ChildSafe
Start the healing

IDENTIFYING INFORMATION

Please answer each question carefully and ask for clarification if you do not understand. The information on the questionaire will be helpful in planning services for you, is confidential and will not be released without your permission.

Client Name: **Age:** **Sex:** **Date of Birth:**

Address:

City: **State:** **Zip Code:**

Home Phone: **Okay to leave message?:** ☐

Cell Phone: **Okay to leave message?:** ☐

Work Phone: **Okay to leave message?:** ☐

Martial Status: **Race:** **Religion:** **Disabled?:** ☐

Occupation: **Place of Employment:**

Monthly Family Income:

Email Address :

O.K. to contact you via email?: ☐

Would you like to receive ChildSafe's e-newsletter and other announcements?: ☐

Other Family Members:

Name	Age	Date of Birth	Relationship
1)_____	--_____	_____	----_____
2)_____	--_____	_____	----_____
3)_____	--_____	_____	----_____
4)_____	--_____	_____	----_____
5)_____	--_____	_____	----_____

Reason for Seeking Help_____
_____
_____

Who Referred you to ChildSafe?_____

Name of client's physician_____ **Phone Number**_____

List any medications client is currently taking and the reason why_____
_____

Have you had previous psychological, psychiatric counseling?_____

Name of therapsit and reason for seeking help_____
_____

Emergency Contact Person: _____ **Phone Number:** _____

Do you have health insurance that covers mental health out patient counseling? _____
If so, ChildSafe will need a copy of your insurance card. You are responsible for any pre-approval if your insurance policy requires that process before beginning therapy.

Name of Insurance Company_____
Name of Policy Holder_____ **Date of Birth**_____
Social Security # of policy holder_____

If you qualify for Victim Compensation and/or Core Service funding please be aware that your insurance must be billed prior to ChildSafe billing those resources. Your signature on this form gives ChildSafe permission to bill these resources on your behalf and also gives permission for therapist(s) to submit treatment plans to your insurance company, Victim Compensation and Core Services.

You are responsible for any unpaid balances. Please see attached Financial Statement.

Signature of Responsible Party_____ **Date**_____

Signature of Intake Therapist_____ **Date**_____

Financial Policy

1. Fees for therapy are $125.00 per one hour individual or family session, $135.00 per one hour play therapy session, $200 per neurofeedback session and $55.00 per group session. ChildSafe accepts contracted rates for health insurance and victim compensation. A sliding scale fee is also available based on income and household size.

2. All fees (including deductibles and co-pays) are due at the time of service. **If you have health insurance or are a private pay client, or are on a sliding scale, you must see the billing personnel to set up a payment schedule for deductibles and co-pays within one week of the Intake appointment.**

3. Any account that has not received payment within 6 months will automatically be turned over to a collection agency. An attorney's fee for any aging account may be added to cover the collection agency's litigation process.

4. If for any reason insurance or other third party payment resources (Victim Compensation or Core Service) refuses payment, clients are responsible for the full amount and the above conditions apply. If sliding scale conditions apply, you will be responsible for your sliding scale fee, at the time services are rendered.

   I agree to the above financial conditions and understand that any exception to this policy must be made in writing and in advance with the billing office.

   _____ Date_____
   Signature of Responsible Party

   _____ Date_____
   Signature of the ChildSafe authorized personnel

Revised:March 2014

CHILDSAFE SLIDING FEE SCALE APPLICATION

PARENT INFORMATION		**TODAY'S DATE:**	
First Name:	Middle:	Last:	Other Names:
Home Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	
Date of Birth:	Social Security #:	Do you have insurance? (circle one) Yes ☐ No ☐	
Marital Status:	Single ☐ In a relationship ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐		

HOUSEHOLD SIZE	
Name	**Date of Birth**

NOTE: In order to give you a discount on our therapy services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year you are receiving services from ChildSafe. Please provide 2 of the following:

-Tax Return or W-2 Form

-2 Paycheck Stubs or Copies of Social Security Checks

-Bank Statement

Your annual income and your family size will be used to

HOUSEHOLD INCOME			
Name	**Amount**	**Frequency (Circle One)**	**Employer**
You	$ 0.00	Weekly ☐ Monthly ☐ Yearly ☐	
Spouse	$ 0.00		
Children	$ 0.00		
Other	$ 0.00		
	$ 0.00		
TOTAL	$ 0.00		

Other Income	You	Spouse	Children	Other	Subtotal
Social Security	0.00	0.00	0.00	0.00	0.00
Student Loans	0.00	0.00	0.00	0.00	0.00
Public Assistance	0.00	0.00	0.00	0.00	0.00
Retirement Pension	0.00	0.00	0.00	0.00	0.00
Food Stamps	0.00	0.00	0.00	0.00	0.00
Child Support, Alimony	0.00	0.00	0.00	0.00	0.00
Family/Friend Support	0.00	0.00	0.00	0.00	0.00
Interest Income	0.00	0.00	0.00	0.00	0.00
Other	0.00	0.00	0.00	0.00	0.00
				TOTAL	$ 0.00

I do hereby swear or affirm that the information provided on this application is true & correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program. I further agree to inform ChildSafe if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply will all the rules and regulations of ChildSafe. I hereby acknowledge that I have read the foregoing disclosure & understand it.

Date:_____ PrintedName:_____

Signature:_____

Late Cancellation Policy

- All appointments scheduled after noon, cancellations MUST be made by 10 AM that same day or a **$10 fee** will be applied that must be paid at your next visit.
- All appointments scheduled prior to noon, cancellations MUST be made the previous day or a **$10 fee** will be applied that must be paid at your next visit.

No Show Policy

- For every appointment that you do not show up for and do not call to cancel, a **$15 fee** will be applied that must be paid at your next visit.

Late Arrival Policy

- If you arrive for your appointment 20 minutes late or more, your therapist will not see you and a **$10 fee** will be applied that must be paid at your next visit.

Neurofeedback Policy

- All of the above policies are in place for neurofeedback clients, however, due to the nature of these sessions, no show fees are raised to **$20.**

If no-shows and late cancellations become habitual, your therapist reserves the right to meet with you to discuss whether services are beneficial at this time. We also reserve the right to give your time slot to someone waiting for a better time if you are not regularly attending scheduled sessions. We understand that there may be an occasional emergency, and you cannot give notice for your missed appointment, but we expect that this would be the exception, not the rule.

By signing this letter, you are indicating that you understand these changes, and are agreeing to follow this policy. Thank-you for trusting us with your care and we hope that this change makes your time with us more helpful.

Sincerely,

The ChildSafe Staff

Name:_____ **Date:**_____

Please keep this copy for your records

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Sincerely,

The ChildSafe Staff

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL TREATMENT INFORMATION

I hereby authorize ChildSafe therapists to disclose and/or receive confidential information concerning me and/or my child,

_____ _____

Myself or Name of Child Date of Birth

including medical records, treatment notes, evaluations, and reports or records of other treatment providers concerning me and/or my child. I authorize ChildSafe to disclose confidential information concerning me or my child verbally and in writing concerning my case. I authorize ChildSafe to use professional judgment in deciding what specific information will be released and communicated, and to use professional judgment in deciding whether specific records or a summary of treatment information should be disclosed. I authorize the exchange of information with the following agencies and/or individuals:

☐	Larimer County Department of Human Services
☐	Larimer Center for Mental Health
☐	Poudre School District (specify school)_____
☐	Thompson School District (specify school)_____
☐	Fort Collins Police Services
☐	Loveland Police Department
☐	Larimer County Sheriff's Department
☐	8th Judicial District Attorney
☐	Probation
☐	Larimer County Child Advocacy Center
☐	ChildSafe Therapists
☐	Medical Professional _____

Others _____

Disclosure Regarding Confidentiality of Treatment Information

I understand that any treatment records concerning my mental health treatment or assessments are confidential under Colorado law, and that a statutory privilege prohibits confidential treatment information from being disclosed without my consent.

This release authorizes the disclosure/exchange of information between ChildSafe staff and the persons or agencies identified above. The persons or agencies receiving this information may not share such information with any other person or agency without obtaining my written consent.

I understand that I have no obligation to sign this authorization for the disclosure of confidential information about myself and/or my child. In addition, **I understand that I may revoke this consent for disclosure of information in writing at any time.** This consent expires automatically as follows:

Thirty days past client's termination from services (to allow for termination summary to be completed and any after-care plans to be coordinated) If you would like to specify a date, event, or condition upon which consent expires:_____

_____ _____

Signature of client or legal guardian **Date**

_____

Relationship to child (if applicable)

Acknowledgement of Receipt of Disclosure Statement and Notice of Privacy Rights.

Name of Client_____
(Please Print Name)

Disclosure Statement and Notice of Privacy Rights:

I hereby acknowledge that I have received a copy of the provider/psychotherapist *Disclosure Statement and Notice of Privacy Rights.* I further agree to read this *Disclosure Statement and Notice of Privacy Rights.* I will talk with my therapist if I have any concerns.

_____ _____
Client Signature Date

_____ _____
Parent or Guardian Signature Date

_____ _____
Therapist/Witness Signature Date

ChildSafe
Start the healing
1148 E. Elizabeth St., Fort Collins, Colorado 80524 Phone (970) 472-4133 Fax (970) 493-6655

DISCLOSURE STATEMENT & NOTICE OF PRIVACY RIGHTS

The Disclosure Statement & Notice of Privacy Rights describes how medical and mental health information about you may be used and disclosed, and how you can get access to this information. Please review this information carefully. During the process of providing services to you, the provider/psychotherapist will obtain, record, and use mental health and medical information about you that is protected health information. Ordinarily, that information is confidential and will not be used or disclosed, except as described below.

I. USES AND DISCLOSURES OF PROTECTED INFORMATION

A. *General Uses and Disclosures Not Requiring the Client's Consent.* The provider will use and disclose protected health information in the following ways.

1. *Treatment.* Treatment refers to the provision, coordination, or management of health care [including mental health care] and related services by one or more health care providers. For example, the provider will use your information to plan your course of treatment. As to other examples, the provider will consult with professional colleagues in this practice or ask professional colleagues to cover calls or the practice for the provider and will provide the information necessary to complete those tasks.
2. *Payment.* Payment refers to the activities undertaken by a health care provider [including a mental health provider] to obtain or provide reimbursement for the provision of health care. The provider will use your information to develop accounts receivable information, bill you, and with your consent, provide information to your insurance company or other third party payers for services provided. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnosis, type of service, date of service, provider name/identifier, and other information about your condition and treatment.
3. *Health Care Operations*. Health Care Operations refers to activities undertaken by the provider that are regular functions of management and administrative activities of the practice. For example, the provider may use or disclose your health information in the monitoring of service quality, staff evaluation, and obtaining legal services.
4. *Contacting the Client.* The provider may contact you to remind you of appointments and to tell you about treatments or other services that might be of benefit to you. The provider does not guarantee confidentiality if you are discussing issues via cell phone, cordless phone etc. and you must give consent for provider to leave a message on an answering machine. Confidentiality cannot be guaranteed if you choose to communicate with your therapist or the agency via email.
5. *Required by Law.* The provider will disclose protected health information when required by law or necessary for health care oversight. This includes, but is not limited to: (a) reporting suspected child abuse or neglect; (b) when court ordered to release information; (c) to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, or regulatory compliance; (d) when a coroner is investigating the client's death; (e) when there is a legal duty to warn or take action regarding imminent danger to others, for example, (school violence, a methamphetamine lab or other violent crime). The provider is required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (f) The provider is required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental disorder; (g) The provider is required to report any suspected threat to national security to federal officials.

6. *Crimes on the premises, observed, or reported to the provider.* Crimes that are observed by the provider or the provider's staff, crimes that are directed toward the provider or the provider's staff, crimes that occur on the premises, or crimes reported to law enforcement.
7. *Business Associates.* Some of the functions of the provider may be provided by contracts with business associates. For example, some of the billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services. 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.
8. *Research.* The provider may use or disclose protected health information for research purposes if the relevant limitations of the Federal HIPAA Privacy Regulations are followed. 45 CFR § 164.512(i).
9. *Involuntary Clients.* Information regarding clients, who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.
10. *Family Members.* Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of that discussion. However, if the client objects, protected health information will not be disclosed. Under Colorado law, C.R.S. 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information. If you request treatment information, the therapists may provide you with a treatment summary, in compliance with Colorado law and HIPPA Standards.
11. *Welfare Checks.* When we are concerned about a client's safety, it is our policy to request a Welfare Check through local law enforcement. In doing so, we may disclose to law enforcement officers information concerning our concerns. By signing this Disclosure Statement and agreeing to treatment at ChildSafe, you consent to this practice, if it should become necessary.
12. *Client/Patient Rights.* (1) You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your treatment (if it can be determined), and the fee structure. Please ask if you wish to receive this information from your therapist. (2) You may seek a second opinion from another therapist and may terminate your therapy at any time. (3) In a professional relationship (such as ours), sexual intimacy is never appropriate. If sexual intimacy occurs, it should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.
13. *Confidentiality.* Generally speaking, the information provided by and to a client during therapy sessions is legally confidential and cannot be released without the client's consent. If information is legally confidential, your therapist cannot be required to disclose such information without your consent. There are exceptions to the general rule of legal confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes, as well as other exceptions in Colorado and Federal law. Be advised that legal confidentiality may not apply in a criminal or delinquency proceeding. If a legal exception arises during therapy, if feasible, you will be informed accordingly. The Mental Health Practice Act (CRS 12-43-101, et seq.) is available at http://www.dora.state.co.us/mental-health/Statute.pdf.
14. *Hold Harmless.* I agree to hold harmless, and I will not institute or be part of any claim or suit against the therapists, evaluators, staff and agency in their provision and administration of my services and treatment program
15. *Release of Information.* Information in your case may be shared with the ChildSafe therapists and interns listed in this document for case consultation and supervision purposes. This information is considered confidential for each of these professionals. Your signature gives consent for this consultation and supervision.

B. *Client Authorization or Release of Information.* The provider may not use or disclose protected health information in any other way without a signed authorization or release of information. When you sign an authorization, or a release of information, it may later be revoked provided that the revocation is in writing. The revocation will apply, except to the extent the provider has already taken action in reliance thereon.

II. YOUR RIGHTS AS A CLIENT

A. *Non-Discrimination Practices.* It is ChildSafe's policy to provide a healing environment free from any form of harassment, intimidation, or change in service delivery based on sex, race, religion, national origin, disability, veteran status, sexual orientation or gender expression.

B. *Access to Protected Health Information.* You have the right to inspect and obtain a copy of the protected health information the provider has regarding you, in the designated record set. However, you do not have the right to inspect or obtain a copy of psychotherapy notes. There are other limitations to this right, which will be provided to you at the time of your request, if any such limitation applies. To make a request, ask your therapist.

C. *Amendment of Your Record.* You have the right to request that the provider amend your protected health information. The provider is not required to amend the record if it is determined that the record is accurate and complete. There are other exceptions, which will be provided to you at the time of your request, if relevant, along with the appeal process available to you. To make a request, ask your therapist.

D. *Accounting of Disclosures.* You have the right to receive an accounting of certain disclosures the provider has made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment or health care operations. In addition, the accounting does not include disclosures made to you, disclosures made pursuant to a signed Authorization, or disclosures made prior to April 14, 2003. There are other exceptions that will be provided to you, should you request an accounting. To make a request, ask your therapist.

E. *Additional Restrictions.* You have the right to request additional restrictions on the use or disclosure of your health information. The provider does not have to agree to that request and there are certain limits to any restriction, which will be provided to you at the time of your request. To make a request, ask your therapist.

F. *Alternative Means of Receiving Confidential Communications.* You have the right to request that you receive communications of protected health information from the provider by alternative means or at alternative locations. For example, if you do not want the provider to mail bills or other materials to your home, you can request that this information be sent to another address. There are limitations to the granting of such requests, which will be provided to you at the time of the request process. To make a request, ask your therapist.

G. *Copy of this Notice.* You have the right to obtain another copy of this Notice upon request.

III. ADDITIONAL INFORMATION

A. *Privacy Laws.* The provider is required by State and Federal law to maintain the privacy of protected health information. In addition, the provider is required by law to provide clients with notice of the provider's legal duties and privacy practices with respect to protected health information.

B. *Terms of the Notice and Changes to the Notice.* The provider is required to abide by the terms of this Notice, or any amended Notices that may follow. The provider reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all protected health information that it maintains. When the Notice is revised, the revised Notice will be posted at the provider's service delivery sites and will be available upon request.

C. *Complaints Regarding Privacy Rights.* If you believe the provider has violated your privacy rights, you have the right to complain to the provider. Your therapist is the person designated within the practice to receive your complaints. The Colorado Department of Regulatory Agencies regulates the practice of both licensed and unlicensed persons in the field of psychotherapy. Questions or complaints may be addressed to:

Colorado Department of Regulatory Agencies
State Grievance Board
1560 Broadway, Suite 1340
Denver CO 80202 (303) 894-7766

It is the policy of the provider that there will be no retaliation for your filing such complaints.

D. *Regulation of Psychotherapists.* The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The regulatory boards can be reached at:

1560 Broadway, Suite 1350
Denver, Colorado 80202 (303) 894-7800

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-Masters supervision. 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 Registered Psychotherapist is listed in the State's database and is authorized by law to practice psychotherapy in Colorado, but is not licensed by the Sate and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the State.

E. *Disclosure Regarding Divorce and Custody Litigation.* If you are involved in divorce or custody litigation, your therapist's role is not to make recommendations to the court concerning custody or parenting issues. By signing this Disclosure Statement, you agree not to subpoena your/your child's therapist to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that the therapist write any reports to the court or to your attorney, making recommendations concerning custody. The court can appoint professionals, who have no prior relationship with family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parenting time in the best interests of the family's children.

F. *Additional Information.* If you desire additional information about your privacy rights, ask your therapist. I have been informed of my therapist's degrees, credentials, and licenses