Cirque Meadow Psychiatry, PLLC
Contracted by Colorado Center for Assessment and Counseling
Virginia Mack, MN, PMHNP-BC
3500 John F. Kennedy Parkway, Suite 200
Fort Collins, CO 80521
Phone- (970) 889-8204 ext. 511
Fax: (888) 494-3756
Office Hours: Varies, please call for appointment times

DISCLOSURE STATEMENT AND SERVICES AGREEMENT

Thank you for choosing Cirque Meadow Psychiatry, PLLC ("CMP") for your psychiatric care. I appreciate the opportunity to provide you with professional services, including psychiatric evaluation, medication management, and brief psychotherapy. At all times it is important that you have a clear understanding of why you are receiving services and how we are assisting you in your mental health treatment. You are encouraged to ask for clarification if you have any questions. This Disclosure Statement and Services Agreement is intended to provide you with important information about our office policies, practices and procedures prior to your receipt of mental health services. Please review it carefully.

We will ask you to sign this document indicating that you have read, understood and accepted this Agreement and the other documents included. You can revoke this Agreement in writing at any time. We will consider your written revocation request binding unless CMP has taken action in reliance on the agreement or you have not satisfied outstanding financial obligations to CMP.

Practice/Provider Information

Ms. Mack is licensed by the State of Colorado as both a Registered Nurse (RN) and as an Advanced Registered Practice Nurse (ARNP) with prescriptive authority. Her ARNP license number is APN.0990068-NP. Her RN license number is RN.0197671. She holds Board Certification from the American Nursing Credentialing Center as an Adult Psychiatric Mental Health Nurse Practitioner. This adult age focus allows her to provide psychiatric treatment to individuals 13 and older. She earned her Bachelors of Arts in Nursing from St. Olaf College and her Master's Degree in Nursing from the University of Washington School of Nursing with a graduate specialty in Advanced Practice Nursing in Psychiatry. Ms. Mack's therapeutic orientation includes but is not limited to: brief integrative/holistic therapy, motivational interviewing, and medication management. She is licensed by the State of Colorado to prescribe medications within her specialty and scope of practice.

Right to Refuse Treatment and Choose Treatment Approach

You have the right to refuse treatment at any time, and the responsibility for choosing the provider and treatment approach which best suits your needs, including requesting a different type of treatment, a different clinician, or a referral to other care.

Ms. Mack, your psychiatry provider, is required to inform you of the proposed course of treatment. You have the right to discuss with your psychiatry provider their approach to therapy and medication management, the purpose and nature of any proposed evaluation or course of treatment you will receive, and what problem or issue this evaluation or treatment is intended to address. You have the right to request that a truthful, understandable, and reasonably complete account of your condition be provided to you or those responsible for your care.

You can expect that the first appointment will be an opportunity for you and Ms. Mack to evaluate both the therapeutic relationship, the initial psychiatric evaluation, and then determine whether you will continue to work together. Neither of you is obligated to do so. If Ms. Mack determines that you will not be able to work together effectively or if you would prefer not to continue in treatment, Colorado Center for Assessment and Counseling ("CCAC") will coordinate with Ms. Mack to provide referrals to other qualified professionals.

If a third party such as an insurance company is paying for all or part of your treatment, Ms. Mack/CCAC may be required to provide the third party with a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). If Ms. Mack is required to supply a diagnosis, she will discuss it with you.

Non-Discrimination

Colorado law prohibits Ms. Mack from engaging in unfair discrimination based on age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis prescribed by law.

Referrals and Communication with Other Providers

Ms. Mack may suggest that you consult with another health care provider in furtherance of your mental health treatment. If you are seeing another health care provider, Ms. Mack may ask that you sign a document authorizing her to communicate and share information with that provider in furtherance of your treatment. You have the right to refuse to authorize this communication.

Confidentiality

Everything you say to Ms. Mack in furtherance of her treatment of you is confidential and will not be disclosed to anyone, except in the following circumstances:

- ❑ You authorize the disclosure in writing, or in the event of your death or incapacity.
- ❑ Your personal representative authorizes the disclosure in writing.
- ❑ You bring professional licensing charges against Ms. Mack.
- ❑ Ms. Mack has reasonable cause to believe that a child has suffered abuse or neglect or that a vulnerable adult has suffered abandonment, abuse or neglect and is therefore required to make a report to state or local authorities under CO law (C.R.S 19-3-304, C.R.S 18-6.5-108).
- ❑ It is necessary for Ms. Mack to disclose information to law enforcement or County Designated Mental Health Professionals in order to prevent you from harming yourself or another person.
- ❑ You state that you are going to harm another person, in which Ms. Mack must attempt to warn that person and inform law enforcement.
- ❑ You report that another health care provider licensed in Colorado has engaged in sexual misconduct, other unprofessional conduct, or is impaired from practicing safely, in which case Ms. Mack must inform the Colorado Department of Health.
- ❑ It is necessary for Ms. Mack to disclose the information to your insurance company or other third-party payers in order to obtain payment for services provided to you.
- ❑ Disclosure of the information is needed to determine compliance with state or federal licensing, certification or registration laws or to investigate unprofessional conduct, or to protect the public health.
- ❑ Ms. Mack is compelled to disclose the information by a subpoena or court order.

In addition, Colorado's Health Care Information Act allows Ms. Mack to disclose certain otherwise confidential information to any person or health care provider/facility/law enforcement, without your consent, in order to avoid or minimize imminent danger to your health and safety or that of another person.

If you elect to communicate with Ms. Mack by email, please be aware that this is not a completely confidential means of communication. The internet service provider may retain a copy of each email in its internal logs.

Record Keeping

Ms Mack keeps records through a secure electronic charting system, Therapy Notes, which is shared by clinicians and staff at CCAC. The notes include the date of service, topics discussed, and interventions which occurred during the session. This is your clinical record. The content of your clinical record is confidential and is securely stored. Any confidential information transmitted electronically will be fully encrypted. If you prefer that Ms. Mack keep no records other than the date of service, you must request in writing that she do so.

You have the right to restrict what information from your record is disclosed to others, to inspect and obtain copies of your record, or to request that Ms. Mack provide you with a list ("an accounting") of how she disclosed information. Under Colorado Health Care Information Act, you have the right to request that Ms. Mack allow for a summary of care or complete release of records. Ms. Mack may deny your request under certain circumstances, which are described in the Health Care Information Act. If you request a copy of your record, it is recommended that you first review it with Ms. Mack so that you can obtain clarification if needed.

Medication Refills

If you are an existing client who has been seen within the past two months and you are in need of a medication refill, <u>please contact your pharmacy directly with your request</u> (medication name and dosage), and the pharmacy will subsequently send a refill request to Ms. Mack's office. Allow up to three (3) business days for processing. Refills will not be provided on an emergency basis. If "prior authorization" is required by your pharmacy, the process may require ten (10) days or more.

If you are a new client, Ms. Mack's best practice through CCAC is to see you for at least three consecutive visits before authorizing refills. As a general rule, refills should be coordinated with your next appointment.

Refills requested outside your appointment will be charged $25.

Ms. Mack generally does not provide refills for lost or stolen prescriptions, particularly Schedule II medications (controlled substances). If a police report is filed showing documentation of stolen prescription, Ms. Mack will provide a prescription according to the documentation provided (estimated quantity of tablets/capsules) remaining.

Stimulant medications (ex. Vyvanse, Adderall, Concerta, Ritalin) indicated for ADHD treatment, are Schedule II medications which must be refilled each month, cannot be refilled by fax or phone, and require a written prescription pick up. Routine clinical monitoring during stimulant treatment is necessary at least every 3 months to reassess dosage, tolerability, adherence to medication and reassess the condition in addition to other comorbid conditions common with ADHD (anxiety, substance use, depression). Early refills requests will not be approved under no condition.

Electronic Communication

Per CCAC policy for appt reminder notification, agreement to receive emails, and these points for Ms. Mack for psychiatric care:

- Email is not a secure, confidential form of communication so material that a client transmits by electronic communication cannot be ensured to meet HIPAA regulations governing the privacy of your health information
- Referral requests, medication handouts, cognitive-behavioral techniques, psycho-educational handouts, medication refill requests (remember $25 fee to request refill outside of appointment time) are appropriate forms of communication via electronic communication
- Submission of forms/medical records/labs/etc from a previous provider or outside treatment provider can be submitted via fax or hand-delivered to Ms.Mack at time of appointment
- All electronic communication will be a part of your medical record while under the care of Ms. Mack
- Replies to email may not be prompt and can vary in turnaround time. For prompt response, concerns about current treatment course and medication management, please call (970) 889-8204 ext 511 to notify Ms. Mack or seek out urgent mental health treatment through 24/7 Riverside walk-in clinic (970) 494-4200 or for immediate crisis, call 911 if life-threatening situation.
- Substantial changes in treatment plan, clinical guidance, and diagnostic considerations will not be provided via electronic communication with Ms. Mack. Phone calls can occur with medical management/treatment guidance (see fees).

Client Responsibilities

Timeliness: You are responsible for arriving on time for your session, at the scheduled time. For an initial evaluation, sessions are 90 minutes. If you arrive late, the session will end at the previously scheduled time, so that the next scheduled session is not disrupted. Late charges/cancelation fees will be determined per CCAC policy.

Initial intake evaluations are scheduled by appointment through the CCAC for Ms. Mack on Wednesdays. Follow up appointments, typically 30 or 45 minutes, are scheduled at the end of your appointment with Ms. Mack.

Termination: Treatment is generally terminated when you and Ms. Mack mutually agree that sufficient progress has been made towards your psychiatric treatment goals. If you are dissatisfied or do not feel your treatment is effective, or if you feel that you would like to work with another provider, please let Ms. Mack know. If at any time during your treatment Ms. Mack determines that, in her judgment, her training and skills are not appropriate to address the issue you are facing, she will inform you of this and provide you with referrals to another provider who can better meet your needs.

You will be discharged from care, and your provider/client relationship with Ms. Mack will end, if for any reason you do not return two (2) phone calls, or if you miss four (4) appointments without 24 hours advance notice in a six (6) month period.

Cancelation Policy: When an appointment time is set for you, that time has been reserved for you specifically and CCAC is unable to fill a canceled session unless there is adequate notice. You will therefore be charged per the CCAC cancelation policy (full session fee; note that insurance does not cover missed or late-canceled appointments) if you miss an appointment, for any reason and do not provide 24 hours cancelation notice. Ms. Mack does not charge for sessions canceled with at least 24 hours notice. You are encouraged to reschedule appointments whenever possible, because consistency in care is important. Late cancelation/no show fees will be charged and payable through the CCAC staff.

If weather is inclement and local schools are closed, no cancelation fees will be charged. CCAC follows the closure schedules for Poudre School District and Colorado State University.

Ms. Mack respects your time. If due to unforeseen circumstances you are required to wait more than 15 minutes to begin your session, you will not be charged for the session.

Charges for Sessions

Initial Evaluation (90 minutes):	$265
Follow up Medication Management sessions (30 minutes):	$95
Follow up Medication Management sessions (45 minutes):	$140
Follow up Medication Management sessions (60 minutes):	$180
Refill requests outside of appointment	$25
Medication side effect-related calls	No charge

Phone calls exceeding brief (5 minutes in length) will be charged per CCAC policy ($25/per 15 minutes) and per medical call coding guidelines.
*You will be informed in advance of any change in rates for services listed.

Billing Practices

Fees, including copays, are payable to CCAC at the time of treatment. If any portion of the fee will be submitted to your insurance for payment, you will be expected to provide CCAC with your insurance information, obtain any necessary preauthorization for services, and pay any portion (e.g. deductible, co-pay) that is not paid by insurance.

Emergency Contacts

Ms. Mack will inform you in advance of any anticipated lengthy absences and give you the name and phone number of any covering psychiatry provider during her absence. If you experience an emergency while Ms. Mack is absent, or outside of her regular office hours, please call the 24/7 hour mental health crisis line for assistance: (970) 494-4200 or 1-844-493-TALK (8255) toll free to provide immediate support, solutions and resources. If you or someone you know are experiencing a mental health emergency or substance use crisis, please go straight to Summitstone 24/7 Walk-In Services, 1217 Riverside Avenue, Fort Collins, CO 80524 for professional support. If you believe that you cannot keep yourself safe, please call 911 or go to the nearest hospital emergency room for assistance.

Department of Health Contact Information

As a licensed professional I am accountable for my work. Should you feel that I have been unethical or unprofessional, please talk to me about it. If you have complaints or grievances concerning the services you receive, you may also contact the Colorado Department of Regulatory Agencies, Division of Professions and Occupations, which has an online form, via phone (303) 894-7800, or by mail 1560 Broadway, Suite 1350, Denver, Colorado 80202.

I acknowledge I have read the above information. I have had sufficient time to ask any questions, and I understand the information. Copies of this document and attached handouts have been provided to me. I understand my rights and responsibilities as a client and my clinician's responsibilities to me. I agree to abide by the terms of this document and the attached handouts during my professional relationship with Ms. Mack and CMP. I agree to pay all charges billed. I agree to undertake psychiatric treatment with Virginia Mack, MN, ARNP. I know that I can end psychiatric treatment at any time and that I can refuse any requests or suggestions.

Client/Parent Printed Name	Signature of Client/Responsible Party	Date

Virginia Mack, MN, ARNP	Signature	Date

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

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.

Client or Parent Signature Client or Parent Printed Name Date

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

PSYCHIATRIC DEMOGRAPHIC FORM-ADULT

General Information

Full Name: _____ Today's Date: ____/____/_____ Date of Birth: ____/____/_____
Street Address (include ZIP code): _____
Phone Numbers:
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 _____

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 such as: 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.

Emergency Contact: _____ Phone #: _____

Please tell us a little more about yourself:
Gender (pronouns): _____
Sexual orientation: _____
Ethnicity/Cultural identity: _____
Spiritual beliefs: _____
Disabilities (any): _____
Occupation and/or School & Major: _____
Handedness (right/left/ambidextrous): _____

Please list the reason(s) you are seeking this evaluation: _____
_____

How long have these problems occurred? (number of weeks, months, years): _____

Who referred you to our practice? 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.
_____

Have you had previous neuropsychological testing? Yes _____ No _____
If Yes, where? _____ When? _____
Have you had any additional testing (e.g., psychoeducational, speech/language?) Yes _____ No _____
If Yes, where? _____ When? _____
**If you answered Yes to either of the above questions, please attach or otherwise provide report(s).*

Please list any other healthcare providers involved in your care (e.g., neurologists, other physicians, occupational therapists, etc.): _____
_____

Developmental/Medical History

Pregnancy and Birth (your own, not your children's – leave blank if unknown)

Pregnancy/Birth/Delivery Complications? Please Describe: _____
_____

Medications used during pregnancy? _____

Did your mother engage in any of the following during pregnancy?

Yes No Smoking?How much? _____
Yes No Drug intake? Type? _____ How much? _____
Yes No Alcohol consumption? How much? _____

Length of pregnancy?
(weeks): _____
Age of mother at birth: _____
Birth weight: _____lbs. _____oz.
Birth length: _____
APGAR scores? _____/_____

Type of delivery (check please): _____spontaneous _____induced _____cesarean _____with instruments _____breech

Any complications for mother or infant (yourself) after birth? Please explain:
_____
_____
_____

Developmental Milestones

Yes No Did you enjoy cuddling?
Yes No Were you fussy or irritable?
Yes No Were you more active than other babies?
Yes No Was your development significantly different than your siblings? If yes, please explain: _____
_____

At what age did you first do the following (indicate with year and month of age).

_____ Turn Over _____ Crawl _____ Stand Alone _____ Walk Alone
_____ Walk Upstairs _____ First Words _____ First Phrases

Toilet Trained during the day by age 5? Yes _____ No _____
Did bed wetting or soiling occur after training? _____ Wetting _____ Soiling If yes, until what age? _____

Did you have any speech difficulties? _____
Motor difficulties (e.g. clumsiness)? _____

Medical History

Has your medical history been normal/unremarkable? Yes _____ No _____
If no, please explain: _____
_____
_____

Have you received any medical diagnoses? Yes _____ No _____
Please explain: _____
_____
_____

Circle All that Apply:

Yes No Have you completed genetic testing?
Yes No Have you had an MRI?
Yes No Have you 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?
Yes No Have you experienced anything you would call traumatic (physical, verbal, or emotional abuse; unwanted sexual experiences; accidents or other events)?

Have you ever been hospitalized, had surgeries, or major illnesses?

Age	*How long*	*Reason*
_____	_____	_____
_____	_____	_____
_____	_____	_____

What medications do you currently take? (Include over-the-counter supplements)

Name	*Dose*	*Frequency*	*Reason*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe your 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 diet: _____
_____

Describe your current level and type(s) of exercise: _____
_____
_____

Mental Health History

List any previous or current mental health diagnoses: _____
_____

Have you received therapy services or counseling in the past? **Yes No**

Name of provider: _____ Dates: _____
Name of provider: _____ Dates: _____
Name of provider: _____ Dates: _____

Are you seeing a psychiatric clinician (Psychiatrist, Nurse Practitioner, Physician Assistant) for medication? **Yes No**
Have you in the past? **Yes No**

Name of Clinician: _____ Dates of treatment: _____
Medication(s) Prescribed: _____

Is there a history of self-harm or suicidal thoughts, threats, or attempts? Please explain: _____
_____

Have you ever been hospitalized for mental health concerns? Please explain: _____
_____

Do you have a history of angry outbursts? **Yes No**
If yes, please explain: _____

Have you ever physically assaulted another person, animal, or object? **Yes No**
If yes, please explain: _____

Psychosocial Functioning

Describe your personality: _____
_____
_____

What are your non-academic strengths? _____

What are your non-academic weaknesses? _____

How do you spend your free time? _____
_____
_____

What is your current level of alcohol and/or drug use?

Alcohol: _____ Recreational drugs: _____

How is your social group? Do you have close friends? Any trouble initiating or maintaining relationships?
_____
_____
_____
_____

Please place a mark next to behaviors that you believe you experience to an *excessive or exaggerated degree* when compared to others your age.

Behavior
- ❑ Stubborn
- ❑ Irritable, angry, or resentful
- ❑ Strikes out at others
- ❑ Throws or destroys things
- ❑ Lying
- ❑ Stealing
- ❑ Argues with others
- ❑ Low frustration threshold
- ❑ Daredevil behavior
- ❑ Impulsive (does things without thinking)
- ❑ Trouble empathizing with others
- ❑ Overly trusting of others
- ❑ Does not appreciate humor
- ❑ History of vocal or motor tics
- ❑ Poor sense of danger/risk
- ❑ Cries frequently
- ❑ Excessively worried and anxious
- ❑ Overly preoccupied with details
- ❑ Overly attached to certain objects
- ❑ Not affected by negative consequences
- ❑ Drug use
- ❑ Alcohol use

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

Social
- ❑ Prefer to be alone
- ❑ Excessively shy or timid view
- ❑ More interested in objects than people
- ❑ Difficulty making friends
- ❑ Not sought out for friendship by peers
- ❑ Excessive daydreaming and fantasy life
- ❑ Difficulty seeing another person's point of view
- ❑ Trouble empathizing with others
- ❑ Overly trusting of others
- ❑ Does not appreciate humor

Motor Skills
- ❑ Poor fine motor coordination
- ❑ Poor gross motor coordination
- ❑ "Clumsy" in general

Academic History

Did you ever have an IEP or 504 Plan, or other modified learning program or participation in special education services when younger? **Yes No**

If yes, please describe: _____
_____
_____

What was your high school GPA: _____
What was/is your college GPA: _____
Grad school GPA: _____

How do you generally perform on standardized tests? _____
_____

What are your strongest and weakest points, academically? _____
_____

Legal History

Have you been involved with the court currently or in the past? _____
Date(s): _____
Describe: _____
_____
_____

Currently on Probation? **Yes No** Probation Officer: _____ Phone #: _____

Family History

Are you (choose one): **Married** **Living Together** **Separated** **Divorced** **Single**

If married, for how long? _____
If separated or divorced, when? _____
Do you have children? Ages? _____
Who else lives in your home? _____
_____

Have any of the following diseases occurred among your blood relatives (parents, aunts, uncles, grandparents)? Check all that apply:

- ❑ Allergies
- ❑ Amnesia
- ❑ Asthma
- ❑ ADHD/ADD
- ❑ Bleeding tendency
- ❑ Depression
- ❑ Cancer
- ❑ Suicide
- ❑ Learning problems
- ❑ Deafness
- ❑ Diabetes
- ❑ Glandular problems
- ❑ Heart diseases
- ❑ High blood pressure
- ❑ Kidney disease
- ❑ Alcohol/drug problem
- ❑ Anxiety
- ❑ Autism/Asperger's
- ❑ Intellectual disability/ cognitive delay
- ❑ Seizures
- ❑ Cerebral Palsy
- ❑ Migraines
- ❑ Muscular Dystrophy
- ❑ Bi-polar Disorder
- ❑ Schizophrenia
- ❑ Other (specify): _____

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

AUTHORIZATION TO RELEASE INFORMATION

Client Name: _____ Date of Birth: _____

I understand that the purpose of this release is to increase communication between Colorado CAC providers and other care providers or significant individuals relevant to myself/my child/my family. By signing this release, I authorize the Colorado CAC to release the following information:

- ☐ Acknowledgement of treatment only
- ☐ Relevant diagnostic and treatment information
- ☐ Progress notes or other treatment/evaluation records

I authorize Colorado CAC staff to release this information to the following individuals/agencies: (Please provide any contact information including phone numbers and email addresses of the specific persons involved)

1)_____
2)_____
3)_____
4)_____

In addition, I authorize the above individuals/agencies to release the following information to the Colorado CAC:

- ☐ Acknowledgement of treatment only
- ☐ Relevant diagnostic and treatment information
- ☐ Progress notes
- ☐ Educational records/information
- ☐ Prior Hospitalizations (Visits, Inpatient/Outpatient, Detox/Substance Use Disorder Treatment)
- ☐ Psychiatric Records

I understand that I can revoke this authorization at any time except to the extent that it has already been acted upon. Otherwise, this authorization will expire exactly one year from the undersigned date.

_____

Client/child Signature Printed Name Date

_____

Parent/guardian name Relationship Date

I witness that the above individual freely gave his/her consent but was unable to physically sign.

_____

Witness Name Printed Name Date

Mood Disorder Questionnaire (MDQ)

Name: _____ Date: _____

Instructions: Check (✓) the answer that best applies to you.
Please answer each question as best you can.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	◯	◯
...you were so irritable that you shouted at people or started fights or arguments?	◯	◯
...you felt much more self-confident than usual?	◯	◯
...you got much less sleep than usual and found you didn't really miss it?	◯	◯
...you were much more talkative or spoke faster than usual?	◯	◯
...thoughts raced through your head or you couldn't slow your mind down?	◯	◯
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	◯	◯
...you had much more energy than usual?	◯	◯
...you were much more active or did many more things than usual?	◯	◯
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	◯	◯
...you were much more interested in sex than usual?	◯	◯
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	◯	◯
...spending money got you or your family in trouble?	◯	◯
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? *Please check 1 response only.*	◯	◯
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ◯ No problem ◯ Minor problem ◯ Moderate problem ◯ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	◯	◯
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	◯	◯

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005