Colorado ANGER Solutions

(Please Print) Today's date: _____

CLIENT INFORMATION (FOR ALL CLIENTS)

Client Name (First, Middle Initial, Last)	Marital status D Single D Married	Sex D M D F	Birth date
Street address	City, State, and Zip Code		
Home Phone	Cell Phone	Email	
Occupation	Employer or School	Primary Care Physician	
Who referred you to this practice?	Have you seen our website? D Yes D No	General Health Status	
Any previous counseling? With whom?			
List all medications			

Emergency Contact	Relationship to client	
Home phone	Cell Phone	Work Phone
Responsible for Payment	Home Phone	Cell Phone
Street address	City, State, and Zip Code	

IF MARRIED

Spouse's Name (First, Middle Initial, Last)	Birth date	Cell Phone
Occupation	Employer or School	Work Phone

IF A MINOR

Mother's Name	Occupation	Employer
Street Address	City, State, and Zip Code	
Home Phone	Cell Phone	Work Phone
Father's Name	Occupation	Employer
Street Address	City, State, and Zip Code	
Home Phone	Cell Phone	Work Phone
Siblings (first & last names and ages)		

The above information is true to the best of my knowledge.

Patient/Guardian signature Date

Payment due at time of service

Disclosure Statement
Colorado Anger Solutions, LLC
7851 South Elati, Suite 203
Littleton, CO 80120

The State of Colorado requires that psychotherapy and psychiatric clinicians provide clients with certain information about the psychotherapy process. Please take the time to read this page carefully, ask about any matters that seem unclear, initial where indicated, initial where indicated, and sign the back page of the statement. Signing this form indicates you agree to and understand the policies of Colorado Anger Solutions. A copy will be placed in your files.

REGULATION OF PSYCHOTHERAPISTS

The practice of icensed and 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.

As to the regulatory requirements applicable to mental health professionals: 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 masters 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 licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1,000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelors degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical masters degree and meet the CAC III requirements. A registered psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.

As licensed therapists and registered counselors we desire to integrate sound psychological, medical, and spiritual principles in your treatment. You are entitled to receive information from your counselor about the methods of therapy, the techniques used, the duration of your therapy and the fee structure. You can seek a second opinion from another counselor or terminate counseling at any time. Counselors/clinicians need to be informed if you are working with more than one counselor.

In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

Generally speaking, the information provided by the client during therapy is legally confidential and cannot be released without the client's consent. If the information is legally confidential, the counselor cannot be forced to disclose the information without the client's consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statues, as well as other exceptions in Colorado and Federal law. For example, **mental health providers are required by law to report cases of child neglect or physical/sexual abuse to County Child Protective Services. Additionally, if any individual becomes dangerous to himself/herself or others, or is incapable of caring for himself/herself, confidentiality will be broken in order to arrange for appropriate care.** If a legal exception arises during therapy, if feasible, you will be informed accordingly. The Mental Health Practice Act (CRS 12-43-101, et seq.) is available at: http://www.dora.state.co.us/mental-health/Statute.pdf.

DISCLOSURE REGARDING DIVORCE AND CUSTODY LITIGATION

If you are involved in divorce or custody litigation, my role as a counselor 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 interest of the family's children.

I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the client's responsible party.

_____

SCHEDULING POLICIES
Initial intake sessions are 30 minutes. Group sessions are 90 minutes. Standard individual counseling sessions are 50 minutes. Please call 303-295-8010 or email info@coloradoangersolutions.com, or go to www.coloradoangersolutions.com to schedule or cancel appointments.

Payment Policies: *Please read and* ***INITIAL each item:***

____1. PAYMENT IS DUE ON THE DAY OF YOUR COUNSELING SESSION.

____2. Fees are $60 per 30-minute initial consultation, $45 per 90-minute group session, and $110 per 50-minute individual session. Longer sessions will be charged on a prorated basis of the normal hourly fee. **There will be a $25.00 charge for returned checks.**

____3. The full session fee is charged for MISSED appointments and cancellations not made 24 HOURS IN ADVANCE

____4. Colorado Anger Solutions is out-of-network coverage for insurance companies; therefore, it is the client's responsibility to file with their insurance provider for reimbursement. After full payment, **CAS** will provide an itemized statement for you to file with your insurance. If insurance does not reimburse as anticipated, it is the client's responsibility to address the issue with their insurance provider.

____5. Fees for auxiliary services are pro-rated and charged at the regular hourly session fee. This includes (not limited to) written reports, insurance correspondence, phone calls exceeding 10 minutes, court appearances and school meetings (including travel time).

IF YOU ARE EXPERIENCING A LIFE-THREATENING EMERGENCY, CALL 911 OR GO TO THE NEAREST HOSPITAL EMERGENCY ROOM.

By signing below, I acknowledge I have read the preceding information, understand my rights as a client and agree to counseling under these conditions.

_
Name of Client (s) PLEASE PRINT

_
Signature of Client(s) or Legal Guardian **Date**

Colorado ANGER Solutions

Client Contact Information for Messages and Written Correspondence

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made to alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Colorado Anger Solutions has permission to contact me at the following: (check all that apply)

☐ Home telephone # _____
☐ OK to leave a message with detailed information
☐ OK to leave a message with other family members

☐ Cell Phone # _____
☐ OK to leave a message with detailed information
☐ OK to leave a message with person answering

☐ Work Telephone # _____
☐ OK to leave a voicemail message with detailed information
☐ OK to leave a message with _____

Written Communication

☐ OK to mail to my home address
☐ OK to mail to my work address:
☐ OK to fax to this number: _____
☐ OK to email to this address: _____
☐ Other _____

-

Client Signature Printed Name Date

Anger Management Group Policies

1. **New members** wishing to join a group will be interviewed by one of the CAS counselors in an individual counseling appointment prior to entering the group. This gives your group counselor an opportunity to know your current issues and background and allows you an opportunity to get acquainted with our anger management program. The cost of the initial consultation is **$60 for a 30-minute appointment**. You may begin attending group as soon as you have completed the initial consultation.

2. **Cost of group** is $45 per session, payable at the beginning of each session. We require a $45 deposit (check or credit card) that will only be used if you fail to cancel 24 hours prior to the beginning of the next session.
    a. Checks can be made to Colorado Anger Solutions (CAS) and given to the group counselor at the beginning of the session.
    b. There is no direct billing with any insurance company. Many of the costs of outpatient psychotherapy are covered by health insurance. Please check with your insurance company for information regarding your coverage.

3. **Length:** All group members make a commitment to attend weekly for **a minimum of 12 sessions** to promote stability of the group and to give themselves time to achieve their therapeutic goals. Groups meet one time per week for 90 minutes.

4. **Attendance:** Each member commits to consistent attendance and to coming to sessions on time. For group, you are allowed one excused missed session without charge each calendar month. Excused absences require notification at least 24 hours prior to the group. All other group sessions (or any unexcused absences) are your financial responsibility. As long as you pay for group sessions your space will be held for you whether you attend or not. However, excessive absences may prevent you from remaining in the group. Please consult with the group counselor if you plan to miss group frequently.

5. **Homework:** The group will involve an expectation of reading assignments and/or written assignments. Please set aside time each week to complete the assigned work.

6. **Participation:** All group members are expected to present to the group on occasion concerning what they are working on as part of the group. Group members are also expected to participate in the weekly check in.

7. **Confidentiality.** Each member commits to strict confidentiality regarding what others disclose in the group. What is said in the group stays in the group.

8. **Termination:** When members are ready to terminate from the group they are encouraged to discuss with their counselor and with the group at least two weeks ahead of time. This gives the group members time to go through an appropriate goodbye process. This notice allows you to leave well, having an experience of completion with the group and your group counselor.

I have read, understood, and agree to all group policies.

Client Signature **Therapist Signature**

Client Printed Name **Date**

ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the form of payment you wish to use for any services rendered through this practice. The following forms of payment are accepted: Visa, MasterCard and Discover. Service fees will be deducted from the designated account at the time services are rendered.

Client Information:

Client Name: _____ Date of Birth: _____

Address: _____ City_____ State: _____ Zip: _____

Home Number: _____ Mobile Number: _____

Cardholder Information:

Please indicate the name and address associated with the credit or debit card you wish to use.

Name: _____

Address: _____ City_____ State: _____ Zip: _____

Email: _____

I authorize any service fees to be deducted from the credit or debit card ending in _____ (provide the last four digits of the card).

_____ _____

Cardholder Signature **Date**

Credit/Debit Card Information:

Please provide your payment information below. The debit or credit card information you provide on this form will be destroyed once your first payment has been made.

Card Type (circle one): ☐ Visa ☐ MasterCard ☐ Discover

Card Number: _____

Expiration Date: _____