FRONT RANGE PSYCHOLOGICAL ASSOCIATES

Bridget Engel, PsyD
303-828-3080
DrEngel@FrontRangePsychology.com
www.FrontRangePsychology.com

Client Information

Client Name(s): _____

Social Security Number: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Employer / Work Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____ Work Telephone: _____

Cellular Telephone: _____ Email: _____

Emergency Contact: _____ Contact Telephone: _____

Relationship to Client: _____

What concerns do you have for which you are requesting therapy? _____

_____

_____

How or where did you hear about my services: _____

_____

May I send correspondence to your mail address and to your email address? _____

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303-828-3080
526 Briggs Street
Erie, CO 80516

Mandatory Disclosure Statement

Therapist Information:

- Bridget Engel, PsyD
- Doctor of Psychology from the University of Denver
- Colorado Licensed Psychologist #2909

Client Rights and Important Information:

- You are entitled to receive information about my methods of therapy, the techniques I use, the duration of your therapy (if it can be determined), and my fee structure.
- Treatment and evaluations are voluntary and you have the right to terminate treatment or the evaluation at any time. You also have the right to seek a second opinion from another therapist at any time.
- Psychotherapy is not an exact science and there are no guarantees as to the outcome of treatment.
- The relationship between a therapist and a client is a professional relationship. Sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Department of Regulatory Agencies, Mental Health Section.
- Generally speaking, the information provided by and to a client during therapy sessions is legally confidential. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent.
- Information disclosed to a therapist 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.
- *Please Note:* For individuals who are court ordered for treatment or evaluations and/or are under the supervision of probation, parole, or community corrections, the laws protecting confidentiality do not apply.
- There are exceptions to the general rule of legal confidentiality. These exceptions are listed in the Colorado Statutes (C.R.S. 12-43-218) and include: lawsuits against the therapist; complaints, disciplinary proceedings, and reviews of professional conduct; reporting child abuse and neglect; and *duty to warn* of serious threat of imminent physical violence to oneself or a specific person or persons. Other exceptions will be identified to you as the situations arise during therapy.

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed and unlicensed mental health professionals. The agency within the Department that has responsibility specifically for licensed and unlicensed psychotherapists is the Department of Regulatory Agencies, Mental Health Section. You can contact this agency by calling or writing:

1560 Broadway, Suite #1340
Denver, Colorado 80202
(303) 894-7766
https://www.doradls.state.co.us/alison.php

If you have any questions or would like additional information, please feel free to ask. By signing below, you are in agreement that you have read the preceding information and understand your rights as a client.

_____ _____

Client Signature Date

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date

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Fee Agreement

I, _____, understand that my fee will be as outlined below and that payment is expected at the time of service, unless other arrangements have been made. I understand that phone consultations, except in the case of emergency, may be pro-rated based on the fee specified below. Should it become necessary that my fee rate be changed, Dr. Engel will provide me with this information well in advance of such change, at which time a new agreement will be initiated. I also understand that unless 24 hours notice is given prior to canceling a session, I will be responsible for paying for that session in full. Lastly, I understand that if my account becomes delinquent for more than 60 days, collection proceedings may be initiated.

I, as a client, agree to pay for therapeutic services at _____$110.00__ per hour. Further, I understand and agree that court testimony services are not guaranteed, but should they be needed, it will be charged at $150.00 per hour, and testimony time, commuting, records review, and affidavit writing will be billed at this rate.

_____ _____
Signature of Client Date

_____ _____
Signature of Client Date

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Notice Regarding Email Communication

While the Electronic Communications Privacy Act prohibits interception of any electronic communications, email cannot be completely secure or private unless encrypted. At this time, email communications from Dr. Bridget Engel come from a secure website but are not encrypted. While Dr. Engel encourages, supports and honors email communications, the content of electronic exchanges to and from Dr. Engel cannot be guaranteed to be confidential.

_____ _____

Client Signature Date

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Front Range Psychological Associates

Bridget Engel, PsyD
526 Briggs Street
Erie, Colorado 80516
303-828-3080

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment and Health Care Operations*"
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychotherapist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my office and practice group, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my office or practice group, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An **"***authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that, (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances: (see Colorado statutes: Section 12-43-218, CRS., in particular).

- *Child Abuse* - If I have reasonable cause to know or suspect that a child has been subjected to abuse or neglect, I must immediately report this to the appropriate authorities.
- *Adult and Domestic Abuse* - If I have reasonable cause to believe that an at-risk adult has been mistreated, self-neglected, or financially exploited and is at imminent risk of mistreatment, self-neglect, or financial exploitation, then I must report this belief to the appropriate authorities.
- *Health Oversight Activities* - If the Colorado State Board of Psychologist Examiners or an authorized professional

review committee is reviewing my services, I may disclose PHI to that board or committee.

- *Judicial and Administrative Proceedings* - If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated or a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety* - If you communicate to me a serious threat of imminent physical violence against a specific person or persons, I have a duty to notify any person or persons specifically threatened, as well as a duty to notify an appropriate law enforcement agency or by taking other appropriate action. If I believe that you are at imminent risk of inflicting serious harm on yourself, I may disclose information necessary to protect you. In either case, I may disclose information in order to initiate hospitalization.
- *Worker's Compensation* - I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provided benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of protected health information regarding you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- *Right to Inspect and Copy* - You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* - You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* - You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you with a written copy in person if possible, otherwise a copy will be mailed to you.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact:

Mental Health Occupations Grievance Board
State Board of Psychologist Examiners
1560 Broadway, Suite 1370
Denver, CO 80202
(303) 894-7766
https://www.doradls.state.co.us/alison.php

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The department listed above can provide you with the appropriate address upon request.

Client Signature: _____ Date: _____

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Background Interview

Client Name: _____ Date of Birth: _____

Occupation: _____ Date of Consultation: _____

Ethnic Identity: _____ Gender: _____

The following information will provide me with important information about your current struggles and the sources of your concerns. It will help me get to know you and will be kept strictly confidential.

What are your primary concerns or complaints?

_____

_____

_____

_____

What is the history of this concern? How long have you struggled with this problem and what were the events that led up to it?

_____

_____

_____

_____

_____

_____

What makes you want to seek treatment now?

Have you had any previous psychological help?

Any drug or alcohol use? How long have you been using and what substances do you use? Have you had any negative effects from your use?

How is your sleep generally? :

How is your appetite generally?

Have you ever had or are you having thoughts of hurting yourself or others, or killing yourself or others?

Have you ever heard or seen things that others didn't hear or see?

Do you have any history of trauma, abuse, or violence?

Do you think you have any self-destructive or troubling behaviors?

How would you describe your typically feelings or emotions?

What kinds of thoughts do you have? What do you tell yourself?

How are your interpersonal interactions or social relationships with coworkers, significant others, family etc.?

Do you have any medical problems or concerns?

What is your family like? How was your childhood?

Where do you work? What has your work history been like?

Is there anything else you think I should know about or will assist me in helping you? _____