Erin Giveans, MA, LPC

Consent for Counseling and Mandatory Disclosure Statement

Degrees and Credentials:

- LPC.0002375
- BS in Psychology, Colorado State University, 1992
- MA in Counseling, Denver Seminary, 1995

I received my Bachelor's of Science in Psychology from Colorado State University in 1992, and then went on to earn my Masters in Counseling from Denver Seminary in 1995. I received my LPC through the State of Colorado in 1999. I have gained many years of clinical and counseling experience in a variety of therapeutic environments including counseling clinics, a church counseling center, a psychological hospital ward, high risk homes though a family preservation program, adolescent residential treatment centers, and in private practice counseling. I am a Christian counselor and use the Bible, prayer, and the guidance of the Holy Spirit in the counseling process as I believe that true healing comes from God.

Because you are receiving counseling from Light of the Rockies Christian Counseling Center, you are entitled to know that each of the therapists practice counseling from a Christian perspective. Please feel free to ask questions or discuss this information at any time.

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed and unlicensed counselors and marriage and family therapists. The agency with this responsibility is the State Grievance Board, 1560 Broadway, Suite 1350, Denver, CO, 80202, 303-894-7766. 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 1,000 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 registered/listed with the State Board of Registered Psychotherapists, but is not licensed or certified by the state, and no degree, testing, training or experience is required to obtain registration from the state. You are entitled to receive information from your therapist about the methods of therapy, the techniques used, fee structure and the duration of your therapy (if known). You may ask questions about your therapy at any time. You may discontinue therapy services at any time and for any reason. You are entitled to receive a second opinion from another therapist. If necessary, referrals to other counselors or marital and family therapists will be made available. In a professional therapeutic relationship sexual contact of any kind between a therapist and a client is never appropriate. If sexual intimacy between a client and therapist occurs, it should be reported to the State Grievance Board.

Confidentiality:

Both professional ethics and the Colorado State Mental Health Code-CRS 112.43.214 (1) (d) require that your privacy be carefully protected. Generally speaking, information provided by and to a client in therapy is legally confidential and will not be released to anyone without your written permission. Confidentiality can be broken by your therapist in certain circumstances as required by Colorado law (listed in section 12-43-218 of the Colorado Revised Statutes and the Notice of Privacy Rights you were provided) These circumstances are summarized below:

(1) if you sign a release of information form that allows me to disclose information to individuals or institutions specified by you;
(2) if you are using insurance benefits, I may disclose relevant information regarding diagnosis and treatment if requested by your insurance company;
(3) if you are in danger of causing immediate harm to yourself or another person, I am required by law to report this to appropriate authorities;
(4) if I am ordered by a court of law to disclose information about you (e.g., if I am served with a legitimate subpoena), I am required in some cases to respond to that order;
(5) if you reveal information concerning neglect, physical or sexual abuse of a child or an elder, I am required by law to report this knowledge to the appropriate authorities;
(6) if you are in therapy by order of a court of law;
(7) if you are involved in a criminal or delinquency proceeding;
(8) if I need to provide another therapist with pertinent information when that therapist is on-call for my practice in my absence, or if, I consult with another colleague about your treatment. Supervision and case consultation of cases will occur with staff members

of Light of the Rockies Christian Counseling Center. Any objections to this supervision or known affiliations with these parties should be shared with your therapist immediately.

Couples attending therapy together are informed that information shared with the therapist by one individual may be disclosed to the other party at the therapist's discretion. Other than these exceptions noted above, information shared in therapy is privileged communication and cannot be disclosed in any court of competent jurisdiction in the state of Colorado without your consent. Information shared in couple's therapy when both parties are present cannot be disclosed to other parties without the written consent of both parties attending the couples' sessions.

Payments/Cancellations:
The fee for therapy has been agreed upon by those signed below. The fee has been set at: $_____ per session (50 minutes). Payment of this fee is expected at the beginning of each session. A pro-rated fee will be charged for phone consultations greater than 5 minutes in duration and any written correspondence. If a court appearance/deposition is required, please ask for the separate consent form. The full session fee is charged for appointments at which you do not show or cancel with less than 24-hour notice of the reserved appointment time. Two-hour sessions must be cancelled one week in advance. A $20 fee will be charged for all checks returned for insufficient funds.

Emergencies:
As is the case with most outpatient therapists, I am not available at all times. I encourage clients to develop additional support systems and to have access to other individuals and/or agencies in case of emergencies. Listed below are local emergency telephone numbers should you need them:
Colorado Crisis Support, 494-4200; Walk-in crisis center: 1217 Riverside Dr., Fort Collins
Crisis Assessment Center at Poudre Valley Hospital, 495-8090;
Or, call 911 or go to the nearest hospital emergency room.

Treatment Agreement:
If applicable, those signed below give permission for minor children (_____) to be seen in individual or family counseling and affirm the right and authority to give such consent.

Those signed below have read and understood the above including the Mandatory Disclosure Statement and give consent for professional counseling provided by Erin Giveans, MA, LPC. The therapy has been explained verbally and any questions have been answered.

My signature below indicates my understanding and agreement to these policies and procedures. I understand my rights as a client or as the client's responsible party.

Print Client Name _____

Client or Responsible Party's Signature_____ Date _____

Signature_____ Date _____

Counselor's signature_____ Date _____

If signed by Responsible Party, state relationship to client and authority to consent: _____

_____

Light of the Rockies Christian Counseling Center
5236 Strauss Cabin Rd.
Ft Collins, CO 80528

Notice of Privacy Practices

Acknowledgment of Receipt of HIPAA Notice

Patient/Client Name:_____DOB:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Light of the Rockies Christian Counseling Center's Notice of Privacy Rights. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Susan Witter, Office Manager at Light of the Rockies Christian Counseling Center at 5236 Strauss Cabin Rd., Ft Collins, CO 80528, 970-484-1735.

Client's Signature: _____Date:_____

If not the client, please print and state legal authority to sign for client:_____

Name: _____Relationship:_____

For Light of the Rockies' Use Only

Notice of Privacy Rights was presented to the client or legal guardian today, but the client or legal guardian did not sign this acknowledgement because:

- The client refused to sign.
- The legal guardian refused to sign.
- Other:_____

LOTR Staff Signature: _____ Date: _____

Light of The Rockies

Client Contact & Referral Information

Today's Date:_____

Client Name(s):_____ DOB:_____

_____ DOB:_____ Counselor you are scheduled with:_____

_____ _____

Home Address City State Zip

(_____)_____ (_____)_____

☐ Home Phone ☐ Mobile ☐ Work ☐ Mobile

_____ _____ _____

Email Address Emergency Contact Name Phone

Parent or Guardian Name: _____ DOB:_____

Primary Care Doctor: _____ Phone Number: _____

How did you hear about your therapist or Light of the Rockies?

☐ **Professional referral: Name** _____

☐ **Personal referral: Name** _____

☐ **My pastor / church: Name** _____

☐ **The Yellow Pages / Christian Business Directory Ad / Website / Facebook Page/Find a Christian Counselor (circle one)**

☐ **Google/Web search**

☐ **Other:** _____

Do we have your permission to send a thank you note to the party who referred you?
☐ **YES, please initial_____** ☐ **I prefer you not do so.**
May we use your name in the thank you note? ☐ **YES, please initial: _____** ☐ **I prefer you not do so.**

Do you attend a church? ☐ **No** ☐ **Yes** **Church Name:**_____

May we have your permission to send:

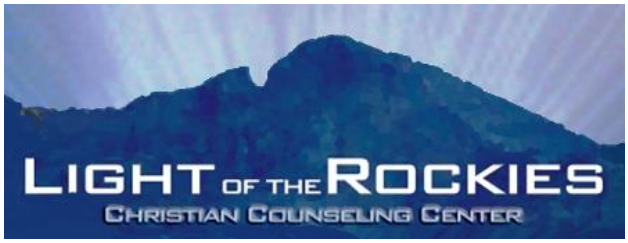
- **An anonymous note to your church stating that one of their members recently sought counseling with Light of the Rockies?**
  If ☐ **YES, please initial:_____** ☐ **I prefer you not do so. (If we can use your name, please initial here: _____)**
- **Do we have your permission to send or email you a 6-month follow up questionnaire once you have completed your counseling?** ☐ **No** ☐ **Yes**
- **Do we have your permission to send or email you occasional mailings in the future concerning Light of the Rockies Christian Counseling Center?** ☐ **No** ☐ **Yes**

Financial Information: ☐ **I want to use insurance.** ☐ **If you want to use the sliding fee scale, fill out below:**
What is your annual gross (pre-tax) income for your entire household? (There will be an application to complete.)

☐ Less than $29,999 ☐ $30,000 — $39,999 ☐ $40,000 — $49,999 ☐ $50,000 — $59,999

☐ $60,000 — 79,999 ☐ $80,000 — $99,999 ☐ $100,000 — $120,000 ☐ Above $120,000

Light of The Rockies
Financial Policies



CANCELLATIONS

- Light of the Rockies Christian Counseling Center requires ***24-hour notice*** for a cancellation of an appointment unless there is a true emergency. Examples of true emergencies would include sudden onset of fever or stomach flu. If you need to cancel your appointment, we prefer as much advance notice as you can give us so that we can potentially make the appointment available for another client. We need 1-week cancellation notice for 2-hour appointments.
- Under certain circumstances (example: a sick child or a snow day) you may be able to have your appointment with your therapist via phone. Please contact our office manager if you wish to have a phone appointment.
- An appointment cancelled with less than 24 hours' notice will be *charged at your regular rate*. Insurance cannot be billed for cancelled appointments, and clients will be responsible for paying the full fee for their missed session.

PAYMENTS

- Payment for your session is due at the time of service.
- Our counseling center prefers to take checks or cash. If necessary, we can also take credit cards (VISA and MasterCard, Discover, we cannot take American Express). We can also receive your benefit credit card (HSA, FSA), so that you can pay for counseling services pre-tax through a plan provided by your employer.
- If you have made other payments arrangements with the Office Manager, we require that all bills be brought up to date by the last business day of the month.

INSURANCE

- As a courtesy to our clients, we can bill your insurance company for your counseling sessions. Please make sure that we have the following information: a photocopy of both sides of your insurance card (which we can make at your first appointment), date of birth (both client and primary on the insurance), and a phone number to contact you.
- If for some reason your insurance does not pay (you may have a deductible due before benefits can be obtained), you will be responsible for the full amount owed. We require a credit card to be on file for this purpose.
- If you are a new client and we are checking your benefits we will ask you to make full payment for the first session. If your insurance allows for a co-pay, we will apply that first session's payment to the co-pay due. If you ever over-pay, a refund will be available to you.
- If you wish to use your insurance for counseling, it is important that you contact your insurance company to determine your mental health benefits. Your therapist may be an out of network provider, and that may affect your insurance benefits.
- If your health insurance requires pre-authorization, it is your responsibility to obtain this authorization code within two business days of your initial session. If this code is not obtained, you will be responsible for any fees not paid by your insurance company.

CLOSING

- For record keeping purposes, if you have not been seen for a counseling session within a two-month period, we will consider your file closed.
- You are always welcome to return to counseling at any time, and we will re-open your file at that time.

I have read and understand the financial policies of Light of the Rockies Christian Counseling Center.

Signature _____ Date _____

Signature _____ Date _____

Therapist _____ Date _____

··· Light of the Rockies ·· 5236 Strauss Cabin Rd. ·· Fort Collins CO 80528 ·· 970-484-1735 ·· info@lightoftherockies.com ···

INITIAL INTERVIEW FORM-ADULT

Today's Date: _____

All questions contained in this questionnaire are confidential and will become part of your clinical record.

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**		**Age:**	

Why are you here today?	

PRESENTING PICTURE

My main symptoms are related to:	☐ Depression ☐ Anxiety ☐ Obsessive Worries ☐ Panic Attacks ☐ Confusion ☐ Drug Use ☐ Focus/Inattention ☐ Hyperactivity ☐ Mood Swings ☐ Self Worth ☐ Spiritual Issues ☐ Relationships ☐ Sex Life ☐ Memory Issues ☐ Anger ☐ Compulsive Behavior ☐ Work/Professional ☐ Other:

The major stressor (s) that precipitated my symptom (s): (Please include start dates)				
	☐ Marital Issues		☐ Parent/Child Issues	
	☐ Job Stress		☐ Past Issues *Abuse, Guilt, Family of Origin*	
	☐ Health Issues		☐ Other:	

My three biggest issues at present are:

1.
2.
3.

History (past issues that may be relevant now)

A. Have you had similar and significant symptoms in the past? ☐ Yes ☐ No. If yes, when:

Did they recently increase? ☐ Yes ☐ No. If yes, when & what caused it?:

B. Have you had any other significant life events that you might want to talk about? ☐ Yes ☐ No If yes, what?

C. Prior Psychiatric Hospitalizations? ☐ Yes ☐ No. If yes, when:

Reason for hospitalization:

D. Past Counseling History? ☐ Yes ☐ No.

If yes, please list therapist and reason, in last year:

Therapists and reasons in last 5 years:

E. Substance Abuse History? ☐ Yes ☐ No. If yes, when started:

Substances:

Treatment Location and Dates:

F. Have you experienced any physical, sexual, verbal, or emotional abuse? ☐ Yes ☐ No. If yes, please list:

G. Any Head/Brain Trauma (concussion, asphyxia, other injury?) ☐ Yes ☐ No. If yes, please list:

H. Have you ever attempted suicide? ☐ Yes ☐ No. If yes, please explain:

Have you been hospitalized for attempted suicide? ☐ Yes ☐ No

Prescribed Psychiatric Medications (Current)			
Medication & Dosage	Reason Taken?	Reactions/Side Effects?	Date Prescribed?
I am currently taking the following over the counter medications:			
Supplements:			
Significant Allergies:			

Employment History (last three employers)			
Employer	Dates Employed	Reason for leaving?	Notes

PERSONAL HABITS

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)						
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)						
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)						
	☐ Regular vigorous exercise (i.e., work or recreation 4-5x/week for 30-50 minutes)						
	☐ Regular vigorous exercise (i.e., work or recreation 5-7x/week for 50+ minutes)						
Sleep	☐ Insomnia (no consistent or sound sleep)						
	☐ Little Sleep (i.e., 2-4 hours per day)						
	☐ Limited Sleep (i.e., 4-6 hours per day.)						
	☐ Regular Sleep (7 hours or more per day on average)						
Diet	Are you dieting?			☐ Yes	☐ No		
	Do you have concerns about your eating patterns or habits?			☐ Yes	☐ No		
	If yes: Height/Weight:		# of meals you eat in an average day?				
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola			
	# of cups/cans per day?						
Alcohol	Do you drink alcohol?			☐ Yes	☐ No		
	If yes, what kind?						
	How many drinks per week?						
	Are you concerned about the amount you drink?			☐ Yes	☐ No		
	Have you ever "passed out" or experienced blackouts?			☐ Yes	☐ No		
	Do you occasionally "binge" drink?			☐ Yes	☐ No		

	Have you driven after drinking?		☐ Yes	☐ No	
Sex	Are you sexually active?		☐ Yes	☐ No	
	Frequency?	Concerns?			

	Any discomfort or dysfunction with intercourse?	☐	Yes	☐	No

Spirituality	How do you identify spiritually/religiously? (i.e., Christian, atheist, Hindu, etc.…):				
	Would you say you have a personal relationship with Jesus Christ? Yes No If so, how long?				
	Do you attend a church (name…)? Yes No If so, how often?				
	Do you pray and/or meditate? If so, how often?				
	Do you read/study the Bible? If so, how often?				
	Do you have personal concerns or questions related to God, the Christian faith, and/or the church?	☐	Yes	☐	No
	Are you open to discussing relevant matters of faith with your therapist?	☐	Yes	☐	No

FAMILY DETAIL				
Your Current Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Other:				
	DOB & AGE		**NAME**	**RELEVANT NOTES**
Spouse				
Children	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
Were your Parents Divorced? ☐ Yes ☐ No. If yes, when:				**Parents Remarried? ☐ Yes ☐ No.**
Previous Spouse (s) (or cohabitant)				Reason for ending relationship…

COUPLES

☐ Communication ☐ Anger management ☐ Guilt ☐ Time management ☐ Parenting Conflicts ☐ Dishonesty
☐ Sexual Connection ☐ Flirting ☐ Emotional Infidelity ☐ Physical Infidelity ☐ Spiritual ☐ Leadership
☐ Structural (family relationships) ☐ Structural (definition of marriage) ☐ Finances ☐ Other:

What have been the recent events leading up to seeking couple's counseling now?
1.
2.
3.

Our three primary goals for marriage counseling are (in order):
1.
2.
3.

When did you first think your problems were serious enough for couple's counseling…? Date:

Date met current spouse: Dating?: Engaged?: Married? Separated?:

Premarital Counseling (date)?

Previous Marriage Counseling?

Other Relevant Notes:

Name: _____ **Age:** ____ **Sex:** ❑ Male ❑ Female **Date:**_____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	