Bonnie Mucklow
Licensed Professional Counselor
7000 E. Belleview, Ste.203
Greenwood Village, CO 80111
720-488-3822 FAX: 303-798-3883

==========

DX_____

CLIENT INFORMATION

• Client Name_____
If the client is a child, put child's name here.

Address _____

City _____State _____Zip_____

Home Phone ( ) _____Work Phone ( ) _____

Client Date of Birth_____Client Social Security # _____

• In case of emergency, you may contact:

Name _____Phone ( ) _____ Relationship_____

• Name of Insured or EAP member: _____

Name of Insurance Company or EAP Employer _____

Member ID# _____Group #_____

Claims Address_____

Claims Phone # ( ) _____

Date of Birth _____

SECONDARY INSURANCE

• Secondary Insurance (if any)_____

Policy # _____ Group # _____

Guarantor Name _____Relationship _____

Address to send insurance claims: _____

Signature of Counselor_____Date_____

CLIENT APPLICATION FOR THERAPY

Client's Name

Please answer each question. On questions with circles, please fill in the circle that best describes your answer. Completely blacken the appropriate circle. Please use the back of this page if you need additional space.

1. What is the PROBLEM(S) that motivated you to seek therapy?

2. What is your GOAL(S) for therapy? What do you want to change through therapy?

3. On a scale of 1 to 10, where does your problem(s) fall? Circle number on the scale below.
Not so bad. 1 .....2 .....3 .....4.....5 .....6 .....7 .....8 .....9.....10 At its worst.

4. Of the following EXPECTATIONS for therapy, which are most important for you?

How important?	None	Minor	Major
• Non-judgmental listening and understanding	O	O	O
• Help focusing on goals to resolve the problem	O	O	O
·Active guidance, and suggestions on steps to take	O	O	O
• Reminders of past successes and personal strengths	O	O	O
• Resources (like books, groups, etc.,) that helped deal with the problem	O	O	O
• Validation of my feelings and a sense of caring	O	O	O
• Homework assignments to practice between sessions	O	O	O
• A different way of seeing myself and my situation	O	O	O
·Referral to a Psychiatrist for medication	O	O	O
• Other	O	O	O

5. How many sessions do you think you will need to work through your problem(s)? _____

6. Have you ever been hospitalized for psychiatric or chemical dependency problems? O Yes O No

7. At this time, how much do you agree with the following statements?

	Completely Disagree		Partly Agree		Completely Agree
- I am feeling good about myself, contented with positive self-esteem	O	O	O	O	O
• I am thinking clearly, able to concentrate, remember, and make decisions	O	O	O	O	O
• I have good health, few illnesses, energy, and few physical problems	O	O	O	O	O
• I am doing well at my job/school/home	O	O	O	O	O
• I am getting along with loved ones, friends, co-workers	O	O	O	O	O
• I am able to handle stress and relax	O	O	O	O	O
• I am not abusing alcohol or drugs	O	O	O	O	O

After reviewing the above information, I agree with the problem(s) definition, goals and expectations:

Signature of Client: _____ Date: _____

Signature of Counselor: _____ Date: _____

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FINANCIAL DISCLOSURE/AGREEMENT

*Name of Client or Clients:*_____

_____

_____

- *I agree that I am financially responsible for the cost of services provided to the above named client or clients.*
- *I agree that, if the client is insured, the provider will bill the insurance company, but I will remain responsible for co-pays, co-insurance, deductibles or amounts not covered by the policy.*
- *I promise to fully co-operate with the provider and the insurance company in the processing of claims submitted by the provider, and, if my failure to cooperate results in a claim being denied, I will pay the provider directly for those services.*
- *I agree that, if I fail to give the provider 24 hours notice of the need to cancel an appointment, I will pay the provider $65 for the missed session.*
- *I agree that co-pays are due at the time of each appointment.*
- *I agree that, if I pay the provider with a check which is returned to her because of insufficient funds, I will reimburse the provider for bank charges.*
- *I understand that, if I fail to pay any statement within 90 days, the account will be turned over to a collection agency.*

*Signature*_____ *Date*_____
No one under 18 may sign this agreement.

*Signature*_____ *Date*_____
No one under 18 may sign this agreement.

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CONSENT FOR TREATMENT

I voluntarily consent to participate in mental health and/or substance abuse services.

Signature_____ Date_____
Underline What Is Applicable: Client, Parent or Guardian, Participating Friend or Family Member

Signature_____ Date_____
Underline What Is Applicable: Client, Parent or Guardian, Participating Friend or Family Member

Signature_____ Date_____
Underline What Is Applicable: Client, Parent or Guardian, Participating Friend or Family Member

Signature_____ Date_____
Underline What Is Applicable: Client, Parent or Guardian, Participating Friend or Family Member

Signature_____ Date_____
Underline What Is Applicable: Client, Parent or Guardian, Participating Friend or Family Member

Signature_____ Date_____
Underline What Is Applicable: Client, Parent or Guardian, Participating Friend or Family Member

****

Whom may we thank for referring you to us?

Name & address:_____

_____

May we have your permission to send the referring agency or individual a thank you?

____Yes ____No

MEDICAL HISTORY QUESTIONNAIRE PI

I. MEDICAL HISTORY:

YES	NO	Please check (/) YES or NO for each item. If YES, furnish details, including date and name of doctor.
		1. During the last 5 years, have you:
YES	NO	A. Been treated for any medical condition or surgical condition? (specify)
YES	NO	B. Had an X-Ray, EKG, or laboratory test? (specify)
YES	NO	C. Been advised to have an operation? (specify)
		D. Date of last ical exam: Dr.
YES	NO	2. During the last 5 years, have you taken any prescription or ron-prescription MEDICATIONS? Medication: Dosage Date started Date ended Prescribing MD:
YES	NO	3. Do you have any ALLERGIES to medications, food, or other? (specify)
YES	NO	4. Have you had any HOSPITALIZATIONS (medical or psychiatric)? Year of Hospitalization(s): Hospital name Reason for Hospitalization Length of Stay
YES	NO	5. Do you drink CAFFEINE products (coffee, tea, soda)? How much?
YES	NO	6. Do you SMOKE? How much?
YES	NO	7. Do you drink ALCOHOL? How much and how often?
YES	NO	8. Except as prescribed by an M.D., have you taken any of the following DRUGS? (please indicate date of last use and typical amount) D heroin D morphine D sedatives D other narcotics D cocaine D tranquilizers D LSD, hallucinogens D amphetamines D marijuana D barbiturates D other drugs

II. FAMILY HISTORY INFORMATION:

	Living? (Y or N)	Age or Age at Death	History of Emotional Problem?	History of Medical Problem?	Describe Emotional Problem, Medical Problem, Cause of Death if noted
Father	y N		y N	y N	
Mother	y N		y N	y N	
Sister(s)	y N		y N	y N	
Brother(s)	y N		y N	y N	

MEDICAL HISTORY QUESTIONNAIRE P 2

Ill. REVIEW OF SYMPTOMS:

CUENT	Have Now	Had in Past	Symptom	Never Had	Have Now	Had in Past	Symptom
			sleep disturbance				tuberculosis
			dizziness or fainting				heart trouble / heart attack
			palpitations or pounding heart				high blood pressure
			shortness of breath				kidney disease
			chronic fatigue				stroke
			stomach pains				jaundice /liver disease
			chronic pain				arthritis / gout / rheumatism
			headaches (severe or often)				AIDS / HIV positive
			eating too much/too little				hypoglycemia
			tremor or shakiness				tumor / cancer
			indigestion, nausea, gas				rheumatic fever
			constipation, diarrhea, colitis				venereal disease
			recent weight O gain/ O loss				diabetes
							anemia
			nosebleeds				paralysis
			unusual bleeding				epilepsy / seizures
			eye problem/ glaucoma				neurological disease / neuritis
			hearing problem / earaches				lupus
			head injury				ulcer
			thyroid trouble (too low / high)				multiple sclerosis
			asthma				urination, painful or frequent
			chronic cough				stomach / bowel disease
			FEMALES: treated for any OB/GYN disorder or change in menstrual patterns?				
			FEMALES: currently pregnant or planning a pregnancy in the near future?				
			MALES: prostate trouble?				

• Please list any disease or condition, which you may have or have had that is not listed above, on the back of this form.

• Please provide information related to "yes" answers above, such as the date(s) of occurrence, duration, and name of doctor who treated you, on the back of this form.

Your medical history questionnaire will be reviewed by your therapist and by a psychiatrist if a referral is made. If your therapist or psychiatrist is concerned that a physical medical problem is contributing to your mental health problem or concerned that you may have a physical illness that demands immediate treatment. you will be referred to your primary care physician for further diagnosis and treatment. You are responsible for attending to your own medical conditions and following up on any recommendations made. Since your provider's recommendations will be based only on the information supplied by you in your answers to this questionnaire, please make sure you fully answer the questions and provide accurate information.

I have read and understand the above statement regarding my responsibility for providing accurate information and the limitation of follow-up referrals made based on information I supply.

Signature of Client _____ Date _____
(or parent or guardian if client is a minor)

Signature of Counselor _____ Date _____

Adolescent and Young Adult Behavioral Health and Infectious Disease Screen

People who come into substance use treatment may be at higher risk for exposure to infectious and communicable diseases. The purpose of this screen to inform you of risks and help you determine if you need additional medical testing. Under the federal regulations 42 CFR, Part 2, and HIPAA, your responses to this screen are protected and confidential. Protected health information cannot be disclosed without your written consent.

I have read and understand the above:_____Date:_____

Please circle yes, no or Idk= "I don't know" for each question

Have you seen a doctor or other healthcare provider in the last year? **No Yes Idk**

Are you able to access medical care when you do not feel well? **No Yes Idk**

FEMALES: Is it possible that you might be pregnant OR have you missed two or more periods? **No Yes**

1. Were you born to a mother diagnosed with hepatitis, HIV or AIDS? **No Yes Idk**
2. Have you ever lived on the streets, on someone's couch, or in a shelter? **No Yes**
3. Have you ever been told that you have Tuberculosis (TB)? **No Yes**
   (A positive skin test where you got a shot in your forearm and a few days later a hard bump like blister appeared?)
4. Within the last 30 days, has anyone you have known or lived with, been diagnosed with TB? **No Yes**
5. Have you ever lived in Africa, Asia, Eastern Europe, Russia or Latin America? **No Yes**
6. Have you had any of the following symptoms lasting for more than 2 weeks? **No Yes**
   If yes, circle those that apply.
   - Fever
   - Drenching night sweats that were so bad that you had to change clothes or bedding
   - Ongoing cough
   - Coughing up blood
   - Shortness of breath
   - Lumps or swollen glands in the neck or armpits
   - Losing weight without meaning to
   - Diarrhea (runs) lasting more than a week
7. Do you live with or have you had close contact with any one with these symptoms lasting for more than 2 weeks? **No Yes Idk**
   If yes, circle those that apply.
   - Fever
   - Drenching night sweats that were so bad that you had to change clothes or bedding
   - Ongoing cough
   - Coughing up blood
   - Shortness of breath
   - Lumps or swollen glands in the neck or armpits
   - Losing weight without meaning to
   - Diarrhea (runs) lasting more than a week
8. A. Have you ever used unsterile needles for: B. Have any of your sexual partners ever used unsterile needles for:
   (by unsterile, we mean, you did not see a package opened, you may not of been the only user of the needle or ink, or you received this in a jail or home)

Tattoos **No Yes, when:_____ Idk**	Tattoos **No Yes, when:_____ Idk**
Piercings **No Yes, when:_____ Idk**	Piercings **No Yes, when:_____ Idk**
Injecting drugs **No Yes, when: _____ Idk**	Injecting drugs **No Yes, when:_____ Idk**

9. Have you have ever snorted drugs or medications? **No Yes, when: _____**
10. Have you ever shared works such as needles, straws, bowls, dollar bills? **No Yes, when: _____**

Please consider any intercourse, including victimization, when answering questions 12-16.

Sexually Transmitted Infections (STI) might include: Hepatitis B & C, bacterial vaginosis (BV), genital herpes, HPV, genital warts, syphilis, gonorrhea, chlamydia, trichomonas, and/ or pubic lice ("crabs").

11. How many sexual partners have you had in the past? _____ *If N/A skip to question 18.*
12. How many of those where in the last 3 months?_____
13. What types of sex do you have with your partners? (*circle all that apply*) **vaginal, oral, anal? give? receive?**
14. Have you ever had sex (vaginal, anal, or oral contact) without a condom? **No Yes Idk**
    If "yes", what percentage of time do you have sex without a condom? _____
    (example: 100% would mean that you never use a condom; 0% would mean that you always use a condom)
15. Have you ever had sex with someone for anything like drugs, money, or a place to stay? **No Yes**
16. Have any of your sexual partners ever had sex with someone for anything like drugs, money, or a place to stay? **No Yes Idk**
17. Have any of your sexual partners had any of the following symptoms? **No Yes Idk**
    If "yes", circle those that apply:
    - Sore or ulcer on the penis/vagina
    - Rash, spots, or other skin problems, especially on the palms or soles of the feet
    - (Females) Unusual vaginal discharge
    - (Females) Pain with vaginal sex
    - (Males) Penal discharge
18. Have you had any of the following symptoms? **No Yes**
    If "yes", circle those that apply & indicate when you experienced this:
    - Sore or ulcer on the penis/vagina _____
    - Rash, spots, or other skin problems, especially on the palms or soles of the feet_____
    - (Females) Unusual vaginal discharge _____
    - (Females) Pain with vaginal sex _____
    - (Males) Penal discharge_____
19. A. Have you ever tested positive for:

    HepC **No Yes, when:**_____

    HIV **No Yes, when:**_____

    STI's **No Yes, when:** _____

    B. Have any of your sexual partners ever tested positive for:

    HepC **No Yes, when:**_____ **Idk**

    HIV **No Yes, when:**_____ **Idk**

    STI **No Yes, when:**_____ **Idk**

If "yes", have you received treatment? ***No Yes, when:*** _____

If you have answered "yes" to questions 1-19, you may be at higher risk for infectious diseases.
Testing is recommended to ensure your safety and the safety of any current or future sexual partners.

Stop: the below is for clinician use only

Screener Asks:

Do you have access to medical care to address any symptoms or concerns? **No Yes Idk**

Would you like help or a referral to medical services? **No Yes Idk**

Youth has been referred to _____ for follow up services. **N/A**

Screener (Clinician signature)_____ Date:_____

QUARTERLY REVIEW: Screener, ask client to read over the previous questions and answers.

Screener Asks:

Have any of the answers changed? **No Yes,** how? _____

Have you seen a doctor or other healthcare provider in the last year? **No Yes Idk**

Would you like help or a referral to medical services? **No Yes Idk**

Youth has been referred to _____ for follow up services. **N/A**

Screener (Clinician signature):_____ Date:_____

QUARTERLY REVIEW: Screener, ask client to read over the previous questions and answers.

Screener Asks:

Have any of the answers changed? **No Yes,** how? _____

Have you seen a doctor or other healthcare provider in the last year? **No Yes Idk**

Would you like help or a referral to medical services? **No Yes Idk**

Youth has been referred to _____ for follow up services. **N/A**

Screener (Clinician signature):_____ Date:_____

QUARTERLY REVIEW: Screener, ask client to read over the previous questions and answers.

Screener Asks:

Have any of the answers changed? **No Yes,** how? _____

Have you seen a doctor or other healthcare provider in the last year? **No Yes Idk**

Would you like help or a referral to medical services? **No Yes Idk**

Youth has been referred to ____________________________________ for follow up services. **N/A**

Screener (Clinician signature):_________________________________ Date:________________________

QUARTERLY REVIEW: Screener, ask client to read over the previous questions and answers.

Screener Asks:

Have any of the answers changed? **No Yes,** how? ____

Have you seen a doctor or other healthcare provider in the last year? **No Yes Idk**

Would you like help or a referral to medical services? **No Yes Idk**

Youth has been referred to ____________________________________ for follow up services. **N/A**

Screener (Clinician signature):_________________________________ Date:________________________

QUARTERLY REVIEW: Screener, ask client to read over the previous questions and answers.

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Have any of the answers changed? **No Yes,** how? ____

Have you seen a doctor or other healthcare provider in the last year? **No Yes Idk**

Would you like help or a referral to medical services? **No Yes Idk**

Youth has been referred to ____________________________________ for follow up services. **N/A**

Screener (Clinician signature):_________________________________ Date:________________________

QUARTERLY REVIEW: Screener, ask client to read over the previous questions and answers.

Screener Asks:

Have any of the answers changed? **No Yes,** how? ____

Have you seen a doctor or other healthcare provider in the last year? **No Yes Idk**

Would you like help or a referral to medical services? **No Yes Idk**

Youth has been referred to ____________________________________ for follow up services. **N/A**

Screener (Clinician signature):_________________________________ Date:________________________

QUARTERLY REVIEW: Screener, ask client to read over the previous questions and answers.

Screener Asks:

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Would you like help or a referral to medical services? **No Yes Idk**

Youth has been referred to ____________________________________ for follow up services. **N/A**

Screener (Clinician signature):_________________________________ Date:________________________

QUARTERLY REVIEW: Screener, ask client to read over the previous questions and answers.

Screener Asks:

Have any of the answers changed? **No Yes,** how? ____

Have you seen a doctor or other healthcare provider in the last year? **No Yes Idk**

Would you like help or a referral to medical services? **No Yes Idk**

Youth has been referred to ____________________________________ for follow up services. **N/A**

Screener (Clinician signature):_________________________________ Date:________________________

NOTICE CONCERNING THE USE AND DISCLOSURE OF CONFIDENTIAL INFORMATION PURSUANT TO HIPAA

FAMILIES AT FIVE
7000 E. Belleview, Ste 203
Greenwood Village, CO 80111
Phone: 720-488-3822 Fax: 303 798 3883

THIS NOTICE CONTAINS INFORMATION CONCERNING HOW CONFIDENTIAL MENTAL HEALTH TREATMENT INFORMATION CONCERNING YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND LET US KNOW ANY QUESTIONS THAT YOU MAY HAVE CONCERNING THIS NOTICE. During the process of providing services to you, FAMILIES AT FIVE will obtain and use mental health and medical information concerning you that is both confidential and privileged. Ordinarily, this confidential information will be used in the manner that is described in this statement, and will not be disclosed without your consent, except for the circumstances described in this Notice.

I. USES AND DISCLOSURES OF PROTECTED INFORMATION

A. General Uses and Disclosures Not requiring the Client's Consent.

FAMILIES AT FIVE (7000 E. Belleview, Ste 203, Greenwood Village, CO 80111) will use and disclose protected health information in the following ways.

1. *Treatment.* Treatment refers to the provision, coordination, or management of mental health care and related services by one or more health care providers in the same agency.

2. *Payment.* Payment refers to the activities undertaken by a healthcare provider to obtain or provide reimbursement for the provision of healthcare. For example, FAMILIES AT FIVE and other healthcare professionals will (1) use information that identifies you, including information concerning your diagnosis, services provided to you, dates of services, and services needed by you and (2) may disclose such information to insurance companies and to businesses that review bills for healthcare services and handle claims for payment of healthcare benefits in order to obtain payment for services. If you are covered by Medicaid, information may be provided to the State of Colorado's Medicaid Program, including, but not limited to, your treatment, condition, diagnosis, and services received.

3. *Healthcare Operations.* Healthcare operations means activities undertaken by health insurance companies, businesses that administer health plans, and companies that review bills for healthcare services in order to process claims for healthcare benefits. These include management and administrative activities. For example, such may use your health information in monitoring of service quality, staff training and evaluation, medical reviews, legal services, auditing functions, compliance programs, business planning and accreditation, certification, licensing and credentialing activities.

4. *Contacting the client.* FAMILIES AT FIVE may contact you to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.

5. *Required by law.* FAMILIES AT FIVE will disclose protected health information when required by law. This includes, but is not limited to: (a) when reporting child abuse or neglect to the

Department of Human Services or to law enforcement; (b) when releasing information pursuant to a court order; (c) when warning law enforcement and the targeted person of an imminent threat of physical violence made by the client against that person; (d) when hospitalizing a client who is imminently dangerous to himself/herself or to others or is gravely disabled for the purpose of obtaining a 72 hour evaluation of the client; and (e) when reporting a threat to the national security of the United States.

6. *Health oversite activities.* Your confidential, protected health information may be disclosed to health oversite agencies (1) for oversite activities authorized by law and necessary for the oversite of the healthcare system, government healthcare benefit programs, and regulatory programs or (2) for determining compliance with standards of such programs.

7. *Crimes on the premises or observed by personnel.* Crimes that are observed by FAMILIES AT FIVE staff or occur on FAMILIES AT FIVE premises will be reported to law enforcement.

8. *Business associates.* Confidential healthcare information concerning you, provided to insurers or to plans for purposes or payment for services that you receive may be disclosed to business associates. For example, FAMILIES AT FIVE may contract with some outside entities for the purpose of obtaining administrative, clinical, quality assurance, billing, legal auditing, and practice management services. In those situations, protected health information will be provided to those contractors as needed for them to perform the tasks contracted for. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.

9. *Research.* Protected health information concerning you may be used with your permission for research purposes if the relevant provisions of the Federal HIPAA Privacy Regulations are followed.

10. *Involuntary clients.* Information regarding clients who are, pursuant to law, being treated involuntarily will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed in compliance with Colorado law.

11. *Family members.* Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of that discussion. However, if the client objects, protected health information will not be disclosed.

12. *Emergencies.* In life threatening emergencies, FAMILIES AT FIVE staff will disclose information necessary to avoid serious harm or death.

B. Client's Release of Information or Authorization. Absent the exceptions noted in A and any other exception pursuant to federal or state law, FAMILIES AT FIVE may not use or disclose protected health information in any way without a signed release of information or authorization. When you sign a release of information or an authorization, it may later be revoked, provided that the revocation is in writing. A written revocation will take effect upon signing, except to the extent that FAMILIES AT FIVE has already acted in reliance on the signed release or authorization.

II. YOUR RIGHTS AS A CLIENT

A. Access to Protected Health Information. You have a right to receive a summary of confidential health information concerning mental health services needed or provided to you. There are some limitations to this right, which will be provided to you at the time of your request, if any such limitation applies. To make a request, ask FAMILIES AT FIVE staff for the appropriate request form.

B. Amendment of Your Record. You have the right to request that FAMILIES AT FIVE or your healthcare professionals amend your protected health information. FAMILIES AT FIVE is not required to amend the record if it is determined that the record is accurate and complete. There are other exceptions, which will be

provided to you at the time of your request, if relevant, along with the appeal process available. To make a request, ask FAMILIES AT FIVE staff for the appropriate request form.

C. Accounting of Disclosures. You have the right to receive an accounting of certain disclosures FAMILIES AT FIVE has made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment, or healthcare operations. In addition, the accounting does not include disclosures made to you, disclosures made pursuant to a signed authorization, or disclosures made prior to April 14, 2003. There are other exceptions that will be provided to you, should you request an accounting. To make a request ask FAMILIES AT FIVE staff for the appropriate request form.

D. Additional Restrictions. You have the right to request additional restrictions on the use or disclosure of your health information. FAMILIES AT FIVE does not have to agree with that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. To make a request ask FAMILIES AT FIVE staff for the appropriate request form.

E. Alternative Means of Receiving Confidential Communications. You have the right to request that you receive communications of protected health information from FAMILIES AT FIVE by alternative means, or at alternative locations. For example, if you do not want FAMIIES AT FIVE to mail bills or other materials to your home you can request that this information be sent to another address. There are limitations to the granting of such request which will be provided to you at the time of the request process. To make a request, ask FAMILIES AT FIVE staff for the appropriate request form.

F. Copy of this Notice. You have the right to obtain another copy of this notice upon request.

III. NOTICE REGARDING USE OF TECHNOLOGY

A. *Email Communications.* Unencrypted emails may not be confidential, and any information regarding protected health information sent by email may not be confidential.

B. *Skype, FaceTime, or Other Similar Videoconferencing Technology.* Communication through Skype or FaceTime may not be confidential.

C. *Internet Communications.* Counseling or communication through the internet may not be confidential.

D. *Storage of Healthcare Information.* Healthcare information maintained on a Cloud may not be confidential, depending on the number of servers involved.

E. *Phone mail or voicemail.* Telephone messages left through voicemail may not be confidential, if they may be accessed by individuals other than the client. Please let me know if you do not want me to use voicemail in contacting you.

F. *Facsimile Communication.* The submission of healthcare information or records by fax may not be confidential; and may lead to a disclosure of confidential information to third parties if the wrong fax number is used to send the information.

G. *Communication by U.S. Mail.* Communication by U.S. mail may lead to disclosure of private information to third parties, depending on who may open the mail. Please let me know if you do not want me to send you correspondence, billing invoices, or other information through the U.S. mail.

IV. ADDITIONAL INFORMATION

A. Privacy Laws. FAMILIES AT FIVE is required by state and federal law to maintain the privacy of protected health information. In addition FAMILIES AT FIVE is required by law to provide clients with notice of its legal duties and privacy practices with respect to protected health information. That is the purpose of this Notice.

B. Terms of the Notice and changes to the Notice. FAMILIES AT FIVE is required to abide by the terms of this Notice, or any amended Notice that may follow. FAMILIES AT FIVE reserves the right to change the terms of its Notice and to make the new notice provisions effective for all protected health information that it maintains.

C. Complaints Regarding Privacy Rights. If you believe FAMILIES AT FIVE has violated your privacy rights, you have a right to complain to the Clinical Director. Please submit a written statement concerning your complaint and the basis for your complaint to FAMILIES AT FIVE at 7000 E. Belleview, Ste. 203, Greenwood Village, CO 80111, You also have a right to complain to the Secretary of Health and Human Services by sending your complaint to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 515F, HHH Building, Washington, D.C. 20201. It is the policy of FAMILIES AT FIVE that there will not be retaliated against for your filing a complaint.

D. Additional Information. If you have any questions about your privacy rights while in treatment at FAMILIES AT FIVE, please ask.

V. CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE CLIENT RECORDS

A. The confidentiality of alcohol and drug abuse client records maintained by FAMILIES AT FIVE is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a client attends the program or disclose any information identifying the client as a drug and alcohol abuser unless: (1) the client authorizes the disclosure in writing; (2) the disclosure is pursuant to a court order; or (3) the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

B. Violation of the federal law protecting the confidentiality of alcohol and drug abuse client records by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

C. Federal law and regulations do not protect any information about (1) a crime committed by a client either at the program or against any person who works for the program; or (2) a threat to commit such a crime. In addition, FAMILIES AT FIVE must disclose to law enforcement and the targeted person an imminent threat of physical violence made by the client toward that person and FAMILIES AT FIVE must report suspected child abuse and neglect to the appropriate state or local authorities.

VI. THIS NOTICE IS EFFECTIVE SEPTEMBER 13, 2015.

I understand the disclosures in this Notice of the Disclosure and Use of Confidential Information

Pursuant to HIPAA, and I have received a copy.

Signature of Client _____ Date Signed _____

Signature of Parent or Guardian _____ Date Signed _____

DISCLOSURES CONCERNING RIGHTS AND GRIEVANCES
FAMILIES AT FIVE

7000 E. Belleview, Ste 203
Greenwood Village, CO 80111
Phone: 720-488-3822 Fax: 303 798 3883

Bonnie Mucklow is your counselor. Ms. Mucklow earned her Master of Science degree in Human Development and Family Relations from Colorado State University and is credentialed in Colorado as a Licensed Professional Counselor, a Licensed Marriage and Family Therapist and a Certified Addiction Counselor, Level III. She has worked in the field of addiction counseling for 34 years and utilizes a cognitive behavioral and systemic approach to treatment.

FAMILIES AT FIVE is an intensive outpatient substance use disorder treatment program licensed by the Office of Behavioral Health of the State of Colorado. Bonnie Mucklow is the Clinical Director of the program.

This document consists of (1) disclosures required by the Office of Behavioral Health; and (2) an explanation of our informal grievance procedure. In addition to these disclosures, you will be given a document entitled Notice Concerning the Use and Disclosure of Confidential Information Pursuant to HIPAA which explains your privacy rights pursuant to the Health Insurance Privacy and Accountability Act.

DISCLOSURE STATEMENT

1. The practice of registered, certified or licensed persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. Questions and complaints regarding such persons can be addressed to the Division of Registrations at 1560 Broadway, Suite 1350, Denver, CO 80202. They can be reached by phone at 303-894-7800. Questions and complaints regarding addiction counselors may be addressed to the Board of Addiction Counselor Examiners at the same address and phone number. The Office of Behavioral Health of the Colorado Department of Human Services has the general responsibility for regulating licensed substance use disorder treatment programs in the state. Questions and complaints may be directed to the Office of Behavioral Health at 3824 W. Princeton Circle, Denver, CO 80236. They can be reached by phone at 303-866-7400.

2. **The regulatory requirements applicable to mental health professionals are as follows:**

- 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 or certified by the State and is not required to satisfy any standardized educational or testing requirements.
- Certified Addiction Counselor I (CAC I) must be a high school graduate or the equivalent, complete required training hours and l000 hours of clinically supervised work experience.
- Certified Addiction Counselor II (CAC II) must meet the CACI requirements, complete additional training hours above the CACI, and 2000 hours of clinically supervised work experience.
- Certified Addiction Counselor III (CAC III) must have a Bachelor's degree in the behavioral health sciences field; complete additional training above the CAC II, and 2000 hours of clinically supervised work experience.
- Licensed Addiction Counselor must have a clinical Master's degree, meet the CAC III requirements, and pass a national examination in addiction treatment.
- Licensed Social Worker must hold a master's degree in social work.
- Psychologist Candidate, Marriage and Family 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.

- Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's degree in their profession and have two years of post-masters supervision.
- Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.

3. **You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy (if known) and the fee structure**. You can seek a second opinion from another therapist or terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Board that registers, certifies or licenses the registrant, certificate holder or licensee.

4. **Counseling is a collaboration between the client and the therapist.** In order for change to occur, both client and therapist must be active participants in the therapeutic process. Treatment Plans are based on identified goals and progress toward goals. Should you feel your needs as a client are not being met, it is your responsibility to share this with me. I cannot guarantee any particular outcome to therapy. I cannot guarantee that you will feel that, as a result of therapy, things have improved.

5. You have a right to review your treatment record. With some exceptions, including an exception for psychotherapy notes, you have a right to review your treatment record. I may deny you access to your treatment record when I believe access to the record is reasonably likely to endanger the life or physical safety of you or another person. If I deny you access to your treatment record on that grounds and you disagree with my decision, you have the right to have my decision reviewed by a licensed professional who (1) is designated by Families at Five to act as a reviewing official; and (2) did not participate in the original decision to deny you access to your record.

6. **Under Colorado law, C.R.S. § 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information.** If a parent requests information from FAMILIES AT FIVE and no court has restricted the parent's access to the minor child's mental health treatment information, I may provide the parent with a treatment summary, in compliance with Colorado law and HIPAA.

7. **Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released 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, FAMILIES AT FIVE and other healthcare providers are required to disclose confidential information when reporting child abuse or neglect to the Department of Human Services or to law enforcement and may disclose confidential information in emergencies to prevent death or serious injury to the client or others. FAMILIES AT FIVE may disclose otherwise protected information when reporting a crime committed on the premises. If a legal exception to confidentiality arises during therapy, if feasible, you will be informed accordingly.

8. **When a client or other program participant, who appears to be impaired by drugs or alcohol to the extent that he or she cannot safely drive a vehicle, intends to drive, staff members will assist the individual in arranging an alternative means by which he or she can return home.** If the client insists on driving, local law enforcement will be summoned immediately.

9. **When I am concerned about a client's safety, it is my policy to request a welfare check through local law enforcement.** In doing so, I may disclose confidential information to law enforcement officers in the course of explaining my concerns. By signing this disclosure statement and agreeing to treatment with me, you consent to this practice, should it become necessary in my opinion.

10. **Please note that alcohol and drug treatment records are protected** under the Federal Confidentiality Regulation, 42 C.F. R., Part 2, governing Confidentiality of Alcohol and Drug Abuse Patient Records. Generally, confidential information cannot be disclosed without written permission unless otherwise provided for by the regulations. Exceptions to confidentiality may also be found in the Notice Concerning the Use and Disclosure of Confidential Information Pursuant to HIPAA which you were given.

THE INFORMAL GRIEVANCE PROCESS

1. If you wish to file a complaint against a counselor with FAMILIES AT FIVE, you can do so formally by contacting the agencies listed in Paragraph No. 1 on the first page of this document. FAMILIES AT FIVE also has an informal complaint process which you can follow in lieu of, or in addition to, filing a formal complaint. The process for filing an informal complaint is explained below in Paragraph No. 2.

2. (a) If you are dissatisfied in any way with the services provided you by any counselor at FAMILIES AT FIVE, you can file an informal grievance with FAMILIES AT FIVE by reporting your dissatisfaction orally or in writing to the Clinical Director or another counselor.

   (b) Any complaint not reported directly to the Clinical Director, Bonnie Mucklow, will be passed to her by the counselor to whom you reported it and, within five days if the date you filed the complaint, you will receive a phone call from her to discuss with you your complaint and possible resolutions.

   (c) Ms. Mucklow will expend her best efforts to resolve you complaint within ten days of learning of it.

   (d) You have the right to be assisted with your complaint by an independent third party. FAMILIES AT FIVE has designated Dr. Tracy Nott as the independent third party available to help you if you so desire. Dr. Nott is a licensed professional counselor with her own private practice with no involvement in the services you receive from FAMILIES AT FIVE. Her office is located at Suite 120, at 6535 S. Dayton Street, Greenwood Village, CO 80111. Her office phone number is 303-792-9418.

   (e) If you so wish, you may lodge an oral or written complaint against counselors for FAMILIES AT FIVE with Dr. Nott directly. If you mail your complaint to Dr. Nott, she will reach you by telephone within five days of receiving your complaint to speak with you concerning your complaint and possible resolutions.

   (f) If you initially file a complaint with FAMILIES AT FIVE directly but come to believe you would like assistance from a third party, you can request Dr. Nott's assistance by contacting her directly or by contacting Ms. Mucklow.

   (g) Whether you lodge your complaint with Dr. Nott directly or request her assistance after filing your complaint with FAMILIES AT FIVE, Dr. Nott will extend her best efforts to work with you and with Ms. Mucklow to resolve your complaint within fifteen days of the date it is filed.

   (h) If, in the course of discussing your complaint with Dr. Nott, you wish her to review any portion of you file, you will have to sign a written consent authorizing FAMILIES AT FIVE to release confidential information to Dr. Nott.

   I have read the preceding information, it has been provided to me verbally, and I understand my rights as a client or as the client's representative.

   Signature of Client,
   Parent or Guardian _____Date Signed_____

FAMILIES AT FIVE PLAN FOR NATURAL DISASTERS AND MEDICAL EMERGENCIES

IN THE EVENT OF A FIRE OR OTHER NATURAL DISASTER NECESSITATING EVACUATION, STAY CALM:

1. The group facilitator will aid individuals in safely evacuating the building through the closest exits, using stairways if necessary.
2. A map of the floor showing emergency exists is posted at the exit from the room in which the group is meeting.
3. No one should attempt to use an elevator.
4. As individuals exit the building, they should proceed to the designated meeting place near the "7000 E. Belleview" sign which is in front of the building near the northwest corner of the parking lot.
5. The group facilitator will then (1) use his or her cell phone to call 911; and (2) take account of the group to insure that everyone in his group has safely evacuated.
6. In anyone is unaccounted for, the group facilitator will tell emergency personnel arriving on scene about individuals who may still be in the building. In no case will anyone from the group re-enter the building to look for someone.
7. Individuals should remain together at the designated meeting place until fire or law enforcement officials direct them otherwise.

IN CASE OF TORNADO:

1. The group facilitators will receive notification of a tornado warning via their cell phones.
2. In the event of a tornado warning, the group facilitators will aid individuals in proceeding to the tornado refuge area which is the hallway located on the first floor in the northwest corner of the building.
3. If there is not enough time to reach the refuge area, individuals should enter the closest stairwell.
4. Once in the refuge area, the group facilitator should take account of individuals to determine whether or not anyone is missing, but no one should leave the refuge to look for anyone.
5. Individuals should remain in place in the refuge until the facilitator receives an all clear signal from his cell phone or until several minutes have passed and the facilitator can determine by sound and sight that the storm has passed.

IN CASE OF A MEDICAL EMERGENCY

1. The group facilitator will call 911 on his cell to summon help.
2. Individuals will aid the sick or injured person to the best of their abilities.
3. The group facilitators will know the location of the nearest Automatic External Defibrillators.
4. The facilitator will direct an individual in the group to go to the front of the building to meet the ambulance and lead emergency personnel to where the injured/sick individual is located.

Bonnie Mucklow

Licensed Professional Counselor
7000 E. Belleview, Ste. 203
Greenwood Village, CO 80111
720-488-3822 Fax: 303-709-3883

RECORD OF RECEIPT OF ACKNOWLEDGEMENTS & DISCLOSURES

_____Acknowledgement of Fees, Costs and Collection Procedures

_____Responsibilities of Clients and Family Members (IOP only)

_____Acknowledgement of Risk Factors for HIV, TB, other Infectious Diseases, and Pregnancy

_____Antabuse Information Sheet

_____Naltrexone Information Sheet

_____Buprenorphine Information Sheet

_____Families at Five Plan for Natural Disasters and Medical Emergencies

Please (1) place your initials next to each of the disclosure above which you have received a copy of and (2) sign the acknowledgement below.

I hereby acknowledge that I have been given a copy of each of the above disclosures which I have placed my initials next to.

Client's Signature_____ Date_____

Signature of Parent or Guardian _____Date_____

RESPONSIBILITIES OF CLIENTS AND FAMILY MEMBERS

Clients and family members have the following responsibilities:

1. Neither clients nor the participating family member may attend any treatment function under the influence of either alcohol or drugs. If a staff person believes the client or family member is under the influence of alcohol or drugs, they will both be asked to leave. If a staff person suspects that the client is under the influence of alcohol, they may, but are not required to, ask the client to submit to a breathalyzer.

2. Neither clients nor family members may threaten violence to anyone in the program including staff and family members.

3. Clients must comply with the financial agreement.

4. Clients must adhere to specific behavioral contracts made with their therapist or therapy group.

5. Clients must attend all sessions with a participating family member. Neither the client nor the family member will be allowed to participate unless they are both present.

6. Clients and family members must keep confidential the information they learn about others while participating in treatment groups.

7. Minors must attend the program with a parent or guardian.

8. The participating parent or guardian is responsible for managing the behavior of the minor.

9. Except for the group sessions for clients only, minors must be in the presence of and be supervised by the participating parent or guardian.

10. Without exception, minors will not be allowed to enter or leave the facility unless accompanied by the participating parent or guardian.

11. Clients must keep appointments unless excused by the therapist.

*** In the event that the Clinical Director determines that Families at Five should be cancelled because of inclement weather, each family will be contacted by phone at least two hours prior to the scheduled meeting. At the same time, a voice mail message advising callers of the program cancellation will be left on the office voice mail.**

ACKNOWLEDGEMENT CONCERNING HIV/AIDS, OTHER INFECTIOUS DISEASES AND PREGNANCY

1. It is the policy of Families at Five not to discriminate against consumers at risk of HIV/AIDS or TB, who otherwise meet the identified criteria for treatment. All potential clients will be screened for infectious diseases including TB. All consumers will be assessed for history or presence of HIV/AIDS risk factors.

2. AIDS is a deadly disease caused by a virus. A virus is a special type of germ. The virus that causes AIDS is called HIV. AIDS is caused when HIV attacks the body's immune system (the body's natural defenses). When this happens, the body is no longer able to fight off other diseases. Some people have had the virus for many years without getting sick. These people may not even know they have the virus. Even though these people look and feel healthy, they can pass the virus to others through sex or sharing needles. A woman infected with HIV can pass the virus to her unborn baby.

   The HIV antibody test can tell you if you have been infected with HIV. HIV infection is a serious medical problem. If you have the virus, you need to know. There are many things that can be done that may help people with the virus stay healthy. Good health care may help keep you from developing AIDS. Your counselor can give you the names of testing sites. Testing is free and test results are private.

   Several behaviors are associated with an increased risk of transmitting or acquiring HIV/AIDS. Those include the following:

   Injection drug use
   Sex with an injection drug user
   Sex with a partner who has HIV/AIDS
   Multiple sex partners
   Sex with a partner who is at high risk of HIV/AIDS
   For women, having sex with a man who has had sex with other men
   Sex for money, drugs or other consideration
   Hemophilia
   Blood transfusions
   Blackouts

3. Using alcohol or other drugs while pregnant, can harm your unborn baby.

OUT-OF-STATE OFFENDER
CLIENT QUESTIONNAIRE

The following questions must be answered by all clients seeking admission to this program for alcohol and drug education, or treatment and are required by Colorado law. Refusal to cooperate, or failure to provide complete or accurate information, including failure to sign a release of information to the referring criminal justice agency, will result in immediate discharge from the treatment program and notification of authorities, in accord with the requirements in 17-27.1-101, CRS.

1) Are you applying for treatment because of a current requirement to attend a treatment program in Colorado by any court, department of corrections, state board of parole, probation department, parole division adult diversion program, or any other similar entity or program in another state? Yes No

If yes, please answer the following question:

2) Are you, or will you be under the supervision of a probation officer or parole officer in Colorado? Yes No

(Note: if you do not have an assigned Colorado probation officer or parole officer, the Interstate Compact Office will be notified).

3) For DUI offenders only: Are you seeking education or treatment for the sole purpose of restoring your driving privileges as the result of an alcohol or drug related driving offense in another state but are not under a court order to do so? Yes No

Your Name: _____ Date of Birth: _____

Social Security number: _____ Place of Birth: _____

Signature: _____ Today's Date: _____

If you answered "Yes" to 1) or 2) above, please provide the following:

Name, address and phone number of your probation officer, parole officer, judge or diversion officer. _____

_____

_____

_____

A copy of your probation, parole, court, or diversion order, including treatment requirements.