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.

Child's Name: _____ Age: _____ Date of Birth: _____

Race: _____ Gender:_____ Preferred Pronouns: _____ Disabled: Y/N

Please list any siblings below under "Other Family Members"

Parent/Guardian Name: _____ Age: ____ Date of Birth: _____

Martial Status: _____ Race: _____ Disabled: Y/N

Gender: _____ Preferred Pronouns: _____

Address: _____ City: _____ State: ____ Zip Code:_____

Cell Phone: _____ Okay to leave message?: Y/N

Home Phone: _____ Okay to leave message?: Y/N

Work Phone: _____ Okay to leave message?: Y/N

Occupation: _____ Monthly Family Income: _____

Place of Employment: _____

Email Address _____

May we contact you via email?: Y/N

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

Other Family Members:

Name	DoB	Age	Relationship to Child	Race	Disabled?
1)					Y/N
2)					Y/N
3)					Y/N
4)					Y/N
5)					Y/N
6)					Y/N

Reason for Seeking Help: _____

_____

_____

Who referred you to ChildSafe?: _____

Name of child's physician: _____ Phone Number: _____

List any medications child is currently taking and the reason why: _____

_____

Has the child received previous psychological, psychiatric counseling?: _____

Name of therapist and reason for seeking help: _____

_____

Emergency Contact Information:

Name: _____ Phone Number: _____ Relationship: _____

Do you have health insurance that covers mental health outpatient counseling?: Y/N
If so, ChildSafe will need a copy of your insurance card. You are responsible for any pre-approval if your insurance policy requires it before beginning therapy.

Name of Insurance Company: _____
Name of Policy Holder: _____ Date of Birth: _____
Social Security # of policy holder:_____

By signing this form, I authorize ChildSafe Colorado to bill my insurance provider on my behalf. I authorize ChildSafe Colorado to release all necessary information required by my insurance company to process claims. I authorize payment of medical benefits directly to ChildSafe Colorado.

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 staff 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 after a six months of delinquency may 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 ChildSafe authorized personnel

Revised: April 2016

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**

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

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

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 two 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 calculate your fee.

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: _____ Printed Name:_____ Signature:_____Dear

Consent For Psychotherapy Treatment For A Minor

I _____ of _____
(Parent/Guardian) (Address)

authorize ChildSafe therapist(s) to meet with_____
_____ (Minor's Name)

_____, _____, _____,
(Minor's Name) (Minor's Name) (Minor's Name)

for the purpose of psychotherapeutic treatment.

Furthermore, I certify that I have the legal authority to give this permission.

_____

Signature of Client (if client is15 years of age & older) — Date

_____

Signature of parent, guardian, or authorized legal agent for minor — Date

_____

Signature of witness — Date

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:

Please Initial:

_____ Department of Human Services (Specify County) _____

_____ SummitStone Health Partners

_____ School Personnel (specify school/s) _____

_____ Law Enforcement Agency (Specify) _____

_____ Victims Compensation Program (Specify County) _____

_____ District Attorney's Office (Specify County) _____

_____ Probation (Specify County) _____

_____ Child Advocacy Center (Specify County) _____

_____ ChildSafe Therapists (Required)

_____ Medical Professional (Specify) _____

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

Acknowledgement of Disclosure & Agreement Revised Feb 2020

Harborview Trauma Screen - Caregiver

Name: _____ Date: _____

Stressful or scary events happen to many kids. Below is a list of stressful and scary events that sometimes happen. Please answer to the best of your knowledge. Mark YES if it happened to your child. Mark NO if it didn't happen to your child.

1.	Serious natural disaster like a flood, tornado, hurricane, earthquake or fire.	Yes	No
2.	Serious accident or injury like a car/bike crash, dog bite, sports injury.	Yes	No
3.	Robbed by threat, force or weapon.	Yes	No
4.	Slapped, punched, or beat up by someone in your family.	Yes	No
5.	Slapped, punched, or beat up by someone <u>not</u> in your family.	Yes	No
6.	Saw someone in your family slapped, punched or beat up.	Yes	No
6a.	Heard someone in your family (or knowing about someone in your family) being slapped, punched or beat up.	Yes	No
7.	Saw someone in the community slapped, punched or beat up.	Yes	No
8.	Someone older touched your child's private parts when they shouldn't.	Yes	No
9.	Someone forced or pressured sex when your child couldn't say no.	Yes	No
10.	Someone close to your child dying suddenly or violently.	Yes	No
11.	Attacked, stabbed, shot at or hurt badly.	Yes	No
12.	Saw someone attacked, stabbed, shot at, hurt badly or killed.	Yes	No
13.	Stressful or scary medical procedure.	Yes	No
14.	Being around war.	Yes	No
15.	Suicide attempted or completed by a family member.	Yes	No
16.	Suicide attempted or completed by a friend.	Yes	No
17.	Family members taken away by police.	Yes	No
18.	Family members ill/sick for a long time.	Yes	No
19.	Family members dying.	Yes	No
20.	Being bullied.	Yes	No
21.	Someone saying to your child that they are no good.	Yes	No
22.	Having to move.	Yes	No
23.	Other stressful or scary event?	Yes	No
	Describe: _____		

Which one is bothering him/her the most now? _____

If you answered NO to all of the above questions, STOP.
If you answered YES to any of the above questions, please complete the rest of this form.

Afraid he/she would die or be hurt badly.	Yes	No
Afraid someone else would die or be hurt badly.	Yes	No
Helpless to do anything.	Yes	No
Ashamed or disgusted.	Yes	No