Crystal Creek Counseling
400 West Midland Avenue, Suite 200
Woodland Park, CO 80863
Phone: 719-686-6703 Fax: 719-325-8958
Email: jeri@crystalcreekcounseling.com
www.crystalcreekcounseling.com

IDENTIFYING INFORMATION

Date of Intake: _____

Full name of Child: _____

Birthdate: _____ Age: _____ Gender: _____

Telephone: _____ _____
Cell Home

Address: _____
Street City State Zip

School: _____ Grade: _____

Email address of preferred contact: _____

This form completed by: _____ Relationship to child: _____

Emergency Contact: _____ Relationship: _____

Phone Number: _____

Referral source: _____

Is there any DHS/DSS or Court Involvement: _____YES _____ NO

If Yes, who are the parties involved in your case? _____

Case Worker: _____ Phone Number: _____
GAL: _____ Phone Number: _____

Court papers available: _____ FSP/NCFAS: _____

Reason for Seeking Treatment:
_____
_____
_____
_____
_____
_____

Family Information

Information on Father		**Information on Mother**	
Name:		**Name:**	
Natural___ Step___ Adopted ____ Foster____		Natural___ Step___ Adopted ____ Foster____	
Race/Ethnicity:		Race/Ethnicity:	
Occupation:		Occupation:	
Annual Income:		Annual Income:	
Highest Education Level Completed:		Highest Education Level Completed:	
Residing in home with child?		Residing in home with child?	
If not, where?		If not, where?	
Marital status:		Marital status:	
Place of employment and work phone:		Place of employment and work phone:	
Military?		Military?	
Drug Abuse?		Drug Abuse?	
Alcohol Abuse?		Alcohol Abuse?	
Prior Counseling: □ Inpatient □Outpatient □Medication □Substance Abuse □DV □SO □Family Preservation □Other		Prior Counseling: □ Inpatient □Outpatient □Medication □Substance Abuse □DV □SO □Family Preservation □Other	

Please list all children living and deceased:

Name	School/Grade	Location (if not at home)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please give the name and relationship of anyone else living in the home (including step-parent):

_____

_____

Comments:

Cultural and/or spiritual factors that may impact treatment (may include age, values/beliefs, preferred language, communication needs, gender, sexual orientation, relational roles, among others)

a. ___ Select if cultural factors will not impact treatment

Family history of mental health or substance abuse problems:

a.__ Select if Not Applicable

Mental retardation/developmental disabilities/organic conditions that may impact presentation or functioning

a. __Select if Not Applicable

Medical conditions that may impact presentation or functioning: (include allergies)

a. __Select if Not Applicable
b. __Medical exam referral made to:

Is transportation an issue? _____ Yes _____ No

CONSENT FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION VIA UNSECURE TRANSMISSIONS

This consent form is for the communication of Protected Health Information ("PHI") that Crystal Creek Counseling ("CCC") may transmit without the written authorization of the client as described in the Uses and Disclosure section of CCC's Notice of Privacy Policies.

I, _____, hereby consent and authorize CCC to communicate my PHI through the following unsecure transmissions (please initial all your choices):

_____ Cellular/Mobile Phone this includes text messaging & voicemails
Please Insert Cell Phone Number: _____
_____ Unsecured Email
Client's Email: _____□ Send □ Receive
Please Circle One: Work Personal
Therapist's Email: _____□ Send □ Receive
_____ Appointment/Scheduling Reminder System (Theranest)
_____ Other Media: Please describe: _____
_____ I do not wish to have my protected health information transmitted electronically

Should we agree to communicate by the approved communications listed above, i.e. text, email, telephone, or any other electronic method of communication, confidentiality extends to those communications. However, CCC cannot guarantee that those communications will remain confidential. Even though CCC may utilize state of the art encryption methods, firewalls, and/or back-up systems to help secure our communication, there is a risk that the electronic or telephone communications may be compromised, unsecured, and/or accessed by an unintended third-party. There is never a 100% guarantee information will remain confidential when transmitted electronically.

I, _____, consent to CCC transmitting the following PHI by the above selected electronic communications (please initial all your choices):

_____ Information related to scheduling/appointments
_____ Information related to billing and payments
_____ Information related to your mental health treatment (this may contain personal materials, forms, suggested articles, homework, etc.)
_____ Information related to CCC's operations
_____ Other Information; Please Describe: _____

I further understand that if I initiate communication via electronic means that I have not specifically consented to in this form, I will need to amend this consent form so that my therapist may communicate with me via that method.

_____ _____
Signature of Client/Parent/Legal Guardian DATE

CUSTODY AND/OR DECISION MAKING

I/we attest and certify to Jeri Yingling that I/we are: (Initial Applicable, Cross Out Nonapplicable)
_____Married biological parents and sole decision makers
_____Divorced biological parents and joint decision makers
_____Single biological parent and sole decision maker
_____Remarried biological parent and sole decision maker
_____Unmarried biological parents and joint decision makers
_____Non-biological parent and sole decision-maker
_____Non-biological parent(s) and joint decision maker(s)
_____Adoptive parent(s) and sole decision makers
_____Foster parents(s) decision making resides with
_____
_____15 years of age and a Colorado resident at date of signing
_____Other (specify)

By completing and signing this form, I/we certify:

_____The above checked is true and correct.
_____The most recent supporting court documentation is provided.
_____Any mistakes or misrepresentations are my/our responsibility.
_____I/we will not hold the therapist accountable for omissions

DISCLOSURE REGARDING DIVORCE AND CUSTODY LITIGATION

(C.R.S. 12-43-203, C.R.S. 12-43-222) A dual relationship is prohibited whereby in custody cases the therapist is providing treatment or therapy to a party and also providing opinion or expert witness testimony or a custody evaluation in violation of Chief Justice Directive Standard 4.

The court can appoint a professional (i.e. Child Family Investigator, Parenting Coordinator) who has no prior relationship with the family members, to conduct an investigation or evaluation and make recommendations to the court concerning parental responsibilities or parenting time in the best interests of the family's children.

1. My role as therapist for your child is to create a therapeutic and safe environment for the sharing of feelings related to your divorce. It is understood that my neutrality in any post-divorce dispute is for the benefit of your child.

2. Conflictual issues will not be addressed to me, as your child's therapist. Any concern regarding visitation or parenting will be presented to the court appointed official.

3. It is understood that one therapy has commenced, I will share all information regarding the process of therapy with the court appointed official and will limit direct feedback to each parent to matters concerning how you can individually best parent your child. I will expect input from each parent about concerned and progress.

4 It is also understood that once therapy has commenced, I will not speak with either of your attorneys, nor will I appear in court proceedings related to divorce or visitation disputes.

5, By signing this agreement, you give permission for me to release any and all information regarding the treatment of your child to the agreed-upon court appointed official.

6. Therapy will terminate at such a time as the court appointed official and I agree that the goals of treatment have been accomplished.

7. If you are involved in divorce or custody litigation, my role as a therapist is not to make recommendations to the court concerning custody or parenting issues. By signing this Disclosure Statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that I write any reports to the court or to your attorney, making recommendations concerning custody.

8. You agree that each parent will provide court documents to this therapist as they are updated so that I have the most current parenting plan and custody information.

9. If I am subpoenaed into court for any reason my fee is $200 per hour portal to portal plus expenses.

10. In support of your child's therapy, each of you by signing this agreement acknowledges your willingness to cooperate by providing transportation to and from the therapy hour at the agreed upon day and time.

_____

Signature Date

_____

Signature Date

_____

Therapist Date

AUTHORIZATION TO RELEASE PROTECTED HEALTH AND CONFIDENTIAL INFORMATION

I, _____, authorize Crystal Creek Counseling and Jeri Yingling, to exchange and release the information specified below with the following person/class of persons (Name, Telephone Number, Address, Relationship to Client):

_____

_____

CLIENT NAME: CLIENT DATE OF BIRTH:

_____ _____

PARENT/LEGAL GUARDIAN (if applicable):

_____

ADDRESS:

_____

INFORMATION REQUESTED: I request and authorize the above-named person or class of persons to exchange and release the information specified below to the above named person or class of persons (check all that apply):

□Evaluations/Testing/Assessments **□Psychotherapy Notes** **□Complete Medical/Mental Health Records**

□Treatment Summary **□Medications prescribed** **□Diagnosis/Psychiatric Conditions**

□Drug/Alcohol Abuse Information **□HIV/AIDs Information** **□ Treatment Plan**

□Other: _____

Type/Form of Information Requested (check all that apply):
□ Records □ Verbal Communications □ Electronic Communications such as texts or emails

I understand that the information to be released includes information for the following **purpose:**
□ Psychiatric Condition, Psychological Testing/Assessment **□ Treatment Planning**

□ **Rehabilitation program, development, or services** □ **Legal Issues**

□ **Coordination of Care** □ **Consultation/Supervision** □ **Education**

□ **Drug/Alcohol Abuse** □ **HIV/AIDS** □ **Medical Care**

□ **Other:**_____

The information sought in this request is the minimum necessary to accomplish the intended purpose of the request. 45 C.F.R. 164.502(b)(2)(v). (See 65 FED. Reg. 82530). Information may be released verbally, in writing, photocopy, by fax or mail unless client indicates otherwise.

I understand that the information to be disclosed may include any or all information involving psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism, and/or information involving communicable and/or venereal diseases such as HIV/AIDS. **I understand that this authorization will expire in one (1) year from the date of signing, unless otherwise specified here:**

_____

AUTHORIZATION: I understand that the disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or eligibility to obtain benefits, unless specified in this form. I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by sending a letter to the facility Privacy Officer at the contact information above, or their designee. I understand my revocation will not be effective to the extent that action has already been taken in reliance on it. I understand and I authorize the disclosure of my mental health information to someone who may or may not be legally required to keep it confidential, and understand that it may be re-disclosed and may no longer be protected by the Standards for Privacy of Individually Identifiable Health Information, set forth at 45 CFR Parts 160 and 164. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a reasonable fee will be charged for copies of my mental health record. I understand the facility will provide me a copy of the signed authorization form upon my request. If I have questions about disclosure of my mental health information, I can contact the facility Privacy Officer or their designee. I understand that treatment may not be denied if I refuse to sign this authorization, except: 1) If the authorization is the very reason for seeking the health care (e.g., a pre-employment physical), health care may be denied; or 2) If the authorization is for disclosure to a research study, I may be denied the treatment that is part of the study. In addition, the following consequences might occur if I refuse to sign the authorization: 1) If the authorization is to demonstrate to a health plan that a service should be paid for, the health plan may refuse to pay for it, and 2) If the authorizing is sought by an insurer because I am seeking enrollment or eligibility, the insurer may deny me the coverage I am seeking. I understand that a health plan may not refuse payment or benefits if I refuse to authorize disclosure of certain psychotherapy notes. I understand and affirm, by my signature below, that the benefits and disadvantages of releasing the above information, if known, have been explained to me. **A copy or telefax of this authorization will be as valid as the original.**

_____ _____ _____

Client Signature Printed Name Date

_____

Relationship to Client (if applicable)

****The information disclosed to you may be from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.**

Food Permission and Allergy Notice

I/we give permission to Therapist Jeri Yingling to give our child appropriate food/snacks and/or drink as part of the therapy process.

Child's known allergies: _____
Food/drink to be avoided: _____

Acknowledgement of Appropriate Touch during Therapy

I/we acknowledge that during therapy, appropriate physical contact is sometimes utilized to promote emotional regulation and healing. Such contact may include but is not limited to: shaking hands, patting the head, shoulder, arm, back; touching hands, and hugs when initialed by the client. In Play Therapy, children often initiate touch, especially during play sequences and the Therapist will respond in kind with appropriate touch. If your Therapist is utilizing Play Therapy, activities will likely include appropriate touch. You may be present during these sessions, be privy to and/or participate in the contact. Your Therapist is happy to provide appropriate touch whenever you or your child asks for or initiates it. If at any time you are uncomfortable with the touch you or your child receives, you will notify the Therapist immediately.

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.

_____
Parent/Guardian Signature Date

_____
Therapist Signature Date

Photograph & Video Release Form

I hereby grant permission to the rights of me or my child's image, likeness and sound of his/her voice as recorded on audio or video tape as well as ideas discussed without payment or any other consideration. I understand that the image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the image or recording or ideas discussed. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area. Every effort is made to protect the identity of those video-taped or photographed.

Photographic, audio or video recordings may be used for the following purposes: (Please check)

- conference presentations
- educational presentations or courses
- informational presentations
- on-line educational courses
- educational videos
- Book, article or other written materials

By signing this release, I understand this permission signifies that photographic or video recordings of me or my child may be electronically displayed via the Internet or in the public educational setting.

I will be consulted about the use of the photographs or video recording for any purpose other than those listed above. There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio or video recordings collected as part of the sessions listed on this document only.

By signing this form, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Client's Name: _____

Parent/Guardian's Name: _____
Street Address/P.O. Box: _____
City: _____ Zip:_____
Phone: _____ Email: _____

_____
Signature Date

Notice of Acknowledgement

Name:_____

I hereby acknowledge that I have received a copy of the NOTICE OF PRIVACY RIGHTS and CLIENT RIGHTS further recognize that I am required by State and Federal law to understand these legal responsibilities and will maintain the privacy of all individuals and all protected information on these premises.

_____

Printed Name and Signature of client or responsible party to client Date

_____

Printed Name and Signature of second adult client (if applicable) Date

_____

Printed Name and Signature of Witness Date

The NOTICE OF PRIVACY RIGHTS was presented to the client or legal guardian today but the client or legal guardian did not sign this acknowledgement because:

_____ The client refused to sign.

_____ The legal guardian refused to sign.

_____ The client was incapable of signing.

_____ Other_____

_____ _____

Therapist **Date**

No Show/ Cancellation Policy

A cancelled appointment hurts three people: you, your therapist, and another client who could have potentially utilized your time slot. Therapy sessions are scheduled in advance and are a time reserved exclusively for the client. When a session is cancelled without adequate notice, I am unable to fill this time slot by offering it to another current client or a client on the wait list. In addition, I am unable to bill your insurance company for sessions that are not kept.

1. I understand that I will be charged a LATE CANCELLATION fee of $50 if I fail to give at least 24-hour notice prior to cancelling my appointment. The only time this fee will be waived is in the event of serious or contagious illness, emergency or extreme weather. _____

2. I understand that I will be charged a NO-SHOW fee of $50 if I fail to show for my appointment. _____

3. I understand that these charges are an out of pocket expense and that my insurance carrier will not cover these charges. _____

If you miss two or more scheduled appointments within a 30-day time period without cancelling or rescheduling in accordance with cancellation policy of 24 hours' advance notice, the therapeutic relationship will be terminated. Your case may be reopened at any time should you so choose; however, you may be placed on a waiting list if there are other clients waiting to use your time slot.

4. MEDICAID CLIENTS: Please note that this fee cannot be applied for clients with Medicaid insurance. This does not apply if Medicaid is the secondary insurance. Thus, clients with Medicaid insurance who have three or more late cancellations or missed sessions will be referred to other providers. _____

By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive from this therapist.

_____ _____

Signature of Responsible Party Date

Consent for Treatment

I consent to the evaluation and treatment process with Jeri Yingling, LPC, RPT and I understand that this process may include myself, my minor child, and/or other family members. I am aware that care and treatment is not an exact science and acknowledge that no guarantees have been made to me as the result of treatment. I understand that session length averages from 45-50 minutes and that if I am late for my appointment, my session length will be calculated from the beginning time of the appointment.

PAYMENT AGREEMENT

I will begin counseling on _____. I understand that the fee for this service is $_____ for the initial session and $_____per client session hour. I agree to pay $_____ at the beginning of each session and agree that I will be responsible for all moneys not covered by my insurance plan or other monies as follows:

_____

_____

I understand that I will be responsible to pay, prior to my next appointment, the amount of my agreed full client hour upon missing an appointment without proper 24-hour cancellation.

I understand that counseling services are considered a medical expense and are frequently covered by health insurance, which requires a diagnostic determination. I also understand that my therapist does not assume a contractual agreement with my insurance company. In accepting counseling services, I agree to incur full financial responsibility for those services.

I understand that I will be charged for any requested court reports, mental health assessments, treatment summaries, letters, and/or any other documented information required of my therapist in the continuity of my care, not paid for by my insurance company. I will discuss these rates with my therapist.

I agree to the preceding relevant paragraphs.

_____

Print Client Name

_____

Signature of Client/Parent/Legal Representative Date

_____

Witness