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	Date of Birth	Age	Realtion to Child	Race	Disabled? Y/N
1.					
2.					
3.					
4.					
5.					
6.					

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? _____

If yes, 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, 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: _____

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

2001 S. Shields Street, Building K, Fort Collins, CO 80526-1838
(970) 472-4133 • www.childsafecolorado.org

Telehealth Informed Consent Form

I _____ (client's name) hereby consent to engage in telehealth (e.g., internet, email or telephone based therapy) with my ChildSafe therapist as an alternate mode of my psychotherapy treatment. I understand that telehealth includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications.

I understand that I have the following rights with respect to telehealth:

(1) The right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. (See also Office Policies and HIPAA Notice of Privacy Practices forms, provided to me, for more details of confidentiality and other issues.)

(3) I understand that there are risks and consequences from telehealth. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or misunderstandings can more easily occur, especially when care is delivered in an alternative manner.

(4) In addition, I understand that telehealth-based services and care may not yield the same results nor be as complete as face-to-face services.

(5) With teletherapy, there is the question of where the therapy is occurring – at the therapist's office or the location of the client? It is our policy to inform clients regarding where their therapist is located in delivering their services. Every precaution will be taken to ensure our clients' confidentiality. We cannot control the client's environment as they receive services, but my therapist has discussed the precautions I should take on my end to maximize my privacy.

(6) I understand if I am using my cell phone for telehealth it may ask for access to my camera, audio, and recording. This information is not being collected by ChildSafe and it is my choice whether or not to agree to those terms.

(7) I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the SummitStone Crisis Center at 970-494-4200 opt 4. The Crisis Center is located at 1217 Riverside Ave., Fort Collins, CO. Hours for walk-in services are 8am-12am, and phone calls are 24/7. Clients who are actively at risk of harm to self or others are not suitable for teletherapy services. If this is the case or becomes the case in future, my therapist will recommend more appropriate services.

By signing this **Telehealth Informed Consent Form**, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of tele-therapy.
- That I have been given ample opportunity to ask questions and have had any questions answered to my satisfaction.

_____ _____

Client's (age 15 and up) /parent/guardian signature Date

_____ _____

Therapist signature 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

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

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

2001 S. Shields St., Bldg. K, Fort Collins, Colorado 80526 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

As of July 10, 2020, Clinical interns can no longer register with DORA as Unlicensed Psychotherapists. Therefore, to register a complaint, please contact the student intern's university, and the ChildSafe Clinical Director.

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 unlicensed 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. An Unlicensed Psychotherapist is listed in the State's database and is authorized by law to practice psychotherapy in Colorado, but is not licensed by the State 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. *Record Retention.* Effective July 14 2020, with the House Bill 20-1206, mental health professionals may not maintain client records after seven years.

G. *Clinical Team:* The ChildSafe treatment team consists of Licensed Therapists, Candidates for Licensure (Unlicensed therapists) and Clinical Interns who are currently enrolled in Master's level counseling programs. All therapists are supervised by the Clinical Director, and all Clinical interns are supervised by both the Clinical Director and their University Supervisor. Your treatment team may include a combination of therapists and clinical interns. By signing the acceptance of these disclosures, you agree that you have been informed of the therapist's degrees, credentials, and licenses, on the attached Staff Listing.

H. *Additional Information.* If you desire additional information about your privacy rights, ask your therapist.

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

☐ *CHART or* ☐ *Client COPY*

2001 S. Shields St., Bldg. K
Ft. Collins, CO 80526
(970) 472-4133

Clinical Staff

Val Macri-Lind, MS, LMFT #234
Clinical Director
EMDR Practitioner
(970) 472-4133 Ext. 11202

Danielle Aimone, MSW, LCSW #9926128
(970) 472-4133 Ext. 11209

Jana Carson, MS, LMFT #1838
Bilingual Therapist
(970) 472-4133 Ext. 11206

Marian Febvre, M. Ed., LPC #2909
EMDR Practitioner
(970) 472-4133, Ext. 11207

Melissa Garcia, MS, LPC #14380
EMDR & Neurofeedback Practitioner
(970) 472-4133 Ext. 11208

Morgan Hatling, MA, LPCC #17666, NCC
(970) 472-4133 Ext. 11217

Bri Kurt-Hurst, MA, LPC #16228
EMDR Practitioner
(970) 472-4133 Ext. 11212

Emma MacKenzie, MA, MFTC #14085
(970) 472-4133 Ext. 11218

Kristin Mjelde, MA, LPC #13380
EMDR & Neurofeedback Practitioner
(970) 472-4133 Ext. 11220

Sandi Robbins, MA, LPC #12258
EMDR Practitioner
(970) 472-4133 Ext. 11210

Brian Williams, MA, LPC #13569
EMDR Practitioner
(970) 472-4133 Ext. 11213

Clinical Interns

Alexandra Maes, BA, CAC I
Unlicensed Psychotherapist #106897
(970) 472-4133 Ext. 11211
Capella University

Ali Hummer, BS
(970) 472-4133
Capella University

Alyssa Morrissette, MA, LAC #816
(970) 472-4133 Ext. 11219
Capella University

Lissette Frederick
(970) 472-4133
University of Northern Colorado

Brea Giancaterino, BA, NLC
Unlicensed Psychotherapist #110728
(970) 472-4133 Ext. 11216

Becky McChesney, BA, NLC
(970) 472-4133 Ext. 11215
Regis University

Kathleen Maier, MA, MFTC #110241
Unlicensed Psychotherapist #110241
(970) 472-4133 Ext. 11205

Administrative Staff

Carol Bennis
Executive Director
(970) 472-4133 Ext. 11203

Tim Alexander
Business Operations Manager
(970) 472-4133 Ext. 11201

Pam McCulloch
Front Desk & Billing Coordinator
(970) 472-4133 Ext. 11200

Cathy Jones
Event & Marketing Manager
(970) 472-4133 Ext. 11204

Emily Farquhar
Administrative Assistant
(970) 472-4133