

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

Dear Caseworker,

We are on an exciting journey together. You are playing a crucial role in a precious child’s life, and I look forward to the next months as together we see this child learn and grow. As you already know, to have a caseworker in place means that this child has already been through a great deal of trauma. I am hopeful that together you, the family and our team can make good decisions to help his child heal.

On the front end, there are a few up front things that need to be accomplished:

**Paperwork required**

* Please provide ***documentation that will* *summarize the child's*** *story*. This should include previous diagnosis, family and abuse history, necessary court documents, medical information, reason for placement etc.
* ***Releases.*** If you have custody of the child, I will need to sign a release for any person that I may be required to correspond with including CASA, GAL, teachers, extended family, former foster parents, and medical doctors. The release form is included this packet. You can print as many as you need.
* Family Ties ***Intake Paperwork*** in this packet. Because you have custody, I will need you to sign the legal paperwork for the child. While the foster parent can fill out the intake paperwork, their signature does not account as "official". **I will need the original signed copy** so please mail the original to my office.

**Agreement regarding practice limitations**

* It is important to understand that while regular contact would be ideal, it is difficult to maintain regular phone contact due to a very full counseling schedule. Therefore, if you have any concerns, please feel free to contact me. I will return your calls as quickly as possible.
* Due to my schedule, it is almost impossible to attend staff meetings.
* **I do not attend court appearances for any reason**. Court appearances often require a clinician to take off an unspecified amount of time, and are often changed at the last moment. Because Medicaid is usually involved when there is a caseworker, this means I am not paid, often for up to a day’s wages. As you can understand, this translates to an unpaid mortgage which I cannot afford. In order to see this client, we must agree that I will not be subpoenaed for any reason.
* Finally, if letters or court documents are required for any reason, you must agree that the time spent in preparation and in writing letters will be compensated. Medicaid covers a limited amount of services and writing letters and treatment summaries is not included. Again, I do not have any government funding, grants (etc.) so am not able to spend extensive amounts of time writing letters.

**Treatment Modality and Explanation**

* As you know there are many modalities available for treating children with trauma. While I use an eclectic approach, for the primarily modality used in dealing with traumatized or attachment wounded children, I use Trust Based Relational Intervention (TBRI®). If you are unfamiliar with this approach, there are several resources that will give you some basic understanding of the modality. It is a well researched modality that incorporates the work of some of the top researches in child development.
  + Article: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3877861/>
  + TCU Website: <http://child.tcu.edu/about-us/tbri/>
  + Introductory Video (one hour): <http://child.tcu.edu/resources/videos/>
* What this looks like in the office is a bit different from traditional psychotherapy.
  + **The treatment is family focused.** In order for a child to begin to heal, the home must be safe, nurturing, and the parents must understand the impact of trauma on the child’s emotional, cognitive, and relational style. As a result, I almost always meet only with the parents in the beginning in order to provide them the parenting skills they will need. There are occasions when I work with just the child/adolescent, but this is not the norm.
  + **There is a big learning curve for the parents.** Please be patient with the family as the parents will have to adjust everything to learn a new way of parenting.
  + **Chilren rarely can heal on their own.** Because of the impact of trauma on the brain, a child’s prefrontal cortex goes missing (so to speak) and they cannot think rationally, or access tools they have learned when they become hijacked by anger or fear. This means that the “tools” for healing are “in the moment” tools which require the parent to be active so that the child can get help to push past their hijack. Family therapy is therefore imperative. Again, there are circumstances where I believe individual is best utilized, but in general, family therapy is the way to go. The parent is the agent of change.
  + **The parent will need to do their own emotional work.** All of us have an attachment style that came with us from our own childhood. A parent’s attachment style and issues are highly correlated to how they will be triggered by and/or respond to their child’s behavior. As a result, there is often focus on the parent’s issues. This can be uncomfortable and frightening for some parents but is necessary.
  + **Healing trauma is a whole body approach**. Because trauma impacts so many aspects of a child’s development, I almost always recommend additional services to deal with the child’s additional needs. These services may include:
    - Occupational Therapy evaluation for Sensory Integration. May result in needing sensory tools, toys, blankets, vests etc.
    - Supplements to help calm deficits the child has encountered which impact mental health.
    - Neurofeedback (not covered by insurance) is highly beneficial for many children.
    - Appointment with a medical doctor to check for thyroid and blood sugar issues (not standard to check for this due to age).
    - Evaluation and consult with a nutritionist/doctor of functional medicine.
    - Books and resources to help the parents learn new parenting techniques.
    - Respite.

**Important things to know**

Depending on the level of trauma, a child with attachment wounds and/or significant trauma may have treatment presentations that need to be understood in order for the team to work well together. Here is a quick summary:

* **Parenting:** Traumatized children must be parented in a different way. Traditional discipline that is punitive (reward charts, taking things away, time-outs etc) is not effective. It is important that the treatment team does NOT recommend these ways of discipline as they tend to make things worse.
* **Family Systems:** Traumatized children are in fight-flight-freeze mode, and this shows up in their behavior. Their survival mode often causes triangulation of adults. It is IMPERATIVE that the treatment team does NOT side with the child against the parent. The healing agent is the parent, and when a child is able to turn the treatment team against the parent, it creates chaos. The child should be encouraged to work out their concerns WITH their parent present. Working out their struggles away from the parent is dangerous.
* **Lies:** Traumatized children are compulsive liars about many things including physical and sexual abuse as well as neglect. This is a powerful tool for survival when you are a child. Although it is important to assess when a child makes these allegations, walk with caution. In both foster care and adoptive situations, this is a huge fear for parents. When the allegations are false and the child is believed, it makes healing increasingly difficult.
* **Family Encouragement:** The parents are often EXHAUSTED. They are judged from every direction, misunderstood, and everyone has “another idea” that is generally ineffective. They desperately need their team to “be on their side” by encouraging, building up, and understanding their fatigue. When you find things are you concerned about, please make sure you have interviewed the parent before “addressing” their behavior (as reported by the child). The child’s report is quite often wrong or misinformed, or an out and out lie. They need to know you understand you will not walk in judgement before understanding what is really going on.
* **Confusing Behavior:** It is common for a child to be able to “hold it together” in one area of their life. In other words they are able to be respectful and obedient in school, and then come home and blow it with their family. The mother is the typical target and takes a significant amount of (at times) abusive behavior from the child. This does not always mean the home is the problem. While sometimes the home is the problem, it is more likely that the problem is a child who is exhausted from holding it together at school.
* **Healing:** How they behave, communicate and act around adults has no bearing on how well they are doing. It is wonderful if they can do so, but progress is gauged by how well they are doing at home. Doing well at my office means nothing if the parents do not report increased respect, obedience, and relationship at home. Additionally, healing is a long term process….it is a marathon, not a sprint.

If you have any further questions, please do not hesitate to contact me. If there are additional members of the team that will be highly active in the process with this family, please do not hesitate to share this information with them. As long as you have signed the appropriate release, I will be happy to talk with them as well.

Best regards,

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

Family Ties Counseling, Inc.

****

**CHECKLIST OF REQUIRED PAPERWORK - MEDICAID**

**Mail signature page (with original signature) to:**

Cindy Richman

Family Ties Counseling, Inc.

10 Boulder Crescent St. STE 102H

Colorado Springs, CO 80903

❒ Intake

❒ Client Rights & Informed Consent

❒ Credit Card Policy

❒ Coordination of Care: Release to Medical Provider.

❒ Coordination of Care: Release to Medicaid.

❒ Important Information for Medicaid Members

❒ **Release:** Print as many as you need. CASA, respite workers, teachers, family members, GAL etc.

❒ Informative paperwork such as

* Family history
* Abuse history
* Necessary court documents
* Medical information
* DIAGNOSIS, treatment summaries

****

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**

Check payment that was agreed upon in our initial contact: ❒ 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.**

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

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.**

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

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.**

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

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

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 or hashish

❒ PCP ❒ prescription ❒ nicotine/cigarettes ❒ chewing tobacco

❒ other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there current concern that the use of substances (either alcohol or drugs) has become 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

If there is a history of substance abuse, 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 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?

Provide the name and telephone number of any caseworker, probation officer, GAL etc that is involved with the client:

Name: Agency Phone

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 **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.

\_\_\_\_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 from liability should I 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):

Caseworker Signature:

****

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, 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.

**2. 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. **3. 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 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.

**4. 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.

**5. 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. **6. 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).
2. **7. 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.
3. • Duty to Warn and Protect: By law, Family Ties Counseling is bound to report to appropriate authorities when a client discloses intentions 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.
4. • 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.

• 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.

1. • When you sign a Release of Information you have authorized Family Ties Counseling to provide specific information to an outside person/agency. The release is voluntary, typically lasts 12 months, and can be rescinded in writing at any time.
2. • 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.
3. • 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.
4. • 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.
5. • 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.
6. • 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.

**8. 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.

**9. 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.

**10. 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.

**11. 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.

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

**13. Other.**

1. Due to the confidential nature of therapy, tape-recording of sessions by a client for any reason is not allowed at Family Ties Counseling. 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.

2. Family Ties Counseling, Inc**. does not attend or participate in anything that would require attending or participating in any legal, or court related activities.**

3. Family Ties Counseling Inc. also does **not participate in evaluations for disability** 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 $155.00 Individual session $110.00

Family session $120.00 Group session $45.00

**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 a $55.00 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 follows and 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.

**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.

I have been informed of my rights and give my consent for treatment at Family Ties Counseling, Inc. I also understand and accept the financial arrangements and expectations as described above.

Client Name/Signature Date

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

2nd Parent/Guardian (if applicable) Therapist

Caseworker GAL

****

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.** 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.

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

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):

**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.

**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.

o 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:

o 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

****

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

**Authorization to Release 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:

Agency/Organization:

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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: Date:

Parent/Guardian Signature (if applicable):

Caseworker:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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.