Alpine Connection Counseling Informed Consent

1720 Jet Stream Drive, Suite 205, Colorado Springs, CO 80921 (719) 233-TEEN

Client Rights

To know your therapist's training and credentials:
Christian T. Hill has a Masters in Community Counseling from the University of Northern Colorado; BA in Communications from Stephen F Austin State University; member of the Association of American Marriage and Family Therapists, and ordained pastor.

To report any grievances you may have against your therapist:

Sexual contact between a therapist and their client is illegal in the state of Colorado and is not recognized as any form of therapy.

Contact: Colorado State Department of Regulatory Agencies, Mental Health Section, 1560 Broadway, Suite 1340, Denver CO 80202, or phone: 303-894-7766.

To Confidentiality

Everything we discuss in counseling is legally confidential. This also means I cannot approach you in public unless you approach me first. Some sessions may be audio/video taped for the protection of the client and the therapist and will adhere to all your legal rights of client confidentiality.

Exceptions to confidentiality

Imminent harm to yourself or others; if I suspect any sexual or physical abuse of children; grave disability; if your records were subpoenaed by the courts; third-party billing and or insurance statements; or threat to national security.

Exception unique to Alpine Connection Counseling

Sometimes meeting in out-of-office locations can be beneficial for adolescents who are resistant to the traditional counseling setting. This is a unique and intentional approach of Alpine Connection Counseling that is provided as an option when agreed upon by the parent(s). This approach does, however, present risks to confidentiality due to meeting in public locations. For appropriateness, transportation will only be provided for same gender clients.

(by signing this document you are agreeing to take no legal action regarding confidentiality as it relates to the above specific exception.)

To understand your therapist's approach, methods, and therapy options: www.alpineconnection.org

Financial arrangements

The agreed cost for therapy will be $140.00 per session which will last for 50 minutes (an additional 10 minutes will be spent on therapy notes, referrals, and assessments), or $60 for a 30 minute session.

Cancellation – you must cancel your appointment 24 hours prior or you will be charged the full amount.

I have read the preceding information and understand my rights as a client.

____
Client Name

______________________________________ __________________
Client Signature (Parent or Guardian for a Minor) Date

_____ **Please initial here verifying that there are no legal restraints against your rights as a parent with regards to custody and/or legal guardianship**.

______________________________________ __________________
Therapist Signature Date

Alpine Connection Counseling Intake Form

719-233-8336
Christian T. Hill, MA
5360 N. Academy Blvd., Suite 150, Colorado Springs, CO 80918

Contact information of parent:

First name:________________________Last name:_______________________________

Home phone:________ _____________Cell phone:_______________________________

Business phone:____________________Email:__________________________________

Street Address: ___________________________Zip code:_________________________

Who to contact in case of an emergency? ______________________________________

How did you hear about Alpine Connection Counseling?______________________________
Is it ok to thank them for the referral by sharing your name? Yes No

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Family History

Name:____ Date:______________________________________

My family has a history of:

- ❑ Anxiety
- ❑ Depression
- ❑ Chemical Dependency/Abuse
- ❑ Suicide
- ❑ Bipolar
- ❑ Schizophrenia
- ❑ Legal issues
- ❑ Medical conditions
- ❑ Psychiatric hospitalizations
- ❑ Eating disorders
- ❑ Divorce
- ❑ Abuse
- ❑ Other (please explain):____

If you checked yes to any of the above, please explain - including relationship to family
*(ex. Grandpa on mom's side alcoholic)*____

____

My history:

- ❑ Have a medical condition or significant past injury: (explain)
  ____
- ❑ Am allergic to: (explain)
  ____
- ❑ Have a previous diagnosis of: (explain) ____
- ❑ Am currently taking medications: (list) ____
- ❑ In the past have taken: (explain) ______________________________________ Successful? Yes No
- ❑ Am currently using substances: (explain)
  ____
- ❑ Am having suicidal thoughts: (explain)
  ____

Check all that apply:

- ❑ I have something I want to get out of counseling
- ❑ I sometimes feel depressed
- ❑ I have drastic mood swings
- ❑ I struggle with sleep
- ❑ I currently use drugs and/or alcohol
- ❑ I am sexually active
- ❑ I sometimes have panic attacks
- ❑ I often think about suicide
- ❑ I sometimes cut on myself
- ❑ I sometimes see things and hear things other people don't
- ❑ I have religious beliefs
- ❑ I have experienced physical and/or sexual abuse
- ❑ I have been physically and/or emotionally neglected
- ❑ I'm adopted
- ❑ I'm struggling with career decisions and or my current job situation
- ❑ I'm struggling with friends
- ❑ I'm struggling with relationships
- ❑ I often have anger control problems
- ❑ I have had some legal trouble
- ❑ My parents are divorced
- ❑ Other (please explain):____

Have you had any past experience with a counselor?

a. If yes, for what purpose did you go to the counselor? ______________________________________

b. Was your experience with your counselor positive or negative? ______________________________

c. How could your counselor have been better?____

My hobbies/interests are:

____

I would rate my self-esteem on a scale from 1-10 as: ________

Explain:____

My goals for counseling are:

1. ______________________________
2. ______________________________
3. ______________________________

My 3 positive ways of dealing with stress are:

1. ______________________________
2. ______________________________
3. ______________________________

If you meet criteria for a mental health condition, are you open to discussing medication? Yes No

Is it appropriate to discuss spiritual matters? Yes No

HIPAA AUTHORIZATION FORM

Alpine Connection Counseling, LLC
5360 N Academy Blvd, Suite 150
Colorado Springs, CO, 80918
719-233-TEEN

HIPAA stands for The Health Insurance Portability and Accountability Act of 1996. The purpose of this act was to call upon the Department of Health and Human Services to publish new rules that will ensure:

1. Standardization of electronic patient health, administrative and financial data.
2. Unique health identifiers for individuals, employers, health plans and health care providers.
3. Security standards protecting the confidentiality and integrity of "individually identifiable health information", past, present, or future.

The protected health information disclosed to the entity you listed in Section 3 may include information on chronic diseases, behavioral health conditions, including alcohol or substance abuse, communicable diseases, including HIV/AIDS, and/or genetic marker information.

If the person or entity receiving this information is not a health care provider, or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer be protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatmentor payment or your eligibility for benefits.

You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as a part of a clinical trial, your right to access is suspended until the clinical trial is completed.

Finally, you may revoke this authorization in writing at any time by sending a written notification to Alpine Connection Counseling at 5360 N Academy Blvd., Suite 150, Colorado Springs, CO 80918. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

Sign Here:

___________________________________ Signature of participant or representative

___________________________________ Date of authorization

Alpine Connection Counseling

(This form is optional based on need to share information client protected information)

Authorization to Release Confidential Information

Christian T. Hill
5360 N Academy Blvd., Suite 150
Colorado Springs, CO 80918
(719) 233-8336

This form only needs to be filled out if you would like me to share information with a doctor, school counselor, or other person as it relates to reaching therapeutic goals.

Date of Authorization___________________________

Regarding____________________________________(individual in therapy)

I hereby authorize the parties listed below to exchange, receive and discuss any information related to the psychiatric and psychological treatment of the client listed above. The information exchanged shall include psychological tests/evaluations, psychiatric/medical history, treatment summaries, and other information deemed appropriate, that will enhance current treatment. The parties listed below are hereby released from constraints or liability related to confidentiality. This authorization will be considered in effect for the duration of treatment by, Christian T. Hill of the above named client, unless otherwise revoked in writing.

Name:____ (individual sharing info.)

Phone:____Fax:________________________________

May share any and all related information concerning___________________with:

Christian T. Hill
5360 N. Academy Blvd., Suite 150
Colorado Springs, CO 80918
(719) 233-8336

Information requested: __Medical records __Legal records __Therapy notes __ Relational input

Signed ____**Date**_____________

Relationship to the above client: (circle one) Self Parent Guardian