:

☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other ____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature.

☐ In person conversation ____
☐ Telephone contact ____
☐ Mailing ____
☐ Email ____
☐ Other ____

Staff Name (please print): _________________________________ Title: ______________

Signature: ___________________________________ Date: _______________________