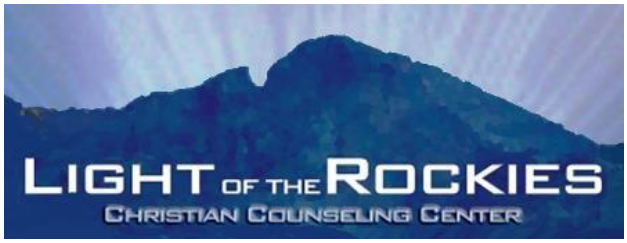
Ginger Masted, MA, LPCC
Consent for Counseling and Mandatory Disclosure



Degrees and credentials:

- Colorado Licensed Professional Counselor Candidate (LPCC.0015730)
- M.A. in Counseling, Colorado Christian University
- B.A. in Communications, University of San Diego

I received a Bachelor's Degree in Communications from University of San Diego and a Master's Degree in Counseling from Colorado Christian University. Prior to becoming a professional counselor, my work focused on pastoral care at various churches in Southern California. I provide an integrated approach to counseling based upon my client's story and personal goals utilizing research-based therapeutic tools and healing modalities. I work with children, adolescents, couples, and families on a myriad of issues and circumstances to provide them an opportunity to walk in the fullness of life they were created for.

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.

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 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:_____

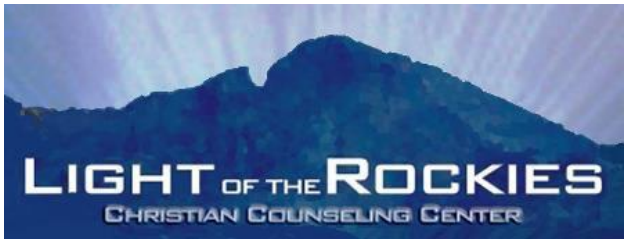
For Light of the Rockies' Use Only

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- High School / Middle School

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?

Please describe the impact of the your struggles on family and friends.

PRESENTING PICTURE

Please check any boxes for stressors, in the past year:	☐ 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	☐ 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 you have:	

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

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

Reason for hospitalization:

C. Past counseling history? ☐ Yes ☐ No.

If yes, please list therapist and reason:

How many times were you 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. Have you 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. Have you ever attempted suicide? ☐ Yes ☐ No. If yes, please explain:
Have you been hospitalized for attempted suicide? ☐ Yes ☐ No
H. Do you have a history of self-harm? ☐ Yes ☐ No
Are you currently self-harming? ☐ Yes ☐ No

Medical History/Medications			
What is your height?			
What is your weight?			
Are you currently physically healthy? If no, please explain. ☐ Yes ☐ No			
List any medications you are on in the chart below.			
Medication & Dosage	Reason Taken?	Reactions/Side Effects?	Date Prescribed?
Have you or any of your 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
Are you currently in school? ☐ Yes ☐ No
Name of the school you attend:
What grade are you in right now?
Are you receiving any special education services (IEP plan, 509 plan)? ☐ Yes ☐ No
If yes, please explain.
Have you 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)	☐ Yes ☐ No	
	☐ Regular Sleep (7 hours or more per day on average)	☐ Limited Sleep (i.e., 4-6 hours per day.)	☐ Yes ☐ No	
Diet	Are you dieting? ☐ Yes ☐ No	Do you have concerns about your eating patterns or habits? ☐ Yes ☐ No		
	If yes:	# of meals you eat in an average day?		
	☐ None	☐ Coffee	☐ Tea	☐ Cola
Caffeine	# of cups/cans per day?			
Sex	Are you sexually active? ☐ Yes ☐ No	Any discomfort or dysfunction with intercourse? ☐ Yes ☐ No		
	Frequency?	Concerns?		
	Anything you want me to know about your sexuality?			

Anything Else You Want me to Know?

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?
	Does 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

Are your 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

The Personality Inventory for DSM-5—Brief Form (PID-5-BF)—Child Age 11–17

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

	Instructions: This is a list of things different people might say about themselves. We are interested in how you would describe yourself. There are no right or wrong answers. So you can describe yourself as honestly as possible, we will keep your responses confidential. We'd like you to take your time and read each statement carefully, selecting the response that best describes you.					**Clinician Use**
		Very False or Often False	**Sometimes or Somewhat False**	**Sometimes or Somewhat True**	**Very True or Often True**	**Item score**
1	People would describe me as reckless.	0	1	2	3	
2	I feel like I act totally on impulse.	0	1	2	3	
3	Even though I know better, I can't stop making rash decisions.	0	1	2	3	
4	I often feel like nothing I do really matters.	0	1	2	3	
5	Others see me as irresponsible.	0	1	2	3	
6	I'm not good at planning ahead.	0	1	2	3	
7	My thoughts often don't make sense to others.	0	1	2	3	
8	I worry about almost everything.	0	1	2	3	
9	I get emotional easily, often for very little reason.	0	1	2	3	
10	I fear being alone in life more than anything else.	0	1	2	3	
11	I get stuck on one way of doing things, even when it's clear it won't work.	0	1	2	3	
12	I have seen things that weren't really there.	0	1	2	3	
13	I steer clear of romantic relationships.	0	1	2	3	
14	I'm not interested in making friends.	0	1	2	3	
15	I get irritated easily by all sorts of things.	0	1	2	3	
16	I don't like to get too close to people.	0	1	2	3	
17	It's no big deal if I hurt other peoples' feelings.	0	1	2	3	
18	I rarely get enthusiastic about anything.	0	1	2	3	
19	I crave attention.	0	1	2	3	
20	I often have to deal with people who are less important than me.	0	1	2	3	
21	I often have thoughts that make sense to me but that other people say are strange.	0	1	2	3	
22	I use people to get what I want.	0	1	2	3	
23	I often "zone out" and then suddenly come to and realize that a lot of time has passed.	0	1	2	3	
24	Things around me often feel unreal, or more real than usual.	0	1	2	3	
25	It is easy for me to take advantage of others.	0	1	2	3	
					Total/Partial Raw Score:	
					Prorated Total Score: (if 1-6 items left unanswered)	
					Average Total Score:	