Consent for Treatment

I consent to evaluation and mental health treatment for myself, my minor child or ward. I am aware that care and treatment is not an exact science and acknowledge that no guarantees have been made to me as to the result of treatment. I also understand that Louann Hillesland is not a crisis therapist. If you have a life threatening emergency, you need to call the Suicide and Crisis Hotline 1(303)860-1200, the police (911), or go to your nearest emergency room. I understand that if Louann Hillesland thinks that I need more intensive services I will be referred to a therapist or organization that has the ability to provide treatment to meet those needs. I also understand that Louann Hillesland will not testify in court as an expert witness, including: divorce, child custody, or criminal cases.

Client Rights

1. You have the right to terminate treatment at any time.
2. Your rights as an individual will be respected at all times without regard to race, color, creed, age, sex, sexual orientation, or political affiliation.
3. You have the right to know the cost of your treatment.
4. You have the right to review and have your therapist review your treatment plans at any time.
5. Your right to confidentiality does not preclude your therapist from reporting information pertaining to a crime committed by you in the office or against another client in treatment with you.
6. Sexual contact between client and therapist is never appropriate.

Exceptions to Confidentiality

1. If you threaten to harm yourself or someone else.
2. If you know of ongoing and current child or elder abuse.
3. If the therapist or her files are subpoenaed by the court.

Consent for Follow-up Contact

I hereby grant permission for my therapist to contact me after my discharge from services to obtain information for research purposes only. All information will be considered confidential.

_____

Client Signature Date

_____

Signature of Parent/Legal Guardian Date

_____

Intake Form for Children and Adolescents

Client's name: _____Date: _____

Gender: ___ F ___ M Date of birth: _____Age: _____ Grade in school: _____

Form completed by (if someone other than client): _____

Address: _____City: _____ State: _____Zip: _____

Phone (home): _____(work): _____ (cell):_____

If you need any more space for any of the following questions please use the back of the sheet.

Primary reason(s) for seeking services:

__ Anger management_ _ Anxiety ___ Coping ____ Depression

__ Eating disorder ____ Fear/phobias ___ Sexual concerns

__ Sleeping problems ___ _____ Alcohol/drugs_

__ Addictive behaviors

__ Other mental health concerns (specify): _____

Parents

With whom does the child live at this time? _____

Are parent's divorced or separated? _____

If yes, who has legal custody? _____

Were the child's parents ever married? Yes No

Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling? No Yes

If Yes, describe: _____

Client's Mother

Name: _____ Age: _____Occupation: _____

Where employed: _____

Mother's education: _____ __

Is there anything notable, unusual or stressful about the child's relationship with the mother?

__ Yes _ No If Yes, please explain: _____

_____

How is the child disciplined by the mother? _____

For what reasons is the child disciplined by the mother? _____

Client's Father

Name: _____Age: ____ Occupation:_____

Where employed: _____Father's education: _____

Is there anything notable, unusual or stressful about the child's relationship with the father?

__ Yes __ No If Yes, please explain: _____

_____

How is the child disciplined by the father? _____

For what reasons is the child disciplined by the father? _____

Client's Siblings and Others Who Live in the Household

Names of Siblings	Age	Gender	Lives	Quality of relationship with the client
_____	___	___ F ___ M	___ home _____ away	___ poor ___ average ___ good
_____	___	___ F ___ M	___ home _____ away	___ poor ___ average ___ good
_____	___	___ F ___ M	___ home _____ away	___ poor ___ average ___ good
_____	___	___ F ___ M	___ home _____ away	___ poor ___ average ___ good

Others living in The household			Relationship (e.g., cousin, foster child)	
_____	___	___ F ___ M	_____	___ poor __ average __ good
_____	___	___ F ___ M	_____	___ poor __ average __ good
_____	___	___ F ___ M	_____	___ poor __ average __ good
_____	___	___ F ___ M	_____	___ poor __ average __ good

Comments: _____

_____

_____

School Related:

Current Grade: _____ Teacher: _____

School Counselor: _____

In special education? _____ Yes _____ No If Yes, describe: _____

In gifted program? _____ Yes _____ No If Yes, describe: _____

Has child ever been held back in school? Yes _No If Yes, describe: _____

Which subjects does the child enjoy in school? _____

Which subjects does the child dislike in school? _____

What grades does the child usually receive in school? _____

Have there been any recent changes in the child's grades? _____ Yes _____ No

If Yes, describe: _____

Has the child been tested psychologically? _____ Yes _____ No

If Yes, describe: _____

Check the descriptions which specifically relate to your child.

Feelings about School Work:

__ Anxious ___ Passive ___ Enthusiastic ___ Fearful

__ Eager ____ No expression ___ Bored ___ Rebellious
__ Other (describe): _____

Approach to School Work:
__ Organized ___ Industrious ____ Responsible ____ Interested
__ Self-directed ___ No initiative ____ Refuses ____ Does only what is expected
__ Sloppy ___ Disorganized ____ Cooperative ____ Doesn't complete assignments
__ Other (describe): _____

Performance in School (Parent's Opinion):
__ Satisfactory ___ Underachiever ___ Overachiever
__ Other (describe): _____

Child's Peer Relationships:
__ Spontaneous ____ Follower ___ Leader ____ Difficulty making friends
__ Makes friends easily ____ Long-time friends ___ Shares easily
__ Other (describe): _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.)

Activity	How often now?	How often in the past?

Nutritional

Meal	How often (Times per week)	Typical foods eaten	Typical amount eaten
Breakfast	____ / week		__ Low __ Med ___ High
Lunch	____ / week		__ Low __ Med ___ High
Dinner	____ / week		__ Low __ Med ___ High
Snacks	____ / week		__ Low __ Med ___ High

Comments: _____

Medical

Most recent examinations

Type of examination	Date of most recent visit	Results
Physical examination		
Dental examination		
Vision examination		
Hearing examination		

Medications:

Current prescribed	Dose	Dates	Purpose	Side effects

Over-the-counter	Dose	Dates	Purpose	Side effects

Chemical Use History

Does the child/adolescent use or have a problem with alcohol or drugs? ___ Yes _____ No

If Yes, describe: _____

_____

Counseling/Prior Treatment History

Information about child/adolescent (past and present):

	Yes	No	When/Where	Reaction or experience
Counseling/Psychiatric Treatment_				
Suicidal thoughts/attempts_____				

Do you believe the child is suicidal at this time? _____ Yes _____ No

If yes, explain: _____

Drug/alcohol treatment _____

Hospitalizations_____

Behavioral/Emotional

Please check any of the following that are typical for your child:

___ Affectionate	___ Frustrated easily	___ Sad
___ Aggressive	___ Gambling	___ Selfish
___ Alcohol problems	___ Generous	___ Separation anxiety
___ Angry	___ Hallucinations	___ Sets fires
___ Anxiety	___ Head banging	___ Sexual addiction
___ Attachment to dolls	___ Heart problems	___ Sexual acting out
___ Avoids adults	___ Hopelessness	___ Shares
___ Bedwetting	___ Hurts animals	___ Sick often
___ Blinking, jerking	___ Imaginary friends	___ Short attention span
___ Bizarre behavior	___ Impulsive	___ Shy, timid
___ Bullies, threatens	___ Irritable	___ Sleeping problems

__ Careless, reckless
__ Chest pains
__ Clumsy
__ Confident
__ Cooperative
__ Cyber addiction
__ Defiant
__ Depression
__ Destructive
__ Difficulty speaking
__ Dizziness
__ Drugs dependence
__ Eating disorder
__ Enthusiastic
__ Excessive masturbation
__ Expects failure
__ Fatigue
__ Fearful
__ Frequent injuries
___ Lazy
___ Learning problems
___ Lies frequently
___ Listens to reason
___ Loner
___ Low self-esteem
___ Messy
___ Moody
___ Nightmares
___ Obedient
___ Often sick
___ Oppositional
___ over active
___ Overweight
___ Panic attacks
___ Phobias
___ Poor appetite
___ Psychiatric problems
___ Quarrels
___ Slow moving
___ Soiling
___ Speech problems
___ Steals
___ Stomach aches
___ Suicidal threats
___ Suicidal attempts
___ Talks back
___ Teeth grinding
___ Thumb sucking
___ Tics or twitching
___ Unsafe behaviors
___ Unusual thinking
___ Weight loss
___ Withdrawn
___ Worries excessively
___ Other:
_____
_____

Please describe any of the above (or other) concerns: _____

_____

How problem behaviors are generally handled? _____

_____

What are the family's favorite activities? _____

_____

What does the child/adolescent do with unstructured time? _____

_____

Has the child/adolescent experienced death? (Friends, family, pets)
Yes No What age? _____ If yes, describe the child's/adolescent's reaction: _____

_____

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)
__ Yes ___ No If Yes, describe: _____

_____

Any additional information that you believe would assist us in understanding your child/adolescent?

_____

_____

What are your goals for the child's therapy? _____

_____

Agreement Regarding Minors

The issue of confidentiality is critical in treating children. Children seen in individual sessions (except under certain conditions) are not legally entitled to confidentiality (also called privilege); their parents have this right. However, unless children feel they have some privacy in speaking with a therapist, the benefits of therapy may be lost. Therefore, it is necessary to work out an arrangement in which children feel that their privacy is generally being respected, at the same time that parents have access to critical information. This agreement must have the understanding and approval of the parents or other responsible adults and of the child in therapy.

- Confidentiality and privilege are limited in cases involving child abuse, neglect, molestation, or danger to self or others. In these cases, the therapist is required to make an official report to the appropriate agency and will attempt to involve parents as much as possible.
- Minors may independently enter into therapy and claim the privilege of confidentiality in cases involving abuse or severe neglect, molestation, pregnancy, or communicable diseases, and when they are on active military duty, married, or officially emancipated. They may seek therapy independently for substance abuse, danger to self or others, or a mental disorder, but parents must be involved unless doing so would harm the child.
- Any evaluation, treatment, or reports ordered by, or done for submission to a third party such as a court or a school is not entirely confidential and will be shared with that agency with your specific written permission. Please also note that I do not have control over information once it is released to a third party.

Now that the various aspects surrounding confidentiality have been stated, the specific agreement between you and your child/children follows:

I, (name) _____(relationship to child) _____

I, (name) _____(relationship to child) _____

Agree that my/our child/children

(Name) _____

(Name) _____

(Name) _____

have privacy in his/her/their therapy sessions, and I agree to allow this privacy except in extreme situations, which I will discuss with the therapist.

I will do my best to ensure that therapy sessions are attended and will not inquire about the content of sessions. If my child prefers/children prefer not to volunteer information about the sessions, I will respect his/her/their right not to disclose details. Basically, unless my child has/children have been abused or is/are a clear danger to self or others, the therapist will normally tell me only the following:

- whether sessions are attended
- whether or not my child is/children are generally participating
- whether or not progress is generally being made

If I believe there are significant health or safety issues that I need to know about, I will contact the therapist and attempt to arrange a session with my child/children present. Similarly, when the therapist determines that there are significant issues that should be discussed with parents, every effort will be made to schedule a session involving the parents and the child/children.

Because my role is that of the child's helper, I will not become involved in legal disputes or other official proceedings unless compelled to do so by a court of law. Matters involving custody and mediation are best handled by another professional who is specially trained in those areas rather than by the child's therapist.

Signature: _____
_____ Date: _____/_____/_____

Signature: _____
_____ Date: _____/_____/_____

Therapist Signature: _____

HIPPA

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.

Our Legal Duties

State and Federal laws require that we keep your records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide by these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information

Information about you may be used by Louann Hillesland for diagnosis, treatment planning, treatment, and continuity of care. She may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, or business affiliates such as insurance providers, billing, or audits.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of this clinic not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Public Safety
Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

Abuse
If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

Prenatal Exposure to Controlled Substances
Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Professional Misconduct
Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings
Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Other Provisions
When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures.

In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

About Client Rights

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice for licensed psychologists, licensed social workers, licensed professional counselors, licensed marriage and family therapists, certified school psychologists, and unlicensed individuals who practice psychotherapy.

The agency within the Department that has responsibility specifically for licensed and unlicensed psychotherapists is the State Grievance Board, 1560 Broadway, Suite 1340, Denver, Colorado, 80802, (303)894-7766.

Client Rights and Important Information:

a. You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of therapy (if I can determine it), and my fee structure. 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 State Grievance Board.

d. Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the therapist is a certified school psychologist, a licensed clinical social worker, a licensed marriage and family therapist, a licensed professional counselor, or an unlicensed psychotherapist practicing under the supervision of a licensed psychotherapist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent.

e. Information disclosed to a certified school psychologist, a licensed clinical social worker, a licensed marriage and family therapist, a licensed professional counselor, or an unlicensed

psychotherapist practicing under the supervision of a licensed psychotherapist, is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

f. There are legal exceptions to the general rule of legal confidentiality. These exceptions are listed in the Colorado Statutes (see section 12-43-218, C.R.S., in particular) There are legal exceptions to the general rule of legal confidentiality. The exceptions include: intent to harm others or yourself; abuse or suspected abuse of children, and possibly the abuse of the elderly or others unable to care for themselves; neglect or suspected neglect of children; subpoenaed testimony in criminal court cases, and orders to violate privilege by judges in child-custody, divorce and other court cases. Also, be aware that, except in the case of information given to a licensed psychologist, legal confidentiality does not apply in a criminal or delinquency proceeding. There are other exceptions that I will identify to you as the situations arise during therapy.

g. I agree to pay $110.00 for each psychotherapy appointment. Psychotherapy is provided in a 50 minute clinical hour instead of a 60 minute clock hour.

h. I agree to pay $40.00 for a group appointment. Maximum group size is 8 individuals. Group sessions are 90 minutes.

As A Psychotherapy Client I Understand That

I understand that Louann Hillesland will not (at the request of the client) testify in court as an expert witness, including divorce, child custody, or criminal cases. I understand that Louann Hillesland will not release information to or communicate with another therapist, (holding any scholastic degree), a child advocate an attorney or any other professional requiring confidential therapy information. This applies even if the client authorizes, with a written or verbal request, the release of Louann Hillesland's confidential client files. I understand that my personal client file belongs to my therapist.

If my therapist is subpoenaed by the Court, I understand that court testimony on my behalf is charged at $250.00 per hour including: testimony related matter like case research, report writing, travel depositions, actual testimony, and cross examination time and courtroom waiting time. Signing this disclosure statement gives permission for me to release confidential information in courtroom testimony and written reports to the Court if legally requested.

I consent to evaluation and mental health treatment for myself, my minor child or ward. I am aware that care and treatment is not an exact science and acknowledge that no guarantees have been made to me as to the result of treatment.

I understand that Louann Hillesland is not a 'crisis' therapist. If I have a life threatening emergency, I will call the Suicide and Crisis Hotline 1(303)860-1200, the police (911) or go to an emergency room. I understand that if my therapist thinks I need more intensive services I will be referred to a therapist or organization that has the ability to provide treatment to meet those needs.

I understand that my psychotherapist provides non-emergency psychotherapeutic service by scheduled appointment. If my psychotherapist believes my psychotherapeutic issues are above and beyond her level of competence, or outside of her scope of practice, she is legally required to refer, terminate or consult.

I understand that there may be times when my psychotherapist may need to consult with a colleague or another professional, like an attorney, about issues raised by me in therapy. My confidentiality is still protected during consultation by my psychotherapist and the professional consulted. Signing this disclosure statement gives my psychotherapist permission to consult as needed, to provide professional services to me as a client.

I understand that in marriage and family counseling, my psychotherapist holds a 'no secrets' policy. All members of the couple or family system are treated equally and 'secrets' are not kept by the psychotherapist that require differential or discriminatory treatment of family members. I understand that any information shared in individual therapy MUST be also shared in couple or family therapy to insure this 'no secrets' policy. Signing this disclosure statement affirms permission to share this confidential information among family members.

I understand that if I have any questions or would like additional information, I may ask during the initial session and any time during the psychotherapy process. By signing this disclosure statement I also give permission for the inclusion of my partners, spouses, significant others, parents, legal guardians, or other family members in psychotherapy when deemed necessary, by myself or my therapist.

I understand that I am legally responsible for payment for my psychotherapy services.

I understand that if I do not give 24 hours prior notice of cancellation to my psychotherapist, I will be charged the full fee for not showing up for the scheduled psychotherapy appointment.

I understand that, like any other professional service, I must pay for all psychotherapy services (psychotherapy in the office, telephone therapy, report writing, consultation, parental consultation, etc.) I receive as a client. If I do not pay for services received I understand that the bill will be turned over to a collection agency to recover payment for my therapist. I also understand I must repay the full amount and any bank fees or other relevant costs to my therapist, for bounced checks.

Client Signature, Acknowledgement, Agreement, and Consent

I have read the preceding information and understand my rights as a client. By signing below I acknowledge my understanding and agree to all the terms discussed in this disclosure statement. By signing this disclosure statement, I also agree to permit supervision and consultation with other psychotherapists, or professionals as the need arises. I also affirm, by signing this form that I am the legal guardian and/or custodial parent with legal right to consent to treatment for any minor child or children that I am requesting psychotherapy services for, from Louann Hillesland.
If you have any questions or would like additional information please feel free to ask.

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

_____ _____
Client/patient signature date

_____ _____
Client/patient signature date

_____ _____

Therapist signature date

About My Psychotherapist: Louann Hillesland, MA, LPC, EMDR

I am a Licensed Professional Counselor in the State of Colorado and hold a Masters level degree in Counseling from Western New Mexico University in Silver City, New Mexico. In addition to private practice since 2005, I have taught healthy relationship and anger management/conflict resolution classes to adults, healthy choices to children and facilitated groups on many topics. I have counseled individuals at both an outpatient mental health center for adults, a local middle school, and a grade school in New Mexico.

Besides a Masters level counseling degree, I have a Bachelors of Science in education from the University of Northern Colorado. As an educator, I taught preschool, grade school, middle school and adult individuals, during a 26 year teaching career.

I specialize in Cognitive Behavioral Therapy, Eye Movement Desensitization and Reprocessing, (EMDR), and have experience working with people of all ages.

FINANCIAL CONTRACT

Standard Therapy Fees

I understand that I will be held financially responsible for payment of the services listed below. I understand that if I default on this contract I could be held responsible for all costs that may incur during an attempt to collect the unpaid portion of this agreement.

I also understand that I am expected to pay for the services at the time I receive such services unless other arrangements are made with my therapist.

____ initial

Individual Session (50 min) Fee:	$ 110
Couples Session (50 min) Fee:	$ 110
Group Session (90 min) Fee:	$ 40
Missed or Cancelled Appointment Fees	$ 110

I understand that the following fees will be incurred due to missed or cancelled appointments that are less than 24 hours from scheduled appointment time—regardless of the reason.

____ Initial

No Show Fee $110
Cancelled 0-24 hours Fee $110

Telephone Therapy Fees

I understand that the following fees will be incurred for unscheduled telephone therapy or consultation calls:

____ Initial

0-5 minutes No fees charged
5-15 minutes Fee $25 (payable at next scheduled session)
15-30 minutes Fee $60 (payable at next scheduled session)
30-50 minutes Fee $110 (payable at next scheduled session)

Therapist Rights

I understand that the therapist has the right to cancel appointments for any reason (including illness, emergencies, or poor weather).

_____ Initial

Please note that Louann Hillesland is not a crisis therapist. If you have a life threatening emergency, you will need to call the Suicide and Crisis Hotline 1 (303)860-1200, the police (911) or go to your nearest emergency room.

Client_____ Date_____

Client_____ Date_____

Therapist_____ Date_____