Heather Tucker, LPC, PC
4297 Austin Bluffs Parkway #204
Colorado Springs, CO 80918
719-338-2324

CONSENT TO TREAT

Name: _____ DOB: _____

I consent to the outpatient psychotherapeutic evaluation and treatment recommended by Heather Tucker, MA, LPC. I am aware that psychotherapy is not an exact science, and that no guarantees have been made regarding the results of treatment.

_____ Date: _____
Client/Legal Guardian Signature

FEE AGREEMENT

_____Self pay only: I agree to be responsible for payment of $100.00 at the time of each session.

_____ If needed, I agree to court costs of $100.00/hour for court preparation and $200.00/hour for expert testimony (2 hour minimum). I agree to provide a retainer fee for court cases of $_____, with additional retainers as required when the original retainer has been exhausted. Any remaining funds will be returned to me upon termination of therapy.

_____I have _____ insurance and agree to be responsible for my co-payment and/or deductible (if applicable) at the time of each session in the amount of _____. If my insurance denies payment for any reason I agree to be responsible for payments for services rendered.

_____I agree to be responsible for payment in the amount of $40.00 for any missed appointment or appointment cancelled with less than 24 hours notice. $50.00 for any missed appointment or appointment cancelled with less than 24 hours notice on a Saturday or a holiday.

_____I agree to pay a case management fee for all contact outside sessions (excluding scheduling) and any letters, reports, or emails written at the rate of $25.00 per 15 minutes.

_____I agree that if my check does not clear the bank I will be responsible for an additional fee of $29.00.

_____I authorize payments of medical benefits to the undersigned physician or supplier for therapeutic services. I accept assignment of benefits to Heather Tucker, LPC, PC.

_____ Date: _____
Client/Legal Guardian Signature

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REGULATION OF PSYCHOTHERAPISTS

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The regulatory boards can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. The regulatory requirements for mental health professionals provide that a Licensed Clinical Social Worker, a Licensed Marriage and Family therapist, and a Licensed Professional Counselor must hold a masters degree in their profession and have two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a master's degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure1. **DISCLOSURE REGARDING DIVORCE AND CUSTODY LITIGATION**

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. The court can appoint professionals, who have no prior relationship with family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interests of the family's children.

2. **CLIENT RIGHTS AND IMPORTANT INFORMATION**

a. You are entitled to receive information from me about my methods of therapy, the techniques I use, and the duration of your therapy, and my fee. Please ask if you would like to receive this information.

b. You can seek a second opinion from another therapist or terminate therapy at any time.

c. In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Board that licenses, certifies or registers the therapist.

d. Generally speaking, information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and the therapist cannot disclose the information without the client's consent. There are several exceptions to confidentiality which include: (1) I am required to report any suspected incident of elder abuse or neglect and child abuse or neglect to law enforcement; (2) I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (3) I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental disorder; (4) I am required to report any suspected threat to national security to federal officials;

(5) I am required by HB 14-1271 to report any threats against locations such as churches, schools, theatres, workplaces, etc to law enforcement, and (6) I may be required by Court Order to disclose treatment information.

e. When I am concerned about a client's safety, it is my policy to request a Welfare Check through local law enforcement. In doing so, I may disclose to law enforcement officers

information concerning my concerns. By signing this Disclosure Statement and agreeing to treat with me, you consent to this practice, if it should become necessary.

f. Under Colorado law, C.R.S. § 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information. If you request treatment information from me, I may provide you with a treatment summary, in compliance with Colorado law and HIPAA Standards.

g. I am in clinical consultation with other mental health professionals, and they may be receiving non-identifying information concerning your treatment and will be consulting with me so that you will receive the best care that I can provide.

h. Pursuant to HB 17-1011, any person who alleges that a mental health professional has violated the licensing laws related to the maintenance of records of a client eighteen years of age or older, must file a complaint or other notice with the licensing board within seven years after the person discovered or reasonably should have discovered this. My practice will maintain records for a period of seven years commencing on the date of termination of services or on the date of last contact with the client, whichever is later. When the client is a child, the records will be retained for a period of seven years commencing either upon the last day of treatment or when the child reaches eighteen years of age, whichever comes later, but in no event shall records be kept for more than twelve years.

I have read the preceding information, and it has been presented to me verbally. I understand the disclosures that have been made to me.

_____ Date: _____
Client/Legal Guardian Signature

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY RIGHTS

I understand that as part of my health care, this office originates and maintains paper and/or electronic records describing my mental health history, symptoms, diagnoses, treatment and any plans for future care or treatment. I have been provided with a *Notice of Privacy Practice Policies* that provides a more complete description of information uses and disclosures. I further acknowledge that, as of today's date, I have no questions regarding *Notice of Privacy Policies.* I understand that this office reserves the right to change their notice and practices and prior to implementation , in accordance with Section 164.520 of the Code of Federal Regulations, should this office change their policy, they will post changes in office as well as provide a revised policy for me upon my request. I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to each disclosure for these permitted uses, including disclosures via fax in accordance with HIPAA guidelines and state law.

_____ Date: _____
Client/Legal Guardian Signature

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INTERAGENCY RELEASE OF INFORMATION OR AUTHORIZATION

_____ _____ _____
(Participant's Name – First, Middle Initial, Last) (Date of Birth) (Social Security Number)

I authorize information about the above references participant to be exchanged between the following System of Care User Group agencies or programs as listed below (initial all that apply):

[ ] CASA – Court Appointed Services Advocate	[ ] Faith Partners: _____	[**X**] Private Behavioral Health Therapist: Heather Tucker, LPC
[ ] Child Care Connections	[ ] Financial: _____	[ ] Project BLOOM
[ ] Child Care Response Team	[ ] GAL – Guardian ad Litem	[ ] Resources for Young Children & Families (Part C)
[ ] Colorado Child Care Assistance Program (CCCAP)	[ ] Health Care: _____	[ ] Social Security Service
[ ] Community Partnership for Child Development	[ ] TESSA (Domestic Violence Prevention	[ ] Healthcare for Children with Special Needs (HCP)
[ ] Court: _____	[ ] Hospital:_____	[ ] The Resource Exchange (TRE)
[ ] Dept. of Human Services Program(s):_____	[ ] Military Program:	[ ] WIC – Women Infants and Children
[ ] Educational Program/School District: _____	[ ] Pikes Peak Family Connections	[**X**] Other: __insurance_____
[ ] EPC Dept. of Health & Environment Program(s)	[ ] Aspen Point Counseling	[ ] Other: _____

(Boxes in this section checked off by staff member)

I understand that the information disclosed may be written, verbal, or electronic form and may include date(s) of contact, locations and reasons for contract, symptoms presented, treatment progress, outcome information, prescriptions, written referrals, educational records, tests performed, and/or diagnosis. I understand that the disclosure may include: psychological/psychiatric; medical; shelter and case management; and/or alcoholism, drug and/or alcohol abuse information.

I understand that the purpose of this information disclosure is to allow the participating entities (identified above) to access and use the information to establish and maintain continuity of care, better assess the effectiveness of the program, and/or to improve their services based upon service utilization studies

I understand that I may refuse to sign this authorization, and no one is conditioning treatment, payment, enrollment or eligibility for benefits on signing this authorization. However, the System of Care User Group can condition those things if, (1) the treatment is researched-related and the authorization is needed to use or disclose protected health information for such research [this form has been so conditioned [ ]), or (2) for services conducted solely to produce information for a third party and the authorization is for the disclosure of the protected health information to that third party[this form has been so conditioned [ ]]. This form has not been conditioned unless one of these has been checked by the staff.

I understand that there is a potential for information disclosed, as a result of this authorization, to be re-disclosed by the recipient and therefore no longer protected by the HIPAA Privacy Regulations. When applicable, an assessment of the minimum necessary amount of information required by this authorization.

I understand that I may revoke this authorization, at any time, by giving written notice to the authorized System of Care User Group agencies or programs, except to the extent that the auction has already been taken to comply with it. Without such revocation this authorization will expire on / / , or if left blank, one year from my signature date, or as the action/event of

_____

I understand I am entitled to a copy of this authorization

_____ _____ _____
Signature of Participant/Authorized Guardian/Legal Representative **Authority to act on Participant's behalf** **Date**

_____

I hereby revoke this Authorization to Disclose Information.

_____ _____ _____
Signature of Participant/Authorized Guardian/Legal Representative Authority to act on Participant's behalf Date

Notice to whom this information is given: This information has been disclosed to you from the records that may be protected by Federal confidentiality rules (42 CFR part2). 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 whim 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.

A copy/facsimile of this authorization is as valid as the original [] Original [] Revised (Date___/____/____)

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AUTHORIZATION FOR COORDINATION OF BEHAVIORAL HEALTHCARE

You should complete this form if you wish to authorize Heather Tucker, LPC, PC to exchange information regarding your behavioral health condition to your primary care provider or other behavioral health providers who may be involved in making decisions regarding your healthcare.

_____

Client Name **Date of Birth**

_____

Doctor's Name

_____

Office Address

_____

Office Phone Number/Fax Number (if known)

_____ **Date:** _____

Client/Legal Guardian Signature

☐ **I do <u>not</u> want to have information shared with my other healthcare provider(s), or I do not currently have any other healthcare provider(s).**

To be completed by Heather Tucker, LPC:

Current Diagnosis:_____

_____

First Date of Service:_____ **Frequency of Appointments:**_____

Treatment Goal:_____

_____

Comments:_____

_____

_____ _____

Heather Tucker, MA, LPC **Date**

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ADMISSION INFORMATION

Name: _____ Date: _____

Date of Birth_____/_____/_____ Social Security Number_____-_____-_____

Parent/Guardian Name (if under 18)_____

Marital Status: Single Married Separated Divorced Widowed

Address: _____

City_____ State_____ Zip Code_____

Home Phone_____ Cell_____ Work_____

Employer_____

Spouse/Significant Other Name_____

Insurance_____

Insured's Name_____

Insured's Date of Birth_____/_____/_____Social Security Number_____-_____-_____

ID Number: _____ Insured's Employer: _____

Group Number: _____Insurance Phone Number: _____

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Name: _____ DOB: _____

Any medical issues? _____

Current medications	**Dosages**	**Prescribed By**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past mental health medications

_____	_____	_____
_____	_____	_____

Social Supports (Friends/Family/Organizations):_____

_____

Leisure/Recreational Activities_____

_____

Previous Counseling? Yes No

When	**Provider**	**Reasons**
_____	_____	_____
_____	_____	_____

Family substance abuse_____

_____

Family history of mental illness_____

_____

Current Employer/School_____

Current Job Title: _____

Educational/Vocational Concerns_____

_____

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Name: _____ DOB: _____

In the past 2 months have you experienced any of the following (circle as many as apply):

sadness	irritability	withdrawing from others/activities
eating less	eating more	sleeping more
sleeping less	problems with memory	problems with concentration
loss of energy	feeling worthless/guilty	mood swings
worries	avoiding situations	nightmares
can't turn your thoughts "off"	anger outbursts	disorganization
losing things	easily distracted	problems completing tasks
impulsivity	problems sitting still	defiance
conflict with family or friends		

Have you EVER had a time in your life when you experienced any of the following:

panic attack	being much more active than usual	not able to sleep (but not tired)
talking more than usual	felt extremely/unusually happy	feel your thoughts are racing
had very poor judgment	spent too much money	feel "invincible"

Alcohol Use: Amount_____ How Often:_____

Tobacco Use: Amount_____ How Often:_____

Marijuana Use: Amount_____ How Often:_____

Any other non-prescription drugs:

Name_____ Amount_____ How Often:_____

Name_____ Amount_____ How Often:_____