

Client Information

Child's Name: _____ Age: _____

Parent's 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? _____



Bridget Engel, PsyD
303-828-3080
Drengel@fronrangepsychology.com
www.fronrangepsychology.com

Authorization to Provide Psychological Services To a Minor

I, _____ authorize Bridget Engel, PsyD to provide:

Therapeutic Services to _____

Psychological Testing and Assessment Services to _____

I attest that I am the legal parent or guardian of this child and have legal authorization to make care decisions for him or her.

Signature of Guardian

Date

Bridget Engel, PsyD
Licensed Psychologist

Date

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

Dr Bridget Engel
Therapist

Date



Bridget Engel, PsyD
303-828-3080
P.O. Box 1154 Erie, CO 80516
DrEngel@FrontRangePsychology.com
www.FrontRangePsychology.com

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

Dr. Bridget Engel

Date



Bridget Engel, PsyD
303-828-3080
PO Box 1154 Erie, CO 80516
FrontRangePsychology.com
DrEngel@FrontRangePsychology.com

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

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: _____



Bridget Engel, PsyD
P.O. Box 1154 Erie, CO 80516
DrEngel@FrontRangePsychology.com
www.FrontRangePsychology.com

Child Intake Interview

Child's Name: _____ Date of Birth: _____

Date of Consultation: _____ Child's 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 regarding your child?

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

What makes you want to seek treatment for your child now?

Has your child had any previous psychological help?

Has your child ever used alcohol or drugs? How long have they been using and what substances do they use? Have you had noticed any negative effects from their use?

How is their sleep generally?

How is their appetite generally?

Have they ever had or are they having thoughts of hurting themselves or others, or killing themselves or others?

Do they ever complain of hearing or seeing things you cannot hear or see?

Do they have any history of trauma, abuse, or violence? Include witnessing any violence.

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

How would you describe their typically feelings or emotions?

What kinds of thoughts do you think they have?

How are their interpersonal interactions or social relationships with friends, classmates, neighbors, family?

Do they have any medical problems or concerns?

Any concerns about their prenatal health or postnatal development?

What is the family like? How has their childhood been like thus far?

How is their academic and cognitive performance in school? What are their behaviors like at school?

Anything else you think I should know about your family or your child?
