

# MEDICAID INTAKE PACKET

**Welcome to Family Ties Counseling, Inc.!** If you are reading this, we have already communicated and agreed that we may be a good fit. The paperwork seems overwhelming I know, but is required by Medicaid and must be completed before your first appointment. Medicaid is heavy on paperwork requirements, and therefore, it often takes two sessions (or more) just to get through all the requirements. Here is a checklist to make sure you don’t forget anything.

* Intake
* Client Rights & Informed Consent
* Credit Card Policy
* Credit Card Agreement
* Coordination of Care: Release to Medical Provider.
* Coordination of Care: Release to Medicaid.
* Important Information for Medicaid Members
* **Release:** If there is need for a signed release to a family member or spouse, print and sign a Release of Information form under “Elective Forms”.
* **Adolescent client:** If the client is an adolescent aged 15 or older, they will also need to sign all the forms, and a family release will also need to be signed (found under Elective Forms).
* **Separation/Divorce:** If the client is a child/adolescent and the parents are either separated or divorced, the “Counseling Agreement & Authorization” form (found under Elective Forms) will be required. It must be signed by both parents who hold custody.
* **Casework Packet:** If a caseworker is involved, you will need them to print and sign the caseworker packet. It is your responsibility to ensure it is signed, and that the documents **with the original signatures** have arrived at or before the first session. If a caseworker is involved but *they do not have custody* then you will simply need to sign a release so that I may talk to them. Generally, if a casework is involved they do have custody so must sign the documents. You will need to sign them too, but theirs is also required.

***CRISIS:*** *If you find yourself in crisis at any time before or after your first appointment, you can call 911 or go to your local emergency room.* ***Also, you may contact the Colorado State crisis number at 1-844-493-8255.***

Cindy R. Richman, M.A., L.P.C.

10 Boulder Crescent Street STE 102H

Colorado Springs, CO 80903

(719) 477-0550 Office (719) 471-7840 Fax

# Intake Information

Please complete the intake packet prior to your first session. If you are completing the intake for a child or adolescent, please complete the information as it relates to them. If you are a married couple seeking counseling, one person will need to be identified as the patient (which is generally the person with the greatest level of distress).

Who referred you to our office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Intake date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I am a parent completing the packet for my child/dependent. I am a biological foster adoptive grand/ parent

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Gender:\_\_\_\_\_\_\_SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Home Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Cell: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Other Cell: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Income (approx): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Work: Full-time or Part-time *(circle one)*?  |
| Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

Parent/s Names (if client is under 18 Years): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital status of client (or of the parent of the client):  Single  Married  Divorced  Separated  Widowed  Re-married If the parent is not the biological parent, indicate how long the child has resided in your home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the client is a child/adolescent, list siblings: Name Age Their relationship to the client

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the client have any allergies, if so please list: Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the client have concerns over transportation that may make it difficult to attend sessions? Yes No

# Payment Information

How do you plan to pay for therapy services:  Cash  Insurance  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Information: (Please provide the **insured’s** information. If the client is a child, the parent’s information is required below.)

Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of the Plan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured's Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Address if Different than Client’s: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’sID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-pay amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your insurance deductible amount? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was your deductible met for this year? Y N

If the Insured is covered by Tricare, please indicate their current military status: Active Duty Retired Other

**SECONDARY INSURANCE:** Family Ties Counseling Inc. is unable to bill to a secondary insurance for you.

# Presenting Problem/Treatment Plan

Please complete the following treatment plan to help us understand your ***needs and goals*** as we begin treatment. You don’t need to write a book, but clarity is important. All items are important and must be filled out per insurance requirements.

What problems/concerns/symptoms have brought you to counseling (example depression, marital problems, anxiety etc).

***List them individually.***

**Problem 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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 Goal: What are your short and long-term goals related to this problem. (Objectives: i.e. communicate better, improved mood, better relationships etc)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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On a scale of **1** (no problem) to **10** (severe) how bad is this problem currently? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long has this problem(s) existed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When did symptoms begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Problem 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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 Goal: What are your short and long-term goals related to this problem. (Objectives: i.e. communicate better, improved mood, better relationships etc)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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On a scale of **1** (no problem) to **10** (severe) how bad is this problem currently? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long has this problem(s) existed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When did symptoms begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Problem 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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 Goal: What are your short and long-term goals related to this problem. (Objectives: i.e. communicate better, improved mood, better relationships etc)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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On a scale of **1** (no problem) to **10** (severe) how bad is this problem currently? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long has this problem(s) existed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When did symptoms begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Client will be ready for discharge when:**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **History**

Please list the names and dates of counselors that have been seen and/or other treatment received:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was it helpful? Yes No

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was it helpful? Yes No

Briefly list the issues/problems that were worked on therapy in the past: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Has the client ever been diagnosed with a mental health diagnosis? *(circle one)* Yes No

If yes, please identify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the client ever been hospitalized for emotional/psychological problems? *(circle one)* Yes No

Is there a history of legal problems? *(circle one)* Yes No If so please summarize the legal history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Family History

Is there a history of mental or emotional illness in the client’s immediate or extended family? *(circle one)* Yes No

If so, please identify the relation(s) and the diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has any family member had inpatient treatment for emotional, substance abuse, eating or mental health disorders?

*(circle one)* Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has any family member been treated with psychiatric medications? *(circle one)* Yes No If so, indicate who/what/why.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the client adopted? *(circle one)* Yes No If so, at what age?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How was the client’s home life as a child? Unhappy Bearable Pleasant Very happy

How is the client’s home life presently? Unhappy Bearable Pleasant Very happy

# Medical Information

Please check any of the following in the client’s medical history:

* Head injury  Birth defects  Ear Infections (for a child)  Dyslexia/other learning disorder(s)
* Alcoholism  Sleep Apnea/disorder  Fetal Alcohol Syndrome  Neglect
* Pregnancy (current)  Serious Accident  Thyroid problems  Diabetes
* Asthma  Malnourishment  Cancer  Chronic headaches
* Mental retardation  Stomach problems  List Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  NA

What is the date of the client’s last physical exam? \_\_\_\_\_\_\_\_\_\_\_\_Is treatment being given for any condition(s)? Y N

**Describe any serious ALLERGIES, hospitalizations or accidents:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Age Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Age Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: Age Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there an Advanced Directive for the client (a living will/medical directions etc)? Yes No (Bring a copy if you desire.)

Are there transportation concerns? Yes No

Name of the client’s Primary Care Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the client’s Psychiatrist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please note any medications being taken **currently** whether for a medical or psychiatric condition:

 Current Medication Dosage and Times per Day Date Started Prescribing Doctor

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list any psychiatric medications that have been taken in the **past**:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Substance Use History *(Adolescent & Adult Clients Only)***

Please indicate any substances used:

* alcohol  amphetamines/speed  barbiturates/downers  cocaine
* crack cocaine  hallucinogens (e.g., LSD)  inhalants (e.g., glue, gas)  marijuana, how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* PCP  prescription  nicotine/cigarettes  chewing tobacco
* other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there current concern that the use of substances (either alcohol or drugs) has become a problem? Yes No

Has there been any treatment for substance abuse? Yes No

Have there been any consequences of the substance abuse (i.e. withdrawal, blackouts etc) Yes No

Please indicate the current status of use:  active abuse  periodic use  sober (if so, for how long?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate any family that has had a history of alcohol or drug abuse:

* father  stepparent/live-in  mother  uncle(s)/aunt(s)
* grandparent(s)  spouse/significant other  sibling(s)  other \_\_\_\_\_\_\_\_\_\_\_

**If the Client is a Child (*Adults skip this section*):**

Who has legal custody of the child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If it is other than the person bringing the child in, a copy of custody papers and/or release from the other parent/caseworker will be required.

What is the child’s grade level?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of the school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the child labeled SIED or in a special classroom at school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have any learning problems been identified? *(circle one)* Yes No If so, are they being treated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What are the child’s emotional / behavioral problems exhibited?

* repeats words of others  distrustful of others  controlling bowels  alcohol/drug abuse  not trustworthy
* extreme worrier  chronic lying  hostile/angry mood  stealing  indecisive
* impulsive  prob. engaging peers  immature for age  easily distracted  fire-setting
* bizarre behavior  poor concentration  playing cooperatively  hyperactive  often sad
* animal cruelty  frequently tearful  breaks things  assaults others  frequently daydreams
* disobedient  lack of attachment  trusts strangers quickly  normal social interaction  inappropriate sex play
* authority conflicts  isolates self  dominates others  very shy  learning problems
* underachieving  alienates self  mean  tantrums  unable to share
* hits/fights  premature interest in sex  Other:

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Spiritual/Social/Cultural

Does the client believe in God or a Higher Power? *(circle one)* Yes No

Is the client affiliated with a church? If so, identify the church. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How important is faith in daily life? *(circle one)* Not at all Somewhat Very

Is the client happy with where they are at spiritually at this time? *(circle one)* Yes No

Family Ties Counseling, Inc. is a Christian based counseling services. Are you interested in integrating faith issues in treatment: *(circle one)* Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What other resources/agencies are involved? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Name: Agency Phone

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How many meaningful persons are in the client’s life that are considered “close friends”? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What ethnicity is the client, other than American? Are there any cultural concerns that the therapist needs to be aware of? *(circle one)* Yes No If so, please identify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Strengths

Please list any *strengths* and *resources* the client may have that will help make positive changes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Waivers and/or Special Instructions: *Initial each line that you understand & agree.***

**Initial Each**

\_\_\_\_ It is important to know that Family Ties Counseling, Inc. **does not attend or participate in court related evaluations or appearances for any reason.** By signing, you indicate that you understand this and agree not to ask for court attendance or request a subpoena for any reason.

\_\_\_\_ It is important to know that Family Ties Counseling, Inc. **does not perform assessments for disability.** By signing, you indicate that you understand this and will not ask for an evaluation of any kind.

\_\_\_\_I understand that my confidentiality cannot be guaranteed when a cell phone, fax or email is used as a means of communication. I hereby release Cindy Richman of Family Ties Counseling, Inc. from liability should I choose to communicate by means of a cell phone, fax or email.

\_\_\_\_If the client is an adolescent/child, I give consent for treatment and am legally able to do so.

\_\_\_\_**I have been offered a copy of the Notice of Privacy Practices** which can be retrieved on the website.

\_\_\_\_We consider that there are no limitations on how we may contact you unless given specific instructions. (Understand also that if you identify limitations but then leave a message with a request contradicting your limitations, we will take your request as verbal permission to contact you in that way.)

The above information is accurate to the best of my knowledge and I testify that I have answered all questions honestly.

Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cindy R. Richman, M.A., L.P.C.

10 Boulder Crescent Street STE 102H

Colorado Springs, CO 80903

(719) 477-0550 Office (719) 471-7840 Fax

## Client Rights & Informed Consent

As a client of Family Ties Counseling, Inc. you have the right to know some important aspects related to your treatment.

1. **Credentials.** My training was received at Regent University in Virginia Beach, Virginia. As a part of my training, I completed an internship at the Genesis Treatment Center within the Virginia Beach Psychiatric Hospital. I have been licensed in the State of Colorado since 1999 as a Licensed Professional Counselor (LPC). My experience is varied having worked as an outpatient therapist, in a residential treatment center for trouble adolescents, a psychiatric hospital, and a day treatment center. I have worked with both adolescents and adults. I am a member of AACC.

1. **Regulation**. The Colorado State Department of Regulatory Agencies regulates the practice of psychotherapy. Any questions, concerns, or complaints regarding the practice of mental health should be directed to: Department of Regulatory Agencies, Mental Health Section • 1560 Broadway Suite 1340 • Denver CO 80202 • (303) 894-7766

1. **Methods of Therapy.** It is difficult to determine the length and duration of your treatment. However, this will be discussed at the beginning of treatment. Sessions are generally 45-60 minutes in length. Therapy can be a highly rewarding and powerful experience due to the positive changes that can be made. However, the process can also be uncomfortable. Therapy requires you to be honest and open about feelings and experiences that may be difficult to discuss and may cause unpleasant feelings to surface. In addition, my job as a therapist is to confront you and to provide new perspectives about certain issues. This often causes clients to feel angry, embarrassed, or any assortment of troubling emotions. The purpose of being challenged is to be able to face things that in the past made you uncomfortable so that you are no longer “stuck” and in bondage to these old emotions. In addition, when you see things from another perspective, it can help you change old habits that have not been working in your daily life. Once you have changed some of the unhealthy ways that you interact with the people and situations in your life, you may find some surprising results. Often, a client may make a healthy change in their own life, only to find that the people around them are angry because their relationship with you has been affected by the change. This is a common experience and is something to work through and discuss in your session. Understand that you are the client and will determine the pace at which you are able to work through your own difficulties. Assignments are often given during session and are intended to provide you with additional resources to effect change in your life. The harder you work, the more results you will realize. There is no guarantee that therapy will fix all of your problems; however, the likelihood is that you will see positive results if you work hard. The approaches that I use vary depending on your needs and problems. Some of the modalities that I may use are emotionally focused therapy, cognitive-behavioral, psychodynamic, solution focused, insight-oriented, family systems, experiential, Theraplay and psycho-educational. If you are interested in more detail regarding techniques, please ask.

1. **Second Opinion.** You are entitled to seek a second opinion from another therapist at your own expense. Referrals will be provided to you at your request.

1. **Termination.** Both you as the client, and your therapist, have a right to terminate therapy services at any time. Before terminating, it is important to discuss the reasons for termination.

1. **Professionalism.** Sexual advances and/or behavior between therapist and client are never appropriate and should be reported to the regulatory board (address and telephone number are listed above).

1. **Confidentiality.** The personal information that you share during counseling is legally confidential.

However, there are some limits to your confidentiality. Some are listed in the Notice of Privacy that you will be offered.

* Duty to Warn and Protect: By law, Family Ties Counseling, Inc. is bound to report to appropriate authorities when a client discloses an intent or a plan to harm another person or persons. Your therapist must warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, your therapist is required to notify legal authorities and make reasonable attempts to notify the family of the client. Your therapist does have the right and privilege to complete an M1 if he/she feels you are a danger to yourself or others. An M1 revokes the client’s rights for a period of 72 hours, and the client is placed in a hospital setting until the hospital staff feel that the client is safe.
* Abuse of Children and Vulnerable Adults: Under Colorado law, when information is shared regarding the abuse or neglect of a child (or a vulnerable adult), whether past or present, your therapist is required to report this information to the appropriate social service and/or legal authorities.
* Prenatal Exposure to Controlled Substances: Your therapist is required to make a report any time that it becomes known that there has been prenatal exposure to controlled substances that can potentially harm an unborn child.
* In the Event of a Client’s Death: In the event of a client’s death, the spouse or parents of a deceased client have a right to access their child or spouse’s records.
* Minors/Guardianship: Parents or legal guardians of non-emancipated minor clients have the right to access the clients’ records.
* Legal: In the event that a subpoena or court order is received to testify or for client records all efforts will be made to maintain client confidentiality. In some cases however, your therapist may be required to submit documents and/or testify. Keep in mind that by coming to Family Ties Counseling, Inc., you are agreeing not to subpoena therapist for any reason.
* Insurance Providers (when applicable): Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries. This does not require a release from you. By using your insurance you have agreed to this.
* When you sign a Release of Information you have authorized Family Ties Counseling, Inc. to provide specific information to an outside person/agency. The release is voluntary and the time frame is indicated on the form. It can be rescinded in writing at any time.
* In the event of an emergency, defined as imminent danger to yourself or others, your counselor may need to contact other individuals for your own or others protection.
* If you have been court ordered, or legally mandated to participate in counseling in any way, you will be required to sign a release of information form.
* Counselors and other health care providers work collaboratively. Therefore, they may exchange information about you as is needed and/or appropriate. In general, there is no confidentiality between your counselors and your other health care providers. This ensures that you will receive the best coordination of care.
* Email, fax and cell phones are not a confidential means of communication. If you decide to utilize any of these methods to communicate, confidentiality cannot be guaranteed.
* In the case that you are participating in family or couples therapy, it is important to understand that your therapist does not have to maintain confidentiality between family members as “secrets” can be damaging to the therapeutic process. In order to participate in family or couples counseling, each party will be required to sign a Release of Information.

1. **Fees/Payment/Missed Appointments.** Financial information and fees are listed on the Financial Information and Rate sheet. You will be asked to review and sign this form which covers all financial policies of Family Ties Counseling, Inc.

1. **After Hours Emergencies**. Your therapist carries an emergency cell for after hour’s services. It is important to note that this cell is for CRITICAL emergencies only. All non-critical communication should be handled during business hours which are generally Monday through Thursday. Due to the nature of cell phones, there are times when there may be a “black hole” and the call may go to voicemail. If you have not heard back within 15 minutes and the emergency remains, you should call 911, or go to your local emergency room. If you feel that you are in need of treatment that would require 24-hour access other than that of a critical nature, you should select a therapist in the community that can offer this service to you.

1. **Limits of Service.** After commencing treatment with you, your therapist may identify that your needs are out of her scope of ability and/or practice. If this happens, a transfer to another therapist will be recommended. This will be discussed with you prior to terminating the therapeutic relationship.

1. **Hospitalization.** If it becomes clear during a session that you are unable to keep yourself or others safe, your therapist may suggest hospitalization. We prefer that if such a situation should arise, that you voluntarily agree to go to the hospital until you are stabilized. However, if your therapist believes hospitalization is necessary and you refuse to go, you can be involuntarily hospitalized by an M1, or 72-hour hold. In this case, the local police or theAMR may be contacted to transport you to the hospital.

1. **Office Hours & Location.** Family Ties Counseling, Inc. is located in downtown Colorado Springs at 10 Boulder Crescent Street, STE 102H and can be reached by calling 719-477-0550. Office hours are by appointment and generally are kept Monday through Thursday.

1. **Other.**
2. Due to the confidential nature of therapy, tape-recording of sessions by a client for any reason is not allowed. If there should be some reason the therapist finds it important to record a session, a release of permission will be signed by the client.
3. Family Ties Counseling, Inc**. does not attend or participate in anything that would require attending or participating in any legal, or court related activities.**
4. Family Ties Counseling Inc. also does **not participate in evaluations for disability** **OR evalutions for a support animal** and will not complete any forms that are required to evaluate for disability.

## Financial Information & Rate Sheet

**Rates & Times**

In general, counseling sessions will range in time from between 45 to 60 minutes in length. The number of sessions is difficult to predict. This number is flexible in nature and may change depending on what occurs in sessions, on how hard you work, and on the nature of the problem you are working on. If you have specific questions about this, you may ask. Rates are as follows, and payment will be accepted in the form of cash, check, or credit. Rates per session vary depending on the service provided as follows:

|  |  |  |  |
| --- | --- | --- | --- |
|  **Service**  | **Rate**  | **Service**  | **Rate**  |
| Intake interview  | $170.00  | Individual session  | $150.00  |
|  Family session  | $150.00  | Group session  | $60.00  |

**Other Financial Information**

**Late or Missed Payments:** Payment is due on the date the service was rendered. We reserve the right to not schedule additional sessions until the account is in good standing. In addition, should payments be overdue and there has been no effort to make payments, Family Ties Counseling, Inc. may use legal means to obtain payment such as courts, collections agencies etc.

**Missed Sessions:** I understand that from time-to-time emergencies will occur that make it difficult to attend the session as scheduled. There will be no charge for sick cancellations or when a client is unable to attend because of weather (such as snow). In the case that your plans have changed and you identify you will not be able to attend your appointment, please call us and leave a voicemail, or cancel online. A session that is canceled on time (with more than a 24-hour notice) will not be charged. Late cancellations (less than 24 hours) or no shows will be charged an $90.00 charge. Insurance does not cover no shows and late cancellations. In the case that you are a Medicaid client (and cannot be charged the no show/late cancellation fee) your therapist has a right to close your chart and terminate your relationship when more than two sessions have been missed without proper cancellation.

**Returned Checks:** A returned check will be assessed a $20.00 fee.

**Credit Card on File:** At Family Ties Counseling, Inc. we require a credit card on file at the beginning of treatment for various reasons. While this credit card may not be the primary source of payment, it can be used (if necessary), to pay for various fees. The credit card policy provides all the specific ways a credit card may be used.

**Adolescent Clients:** In the case that an adolescent client turns 18, the credit card on file will continue to be used based on the parent’s initial agreement to pay for sessions. The parent may rescind permission to bill at any time by calling or writing. Unless notification is given and/or the payment authorization is rescinded, the authorization to bill will be considered in force and the parent will hold responsibility for payment. It is the parent’s responsibility to inform Family Ties Counseling, Inc. if they no longer wish to hold financial responsibility for their now adult child.

**Insurance**

I will be happy to bill the insurance company and/or an outside party (i.e. a church or friend that may be paying for your sessions.) Your signature and provision of accurate information is permission to do so. The minimum information necessary will be provided to the company. Family Ties Counseling, Inc. is not responsible for what the outside company/party does with the information provided and cannot control further disclosure by this company/party. Finally, if for any reason your insurance company or outside party denies payment, **you are held responsible for the balance of the amount due.** It is your responsibility to ensure that your insurance is active at the time of your first session and that your policy covers mental health services. Understand that although I may send a bill to the insurance company, the service is officially charged to the client, not to the insurance company. It is your responsibility to be aware of changes that take place within your plan and to inform us of these changes so that you will not have to pay the full fee. It is your responsibility to provide any updates or new insurance cards that your policy provides you. It is also your responsibility to resolve conflicts in payment should your insurance, for any reason, refuse to pay.

I have been informed of my rights and give my consent for treatment at Family Ties Counseling, Inc. I also understand and accept and understand the financial policies. In the case that the client is a child, I give and am legally able to give consent for treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name/Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1st Parent/Guardian (if applicable) Spouse (if applicable)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2nd Parent/Guardian (if applicable) Therapist

|  |  |
| --- | --- |
|  |  |

# Credit Card Policy

Required for all clients ***\**** *Please read as* ***you are responsible for this information***

**Policy for all Non-Medicaid Insurances or Private Pay:**

Family Ties Counseling, Inc. **requires** that an active credit or debit card be kept on file for **all** clients. Unfortunately, over the past years there have been an exorbitant number of non-payments that have required the use of a collections service. By holding a credit card (CC) on file, our hope is to cut down on missed and forgotten payments. Ultimately, by having a credit card on file, we are able to avoid the use of collections for clients that inadvertently get behind in payments, may have moved, or are having difficulty getting their mail.

This authorization will be kept on file in the HIPAA compliant online virtual terminal that is password protected for your safety. Once your CC information is entered into the system, the authorization signature will be kept on file, but the CC number listed below will be shredded.

1. The CC will be charged automatically in the case of a no-show or a late cancellation (less than 24-hour notice).
2. The CC will be charged automatically if payment is not received at the time of the session.
3. The CC will be used to pay for deductible amounts, co-payments, no-show fees, or other fees that have been incurred.
4. In the event that a check is returned with insufficient funds, a $20.00 fee will be billed to the card.
5. In the event that insurance refuses to pay for services. It is the client’s responsibility to ensure that their insurance is active and that their policy covers mental health services starting with the first appointment. If the insurance is having difficulty resolving a billing problem, it is the client’s responsibility to resolve this issue with their insurance company. If the bill remains unpaid, the amount due will be charged to the credit card. Collections will be utilized for charges that have not been paid after bills are sent and payment has not been made.
6. In the rare event that materials including videos or books are borrowed and not returned, the card will be charged for replacement cost of the item(s).
7. If a card is declined or rejected for insufficient funds, the card will be tried again on subsequent days/weeks until the payment is accepted. A $3.00 fee may be added each time a payment is denied. If the payment remains unpaid within a month, you will be notified and payment will be required immediately for services by check or cash.
8. Adolescent client. Should an adolescent client become an adult (turn 18) during the course of their treatment, the parent has read the Client Rights & Informed Consent and agrees that they will continue to hold financial responsibility for sessions unless permission has been revoked in writing. Fees will continue to be charged to CC on hand as initially agreed.

By signing, you understand that the CC will be billed as stated above, ***without verbal consent*** at the time of the charge. A receipt of the transaction will be emailed to you at the address provided. In the case that a family member or other person agrees to payment for sessions, a separate form should be submitted.

**Policy for Medicaid Insurance:**

Medicaid used for a child in ***foster care are* EXEMPT** and do not require a credit card on file. All other Medicaid only insurance clients *cannot* be charged for missed appointments, late cancellations or any other services. Because of this, when a Medicaid client misses appointments without proper notice, the chart can be closed and the case transferred to another clinician. However, in the event that the Medicaid insurance lapses (and an appointment has already occurred), the client will be responsible for the costs of that session. The credit card information will be used ONLY in the event that the insurance is no longer active on the date of a session. It is the client’s responsibility to ensure that their policy remains in effect.

**I understand and agree to the credit card policy stated above and elect to continue treatment with Family Ties Counseling, Inc. My signature remains active until there has been inactivity for a year or more, or the chart is closed. I promise that I will not contest any payments for services that are rendered according to this policy.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name *(or parent if client is a child)* Date

*Family Ties Counseling, Inc. takes your security seriously. However, no one can provide a 100% guarantee that an online system cannot be breached. By signing, you are saying you understand and accept these risks. You can cancel this at any time in writing and the credit card information will be deleted from the system.*

**Credit Card Agreement**

# *Required at First Session*

**Please read the policy before providing this information**

**Authorization to use credit card:**

I authorize Family Ties Counseling, Inc. to store the following credit card information in the HIPAA compliant, secured system to be used as indicated in the CC policy. This signature will be kept on file and serves as continued authorization for payment of all allowable expenses. I have read and understand the policy, and authorize the use of this card and signature on an ongoing basis so that I do not have to sign at each use. I understand that it is my responsibility to maintain an active credit card on file.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***(Signature must be that of the******client and match the name on the card****)*

I am signing as: *(circle one)* the client parent of the client

 An Email address is required to send receipts and correspondence: *Please print*

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The number below will be cut off and shredded per the credit card policy

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

Type of Credit Card *(circle one)*: Visa Mastercard HSA (see below)

If you choose to use an HSA card for copayments or deductibles, that credit card number will also need to be provided. HSA cannot be used **here** but can be used for session payments. Please provide the HSA card on the reverse of this session of the document.

Name as it appears on your Credit Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address to which your account is attached:

Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Apt# if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: Colorado (circle if mailing address is in CO) or other State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Credit Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Expiration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Code on Back (3 digits): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cindy R. Richman, M.A., L.P.C.

10 Boulder Crescent Street STE 102H

Colorado Springs, CO 80903

(719) 477-0550 Office (719) 471-7840 Fax

##  Coordination of Care

Authorization to Release Information

Medical Release

In an effort to coordinate care with medical doctors and psychiatrists, it can be helpful in certain cases to have a medical release on file. The medical release is not required and you have the right to refuse such a release. Either way, your signature giving us authorization or refusal is required.

* I authorize a release of information as indicated below.
* I do not believe a release is warranted and do not authorize a release of information.

I authorize the release of information regarding ***Client Name***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

to **Cindy R. Richman, L.P.C.** of **Family Ties Counseling, Inc..** Information may be

 (*circle all that apply)* released received to/from the following:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check the information to be released:

|  |  |
| --- | --- |
|  Diagnosis  |  Progress notes/summary  |
|  Educational records  |  Discharge summary  |
|  Psychological test results  |  Medical records  |
|  Intake summary  |  Consultation regarding treatment  |
|  Financial information for the purposes  |  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
|  of billing and payment.  |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
|   |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

Unless otherwise indicated, this authorization expires one year from the date indicated below. The authorization can be withdrawn at any time by verbal request from the client and/or parent or guardian.

Date of expiration ***(circle one)*** does not expire expires in one year expires when release is withdrawn

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notice To The Recipient Of This Information:** This information has been disclosed to you from records which are protected by federal and state laws regarding confidentiality. These laws prohibit you from making any further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by law.

Cindy R. Richman, M.A., L.P.C.

10 Boulder Crescent Street STE 102H

Colorado Springs, CO 80903

(719) 477-0550 Office (719) 471-7840 Fax

## Coordination of Care

Authorization to Release Information

Medicaid Release

In order to provide treatment, you must understand that Medicaid regularly audits charts. In order to use this benefit, you must sign a release giving Family Ties Counseling, Inc. permission to release all records and information required by the insurance company when either an audit occurs, or information is required for purposes of payment. Understand that if this release is not signed, treatment cannot provided.

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Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that Medicaid may require information regarding the service provided, or may want to audit the chart to ensure proper procedures are followed. I authorize Cindy Richman of Family Ties Counseling, Inc, to provide any and all records that are requested by the insurance company to: Medicaid.

Date of expiration: does not expire

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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### IMPORTANT INFORMATION FOR MEDICAID MEMBERS

**As a Medicaid Member, you have the right to:**

 Be treated with respect, dignity and regard for your privacy;

 Be free from discrimination on the basis of race, religion, gender, age, disability, health status, or sexual orientation;

 Get information on treatment options in a way that is easy to understand;

 Take part in decisions made about your health care. This includes the right to refuse treatment, except as required by law;

 Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

 Ask for and get a copy of your medical record. You may ask for it to be changed or corrected;

 Have an independent advocate;

 Ask that we include a specific provider in our network;

 Get a second opinion;

 Receive culturally competent services;

 Get interpreter services if you have disabilities or if you do not speak English;

 Be told if your provider stops seeing members or has changes in services;

 Tell others your opinion about our services. You can tell regulatory agencies, the government, or the media without it affecting how we provide covered services;

 Get medically necessary mental health care services according to federal law;

 Be free to use all of your rights without it affecting how you are treated; and

 Be free from sexual intimacy with a provider.

* If this happens, report it to the: Colorado Department of Regulatory Agencies

(DORA). Phone: 303-894-7788 or write to: DORA, 1560 Broadway, Suite 1350, Denver, CO 80202

**As a Medicaid Member, you have the Responsibility to:**

 Learn about your mental health benefits and how to use them

 Be a partner in your care. This means:

* Following the service plan you and your therapist have agreed on o Participating in treatment and working toward the goals of your service plan o Taking medications as agreed upon between you and your prescriber.

 Tell your therapist or if you do not understand the service plan, if you do not agree with the plan, or if you want to change it.

 Give your therapist or doctor the information s/he needs to provide good care. This includes signing releases of information so that your providers can coordinate your care.

 Come to your appointments on time. Call the office if you will be late or if you can’t keep the appointment.

 Cooperate with ValueOptions, the Medicaid contractor that works with your provider. You may call

ValueOptions at 1-800-804-5008 for questions about choosing a provider or making your first appointment.

 Let us know when you change your address or phone number, and when you have lost or renewed your eligibility for Medicaid.

 Treat others with courtesy and respect as you want to be treated.

**Advance Directives:**

Even though ValueOptions and your therapist provide mental health services, federal law requires that we tell adult patients about Colorado laws relating to your right to make health care decisions and Advance Directives. Your provider will provide mental health care whether or not you have an advance directive.

**What is a Medical Advance Directive?** Advance Directives are written instructions that express your wishes about the kinds of medical care you want to receive in an emergency. In Colorado, Medical Advance Directives include:

 **Medical Durable Power of Attorney:** This names a person you trust to make medical decisions for you if you cannot speak for yourself.

 **Living Will:** This tells your doctor what type of life supporting procedures you want and do not want.

**Cardiopulmonary Resuscitation (CPR) Directive of “Do Not Resuscitate Order”:**

This tells medical personnel not to revive you if your heart or lungs stop working. Your provider will ask you if you have an Advance Directive. If you wish, your provider will put a copy of your Advance Directive in your medical file. If a medical provider does not follow your Advance Directive, you may call the Colorado Department of Public Health and Environment at 303-692-2980.

For more information about Advance Directives, talk with your **P**rimary **C**are **P**hysician (PCP). To get a copy of ValueOptions’ policy on Advance Directives, call the Office of Member and Family Affairs at 303-432-5956 or 1-866-245-1959.

**Well-Child Exams (EPSDT)**

For clients under the age of 21, we are required to ask if any mental health issues were identified in the last medical visit or well-child exam. We want to address the issues that were identified and coordinate care with your primary care physician (PCP). Your provider will ask you to sign a release of information.

If your child has not had a well-child exam within the last year, your therapist will recommend that you schedule an appointment. If you do not have a PCP or you want a new PCP, you may contact Health Colorado for assistance in Denver 303-839-2120; outside of Denver 1-888-367-6557 (The call is free.); TTY**:** 1-888-876-8864.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider signature

\_\_\_\_\_\_\_\_\_\_\_\_ Date

Rev. 10-20-11

**KEEP THIS FOR YOUR RECORDS**

## General Information

**CRISIS:** If you find yourself in crisis at any time before or after your first appointment, you can call 911 or go to your local emergency room. **Also, you may contact the Colorado State crisis number at 1-844-493-8255.**

**Appointment Reminders:**

You can opt to receive a text or email reminder of your next appointment the day before. You can change this in your online account at any time.

 **REMINDER**: The text/email is a courtesy reminder only and it is YOUR responsibility to make sure you remember the appointment. **Technology does fail at times but you will still be charged for a no-show if the text is not delivered and you do not arrive at your stated appointment.**

**Online Scheduling:**

You can enjoy the convenience of online scheduling at any time. The weekend after your first appointment (your account must be have administrative completion) you may visitthe website in order to schedule/reschedule your appointments.

**WEBSITE:** [**www.familytiescounselinginc.com**](http://www.familytiescounselinginc.com/)

**Write down your login name and password so that you remember your information:**

Login name: |\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_| Password: |\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|

 (letters or numbers only)

**Cancellations/No-shows:**

See the website for specific cancellation questions. As a summary, a 24 notice is required or an $80.00 charge will be billed. If a cancellation is received in less than 24 hours, or a no-show occurs, we have the right to charge the client for the missed appointment as sessions are difficult to fill on such short notice.

**Child Client:**

1. **If the client is a child and in the care of separated or divorced parents, additional forms will be required. The form “Counseling Agreement & Authorization” must be signed by *both* parents before the second session occurs.** We cannot treat the child without permission from both parents. All necessary forms can be printed from the website.
2. If the **child is in the custody and care of the Department of Human Services, the foster/adoptive parent will be required to obtain signatures on the following forms from the Caseworker.** 1. Page 3 of Client Rights/Informed Consent (this form); 2. Releases of Information for GAL, foster family, others that may become involved such as teachers, relatives etc.; 3. Coordination of Care; 4. Client Rights (Medicaid Only). The caseworker should sign and return the original signature page by mail. It is the foster parent’s responsibility to follow through on this.
3. If the child is in a situation that requires intensive case management, attending meetings or writing regular reports for any reason, it is recommended that you seek a therapist (perhaps in a large counseling practice) that is able to meet such demands. Because of the small nature of this practice, it is impossible to provide the case management that is required in a complicated situation.