Fort Collins Therapists
1221 E Elizabeth St
Suite 3
Fort Collins, CO 80524

Four Points Counseling Center

Loveland Therapists
4190 N Garfield Ave
Suite 1
Loveland, CO 80538

Minors Intake Form B
Disclosure and Consent to Treatment

Therapist Name & Credentials: _____ **Office Phone:** 970-682-1337

Professional Disclosure
Four Points Counseling Center (Four Points) employs mental health professionals licensed under the Colorado Department of Regulatory Agencies (DORA). This includes Licensed Clinical Social Workers, Licensed Marriage & Family Therapists and Licensed Professional Counselors who hold a Master's degree in their field and complete:

- **Licensed Clinical Social Workers:** 3360 hours over 24 months minimum and 96 supervision hours
- **Licensed Marriage & Family Therapists:** 2000 hours over 24 months minimum and 100 supervision hours
- **Licensed Professional Counselors:** 2000 hours over a minimum of 24 months while under supervision

Four Points also employs provisionally licensed clinicians under supervision of licensed therapists. This includes Licensed Social Workers, Social Worker Candidates, Marriage and Family Therapist Candidates, and Licensed Professional Counselor Candidates who hold degrees in their fields and are accumulating hours for full licensure.

Colorado-Based Services
Four Points therapists are licensed to practice in Colorado only and authorized to provide services that occur within state boundaries. This includes services held in person and services provided via telehealth (teletherapy). Services may not be provided when any individual is outside of Colorado, which applies to both clients and therapists.

Client Rights: You Have the Right To
- Receive information about your therapy in a way that is easy to understand including methods, techniques, anticipated treatment duration and applicable fee structure.
- Collaborate on treatment goals and participate in an individualized treatment planning process.
- Seek a second opinion from another therapist, refuse services, or terminate therapy at any time.

Cancellation Policy
Cancellation is requested with at least 24 hours notice. Late cancellations and appointments missed without notice (no shows) will incur a fee equal to the full rate of the service. Saturdays, Sundays and federal holidays are not considered business days. Notice given on these days is considered to be received the next business day. Due to Colorado Medicaid regulations, clients with Medicaid are not subject to these fees.

Electronic Communication
Text and email communication is used for limited reasons. Four Points takes privacy seriously and cautions that sending unencrypted information creates security risks. Others may access your devices or accounts and compromise your privacy, undermine your identity security, or disclose that you receive mental health services.

Four Points will never send you marketing messages. If you have concerns about communications, please call (970) 682-1337 and ask for management.

You may receive electronic communication for the following reasons:

- Appointment reminders/confirmations
- Scheduling and administrative communications
- Matters related to billing, insurance and payment
- Office alerts (ex: parking lot closure)

Do you consent to electronic communication? [] Yes [] No

If you answered no, please give a preferred phone number: _____

Disclosure and Consent to Treatment

Will you allow email requests for feedback about your experience? [] Opt in [] Opt out
This occurs at most twice per year and never contains marketing material.

Text messages to your therapist: Messaging therapists via text is permissible for the purposes of discussing scheduling only. For other matters, please contact your therapist via phone call or discuss during a session.

Professional Relationship & Treatment Termination

Mental health professionals are bound by ethics codes of their regulatory boards which includes holding the boundary of the professional relationship. It is a violation for a therapist to develop a friendship, sexual relationship or romantic relationship with a client. It is never appropriate for a therapist to be physically intimate with a client. Therapists are unable to accept requests to connect on social media due to the emphasis on confidentiality and the importance of avoiding dual relationships

Typically, treatment ends as the result of collaborative planning between client and therapist over a period of time. A few exceptions include but are not limited to:

- Misalignment between therapist and client
- Threatening or abusive behavior/communication to Four Points staff
- Clinical need for higher level of care
- Non-payment of fees/services

Confidentiality

Information shared in therapy is privileged and protected as confidential under state law. Therapists cannot be forced to make disclosures without consent with some exceptions (12-43-218 CRS) which do not require consent:

- Imminent threat of harm to self or others
- Court order requiring therapist involvement
- Court-mandated treatment
- Grave disability
- Suspected abuse/neglect of children, elders, disabled persons
- An official complaint or lawsuit against the therapist
- Criminal/delinquency proceedings (exception: 13-90-107 C.R.S.)
- Additional exceptions under Colorado law

Important Notes About Your Health Information

- Confidentiality is maintained in compliance with the Health Insurance Portability and Accountability Act (HIPAA).
- Sharing information with other clinicians may be needed as part of treatment or if you seek care from another provider. Your therapist may seek consultation from another mental health professional. Your identity is not revealed without consent and your privacy is protected by that professional.
- State law allows parents of clients under 15 to access mental health care information unless a court restricts access.
- Records are Four Points' sole property, intended for therapists' sole use and stored for 10 years after treatment ends or seven years after minors reach age 18. See *Privacy Practices* for more on the use of your information.

Legal Proceedings

Therapist involvement in legal matters is shown to be detrimental to the therapeutic relationship. You agree to refrain from involving your therapist in legal proceedings. If subpoenaed, no statements of clinical judgment will be issued and time will be billed at $250/hour including but not limited to preparation and travel time.

Grievances

We hope to address concerns by working with you directly. You are welcome to discuss concerns with your therapist or with management. You may also file a complaint with the following agencies.

Department of Regulatory Agencies
1560 Broadway, Ste 1340, Denver, CO 80202
(800) 886-7675/ DORA_customercare@state.co.us

Behavioral Health Admin, Department of Human Services
3824 W. Princeton Circle, Denver, CO 80236
(303) 866-7400/ CDHS_BHA_complaint@state.co.us

Disclosure and Consent to Treatment

Crisis Resources

Four Points is unable to provide emergency services. Your therapist may be available after hours within reason by contacting their direct number. If you or someone else are in a life-threatening situation, call 911 or go to an emergency room or crisis center. Some services may incur a cost to you and insurance may or may not contribute.

Greeley	Fort Collins	Loveland
CO Crisis Services 844-493-8255 928 12th St, Greeley, CO 80631	Poudre Valley ER 970-495-7000 1024 S Lemay Ave, Fort Collins, CO 80524	Mckee Medical Center 970-820-4640 2000 N Boise, Loveland, CO 80538
N. CO Medical Center 970-810-4121 1801 16th St, Greeley, CO 80631	Banner N. Colorado ER 970-821-4000 4700 Lady Moon Dr, Fort Collins, CO 80528	UCHealth MCR Emergency Care, 970-624-1600 2500 Rocky Mountain Ave, Loveland, CO 80538
UCHealth West, 970-392-4320 6906 W 10th St, Greeley, CO 80634	SummitStone Walk-In, 970-494-4200 1217 Riverside, Fort Collins, CO 80524	

Hotlines CO Crisis: 844-493-8255 National Suicide Line: (800) 273-8255

Advance Directives: Federal law requires we share information about advance directives and your rights about healthcare decisions. An advance directive is a legal document that tells your health care team about your wishes and the care you want when you are unable to make decisions for yourself. Having an advance directive or not does not impact the ability to receive services.
More information: https://cdphe.colorado.gov/colorado-crisis-standards-of-care/advance-care-planning-for-patients-and-families

Informed Consent to Treatment

I give Four Points Counseling Center and its therapists permission to conduct therapy services. I understand there are benefits and risks of therapy. Risks include but are not limited to experiencing discomfort and vulnerability. Therapy involves sharing personal information which may feel distressing. The processing of events, memories, and difficulties may evoke emotions including anger, fear, sadness, and guilt, among other emotions. Benefits of therapy include but are not limited to improving coping skills, decreasing symptoms, gaining insights about oneself and others, achieving progress toward goals, repairing relationships and beginning to heal from trauma. Four Points cannot guarantee outcomes and may provide referrals in the interest of meeting your needs.

Individuals age 12 and older in Colorado may consent to treatment. *(Under 12: see Direction for Treatment of Minors)*

COVID-19: Four Points follows all public health orders, however there is the possibility of COVID-19 exposure. I understand that by receiving in person services, I assume the risk of exposure. I understand I may inquire about receiving telehealth services as an alternative.

Recordings: _____ Session and/or therapist recordings of any kind are prohibited. Sessions shall not be recorded by any party at any time unless express permission is granted in writing. (*Please initial to indicate agreement.)*

Acknowledgement

My signature indicates my consent to treatment and my understanding and agreement to the information in this disclosure. I understand I may ask questions about the information in this document at any time.

Client Name _____ Date of Birth _____

Signature _____ Date _____

Parent/Representative, if applicable _____

Notice of Privacy Practices

Effective November 1, 2021: This notice outlines the policies of Four Points Counseling Center (Four Points) related to the use and disclosure of protected health information (PHI) and how to access this information. **Protected health information refers to information about you, including demographic information, that may identify you** or be used to identify you, and that relates to your past, present or future physical or mental health or condition, the provision of health care services, or the past, present or future payment for the provision of health care services. Please review it carefully.

This notice may be changed at any time; the current version will be the version in effect for all health information collected and maintained by Four Points. You may obtain a copy by emailing info@fourpointscc.com or calling 970-682-1337. Information is released only in accordance with state and federal laws.

Four Points is permitted to disclose PHI for the health care functions of providing treatment, collecting payment for services, and conducting health care operations, which is necessary to provide quality care and allowed by state and federal law. **Four Points may use and disclose PHI for the following reasons:**

- **Provide, manage and coordinate care** with entities involved in your care; communicate with referral sources.
- **Collect fees;** verify insurance benefits and coverage and process claims.
- **Schedule appointments and manage routine business** and administrative functions regarding your care; conduct internal audits to improve your care; attend to compliance, audit, investigation and licensing requirements.
- **Other Uses & Disclosures Without Your Consent:** Mandated reporting, emergencies and criminal activities; coroners, medical examiners and related professionals; research (rare and requires a rigorous approval process); any and all other uses and disclosures as required by law

Your Rights: You Have the Right to

Confidential Communication: You have the right to request where you are contacted and for communication to occur in a specific, limited, confidential manner. See “electronic communication” in the Professional Disclosure and Consent to Treatment for one way to state preferences. Four Points accommodates all reasonable requests.

Obtain and Release Records: You may submit a written request for an electronic or paper copy of your record or to have records sent to a third party. Contact Four Points for information about making this request. We may provide a copy or summary within thirty days of your request in compliance with applicable laws. We may charge a reasonable, cost-based fee. You have the right to revoke releases of information in writing. Revocation is not valid to the extent that Four Points has acted in reliance on previous authorization.

Request an Amendment: You may request to correct information about you that you think is incorrect or incomplete. Contact Four Points to learn about making this request. Requests may not result in formal modification to the record. The request for the correction, however, will be added to the health record as an addendum.

Accounting of Disclosures: You may obtain a list of disclosures of PHI for six years prior to the date of your request including the recipient and reason for disclosure. We will include all disclosures except those about treatment, payment, and health care operations, and certain other disclosures, such as those requested by you with a signed release or those made to law enforcement. Four Points will provide one accounting per year without charge. Four Points will charge a reasonable, cost-based fee for other requests within the same twelve month period.

Request Restrictions on PHI Uses and Disclosures: You may request that we not use or share certain health information for treatment, payment, or operations. Four Points is not required to agree to the request, and may decline if it would affect your care or the legal requirements of Four Points.

File a Complaint: If you feel your rights have been violated and wish to file a complaint, you may contact us directly at info@fourpointscc.com or 970-682-1337. You may also contact the US Department of Health and Human Services. Please know we will not retaliate against you in any way for filing a complaint.

By signing, you attest that you have read and understand your rights and responsibilities under federal law regarding your protected health information. If you have questions about Four Points’ privacy practices, please contact Compliance Officer Lauren Stanley at 970-682-1337 or lauren@fourpointscc.com.

_____

Client/Representative Signature

Four Points Counseling Center

Direction for Treatment of Minors

Client Name: _____ Date of Birth: _____

Relationship to Client

[] Self (client is age 12+) [] Parent* [] Legal guardian [] Department of Human Services

**Biological, adoptive or foster parent with legal rights*

Has legal action been taken that impacts decision-making for the minor client?*

[] Yes [] No

This may include but is not limited to legal separation or divorce, determination of custody and/or guardianship, limitation or termination of parental rights, actions related to paternity, and proceedings regarding participation in mental health services.

*If you indicated No, please skip the section below titled Medical Decision-Making.

Medical Decision-Making

Do legal documents exist that address the following for the minor client:

Medical decision-making authority? [] Yes [] No

Participation in mental health therapy or other mental health services? [] Yes [] No

Payment for medical treatment and/or mental health therapy services? [] Yes [] No

Required Documentation

If indicated below, documented verification of legal authority to make medical and/or mental health care decisions on behalf of the minor client must be provided before the client can be seen for services. Please read carefully.

Signing Individual	Is documentation required?
Minor client age 12+	Not required
Biological/adoptive parent with no legal action impacting decision-making	Not required
Biological/adoptive parent **with legal action** impacting decision-making authority	Documentation required
Adult who is **not** the biological/adoptive parent	Documentation required

Example documentation: Separation agreement, divorce decree, medical/mental health care power of attorney, emergency guardianship order, other court order

Other Authorized Individuals

Please list full names of all additional individuals with medical decision-making authority for the minor client.

_____

Attestation

By signing this document, I attest that the information I have entered is accurate and I have not knowingly omitted information from this form.

I attest that I have legal decision-making authority related to medical, mental health and/or substance use treatment for the minor client named on this form.

_____ _____ _____

Printed Name Signature Date

Telehealth Disclosure & Consent

You may attend therapy exclusively via telehealth, occasionally as requested by you or your therapist, or not at all. We ask all clients to review this policy so that the flexibility of telehealth is available should the need arise.

IMPORTANT: Although telehealth allows remote attendance, it is required that individuals receiving services be within Colorado state limits in order to attend telehealth sessions.

Potential Benefits of Telehealth

- ❖ High level of convenience
- ❖ Increased access to services and clinicians
- ❖ Outcomes comparable to face-to-face services
- ❖ Adaptability in shifting circumstances (ex: bad weather)

Potential Risks of Telehealth and Risk Mitigation

- ❖ Technology issues may disrupt your session or delay its start. Internet stability and speeds may change suddenly and result in the loss of your connection and may be unpredictable from one session to another.
  > Your therapist will discuss how technology issues are managed and what to expect if you are disconnected.
- ❖ Clients must be able to launch and navigate the telehealth platform to engage in telehealth sessions.
  >Platforms chosen by Four Points have been made as user-friendly as possible with guides to assist clients.
- ❖ Confidentiality may be compromised. The nature of telecommunication is such that Four Points cannot guarantee that information will remain confidential, secure, or that unauthorized persons will not gain access.
  >Four Points uses encrypted online services and information is transmitted over a secure network. We recommend that clients only use secure networks for telehealth and that devices are password protected.
- ❖ Conversations may be overheard by unintended individuals.
  >Therapists use private spaces for telehealth sessions. They may inquire about the space you use for sessions and make recommendations to increase your privacy if possible.
- ❖ Telehealth is not recommended for all clients. Ex: Those in need of a higher level of support and intervention.
  >The intake appointment is used to ascertain your needs so your therapist can develop a plan with you if telehealth is not currently an option.

Alternatives to Telehealth: Face-to-face services, or "in-person" services, in which the therapist is physically present with the client, is an alternative to telehealth. At times, access to in-person services may be limited.

Fees & Coverage: Self-pay rates, or fees for those not using insurance, are the same whether sessions are in person or via telehealth. For those using insurance, rates for telehealth and in-person sessions are often the same, but not always, as insurance companies establish service rates. Four Points will attempt to estimate your payment and determine benefits, but it is ultimately your responsibility to understand your benefits. Telehealth sessions may not be covered and in such cases you will be responsible for the full fee for services. It is strongly encouraged that you contact your insurance company prior to engaging in telehealth services.

Informed Consent

The terms of this agreement are in addition to those described in the Disclosure and Informed Consent to Treatment and does not amend the terms therein. Terms here are presented separately for clarity.

I understand and/or agree that:

1. Signing this disclosure and consent is not a commitment to engage in telehealth services.
2. Should I choose to engage in telehealth, I grant my therapist permission to conduct therapy via telehealth.
3. I will be physically within Colorado state limits when I engage in telehealth sessions.
4. It is my responsibility to ensure the privacy of the space I use for telehealth sessions.
5. I have received information about the risks of telehealth and alternatives to telehealth.
6. My therapist or I may discontinue telehealth sessions if the modality does not seem to meet my needs.
7. The extent and limits of confidentiality outlined in the Informed Consent apply to telehealth services.
8. My healthcare information may be shared for scheduling/billing purposes in addition to allowances under HIPAA.
9. I may ask questions about these policies or practices by contacting Four Points or asking my therapist.

My signature indicates my understanding and agreement to the information contained in this disclosure.

Client/Representative Signature _____

Financial Policy and Charge Authorization

It is Four Points' policy that a credit or debit card is on file, except for those with Medicaid, to be used for payment responsibility including copay, coinsurance, deductible, and private pay amounts. Charges may include amounts unreimbursed by insurance and/or fees for missed appointments. Card data is managed via PCI-compliant encryption with International Bancard. You may revoke authorizations by informing your therapist, calling 970-682-1337 or emailing info@fourpointscc.com. If you consent to electronic communication, we may contact you via email regarding balances or other billing matters.

Is a credit or debit card on file? [] Yes, I saved a card [] No, I have not added a card [] I have a Medicaid plan

Benefits: If applicable, Four Points will attempt to estimate your payment. It is your responsibility to understand your benefits and Four Points is not responsible for any inaccuracies. You are strongly encouraged to contact your insurance company prior to beginning services.

Fees: Late cancellations (less than 24 hours notice) and appointments missed without notice (no shows) incur a fee equal to the full rate of the service. If you are unsure of the rate applicable to your service, please ask for this information from your therapist or contact Four Points administration. Clients with Medicaid are not subject to fees.

Missed appointment fees are not billable to insurance. If your responsibility for therapy services is a copay or coinsurance payment, this does not represent the full service rate, but is a portion of the full rate.

Collateral service fees, such as writing a letter, vary by therapist and service; the returned check fee is $20.
Court-related matters including but not limited to preparation and travel time: $250 per hour

Surprise Billing

As of January 1, 2020, state law protects some individuals from *surprise billing*, also known as *balance-billing*. This does *not* apply to all Colorado health plans. It only applies if you have "CO-DOI" on your insurance card. These protections apply when you: Receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado and/or you unintentionally receive covered services from an out-of-network provider at an in-network facility.

What is balance-billing? When does it happen? If you see a provider or use facility/agency services not in your plan's network, sometimes referred to as "out-of-network," you may receive a bill for additional costs. Out-of- network providers often bill the difference between what your insurer says is the eligible charge and what out-of- network providers bill as a total charge.

When You CANNOT Be Balance-Billed: Emergency Services If you receive emergency services, the most you can be billed is your plan's in-network cost-share amounts: copayments, deductibles, and/or coinsurance. You cannot be balance-billed for other amounts including the emergency facility where you receive services and providers you see for emergency care.

Non-Emergency Services at In-Network or Out-of-Network Provider The provider must tell you if you are at an out-of-network location or at an in-network location using out-of-network providers. They must tell you what types of services you will be using that may be provided by an out-of-network provider. You have the right to ask that in-network providers perform covered services, but you may have to receive services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for **covered** services is the in-network cost-sharing amount: copayments, deductibles, and/or coinsurance. These providers cannot balance-bill you for additional costs. Additional protections include:

- Your insurer will pay out-of-network providers and facilities directly.
- Your insurer must count amounts you pay for emergency services or certain out-of-network services (above) toward your in-network deductible and out-of-pocket limit.
- Your provider, facility, hospital, or agency must refund overpaid amounts within 60 days of being notified.
- No one (provider, hospital, or insurer) can ask you to limit or give up these rights.

If you receive services from an out-of-network provider, facility, or agency, you may be balance-billed or responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider, you may also be balance-billed.

To submit a provider complaint, visit: https://www.colorado.gov/pacific/dora/DPO_File_Complaint. If you think you have been billed for amounts other than copays, deductible, and/or coinsurance, please contact Four Points management or the CO Division of Insurance at 800-930-3745. Please contact your insurance plan or the CO Division of Insurance with questions.

My signature indicates my understanding and agreement to the terms in this policy. I authorize Four Points to keep my credit or debit card on file and to charge amounts for which I am responsible including those for late cancellations and missed appointments, except where prohibited by law. I understand I have the right to request that my card is removed at any time.

Client/Representative Signature: _____

Card-On-File Authorization

Please provide the card that may be stored in your account and charged for payment responsibilities. Clients with Medicaid do not need to complete this form.

Client name _____

Client date of birth _____

Purpose of Authorization

This form enables Four Points Counseling Center to store your credit card on file and to charge your card for amounts owed. Card data is managed via PCI compliant encryption with International Bancard.

For more information about Four Points' financial policies, please refer to the *Financial Policy and Charge Authorization* document located within the intake packet.

Credit Card Information

Cardholder full name _____

Credit card number _____

Expiration (mm/yyyy) _____

CVV (code on back) _____

Billing ZIP code _____

Please initial to affirm that you are either A) the cardholder or B) you have the express consent of the cardholder for use of the card above.

Initials _____

Authorization and Acknowledgement

I authorize Four Points to store my debit, credit, or HSA card on file and to charge my card the amounts for which I am responsible, including those related to late cancellations and missed appointments.

I understand I can make changes to the card on file through the client portal. I understand I may revoke this authorization at any time by notifying Four Points Counseling Center.

Signature _____

Date _____

Coordination of Care

The state of Colorado requires brief questions about primary and dental care **and** inquire if you will allow communication about your mental health services with your primary care provider (PCP).

You are not obligated to allow the sharing of information. Declining will not impact your ability to receive services from Four Points Counseling Center.

Do you authorize the therapist to share information with the primary care provider?

[] Yes [] No *If yes, please continue with the release of information. If no, please skip fields in the box below.*

Authorization to Exchange Protected Health Information

I authorize Four Points Counseling Center (Four Points) to exchange the health information of the client named at the bottom of this form with the following individual/entity.

Primary care provider: _____

This authorization permits Four Points to disclose the following information about the client:

Diagnosis	Treatment goals
Presence/participation in treatment	Treatment progress
Session frequency/dates of attendance	Discharge/transfer information

Revocation: I understand that I have the right to revoke this authorization at any time. I understand that revocation or modification of this authorization must be provided in writing to FPCC staff to be effective. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

Risk of Redisclosure: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a state law applies that is more strict than HIPAA and provides additional privacy protections.

Authorization: I understand that only the individual who has consented for care, including a minor as required or permitted by state law, can authorize the release of protected health information (PHI). I understand that I have the right to withhold my consent and refuse the signing of this authorization. The provider shall not condition treatment upon this refusal. I understand that I am voluntarily signing this form to release health information to the party or parties designated.

This authorization will **expire six months after termination of treatment** with FPCC. If an alternative expiration is desired, please indicate so here: _____

_____	_____	_____	_____
Printed Name	Date of Birth	Client/Representative Signature	Date

Representative's relationship to client: _____