*Hannah Salander, MA, LPC*

*575-224-1312*

*License # 0013532*

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*Client Information*

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/School Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party:

If you are the parent or legal guardian of a client who is under the age of 18, please complete the following with your information. If you are over the age of 18, please proceed to the next section.

Name of Parent(s) or Legal Guardian(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/School Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Information:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who Were You Referred By?**

□ Website- which one? \_\_\_\_\_\_\_\_\_ □ Physician □ Family/Friend □ Counselor □ School □ Church

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we contact this person to thank them? Yes No

**Name of Physician:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May I contact your Physician for continuity of care? Yes: \_\_\_\_\_\_\_\_ No: \_\_\_\_\_\_\_\_\_\_\_

***Clinical/Psychosocial History***

**Client marital status**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Names and ages of Immediate Family Members**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Currently a Student?** Yes\_\_\_\_\_No \_\_\_\_\_ **Current Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Partner’s Occupation**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client’s spiritual/religious involvement, interests, commitments,** **etc** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Client’s cultural involvement, interests, commitments, etc** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Describe why you are seeking counseling at this time?**

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 **What goals do you hope to achieve from therapy?**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What support do you believe you will need to reach these goals?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical and Psychiatric History:** Please list dates and reason why. Include major illnesses, surgeries, hospitalizations, accidents, in patient treatment, injuries, and traumas \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Current Medications:** Please list medication and reason for being on medication, including herbs and natural remedies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current and or Past Substance Abuse/Addiction:** Please include tobacco, illicit, prescribed & OTC substance. Please include if you are sober and if so, how long you have been sober. What supports do you have in place to maintain sobriety?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Addictive Behavior:** Please circle any that apply.

Gambling Pornography Sex Shopping Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:** Pleaseinclude medication allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current diet/exercise/sleep patterns**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**FAMILY PSYCHIATRIC HISTORY**

**Are you currently working with a psychiatrist?**

* Y Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* N Previously? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List family members, conditions, and hospitalizations:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_LList any previous or current diagnosis:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY DYNAMICS**

What did you learn from your family about being emotional and vulnerable?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What do you remember happening when you were little and you were hurt? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Who did you turn to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Could you say that you were hurting? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the response?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you remember feeling safe with someone in your family?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, who was is and how did you know you were safe?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did that person ever betray your trust?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you let this person know that you needed connection and comfort?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe your current romantic relationship if you are in one?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**COUNSELING HISTORY**

Have you ever consulted a therapist before? Yes \_\_\_\_\_ No\_\_\_\_\_ If so When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long? Briefly state the reasons you sought counseling at that time? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

What was helpful in your past counseling experiences? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you recently or in the past thought about suicide? Yes\_\_\_\_\_\_\_ When\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_

Have you ever attempted suicide? Yes\_\_\_\_ No\_\_\_\_

If your answer is yes to either of these questions, please describe what treatment you have had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**STRENGTHS**

How do you reduce your stress? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What are your strengths, and the strengths of your family/partnership if you are currently in one? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Consent of Treatment**

Hannah Salander, MA, LPC

CO License # 0013532

Training in Art and EMDR Therapy

I understand the potential benefits from counseling are many and may include improved personal functioning and relationships, as well as self-image and mood, and the attainment of personal goals. I also understand that discussing psychological and emotional issues can be distressing, that healing and growth can be challenging, and some discomfort will likely be part of the process. I agree to inform my therapist of changes in mood and/or physical wellbeing to best support treatment. I understand that if an emergency should arise and I am unable to contact my therapist, I should go to the local Hospital Emergency Room or call 911.

**Confidentiality/Personal Health Information**

All communications and record with Hannah Salander are held in strict confidence. Information may be released in accordance with Colorado law, when (1) the client signs a written release indicating consent to release; (2) the client expresses serious intent to harm self or someone else; (3) there is reasonable suspicion of abuse against a minor, elderly person or dependent adult; (4) to acquire payment for services or billing purposes, or (5) a subpoena or court order is received directing the disclosure of information. To protect your privacy to the greatest extent of the law, it is my policy to assert either (a) privileged communication in the event of #5 or (b) the right to consult with clients, if at all possible, before mandated disclosure in the event of #2 or #3.

I have read, fully understand and agree to honor this agreement, and have sought clarification as needed. I give consent to allow Mrs. Hannah Salander, LPC to treat me or my child.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian if client is under age 18 Date

**Client Rights Policy**

I, Hannah Salander LPC, agree to protect and promote the rights of each individual who is provided counseling and support services through this relationship to the highest degree.

As a client you have the right:

1. To give informed consent
2. To refuse treatment
3. To be advised of the potential consequences of refusing treatment
4. To actively participate in the development of an individualized treatment plan and goals
5. To actively participate in periodic review of the individualized treatment plan
6. To know the qualifications of your therapist
7. To a grievance procedure
8. To a humane and safe environment
9. To be free from abuse, neglect and exploitation
10. To dignity and respect
11. To personal privacy and confidentiality
12. To have access to your records
13. To request limits on the information we share
14. To know the cost of treatment
15. To be informed of any limitations of service during the course of treatment
16. To refuse to participate in research
17. To receive a complete explanation of your rights that is clear and understandable
18. To receive treatment that is non-discriminatory based on race, ethnicity, gender, religion, age, ability or sexual orientation.

I have read the above rights and have had an opportunity to ask for clarification if it was needed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/guardian signature Date

**Release of information**

Hannah Salander, LPC has my permission to release the following information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To:

Name of person/position \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact phone/email/fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization for use or disclosure of medical information is being requested to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Sections 56 et seq. The purpose of this release is to allow Hannah Salander, LPC, to communicate with the above named family members and professionals regarding your care.

I authorize the above named family members and professionals to release and receive information concerning the above named participant to and from Hannah Salander, LPC.

I further authorize the release of this information to be received via E-mail, Internet technology, voice mail or US mail. While every effort will be made for confidentiality, Hannah Salander accepts no responsibility in the mis-transmission that could result or information becoming available to someone other than the intended receiver.

I understand that my confidential records are protected under the federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I certify that this authorization has been made freely, voluntarily and without coercion. I understand that I may revoke this authorization at any time except to the extent that the action has already been taken.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Guardian signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist signature Date

**Financial Agreement**

**Standard Service Fees:**

Please review the rates for the following services. The rates listed below are based on a 50 minute clinical hour. Therapeutic sessions lasting over 50 minutes in length may be subject to additional service fees.

* Individual: $125
* Couples, Family: $150
* Phone Consultations: 15 minutes free of charge, and full fee rate afterwards
* Emergency or After-Hours Consultations: $125
* Consultation and Correspondence Rate: $125 per hour

If a report or consultation with an outside party is requested. I understand I will be billed for any time needed to prepare documentation or to conduct an in-person or phone consultation. My therapist’s standard service fee will apply.

**Discount Rates:**

If you are currently receiving a rate reduction which has been previously arranged by your therapist, please enter this rate here: \_\_\_\_\_\_\_\_\_\_\_\_\_.

**Cancellation Policy:**

In the event you need to cancel an appointment, please provide notice to your therapist within 24 hours of your scheduled appointment time. If you cancel less than 24 hours before your scheduled appointment, you will be charged a fee of $125. If no notice is given at all, your therapist’s standard service fee as agreed upon in this disclosure will be assessed for that session.

**Policy for Non-Payment:**

In the event billing efforts fail, delinquent accounts may be subject to collections. This therapist will make every attempt to develop a payment plan with any client struggling to pay a past due balance prior to sending a balance to collections.

I certify the information provided above is accurate to the best of my knowledge. I understand and agree to the proceeding Financial Agreement and Consent for Treatment. I also authorize any service fees to be deducted from the form of payment designated on this form. Should any of the information provided change, I agree to update my provider as soon as possible.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client (Legal Guardian if Client is a Minor) Date

**Unsecured Technological Communications Request and Consent Form**

**Hannah Salander requires consent from clients to communicate with you and, if necessary, with other providers, business associates via unencrypted technological correspondence regarding your protected health information, billing information and appointment times and dates. Technological correspondence may include emails, text messages, shared informational spreadsheets, and cloud storage systems. If a client is paying for services through insurance, or attempting to be reimbursed for services through insurance, potential unsecured correspondence with insurance clearinghouses may also occur.**

The purpose of this consent form is to notify the individual of the risks associated with unencrypted correspondence. There is some level of risk that information sent via unencrypted correspondence will be read by a third party. If you consent to and request to receive information individually, and also consent to and request the unencrypted correspondence of information between business associates and other workforce members with Hannah Salander regarding your protected health information, Hannah Salander is not responsible for unauthorized access of protected health information while in transmission based on the individual’s request and consent. Further, Hannah Salander is not responsible for safeguarding information once delivered to the individual or business associate.

I have been informed of the potential risks involved in both sending and receiving unencrypted technological correspondence regarding my protected health information. I have read the preceding information and I understand my rights as a client/patient.

* I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, consent and request to unsecured technological correspondence between my provider and myself or business associates as needed.
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client (Legal Guardian if Client is a Minor) Date

* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature Date

 **Social Media Policy**

**The purpose of this form is to provide information about the social media conduct policy of Hannah Salander, LPC. Please read it to understand how we will respond to various interactions that may occur between Hannah Salander and clients on the Internet.**

**If you have any questions about this document, please discuss them with your therapist.**

**Friending, Fanning, and Likes**

The policy of Hannah Salander, LPC is for therapists to neither accept nor solicit friend, fan, or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, Instagram, etc). It is our belief that clients as friends or contacts on these sites can compromise your confidentiality. It may also blur the boundaries of the therapeutic relationship. Please also be aware that if you “like” any Facebook posts that your therapist keeps for his/her professional practice, it may compromise your confidentiality as a client. If you have questions about this, please bring them up with your therapist.

We believe having clients as social media contacts creates a greater likelihood of compromised client confidentiality, and we feel it is best to be explicit to all who may view social media sites and pages that they will not find client names unless that client has willingly posted or “liked” something of their own volition. In addition, the American Psychological Association’s Ethics Code prohibits soliciting testimonials from clients. We feel that becoming a social media contact comes too close to the boundary of an implied request for a public endorsement of our practice.

**Following**

Many therapists publish blogs on professional websites and post psychology news on Twitter. If you use an easily recognizable name online, be aware that following these blogs or Twitter streams may compromise your confidentiality.

Note that if you choose to follow your therapist, your therapist will not follow you back. The policy of Hannah Salander is for therapists to only follow other health professionals on Twitter and to not follow current or former clients on blogs or Twitter. Our reasoning is that casual viewing of clients’ online content outside of the therapeutic relationship can be inappropriate. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with your therapist, please bring them into your session where you can view and explore them together, during the therapy hour.

**Social Media to Contact Hannah Salander**

Please be aware that using any means of public communication from a social networking site such as Twitter, Facebook, or LinkedIn to contact your therapist could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal/medical record and will need to be documented and archived in your chart. In addition, be aware that your therapist will not respond to public communications via social networking sites. If you need to contact your therapist, please do so by phone, email, or text.

**Business Review Sites**

You may find our therapy practice on sites such as Yelp, Psychology Today, Good Therapy, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find your therapist or Light Quest Counseling on a listing on any of these sites, please know that this listing is NOT a request for a testimonial, rating, or endorsement from you as a client. If you choose to contribute to a business review site forum, be aware that this may compromise your confidentiality as a client.

* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature (Legal Guardian if Client is a Minor) Date

* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature Date

**Transport of information Policy**

The policy of Hannah Salander, LPC is to accept the use of personal laptops, cell phones, iPads, tablets, and any other portable electronic device for the recording and storage of case notes and other identifying client information. Because of this, your therapist may transport your information by moving these devices to and from the office in their vehicles. They may also transport your physical client file to and from the office in their vehicles.

With the transport of these materials, there is a level of risk involved to your file or the device which contains your information, which includes loss of information due to technical corruption or failure, hacking via malicious software or unauthorized access, and loss of information due to theft, misplacement, or accidental destruction.

We take these risks very seriously and value your confidential information and privacy as a priority. The policy of Hannah Salander, LPC is for all information kept on electronic devices to be password protected, and for all physical files to be stored in a locked location both at the office and elsewhere when in the possession of your therapist. Your information will never be transported carelessly or with unnecessary risk.

By signing this form you authorize your therapist to transport your files to and from the office as necessary.

* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature (Legal Guardian if Client is a Minor) Date

* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature Date

**Disclosure Statement**

Colorado Law requires that the following information be provided to all clients.

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

The agency within the Department that has responsibility specifically for licensed and unlicensed psychotherapists is:

Department of Regulatory Agencies

Mental Health Section

1560 Broadway, Suite 1350

Denver, CO 80202

(303) 894-7766

If there are any complaints or concerns regarding the practice of mental health, please direct them to the above listed department.

A separate addendum to this disclosure, which identifies your therapist’s training and license, will be provided to you.

You are entitled to receive information from me regarding methods, techniques, fee structure and duration (if known) of the sessions. You have the right to seek a second opinion from another therapist or terminate therapy at any time.

The information provided by you during counseling is legally confidential except as required by law and 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. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent. There are exceptions to the rule of confidentiality that can be explained and will be identified to you should any situations arise during therapy. Some of these exceptions are listed in section 12-43-218 and in the Notice of Privacy Rights you were provided. In general, the exceptions include a “threat of serious harm to yourself or others” as in the case of child abuse, suicide, grave disability; under a court order; or in response to any legal action taken by you against this agency. You should also be aware that provisions concerning disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in section 13-90-107 C.R.S.

In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

As to the regulatory requirements applicable to mental health professionals: a Licensed Clinical Social Worker, a 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. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a master’s degree in social work. A Psychologist Candidate, a Marriage and Family

Therapist 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. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelor’s degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master’s degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required. However the registered psychotherapist is listed in the State's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing

I understand I am responsible for all fees agreed to in the financial agreement. Fees are due upon receipt of services, and should billing attempts fail, delinquent accounts will be turned over to a collection agency.

I have been informed of my therapist’s degrees, credentials and licenses. I have read the preceding information, it has also been provided verbally, and I understand my rights as a client/patient.

* I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have received a copy of Hannah Salander, LPC Notice of Privacy Practices.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client Date Therapist Date

(Parent or Guardian for a minor)

Center Sight Counseling Waiver

**Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**E-mail:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

                Name                    Phone                 Relation to Client

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(print name) understand that physical activities such as, but not limited to yoga and hiking on uneven trails, include physical movements, which may become strenuous. These activities also offer an opportunity for relaxation, stress re-education and relief of muscular tension. As is the case with any physical activity, the risk of injury, even serious or disabling, is always present and cannot be entirely eliminated. If I experience any pain or discomfort, I will listen to my body, adjust the posture or change the activity. I will ask for support from the therapist, or gently come out of the posture or activity and rest. I understand that I can rest at any time. I will respect my body’s limits on any given day.

I understand that physical activities such as, but not limited to yoga and hiking on uneven trails, is not a substitute for medical attention, examination, diagnosis or treatment. I understand that physical activities such as, but not limited to yoga and hiking on uneven trails, is not recommended and is not safe under certain medical conditions. I affirm that I alone am responsible to decide whether to practice said activities, and whether to attempt or to enter any particular posture. I also understand that if I participate in an activity outside of the office setting, Hannah Salander will do her best to keep confidentiality. I understand that there is a risk that someone could overhear me and Hannah Salander discussing my personal information, and I could lose confidentiality. I hereby agree to assume full responsibility for any risks, injuries or damages, known or unknown, which may occur as a result of participating in therapeutic sessions and Center Sight Counseling, led by Hannah Salander, LPC. I will not hold Center Sight Counseling, Hannah Salander, LPC, or any additional staffing members of Center Sight Counseling for any injuries or losses, and hereby agree to release and hold harmless those entities and individuals for any liability or claims arising from my participation in the Center Sight Counseling, led by Hannah Salander, LPC, as well as any yoga classes, wilderness experiences, workshops, or other events sponsored or run by them.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_         \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name Date

***COVID-19 Regulations, June 16, 2020***

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(print name) understand that during this time of COVID-19, my therapist’s regulatory agency, DORA, has strict guidelines which at this time recommend using telehealth whenever possible to minimize face to face contact. DORA also requires my therapist to screen me for any symptoms of COVID-19 prior to meeting face to face. I understand that my therapist will ask me a list of questions around symptoms, not to diagnose me medically, but to respond responsibly if I have any signs/symptoms of COVID-19. My therapist will not see me face to face if I report signs of COVID-19. I understand my therapist can still meet with me via telehealth if I report signs of COVID-19. If my therapist and I meet in person, I understand that Hannah Salander and I need to be at least 6 feet apart and we will both need to wear PPE, which will include a face mask. I understand that if I meet in person with Hannah Salander outside, I need to maintain 6’ or greater of distance between us and that meeting outside risks my confidentiality due to the potential of other people overhearing our conversation, as is stated in Hannah Salander’s “registration and waiver” form. In the event that I do meet face to face with Hannah Salander, I understand that she will be following DORA’s guidelines, and I agree to follow them. I understand that any face to face contact could lead to getting COVID-19. I hereby agree to assume full responsibility for any risks, injuries or damages, known or unknown, which may occur as a result of participating in therapeutic sessions and Center Sight Counseling, led by Hannah Salander, LPC. I will not hold Center Sight Counseling, Hannah Salander, LPC, or any additional staffing members of Center Sight Counseling for any injuries or losses, and hereby agree to release and hold harmless those entities and individuals for any liability or claims arising from my participation in the Center Sight Counseling, led by Hannah Salander LPC, as well as any yoga classes, wilderness experiences, workshops, or other events sponsored or run by them.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_         \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name Date

*INFORMED CONSENT FOR TELETHERAPY*

This Informed Consent for Teletherapy contains important information concerning engaging in electronic psychotherapy or teletherapy. Please read this carefully and let me know if you have any questions. This consent shall only apply to clients physically within the State of Colorado seeking therapeutic treatment within the State of Colorado.

**Benefits and Risks of Teletherapy**

Teletherapy refers to the remote provision of psychotherapy services using telecommunications technologies such as video conferencing or telephone. One of the benefits of teletherapy is that the client and therapist can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or therapist moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It can also increase the convenience and time efficiency of both parties.

Although there are benefits of teletherapy, there are some fundamental differences between in-person psychotherapy and teletherapy, as well as some inherent risks. For example:

* Risks to confidentiality. Because teletherapy sessions take place outside of the typical office setting, there is potential for third parties to overhear sessions if they are not conducted in a secure environment. I will take reasonable steps to ensure the privacy and security of your information, and it is important for you to review your own security measures and ensure that they are adequate to protect information on your end. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.
* Issues related to technology. There are risks inherent in the use of technology for therapy that are important to understand, such as: potential for technology to fail during a session, potential that transmission of confidential information could be interrupted by unauthorized parties, or potential for electronically stored information to be accessed by unauthorized parties.
* Crisis management and intervention. As a general rule I will not engage in teletherapy with patients who are in a crisis situation. Before engaging in teletherapy, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our teletherapy work.
* Efficacy. While most research has failed to demonstrate that teletherapy is less effective than in person psychotherapy, some experienced mental health professionals believe that something is lost by not being in the same room. For example, there is debate about one’s ability when doing remote work to fully process non-verbal information. If you ever have concerns about misunderstandings between us related to our use of technology, please bring up such concerns immediately and we will address the potential misunderstanding together.

**Electronic Communications**

We will discuss which is the most appropriate platform to use for teletherapy services. You may be required to have certain system requirements to access electronic psychotherapy via the method we choose. You are solely responsible for any cost to you to obtain any additional/necessary system requirements, accessories, or software to use electronic psychotherapy.

For communication between sessions, I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not include any clinical material by email and prefer that you do not as well.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions, however if an urgent issue arises, you should feel free to attempt to reach me by phone. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

**Confidentiality:**

I have a legal and ethical responsibility to make my best efforts to protect all communications, electric and otherwise, that are a part of our teletherapy. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential and/or that a third party may not gain access to our communications. Even though I may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic communications may be compromised, unsecured, and/or accessed by a third party.

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Disclosure Statement/Informed Consent still apply in teletherapy. Please let me know if you have any questions about exceptions to confidentiality.

**Appropriateness of Teletherapy**

If at any time while we are engaging in teletherapy, I determine, in my sole discretion, that teletherapy is no longer the most appropriate form of treatment for you, we will discuss options of engaging in face-to-face in-person counseling or referrals to another professional in your location who can provide appropriate services.

**Emergencies and Technology**

Assessing and evaluating threats and other emergencies can be more difficult when conducting teletherapy than in traditional in-person therapy. In order to address some of these difficulties, I will ask you where you are located at the beginning of each session and I will ask that you identify emergency resources that are near your location that I may contact in the event of a crisis or emergency to assist in addressing the situation. I may also ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session cuts out, meaning the technological connection fails, and you are having an emergency do not call me back, but call 911, the Colorado Crisis Hotline at 844-493-TALK (8255), or go to your nearest emergency room. Call me after you have called or obtained emergency services.

If the session cuts out and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the teletherapy platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call me on the phone number I provided you (575-224-1312).

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

**Fees:**

The same fee rates shall apply for teletherapy as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted using electronic psychotherapy. If your insurance, HMO, third-party payer, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in teletherapy sessions in order to determine whether these sessions will be covered.

**Informed Consent:**

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together. Your signature below indicates agreement with its terms and conditions. This agreement is supplemental to my general informed consent and does not amend any of the terms of that agreement.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the client, having been fully informed of the risks and benefits of teletherapy; the security measures in place, which include procedures for emergency situations; the fees associated with teletherapy; the technological requirements needed to engage in teletherapy; and all other information provided in this informed consent, agree to and understand the procedures and policies set forth in this consent.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client Date