The Colorado Center for Healing and Change
Phone: (720) 771-3144
| Email: kelly@centerforhealingandchange.com|
www.centerforhealingandchange.com

CHILD INTAKE

Welcome!

I am honored to have the opportunity to work with you or your organization. This packet contains information and forms that I will need to have on file before our second meeting.

Please review and complete these documents:

Office Policy Statement-to be reviewed and signed.

1. Client Information Form, to be completed and *signed.*
2. Disclosure Statement, to be reviewed and *signed.*
3. All *signed* forms are to be returned to the Colorado Center for Healing and Change.

You may retain a copy of this information for your records if inclined.

Sincerely,
Kelly Johnson

Office Policies:

It is the policy of The Center for Healing and Change to regard every client with the same level of respect and professionalism. Each client will have the opportunity to meet with a counselor for an initial session in order to get an idea of the proficiency, personality, and style of the counselor. Supplementary sessions will be scheduled in accordance with the treatment goals of the client or family.

Scheduling/Session

You may call (720) 771-3144 concerning any questions you may have and you will be contacted as soon as I am able. Please note, The Colorado Center for Healing and Change is not a 24-hour counseling center. In an emergency, please go to your nearest mental health center or call 911. Sessions are by appointment only and are typically scheduled weeks in advance. Because this time is reserved solely for you, you will be charged for appointments that are not canceled at least 24 hours in advance. In the event of an emergency, special consideration may be given regarding the cancellation policy. Sessions are typically scheduled for 50 minutes at a frequency determined by the counselor and client. It is imperative for you to feel at ease with your counselor. For this reason, you are encouraged to ask me about my education, techniques, supervision, professional experience, and therapeutic orientation.

Fee and Payment Options Structure

Hourly Rate (50 min) $90.00

Extended session (80 min) $120.00

Premarital Counseling Program (6 sessions) $450.00

Please Circle the above services you are interested in

The regular fee is $90.00 per 50-minute session. Payment is due at the time of each session. Cash, checks, and credit card payments are accepted. Therapeutic phone calls longer than ten minutes will also be prorated accordingly. If you have a health insurance plan, your visits may be partially paid for by your insurance company. Billing statements will be available on a request basis the first week of each month for the previous month's services. Statements will contain all pertinent information required by the insurance company for reimbursement.

I have read and understood the above information. I agree to the session fees and understand that I am responsible for full payment of this amount.

____

Client Signature *(parent or guardian for minor)* Date

CHILD INTAKE

Parent/Guardian Information

Name: ______________________________ Date: ______________________________
Home Address: ______________________________ City/State/Zip: ______________________________

Home Phone: ______________________________ Work Phone: ______________________________

Cell Phone: ______________________________ Email: ______________________________

May I call and leave messages at home? □ Yes □ No Work? □ Yes □ No Cell Phone? □ Yes □ No

Marital Status: □ S □ M □ D □ W No. of Marriages:___ Date of Current Divorce/Sep. ___________

If Divorced, Name of Other Custodial Parent: ____________________Phone: ______________________

Occupation: ______________________________ Highest Level of Education: ______________________

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Children(s) Name(s): ______________________________ DOB: _____________________ □ M □ F

______________________________ DOB: _____________________ □ M □ F

______________________________ DOB: _____________________ □ M □ F

______________________________ DOB: _____________________ □ M □ F

How much contact per week do you see the child coming for treatment?
____

Client Information (Child Coming For Treatment)

Name of Child: ____

Grade in School: _________

The Child is Currently Living with______________________ School: ___________________________

Extracurricular Activities/Interests:
____

Medical History

How would rate the child's current physical health? □Excellent □ Good □ Fair □ Poor

Is the child currently complaining of any physical problems? □ Yes □ No If Yes, Please Explain:
____

Please list any medical conditions/disabilities/learning disabilities:
____

Previous Hospitalizations: Date: _________________________ Reason________________________

Date: ____________________ Reason: _________________________

Daily Medication(s) and Dosage Over the Counter or Prescription	Prescribing Physician

Pediatrician/Family Physician: _____________________________ Phone: ________________________

Counseling and Psychiatric History

Has the child had previous counseling? □ Yes □ No If yes, for how long?
________________________ When? ____________

For what reason? _____________________ Name of Counselor: ________________________________

Has the child ever been diagnosed or treated for any type of mental illness? If yes, what type?
____

Has anyone in the family ever been diagnosed with or treated for any type of mental illness? If yes, what type? ____

Daily Psychiatric Medications and Dosage	Prescribing Physician

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REASONS FOR SEEKING HELP

What concerns about the child have brought you to counseling today?
____
____

Where are these concerns causing the most problems for the child? □ Home □ School □ Social □ Other

When did these concerns begin to be a problem for the child?
____

What concerns about the child have been identified by others?
____

Please indicate which of the following are currently problems for the child:

□ Crying Spells
□ Excessive Fear/Anxiety
□ Bullying/Picking Fights
□ Hearing Voices
□ Lack of Motivation
□ Decreased/Increased Appetite
□ Difficulty Making or Keeping Friends
□ Obsessions/Compulsions
□ Cutting
□ Hyperactivity
□ Refusal to Respond to Authority
□ Nightmares
□ Difficulty Separating from Specific Family Members
□ Tantrums
□ Lack of Self-Confidence
□ Loss of Interest in Usual Activities
□ Insomnia/Hypersomnia

Is there anything else that you would like for me to know today?
____
____

Please know the Colorado Center For Healing And Change thrives off of people having a good experience in therapy. If your experience has been positive here, feel free to pass our information on to a friend or loved on in need of counseling services.

THANK YOU!!!

DISCLOSURE STATEMENT

Kelly Johnson
720.771.3144
2323 S Troy St, 1-310
Aurora, CO 80014

- I am an unlicensed Psychotherapist from the University of Northern Colorado. I have a MA degree from the University of Northern Colorado in Clinical Counseling and School Counseling. I am registered in the state of Colorado to practice counseling.
- Bachelor of Arts, Psychology, 2004
  Colorado Christian University
- I receive regular supervision from a Licensed Marriage and Family Therapist where I discuss cases and receive feedback on techniques and interventions used.

Dear Counselee:
My desire is to help you in the best possible fashion while always being above reproach legally and ethically. Since counseling can raise differing expectations, it is my desire to give you some upfront information and set some clear guidelines for our counseling relationship. I offer comprehensive mental health services including: individual, couples, family, and adolescent counseling. Payment for services is expected at the time the service is rendered unless an agreement has been made as an exception.

Counselees Rights
I strive to maintain the highest quality of service. I follow ethical guidelines set by various organizations including the American Counseling Association. You are entitled to receive information about methods of therapy, techniques, duration of therapy (if determinable), and fee structure. Please ask if you would like to receive this information. You may accept or reject any recommended therapy intervention. You can also ask for a second opinion from another therapist or terminate therapy at any time.

In a professional relationship, sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Department of Regulatory Agencies, Mental Health Section.

Generally speaking, the information provided by and to a client during therapy sessions is legally confidential. The therapist cannot be forced to disclose the information without the client's consent. Information disclosed is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

There are exceptions to the general rule of legal confidentiality. Exceptions are listed in the Colorado statutes (C.R.S 12-43-218). These exceptions include child abuse/neglect and serious threats of violence to self or others. You should be aware that provisions concerning disclosures of confidential communications should not apply to any delinquency or criminal proceedings, except as provided in section 13-90-107 C.R.S.

The Colorado Department of Regulatory Agencies, Mental Health Section has the responsibility of regulating the practice of individuals who practice psychotherapy. Their information is listed below

The Colorado Department of Regulatory Agencies, Mental Health Section
1560 Broadway, Suite 1350,
Denver, Colorado 80202.
Telephone: (303) 894-7766.

If you have concerns about your treatment, I would hope that you would contact me first so we could talk about it. In the situation you did not feel comfortable, feel free to contact the Colorado Department of Regulatory Agencies

If you have any questions or would like additional information, please feel free to ask.
I have read the preceding information and understand my rights as a client.

Client Signature *(parent or guardian for minor)* Date

Colorado Notice Form of HIPAA Legislation

Notice of Psychotherapist's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions: *PHI* refers to information in your health record that could identify you. *Treatment, Payment, and Health Care Operations*. *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider,such as your family physician or another psychotherapist. *Payment* is when I obtain reimbursement for your healthcare. Examples are when I disclose your PHI to your health insurer for reimbursement for health care or to determine eligibility or coverage. . *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits, administrative services, case management, and care coordination. Use applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you. Disclosure. applies to activities outside of my [office, clinic, practice group, etc.] such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An .*authorization*. is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. .*Psychotherapy Notes*. are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse . If I have reasonable cause to know or suspect that a child has been subjected to abuse or neglect, I must immediately report this to the appropriate authorities.
Adult and Domestic Abuse . If I have reasonable cause to believe that an at-risk adult has been mistreated, self-neglected, or financially exploited and is at imminent risk of mistreatment, self-neglect, or financial exploitation, then I must report this belief to the appropriate authorities.
Health Oversight Activities . If the Grievance Board for Unlicensed Psychotherapists or an authorized professional review committee is reviewing my services, I may disclose PHI to that board or committee.
Judicial and Administrative Proceedings . If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privileged does not apply when you are being evaluated or a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious Threat to Health or Safety . If you communicate to me a serious threat of imminent physical violence against a specific person or persons, I have a duty to notify any person or persons specifically threatened, as well as a duty to notify an appropriate law enforcement agency or by taking other appropriate action. If I believe that you are at imminent risk of inflicting serious harm on yourself, I may disclose information necessary to protect you. In either case, I may disclose information in order to initiate hospitalization.

Worker's Compensation . I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provided benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychotherapists Duties

Patient's Rights:

Right to Request Restrictions . You have the right to request restrictions on certain uses and disclosures of protected health information regarding you. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations . You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)

Right to Inspect and Copy . You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

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Right to Amend . You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to an Accounting . You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy . You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychotherapist's Duties:
I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

COLORADO NOTICE FORM OF HIPAA LEGISLATION

I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will notify my client by mail.

V. Questions and Complaints
If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact the Kelly Johnson at 720-771-3144. If you believe that your privacy rights have been violated and wish to file a complaint with me / my office, you may send your written complaint to: The Colorado Center For Healing And Change. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy
This notice will go into effect on September 1st, 2007. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail within ten business days prior to changes.

VII. Client Signature
I have read the above terms and understand them as stated. I have been informed of my therapist.s policies and practices to protect the privacy of my health information.

Client Name (please print) Parent or Guardian *(for Minor)* Name

____

Client Signature /Date

____

Parent or Guardian Signature/ Date

____

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