INFORMED CONSENT age 12-18

My name is Holly James and I am the counselor you will be seeing today. My office address and phone number is 941 Lincoln Ave Suite 200c, 970-871-7857. Today's appointment will take about 45 – 55 minutes. I know that that starting counseling is a big decision and you may have many questions. I will do my best to answer any questions or concerns. This form explains information about me, my policies, State and Federal Laws and your rights about counseling. My formal education includes a Bachelor of Psychology and a Masters Degree in Clinical Mental Health Counseling from the University of Phoenix. I am licensed by the State of Colorado as a Licensed Professional Counselor. In counseling I use the type of therapy called cognitive behavioral therapy, which is called CBT. Other counseling approaches can be used depending on the person or condition. Counseling practices, philosophy and plan imitations and risks will be discussed with you today.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: What we talk about and my notes are not shared with anyone without your written permission except for: 1. Diagnosis and dates of service shared with your insurance company to process your claims, 2. Information you tell me about physical, sexual or elder abuse; then, by Colorado State Law, I have to report this to the Department of Children and Family Services, 3. Where you sign a release of information to have specific information shared 4. If you tell me you are in danger of harming yourself or others 5. Information shared with my supervisor or consultant and 6. When required by law.

If you need to contact me between counseling sessions please call my office. E-mail, text messages and social networking sites are not confidential and I may not be able to respond. If an emergency situation would happen you can call my office to have a counselor call you. If no call is received within 15 minutes or you can't wait call 911.

Signature____Date:________

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COORDINATION OF TREAMENT: It is important that all health care providers work together. As such, I would like your permission to communicate with your family Doctor and/or Psychiatrist. Your permission is good for one year. If you don't want me to communication with your Doctor, it is ok and no information will be shared. Please check the correct box below.

____**You may communicate with my Doctors(s)**
____**You may not communicate with My Doctor(s)**

PHYSICIAN NAME:____
CLINIC:____
ADDRESS:____
PHONE:_________________________________

Signature_______________________________________Date_______

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: I have read and received a copy of the Notice of Privacy Practices and Client Rights document.

May I contact you at home (circle one) **yes no**? May I contact you at work **yes no?**
May I contact you by cell phone **yes no?** Cell number_____________________
Where may we contact you ______________________________________?

Signature_______________________________________Date______________

You may have a copy of this form if requested.