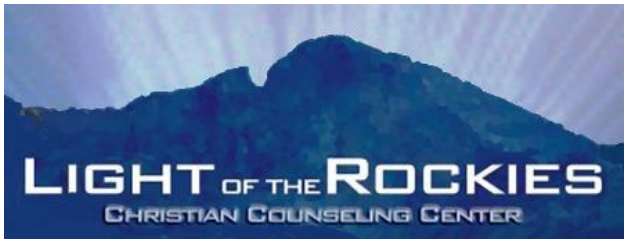
Erin Giveans, MA, LPC

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

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 marital and family therapy provided by Chris Bassett, M.A., LMFT. 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 toconsent: _____

_____

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:_____

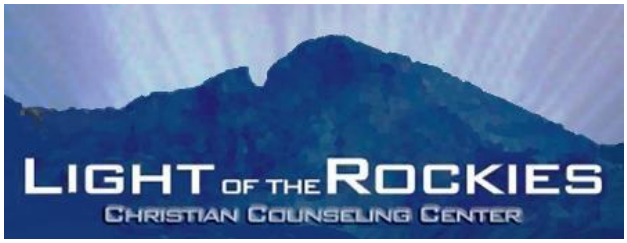
For Light of the Rockies' Use Only

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
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

- Some of our therapists take insurance. If you are hoping to bill insurance for your session, please call the office and we can help you determine if your therapist participates with your insurance and what your options may be.
- It is your responsibility to know and understand what your insurance will cover. If you wish to use your insurance for counseling, it is also important that you contact your insurance company to determine your mental health benefits.
- We will require a credit card to be on file for any insurance company that we submit claims for.
- Your insurance policy is an agreement between you and your insurance company. Our relationship is with you, not your insurance company. Therefore, all charges are ultimately your responsibility, regardless of your insurance status. You are responsible for getting proper referral and pre-authorization information prior to your counseling sessions.
- At the time of your first appointment, if we are submitting claims for you, please make sure that we have a copy of both sides of your insurance card (which we can make at that first appointment), date of birth (both client and primary on the insurance), and a phone number to contact you.

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

Client Contact & Referral Information

Today's Date:_____ Sex:_____

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. Primary Insured_____ DOB:_____**

☐ **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 – $49,999	☐ $50,000 – $59,999	☐ $60,000 – 79,999
☐ $80,000 – $89,999	☐ $90,000 – $99,999	☐ $100,000 – $119,999	☐ Above $120,000

INITIAL INTERVIEW FORM - MINOR- Elementary / Preschool

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 seeking counseling for your child?

Please describe the impact of the child's struggles on his/her family and friends.

PRESENTING PICTURE

Please check any boxes for stressors, in the past year, for your child:	☐ Depression ☐ Anxiety ☐ Obsessive Worries ☐ Death of a pet ☐ Death of a family member ☐ Moves ☐ Hyperactivity ☐ Mood Swings ☐ Self-Worth ☐ Spiritual Issues ☐ Relationships ☐ Marital Conflict ☐ Divorce ☐ Family Financial Issues ☐ Compulsive Behavior ☐ Other:
Please check any current challenges for your child:	☐ Problems with fatigue or motivation ☐ Problems with having too much energy ☐ Sleep problems ☐ Anger outbursts ☐ Eating more or less than usual ☐ Being non-compliant with commands ☐ Poor grades ☐ Anxiety/Tension ☐ Aggression towards others ☐ Problems with memory ☐ Behavioral problems at school or home ☐ Sadness
Three strengths your child has:	

List the three greatest struggles for your child/family in regard to how therapy can help:

1.
2.
3.

History (Past Issues that may be relevant now)

A. Has your child 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. Prior Psychiatric Hospitalizations? ☐ Yes ☐ No. If yes, when:

Reason for hospitalization:

C. Past counseling history for your child? ☐ Yes ☐ No.

If yes, please list therapist and reason:

How many times was your child seen by the therapist?

Was it a positive/useful experience? ☐ Yes ☐ No

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

Substances:

Treatment Location and Dates:

E. Has your child experienced any physical, sexual, verbal, or emotional abuse? ☐ Yes ☐ No. If yes, please list:
F. Any Head/Brain Trauma (concussion, asphyxia, other injury?) ☐ Yes ☐ No. If yes, please list:
G. Has your child ever attempted suicide? ☐ Yes ☐ No. If yes, please explain:
Has your child been hospitalized for attempted suicide? ☐ Yes ☐ No
H. Does your child have a history of self-harm? ☐ Yes ☐ No
Is your child currently self-harming? ☐ Yes ☐ No

Medical History/Medications			
What is your child's height?			
What is your child's weight?			
Is your child currently physically healthy? ☐ Yes ☐ No If no, please explain.			
List any medications your child is on in the chart below.			
Medication & Dosage	Reason Taken?	Reactions/Side Effects?	Date Prescribed?
Has your child or any of your child's relatives, suffered from any major illnesses (i.e. cancer or diabetes) or mental health issues (depression, bipolar, substance abuse, etc.)?			
Family Physician (including location and phone number):			
Month and Year of last physical?			
Significant Allergies:			

Educational History
Is your child currently in school? ☐ Yes ☐ No
Name of the school your child is attending:
What grade is your child in right now?
Is your child receiving any special education services (IEP plan, 509 plan)? ☐ Yes ☐ No
If yes, please explain.
Has your child had any behavioral struggles at school? ☐ Yes ☐ No
If yes, please explain.

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	Is your child dieting?				☐	Yes	☐	No
	Do you have concerns about his/her eating patterns or habits?				☐	Yes	☐	No
	If yes:			# of meals you eat in an average day?				
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola				
	# of cups/cans per day?							

Spirituality	How does your child identify spiritually/religiously? (i.e., Christian, atheist, Hindu, etc.…):						
	Would you say your child has a personal relationship with Jesus Christ? Yes No If so, how long?						
	Does your child attend a church (name…)? Yes No If so, how often?						
	Does your child have personal concerns or questions related to God, the Christian faith, and/or the church?	☐	Yes	☐	No		
	Is your child open to discussing relevant matters of faith with his/her therapist?	☐	Yes	☐	No		

FAMILY DETAIL				
Are the child's parents currently married?				
If there is shared custody, please describe the arrangement.				
	DOB & AGE		**NAME**	**RELEVANT NOTES**
Siblings	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
Please describe any important family events that may have had an impact on your child's current issues (i.e. divorces, custody changes, moves, etc.).				
Please describe any cultural factors (family beliefs and values, religion, ethnicity, language, etc.) that are important to your family				

Early Development and Home Background (EDHB) Form—Parent/Guardian

Child's Name: _____ **Age:** ____ **Sex:** ❑ Male ❑ Female **Date:**_____

Instructions to Parent or Guardian: Questions P1-P19 ask about the early development and early and current home experiences of your child. Some questions require that you think as far back as to the birth of your child. Your response to these questions will help your child's clinician better understand and care for your child. Answer each question to the best of your knowledge or memory.

What is your relationship with the child receiving care? _____

Please choose one response (✓ or x) for each question.					
Early Development		**No**	**Yes**	**Can't Remember**	**Don't Know**
P1.	Was he/she born before he/she was due (premature)?	☐	☐	☐	☐
P2.	Were the doctors worried about his/her medical condition immediately after he/she was born?	☐	☐	☐	☐
P3.	Did he/she have to spend any time in a neonatal intensive care unit (NICU)?	☐	☐	☐	☐
P4.	Could he/she walk on his/her own by the age of 18 months?	☐	☐	☐	☐
P5.	Has he/she ever had a seizure?	☐	☐	☐	☐
P6.	Did he/she ever lose consciousness for more than a few minutes after an accident?	☐	☐	☐	☐
Early Communication					
P7.	By the time he/she was age 2, could he/she put several words together when speaking?	☐	☐	☐	☐
P8.	Could people who didn't know him/her understand his/her speech by the time he/she reached age 4?	☐	☐	☐	☐
P9.	Have you ever been concerned about his/her hearing or eyesight?	☐	☐	☐	☐
P10.	By the time he/she was age 4, was he/she interested in playing with or being with other children?	☐	☐	☐	☐
Home Environment					
P11.	Was there ever a time when he/she could not live at home and someone else had to look after him/her?	☐	☐		☐
P12.	Has he/she ever been admitted to the hospital for a serious illness?	☐	☐	☐	☐
P13.	Does anyone at home suffer from a serious health problem?	☐	☐		☐
P14.	Does anyone at home have a problem with depression?	☐	☐		☐
P15.	Does anyone at home regularly see a counselor, therapist, or other mental health professional?	☐	☐		☐
P16.	Does anyone at home have a problem with alcohol, drugs, or other substances?	☐	☐		☐
P17.	Would you say that the atmosphere at home is usually pretty calm?	☐	☐		☐
		Less Than Once a Month	**Between Once a Week and Once a Month**	**More Than Once a Week**	**Most Days**
P18.	How often are there fights or arguments between people at home?	☐	☐	☐	☐
P19.	How often does your child get criticized to his/her face by other family members when he/she is at home?	☐	☐	☐	☐

David Shaffer, F.R.C.P., F.R.C., Psych.