Colorado Center *for* Assessment & Counseling
KNOWLEDGE *to* THRIVE

phone 970-889-8204
fax 888-494-3756
web coloradocac.com

office 3500 John F. Kennedy Pkwy
Suite 200
Fort Collins, CO 80525

AGREEMENT/INFORMED CONSENT

I consent to enter treatment or a psychological evaluation, for either myself or my child, with the staff at the Colorado Center for Assessment & Counseling. I understand therapy or an evaluation is a joint effort between the clinician and client, the results of which cannot be guaranteed. Progress depends on many factors including motivation, effort, and other life circumstances. I agree that I will be responsible for the payment of all professional fees. I know I can end my relationship with my clinician at any time I wish and I can refuse any requests or suggestions made by my clinician.

By signing below, I am indicating that I have read, understand, and agree to the information contained in the Office Policies or Group Participation Agreement document, and I have received and reviewed a copy of this office's "Notice of Policies and Practices to Protect the Privacy of Your Health Information." These forms are all available on our website. A printed version is available upon request.

My clinician has verbally reviewed the following with me:

- Limits to confidentiality (harm to self or others, mandated reporting, legal situations, and public safety)
- Policies regarding unpaid balances, late cancellations, and no show fees based upon insurance provider

I acknowledge that I have received the information listed above from my clinician at Colorado Center for Assessment & Counseling. I also understand that it is very important that I read this information carefully before our next session. I understand that I can discuss any questions I have about the procedures at that time.

____

Client or Parent Signature Client or Parent Printed Name Date

____

Therapist Signature Date

INSURANCE AUTHORIZATION/RELEASE OF INFORMATION

(Signature necessary only if using insurance to pay for services) *By signing below, I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of insurance benefits to the party who accepts assignment (Colorado Center for Assessment & Counseling).*

____

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Late Cancellation and No Show Policy

Intake Appointments: $150 fee for cancellations less than **48 hours or 2 business days** before the appointment.

Therapy Appointments: $75 fee for cancellations with less than **24 hours or 1 business day** before the appointment and is unable to reschedule within the business week *according to clinician availability*. Appointments on Saturday and Monday must be canceled by **8 am the Friday before the appointment**.

Every therapy client gets **one "freebie" late cancellation every three calendar months** and we will not process a fee. The only other circumstance when we routinely waive the fee is for adverse weather. This is determined by Poudre School District, CSU, or the client's local school district closing for adverse weather. Late cancellations due to emergency situations are handled on a case-by-case basis and may require additional documentation. If a client is late **by 30 minutes** or more, it will be considered a late cancellation and rescheduled. If a client arrives for a session in an intoxicated state that is deemed unconducive to constructive therapy by their clinician, their clinician reserves the right to refuse services and charge a cancellation fee.

Evaluation Appointments: $500 fee for cancellations less than **48 hours or two business days** before testing day appointments.

No Shows: If a client misses an appointment without any notification prior to the appointment start time, a no-show fee is **automatically** applied. The no-show fee is equal to the clinician's full session rate ($_____). Prior notification requires getting in touch with the clinician or the office staff **before** the session start time.

There are **no** routine fee waivers for missed appointments. However, if the clinician is able to get in touch with a client during the appointment time, and a phone session is deemed appropriate, a phone session can then be held with no fee charged. Missed appointments due to emergency situations will be handled on a case-by-case basis and may require additional documentation.

Repeated cancellations/No Shows: In the event that a client frequently cancels or misses appointments (i.e., 3 late cancels or no-shows in a row), developing a plan to avoid future recurrences will be handled by each clinician on a case-by-case basis. Actions may include no longer holding a designated appointment time for the client until a commitment to attendance is demonstrated or consideration of treatment termination until a future time when the client is more committed to treatment.

Clients with Medicaid Coverage: Medicaid guidelines do not allow Medicaid clients to be charged for late cancellations or missed appointments. As a result, clinicians are not paid for canceled or missed appointments with Medicaid clients. For Medicaid clients we have the following policy:

- ❏ First late cancellation or missed appointment: The clinician will contact the client to troubleshoot the situation.
- ❏ Second late cancellation or missed appointment: The clinician will discuss strategies to mitigate the recurrence. This may include losing a regularly scheduled appointment time until the clinician decides to reinstate this option.
- ❏ Third late cancellation or missed appointment: It will be assumed the client is no longer interested in services at our agency. Should this not be the case, the situation will be handled on a case-by-case basis.

How to Cancel an Appointment: Clients are offered two different options for canceling appointments. You may email or call our office staff (contact@coloradocac.com; 970-889-8204), or you may email or call your individual clinician.

I hereby certify that I have read and agree to the CCAC Late cancellation & No Show Fee Policy:

____ _____________
Client or Parent of Client Signature Date

____ _____________
Clinician Signature Date

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PAYMENT AUTHORIZATION FORM

Client Name: ____ Date of Birth: ____/____/_______

Clients With Private Insurance or Direct Pay

The Colorado Center for Assessment & Counseling requires a credit or debit card on file for all services. We will NOT charge this card without your permission, EXCEPT in the following cases (please initial below to indicate an understanding of these circumstances):

- Late cancellations or appointment no-shows: ________ **Initial Here**
- Your bill is more than 90 days past due, without alternative arrangements in place: ________ **Initial Here**

Medicaid Clients (If you have Medicaid for your insurance provider, please read and initial here instead of above.)

Clients with Medicaid are not allowed to be charged fees for cancelations or missed appointments. However, we still require a card on file. Most of our services are fully covered by Medicaid; however, occasionally there will be a copay for some clients/services. In the event that a service is not fully covered, or that your coverage lapses, you will be charged if you have a balance that is over 90 days past due (without alternative arrangements in place). ________ **Initial Here**

Payment Processing for Appointments and Ongoing Sessions

For your convenience, our practice will save this card in our secure payment portal and process a payment automatically for any copayments, co-insurances, or other session balances owed on an ongoing basis. Please let us know if you want to pay with cash or with a check for sessions. ________ **Initial Here**

Late Cancelation Policy (the full policy is listed in our Office Policies Document found on our website: www.coloradocac.com/forms)

Our practice applies fees for late cancelations and no shows that are not able to be rescheduled within a business week as follows:

- Intake Appointment: Applied for cancelations/no shows within 48 hours or 2 business days. ($150 fee)
- Therapy/Follow Up Sessions: Applied for cancelations/no shows within 24 hours or 1 business day. ($120 fee)
- Testing Day Appointment: Applied for cancelations/no shows within 48 hours or 2 business days. ($500 fee)

If a client is late **by 30 minutes** or more to an appointment, it will be considered a late cancelation and rescheduled. Emergency situations will be handled on a case-by-case basis and may require additional documentation. ________ **Initial Here**

For Office Staff to Complete at Your Intake Appointment Check In:

Card Type: ❑ Visa ❑ MasterCard ❑ Discover ❑ AMEX Last 4 digits of card: ________
Date scanned or manually entered into the secure payment portal: ___/___/______ Staff Member Initials: _________

By signing, I authorize Colorado Center for Assessment & Counseling to use and store my credit/debit card information to charge my credit/debit card. I understand that this card will be charged for either late cancellations, no-shows, and past due balances, as outlined in the Office Policies Document. My signature also indicates that I will inform my clinician and/or office staff of any changes to my billing information over the course of our work together.

____

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DEMOGRAPHIC FORMS-CHILD THERAPY

General Information

Today's Date: ___/___/_______ Child's Date of Birth: ___/___/_______ Child's Age: _______
Child's Full Name: ____
Mailing Address: ____
City: ____ State: ________ ZIP: _________________

Phone: Home: ____________________________ Is it okay to leave a detailed message at this number? Yes ___ No ___
Cell: ______________________________ Is it okay to leave a detailed message at this number? Yes ___ No ___

Emergency contact or parent/guardian name: ____
Phone #: ________________________ Email Address: ____

E-Mail Address: ____
Do I have your consent to email an appointment reminder prior to sessions? Yes ___ No ___
Do I have your consent to email digital copies of:
1) Records: Yes ___ No ___
2) Billing statements: Yes ___ No ___

We would like to invite you to join our CCAC email list! We will only send emails when we have new services to share with you like: new therapy groups, new individual/couple/family therapy offerings, or new evaluation specialty areas. You would only receive an email from us approximately once per month or less. We will never send you spam or sell/share your email address. You will be able to unsubscribe from our mailing list at any time.

____ Yes, I would like to receive email updates on new CCAC service offerings.
____ No, I would prefer not to receive email updates on new CCAC service offerings.

Please tell me a little more about your child:
Gender (pronouns): ____
Sexual orientation: ____
Ethnicity: ____
Spiritual beliefs: ____
Disability (if any): ____
School & Grade: ____
Handedness: ____

Please list the reason(s) for referral or primary concerns that led you to seek therapy at this time:
____
____
____

Who referred you to our service? Please provide contact information: ____
____

Is this referral a result of or related to any legal or court proceedings? If so, please provide name of attorney.
____

Academic History

Does your child have an IEP or 504 Plan, or any other modified learning program? **Yes No**
Please check any services child currently receives through an IEP or 504 Plan (if applicable):

____ Speech therapy ____ Occupational therapy ____ Physical therapy
____ Adaptive PE ____ Tutoring ____ Pull-out services (math, reading, writing)

What are your child's typical grades? ____
What are your child's strongest and weakest points, academically?
____

Developmental/Medical History

Medical History

Yes No Has your child's medical history been normal/unremarkable? If no, please explain: _______________________
____

Yes No Has your child received any medical diagnoses? Please specify: ____
____

Yes No Has your child had genetic testing?
Yes No Has your child had an MRI?
Yes No Has your child had an EEG?
Yes No Frequent ear infections?
Yes No Were ear tubes ever placed?
Yes No Hearing problems?
Yes No Vision problems?
Yes No Headaches?
Yes No Meningitis?
Yes No Seizures?
Yes No Asthma?
Yes No Slow/fast growth?
Yes No Head injury?
Yes No Allergies?
Yes No Hospitalizations? Describe below.
Yes No Physical/Sexual Abuse?

If yes to any of the above, please describe: ____
____

Has your child ever been hospitalized, had surgeries, or major illnesses?

Age	*How long*	*Reason*
____	________________	____
____	________________	____

What medications does your child currently take? (Include over-the-counter supplements)

Name	*Dose*	*Frequency*	*Reason*
_________________________	___________	___________	_________________________________
_________________________	___________	___________	_________________________________
_________________________	___________	___________	_________________________________

Describe your child's sleep routine:

Typical bed time: ___________
Typical wake time: ___________

Trouble falling asleep? **Yes No**
Trouble staying asleep? **Yes No**
Trouble waking up early? **Yes No**

Any other sleep problems? Explain: ____
____

Describe your child's diet: ____
____

Describe your child's current level and type(s) of exercise: ____
____

Mental Health History

Has your child had previous psychotherapy services or counseling in the past? **Yes No**
If Yes: Name of Provider: _______________________________________ Dates? __________________________
Name of Provider: _______________________________________ Dates? __________________________

Is your child seeing a psychiatrist for medication? **Yes No**
Name of Psychiatrist: ____ Dates: _______________________
Medication the Psychiatrist Prescribed: ____

Is there any history of self-harm or suicidal thoughts, threats, or attempts? Please Explain: _________________
____
____

List any previous or current mental health diagnoses: ____
____
____

Psychosocial Functioning

Describe the child's personality: ____
____
____

What are your child's non-academic strengths? ____
____

What are your child's non-academic weaknesses? ____
____

How does the child spend his/her free time? ____
____

In what community or extracurricular activities is your child involved? _______________________________
____
____

Any concerns about child's social group/friends? Explain: ____
____
____

Any concerns about substance use? Explain: ____
____

Please place a mark next to behaviors that you believe your child exhibits to an *excessive or exaggerated degree* when compared to other children his or her age.

Sleeping and Eating

- ❑ Nightmares
- ❑ Trouble falling asleep
- ❑ Trouble staying asleep in the morning
- ❑ Decreased need for sleep without getting tired
- ❑ Excessive snoring during sleep
- ❑ Eats Poorly
- ❑ Eats excessively

Social Development

- ❑ Prefers to be alone
- ❑ Excessively shy or timid
- ❑ More interested in objects than people view
- ❑ Difficulty making friends
- ❑ Teased by other children
- ❑ Bullies other children
- ❑ Excessive daydreaming and fantasy life

Motor Skills

- ❑ Poor fine motor coordination
- ❑ Poor gross motor coordination
- ❑ Generally "clumsy

Other Problems

- ❑ Bladder control problems
- ❑ Poor bowel control (soils self)
- ❑ Any history of motor/vocal tics
- ❑ Overreacts to noises
- ❑ Overreacts to touch
- ❑ Problems with taste or smell

Behavior

- ❑ Stubborn
- ❑ Irritable, angry, or resentful
- ❑ Frequent tantrums
- ❑ Strikes out at others
- ❑ Throws or destroys things
- ❑ Lying
- ❑ Stealing
- ❑ Argues with Adults
- ❑ Low frustration threshold
- ❑ Daredevil behavior
- ❑ Runs away
- ❑ Needs a lot of supervision
- ❑ Doesn't empathize with others
- ❑ Overly trusting of others
- ❑ Doesn't appreciate humor
- ❑ Impulsive (does things without thinking)
- ❑ Poor sense of danger
- ❑ Skips school
- ❑ Seems depressed
- ❑ Cries frequently
- ❑ Excessively worried and anxious
- ❑ Overly preoccupied with details
- ❑ Overly attached to certain objects
- ❑ Not affected by negative consequences
- ❑ Drug use
- ❑ Alcohol use
- ❑ Sexual activity, behavior, or sexual talk
- ❑ Not sought out for friendship by peers
- ❑ Difficulty seeing another person's point of view

Family History

Parents are (choose one): **Married** **Separated** **Divorced** **Living Together**

If separated or divorced; how old was the child when the separation occurred? ____________________________________

Child lives with (choose one): **Both parents** **Mother** **Father** **Other**

Who has legal custody? ____

Who else lives in the home? ____

<u>Biological Mother</u>: Current age: ___________

Name: ______________________________

Occupation: __________________________

Highest grade completed: _______________

<u>Biological Father</u>: Current age: ___________

Name: ______________________________

Occupation: __________________________

Highest grade completed: ______________

If child is adopted...

Adoption source: ____

Reason and circumstances: ____

Age when child first in home: _________________ Date of legal adoption: ____________________________

What has the child been told regarding the adoption?

____

Have any of the following conditions occurred among the child's blood relatives (parents, aunts, uncles, grandparents)? Check all that apply:

- ❑ Allergies
- ❑ Amnesia
- ❑ Asthma
- ❑ ADHD/ADD
- ❑ Bleeding tendency
- ❑ Depression/Bipolar disorder
- ❑ Cancer
- ❑ Suicide
- ❑ Dyslexia or math struggles
- ❑ Deafness
- ❑ Diabetes
- ❑ Glandular problems
- ❑ Heart diseases
- ❑ High blood pressure
- ❑ Kidney disease
- ❑ Alcohol/drug problem
- ❑ Anxiety/OCD/Panic
- ❑ Tics
- ❑ Autism/Asperger's
- ❑ Intellectual disability/cognitive delay
- ❑ Seizures
- ❑ Cerebral Palsy
- ❑ Migraines
- ❑ Muscular Dystrophy
- ❑ Other (specify): __________________________

Legal History

Has the child been involved with the court currently or in the past? ____
Date(s): ____
Describe:____
____
____

Current Probation? **Yes No** Probation Officer: _______________________ Phone #: _________________________

Is there any other pertinent information to your child's therapy that you would like to include here? Do you have any questions you would like to ask your child's therapist at your intake appointment? (This section can be left blank):

____
____
____
____
____
____
____
____
____
____
____
____
____
____