Kiser Counseling Inc
Mandatory Disclosure Statement
for services rendered by: Bethany Kiser, MA, LPC

1. My name is Bethany Kiser and I am a Licensed Professional Counselor in Colorado (#13433). I also hold a license in the State of Nebraska; I am a Licensed Independent Mental Health Practitioner (#1066). In order to obtain these licenses, I had to get a Master's degree in Counseling, have at least 2 years post-Master's experience and pass a National Exam. I received my Master of Arts degree in Community Counseling from The University of Northern Colorado in 2006. I received my Bachelor of Science in Psychology degree from Colorado State University in 2005. My practice is Kiser Counseling Inc, located at 518 28 Rd., Suite B203, Grand Junction, CO 81501. The office phone number is 970-812-3162.
2. There are a number of professionals who practice psychotherapy in the State of Colorado. These are outlined below:
    a. Licensed Professional Counselor (that's the license I have): must hold a master's or doctorate degree in counseling, have at least 2 years post-masters or 1 year post-doctorate experience and pass an exam in professional counseling.
    b. Licensed Psychologist: must hold a doctorate degree in psychology, have one-year post-doctoral supervision and pass an exam in psychology.
    c. Licensed Marriage and Family Therapist: must hold a master's or doctorate degree in marriage and family therapy, have at least 1-2 years post degree supervision/experience and pass an exam in marriage and family therapy.
    d. Psychologist Candidate, Marriage and Family Therapist Candidate, and Licensed Professional Counselor Candidate: must hold the necessary licensing degree and be in the process of completing the required supervision for full licensure.
    e. Licensed Social Worker: must hold a master's degree in social work and pass an examination in that social work.
    f. Licensed Clinical Social Worker: must hold a master's or doctorate degree in social work, have at least 2 years experience practicing as a social worker and pass an examination in social work.
    g. Registered Psychotherapist: This is an individual who is registered in the State's database and is authorized by law to practice psychotherapy in CO but is not licensed by the State and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.
    h. Certified Addiction Counselor I (CAC I): must have a high school diploma or equivalent, complete required training hours and 1,000 hours of supervised experience.
    i. Certified Addiction Counselor II (CAC II): must have a high school diploma or equivalent, complete CAC I requirements, and obtain additional required training and 2,000 additional hours of supervised experience and pass a national exam.
    j. Certified Addiction Counselor III (CAC III): must have a bachelor's degree in behavioral health, complete CAC II requirements, and complete additional required training hours, 2,000 additional hours of supervised experience and pass a national exam.
    k. Licensed Addiction Counselor: must have a clinical master's degree, meet the CAC III requirements and pass a national exam.
3. The Department of Regulatory Agencies (DORA) is the governing body over many things in the State of Colorado and DORA has many divisions and subsections. The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Professions and Occupations. The Board of Licensed Professional Counselors can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303)894-7800. You may also get information or contact them from DORA's website: www.colorado.gov/dora.
4. As a Client you are entitled to receive information about the methods of therapy, the techniques used, the duration of therapy, if known and the fee structure. I have outlined some of this information for you here, but you are welcome to ask questions any time during your treatment. Primarily I use Cognitive Behavioral Therapy with adults and with children I primarily will use my training in Play Therapy, Child Parent Psychotherapy, or Trauma Focused CBT. I provide Clients with psychoeducation on diagnosis and best practice treatment approaches. Duration of therapy depends on many factors and we will discuss this together. The fee structure is $200 for an intake/assessment, $140 for family services and $125 for individual services. I will bill your insurance for you if you would like but you are ultimately responsible for payment.
5. As a Client you may seek a second opinion from another therapist or you may terminate therapy at any time.
6. In a professional relationship, sexual intimacy is never appropriate and should be reported to The Licensing Board from above.
7. Information provided by you during therapy sessions is legally confidential in the case of licensed marriage and family therapists, professional counselors, social workers and psychologists; licensed or certified addiction counselors; and registered psychotherapists, except as provided in 12-245-220 and except for certain legal exceptions that will be identified by me should any such situation arise during therapy.
8. Custody/Divorce Issues: If you are bringing your child in for therapy services and you have joint legal custody, both parents must consent to treatment in order to proceed. If one parent has primary legal custody only consent of the primary legal custodian is required, but it is preferable if both parents consent unless deemed to not be appropriate to obtain consent from the noncustodial parent. You will need to bring in a copy of your custody paperwork by the second session which will be kept in the clinical chart. If you are in the process of or anticipate being in the process of a CFI or PRE relating to your child I will only participate in these proceedings if both parents consent. Participating in a CFI or PRE is as much as I am willing to get involved in your custody case. I will not testify on behalf of either parent.

9. Abuse/Neglect: I am a mandated reporter of suspected or known child abuse or neglect. If I learn information of this nature during the course of therapy, I am mandated by law to report it to the child protective services hotline.
10. Records Release: If you need a copy of your medical records, whether that be for yourself or sent to a third party you will need to sign an appropriate release form. If the records are for a child whose parents share joint legal custody and/or decision making either parent may sign for records to be released. If records are for a child where one parent has primary legal custody and/or decision making the release must be signed by the primary custodial parent. I charge a fee for copying records and you will have to pay that before records are released. The cost is 25 cents per page plus the cost for mailing the items to you (if applicable).
11. Tele-Health: I offer tele/video-health therapy services. I use a HIPAA compliant platform for these sessions. Please inquire should you desire more information regarding this service.
12. EMR: I use an Electronic Medical Records system that is fully HIPAA compliant. Any paper forms you fill out are scanned into this system and the originals are destroyed.
13. No Shows: If you have three No show and no calls to appointments you will be discharged from services with appropriate referrals.
14. Non-payment: If your account is over 90 days past due you may be sent to collections.
15. Court fees: I charge $200/hour for any court related activity which includes but is not limited to court preparation, time in court, travel to and from court. If the court proceedings result in my need to travel outside of Mesa County you will be responsible for my gas/mileage in addition to room and board. There will be a per diem fee for food of $60. These fees must be paid in advance.
16. Couples: In the event that I am seeing you for couples counseling, I require that you each sign appropriate release forms for each other. I will not keep secret information given to me by one party that could result in collusion against the other party.
17. DHS involvement: When referred by DHS appropriate release forms must be signed to be in compliance with the referral.

I have read the preceding information and understand my rights as a client or as the client's responsible party. By signing this form I am also providing my informed consent for treatment.

_____
Print Client's Name

_____ _____
Client's or Responsible Party's Signature Date

If signed by Responsible Party, please state relationship to client and authority to consent:

_____

Kiser Counseling Inc

518 28 Rd. Suite B203, Grand Junction, CO 81501

Client Information Sheet

Date: _____

Demographic Information:

Client Name: _____ Social Security #: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____

(Street/PO Box) (City) (State) (Zip)

Primary Phone #: _____ (Home/Cell) Secondary #: _____ (Home/cell)

Is it ok to leave a message at these #'s? _____

Would you like an email reminder for appointments? No Yes, Email address: _____

Height: _____ Weight: _____ Hair color: _____ Eye Color: _____

Religious affiliation: _____ Ethnicity: _____

I am: Single (never married) Divorced Separated (legal) Married Other_____

Employment Status: Full-time Part-time Unemployed Disabled (receiving benefits) N/A (student)

Employer: _____ Occupation: _____

Primary Insurance Coverage:

Insurance Company: _____ Insurance ID #: _____

Name of Policy Holder: _____ DOB of Policy Holder: _____

Policy holder's Social Security #: _____ Group #: _____

Mailing address of policy holder (if different from above): _____

Phone # of policy holder: _____

Secondary Insurance Coverage:

Insurance Company: _____ Insurance ID #: _____

Name of Policy Holder: _____ DOB of Policy Holder: _____

Policy holder's Social Security #: _____ Group #: _____

Mailing address of policy holder (if different from above): _____

Phone # of policy holder: _____

Emergency Contact:

Name: _____ Phone #: _____

Relationship to Client: _____

I hereby authorize Kiser Counseling Inc. to release any information necessary to expedite insurance claims. I understand that the Health Insurance Portability and Accountability Act allows for the release of Protected Health Information without the need for a signed authorization for the purposes of treatment, payment and operations. I understand and agree that although Bethany Kiser will submit claims to my insurance, this is done as a courtesy and that I am fully responsible for payment of any services rendered by this office should my insurance deny payment for any reason. I understand that if I have a co-pay that I will submit my portion of payment on the date of service.

_____ _____ _____

Client Signature (if over age 18) Parent/Guardian Signature (if under 18) Date

Client's Rights and Responsibilities Statement

Clients have the RIGHT to:

- Be treated with dignity and respect.
- Be treated fairly, regardless of their race, religion, gender, ethnicity, age disability or source of payment.
- Have their treatment and other member information kept confidential. Only where permitted by law may records be released without the member's permission.
- Easily access care in a timely fashion.
- Know about their treatment choices. This is regardless of cost or coverage by their benefit plan.
- Share in developing their plan of care.
- Receive information in a language they can understand.
- Receive a clear explanation of their condition and treatment options.
- Receive information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Clients' Rights and Responsibilities policy.
- Know about advocacy and community groups and prevention services.
- Freely file a complaint or appeal and learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Request certain preferences in a provider
- Have provider decisions about their care made on the basis of treatment needs.

Clients have the RESPONSIBILITY to:

- Treat those giving them care with dignity and respect.
- Give providers and insurance companies information that they need. This is so providers can deliver quality care and insurance companies can deliver appropriate services.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Client should call their provider as soon as they know they need to cancel visits.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.

My signature below states that I have been informed of my rights and responsibilities and that I understand this information.

Signature of Client (if over age 18) Signature of Parent/Guardian (if under age 18) Date

_____

Signature of Provider Date

Notice of Privacy Practices/Receipt and Acknowledgement of Notice

Client Name: _____ DOB: _____ SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Kiser Counseling Inc's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice of my privacy rights, I can contact Kiser Counseling Inc.

_____ _____

Signature of Client (if over age 18) Date

_____ _____

Signature of Parent/Guardian (if under age 18) Date

_____ _____

Signature of Witness/Staff member Date

____ Check here if Client refused to acknowledge the receipt of the Notice of Privacy Practices

Name:_____ Date:_____

Symptom Checklist

Please read through the following symptoms. Some of these happen to all of us at some point or another. Please check only if this symptom occurs often or if the symptom is a major concern for you or your child:

Depressed mood

Irritable mood

Tearful or cries often

Withdrawing/Isolating from family or peers

Anger outbursts

Low energy

Change in appetite

Changes in sleeping habits

Unmotivated

Loss of interest in things

Thoughts of suicide

Preoccupied with death/dying

Cutting or other self-harm behavior

Anxious mood

Worries a lot

Complains of trouble breathing

Complains of stomach aches

Complains of headaches

Nervous/jittery/tense

Panic attacks

Complains of heart racing

Angry mood

Yells/Screams

Doesn't listen

Defiant attitude

Argues with adults

Tells lies

Mean to others

Hurts people/animals

Spiteful/Vindictive

High energy/Hyper

Always on the go

Climbs on furniture

Difficulty with quiet activities

Talks excessively

Forgetful

Gets distracted easily

Rushes through homework/chores

Doesn't pay attention to detail

Makes simple mistakes

Avoids/lies about homework

Dislikes school

Talking out of turn/interrupts

Can't sit still

Difficulty with sustaining attention

Disorganized

Poor eye contact

Struggles in school

Trauma history

Nightmares

Startles easily

Flashbacks

Avoids trauma triggers

Acts out parts of traumatic event

Tics/repetitive movement

Wets bed

Daytime accidents

Mood swings

Clingy

Fearful

Substance Abuse

Other Concerns (list below)

Health History

Medical Information and History (All Clients fill out this portion)

Primary Care Physician: _____ **Clinic Name:** _____

Are you comfortable with me communicating with your PCP? Yes No

What Medical Conditions are you struggling with currently? _____

Would you describe yourself as: Underweight Thin Athletic Normal/Average Overweight Obese

How often do you exercise? Never A few times per month 1-3 days/week 4 or more days/week

How intense is this exercise? Low (walking at a leisurely pace) Moderate (brisk walk) High (running or equivalent)

What are other medical issues you think are important for me to know? _____

Significant Family Medical History: _____

Developmental History (For Under age 18 only)

- How many weeks gestation was child born? _____
- Any complications during pregnancy or delivery? No Yes _____
- Was the child exposed to drugs or alcohol during pregnancy? If so, what substance? _____
- How would you describe the child's temperament as a baby/toddler? _____
- When did the child: Crawl _____ Walk _____ Potty Train _____ Speak in sentences _____
- Has your child received any of the following(circle if yes): Physical Therapy Occupational Therapy Speech Therapy
- Has the child been diagnosed with a learning disability? If so, what specific disability? _____
- Does your child have an IEP? No Yes
- Is your child in the gifted and talented program? No Yes
- Has the child had any brain trauma? If yes, what and when? _____
- Do any of these apply to your child (circle if yes): Sensitive to loud noise Sensitivity to clothing (tags, socks, material)

  Prefers very loud volume (tv, radio) Avoids hugs, snuggles, other touch Craves hugs, snuggles, other touch

  Plays too rough Talks very loud Is clumsy Picky eater Spins around frequently Flaps hands

  Strictly adheres to routines Has excessive interest in certain topic (dinosaurs, trains, sports, cars, etc.)

  Rocks back and forth Hits self Has frequent tantrums/meltdowns Poor eye contact

Behavioral Health History (All Clients fill out this portion)

Previous Diagnosis: (depression, anxiety, bipolar, ADHD, etc.) _____

When was this first diagnosed? _____

Have you had counseling before? No Yes

If yes, how long ago was this? _____

What was the name of your previous counselor and agency they worked? _____

Current Medications and dosage to manage mental health concerns: _____

Who prescribes these medications for you?____ _____

Have you ever been hospitalized in a psychiatric or behavioral health unit for mental health related concerns? Yes No

If yes, what facility and when: _____

What are a few of your coping skills? _____

What are 2-3 strengths about your personality? _____

What are 2-3 things you are good at/enjoy doing? _____

Brief Bio-Psycho-Social History Form- **ADULT (See CHILD form below for child information)**

Family/Social History

Where were you born?_____ Other places you've lived? _____

Who raised you? _____ Were your parents ever married? _____

Are your parents still married? _____ If no, how old were you when they got divorced?_____

Were you ever in foster-care or placed out of home during your childhood? _____

How would you describe your relationship when you were a child with: (healthy, absent, abusive, strained, etc.)

Your mom _____ Your dad _____

Step-parent(s) _____ Other caregiver(s) _____

Were you ever a victim of childhood abuse/neglect? _____

If so, was it: Verbal abuse Emotional abuse Physical abuse Sexual Abuse

Witness to Domestic Violence Neglect

How many siblings do you have? _____

Names and ages: _____

Relationship History

Are you currently: married separated divorced in committed relationship single

If you are in a relationship what is your current level of happiness? Low Moderate High

Are you seeking counseling for a relationship/marital issue? _____

Do you have children? _____ If so, names and ages: _____

Do you have concerns regarding your children, if so what are your concerns: _____

How is your relationship with your parents/caregivers (whoever raised you) now that you are an adult?

Mom/Maternal figure: _____ Dad/Father figure: _____

Adult Trauma History: Have you experienced any traumatic event in your adult life? _____

If yes, do you believe this is currently affecting you? _____

Legal/Criminal History: Have you ever been convicted of a crime? _____

If yes, please list charges, year of conviction and any jail/prison time

Substance Use History:

Caffeine: Yes No How much and how often? _____
Alcohol: Yes No How much and how often? _____
Nicotine: Yes No How much and how often? _____
Other Substances (please list- use back if necessary): Yes No How much and how often? _____

Brief Bio-Psycho-Social History Form- **CHILD** **(Leave blank if your child is not seeking services)**

Family/Social History

Where born?_____ Other places lived? _____

Mom's name and age: _____ Dad's name and age: _____

Other caregiver(step parent/guardian/grandparent) names and ages: _____

Are child's parents: Married Divorced/Separated Together but never married Never married

If child's parents are divorced, how old was child when they got divorced?_____

Has child ever been in foster-care or placed out of home? _____ If so, when and how long? _____

How would you describe the relationships this child has with:

Mom _____ Dad _____

Step-parent(s) _____ Other caregiver(s) _____

Has the child ever been a victim of childhood abuse/neglect? _____

If so, was it: Verbal abuse Emotional abuse Physical abuse Sexual Abuse

Witness to Domestic Violence Neglect

How many siblings does the child have? _____

Names and ages: _____

How are the relationships between this child and their sibling(s)? _____

Family Dynamics

Please describe any family dynamics or issues that I need to be aware of prior to starting counseling with your child. This would be the place to put information regarding custody issues, legal issues, HHS involvement, parental alcohol/substance abuse issues, or other important information that you may not want to discuss in front of your child: (continue on back if needed).

_____
_____
_____
_____
_____
_____

Social History

Does your child make friends easily? Yes No

Does your child prefer friendships with: Same age peers Much younger children Much older children/adults

How would you describe your child's personality? Outgoing Shy Other _____