Mountain Treatment Services PLLC

6949 Hwy 73
Evergreen, CO 80439
Phone: (303)674-7004

CLIENT INFORMATION: Name:_____

Address: _____

City: _____State:_____Zip:_____

Cell Phone: _____

May I contact you via text messaging?:_____

Please provide me with a short summary as to what is bringing you in seeking therapy:

Credit Card number :_____

Security Code:____ Expiration Date:_____Zip Code:_____

PAYOR INFORMATION: Self-pay CLIENT must add CC information. RESPONSIBLE PAYOR PARTY Including : SonderMind, Headway, or Aware, do not need to add CC information.

SIGNATURE:X_____

Date: X_____

DISCLOSURE INFORMATION

This statement is being provided to you so that you are aware of your rights as a psychotherapy client. Please read this and discuss any questions or concerns you have before signing it.

Therapist:

Christine Fale LAC, LPC, NCC 6949 Hwy 73 L-3
Evergreen, CO 80439
Phone: (303)674-7004

Education:

I received my Bachelor of Science degree in Human Services with a Mental Health and Addictions concentration in December 2003 from Metropolitan State University of Denver. I received a Master of Arts in Clinical Mental Health Counseling from Alamosa State University in May 2017.

I am recognized by the State of Colorado as a Licensed Addictions Counselor, and a Licensed Professional Counselor. I am also a Nationally Certified Counselor.

Client Rights and Important Information:

Colorado State Law requires that I provide you with the following information:

The practice of licensed and unlicensed psychotherapists is regulated by the Colorado Department of Regulatory Agencies, specifically the Mental Health Section. Questions and complaints may be addressed to the State of Colorado Grievance Board, which is located at: 1560 Broadway, Suite 1340, Denver, CO 80202; (303) 894-7766.
You are entitled to receive information about the methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure. Please ask if you would like to receive this information. You may seek a second opinion from another therapist or may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the grievance board. The information provided by the client during therapy session is legally confidential except for certain legal exceptions which include:

1) Suspected child abuse or neglect;
2) Imminent threat of harm to self or another person;
3) Suspected abuse and exploitation of at-risk elders;
4) Suspected abuse and exploitation of at-risk adults with intellectual and developmental disabilities;
4) Specific authorization from the client;

5) Defense of lawsuit or grievance;
6) Third party payment, and 7) Specific order of the court.

I may consult with a colleague for peer consultation or to obtain supervision. Supervisors and colleagues are subject to the same confidentiality laws described above.

Fees and Cancellation Policy:

• Sessions are billed by the hour at a rate of $125 per hour for individual sessions and $170 per hour for couple sessions. Payment for each session is due at the time of each session.
• Missed sessions will be billed at half the full rate unless cancelled at least 24 hours prior to the scheduled session.
• If you are a SonderMind client, your billing will be taken care of through them.

EMERGENCIES:

I am not able to handle 24-hour contact and/or emergencies. Any personal emergency should be directed to emergency personnel such as the services provided by calling 911, the police, the fire department, a hospital, or your county mental health department.

Health Information Privacy Notice (HIPAA):

By signing this disclosure you acknowledge receipt of the HIPAA policies for your review. Once you have reviewed these policies, please return a signed copy to me. You are not required to sign this notice to receive treatment. Please verbally inform me if you elect to not sign the notice. I have read the preceding information, it has also been provided verbally, and understand my rights as a client.

Client Signature:_____ Date:_____

Therapist:_____Date: _____

If client refuses to sign an acknowledgment, mark the appropriate box below:
€ Client refused to accept Notice of Privacy Practices and refused to sign Acknowledgment.

€ Client accepted Notice of Privacy Practices but refused to sign Acknowledgement.

_____ _____
Name of Client Date Notice was offered

Notice of Federal Requirements Regarding
Confidentiality of Alcohol andDrug Patient Records

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by federal law and regulations. Generally, the program may not want to say to a person outside o the program that a patient attends the program, or disclose any information identifying a patent as an alcohol or drug abuser unless:

(1) The patient consents in writing;

(2) The disclosure is allowed by court order, or

(3) The disclosure is made to a medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threats to commit such crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate State or local authorities, see 42 U.S.C.290dd-3 and 42 U.S.C 290ee-3 for Federal laws and 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

Client Signature:_____ Date:_____

Counselor Signature:_____Date:_____

TELEHEALTH CONSENT FORM

1. **I hereby authorize Mountain Treatment Services, Christine Fale, to use the Telehealth practice platform for telecommunication for evaluating, testing and diagnosing my medical condition.**

2. **I understand that technical difficulties may occur before or during the Telehealth sessions and my appointment cannot be started or ended as intended.**

3. **I accept that the professionals can contact interactive sessions with video call; however, I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed cannot be met.**

4. **I understand that my current insurance may not cover the additional fees of the Telehealth practices and I may be responsible for any fee that my insurance company does not cover.**

5. **I agree that my medical records on Telehealth can be kept for further evaluation, analysis and documentation, and in all of these, my information will be kept private.**

Client's Printed Name: X_____
Date:X_____Signature:X_____