



Higher Ground Counseling

Name _____ DOB _____

Parents Name (minor only) _____

Address _____

Phone _____

Best Phone to be reached _____

Name/Phone of Emergency Contact _____

What do you hope to gain by coming here? _____

History of Depression? ☐ YES ☐ NO ☐ UNKNOWN

Do You See a Psychiatrist or Doctor for TX? ☐ YES ☐ NO

If Yes, Will You Sign A Release? ☐ YES ☐ NO

Are There Guns In the Home? ☐ YES ☐ NO

How Are They Stored or Kept? _____

Is there a history of violence in the home? ☐ YES ☐ NO

If YES Explain: _____

Drug or Alcohol use in the home? ☐ YES ☐ NO Frequency and Amount

Tobacco Use? ☐ YES ☐ NO

If YES would you like information on how to quit? ☐ YES ☐ NO

Texting your counselor: If you send a text message please note that the text may not be seen or noticed until 24 hours after you have sent the text. If it is an emergency please call or go to the local ER.



Client Name_____ **Birthdate**_____

We will bill your insurance as a courtesy to you. You are responsible for all expenses they do not cover. You must pay in full until this form is completed and signed.

You are responsible for contacting you insurance company should you not have the following information with you.

Insurance Company Name:_____

Photo Copy of card will be taken.

Permission to **Bill** and **receive** payment from your insurance company. I Authorize **Higher Ground Counseling** to release any information needed to process claims.

Client Signature_____ Yes:____ No:____ Date_____



Fee Agreement, Collection Procedures and Cancellation Policy

- 1) Individual Therapy **\$85**
- 2) Initial Session **\$125**
- 3) Family Therapy **\$125**
- 4) Couples Counseling (marriage or premarital) **\$125**
- 5) Evaluation report for court other parties **\$200** a report
- 6) Representation in court is a minimum of **\$700** per appearance

Sessions are 45 min to 1 hour. Couples sessions are normally 1.5 hours

Fees (copay) are due when services are rendered. In case of an emergency, other arrangements can be made.

I agree that I am participating in a contract with Higher Ground Counseling and that I will be responsible for all balances that are not covered by my insurance carrier.

I understand that if I do not pay my copay, I will be turned over to collections for payment.

If you sign a release to allow your records to be submitted in court and a subpoena is served to this counselor the fee will be \$700 at a minimum for my appearance in court.

Cancellation Policy

24 hour notice is required to cancel an appointment without being charged 100% of the scheduled fee.

Texting your counselor: If you send a text please note that the text may not be seen or noticed until 24 hours after you have sent the text. If it is an emergency please call or go to the local ER.

Client Signature _____ **Date** _____



Disclosure Statement

Higher Ground Counseling
128 W 14th Suite 201
Durango CO, 81301
(970) 676-1029

Your Primary Therapist is: **Darren McKinnis LCSW**

Received a Master's of Social Work at Loyola University (2000). I currently hold a Clinical Social Workers License in the State of Colorado (814).

Any and all therapists at Higher Ground are registered with the Colorado Department of Regulatory Agencies, that have the general responsibility of regulating the practice of licensed psychologists, licensed clinical social workers, licensed marriage and family therapists, certified school psychologists, and unlicensed individuals who practice psychotherapy.

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

Department of Regulatory Agencies Mental Health Section
1560 Broadway, Suite #1370
Denver, CO 80202
(303) 894-7766

Client Rights and Important Information:

- A . You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy (if I can determine it) and my fee structure. Please ask if you would like this information.
- B. You can seek a second opinion from another therapist or terminate therapy at any time.
- C. In a professional therapeutic relationship (such as ours), certain guidelines apply. Among these guidelines are:
 - 1. Sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the State Grievance Board.
 - 2. It may be inappropriate for Therapists and Clients to have "dual relationships". Specifically, it is unethical for the therapist and client to have other business or personal relationships, in addition to the therapeutic relationship. If you or a member of your family has a personal or business



relationship with your therapist or her family, please discuss this immediately with your therapist.

D. Generally speaking, the information provided by and to a client during therapy is LEGALLY CONFIDENTIAL if the therapist is a licensed professional counselor and/or licensed clinical social worker. If the information is legally confidential the therapist cannot be forced to disclose the information without the client's consent.

Therefore, any information you share with me is privileged communication and cannot be disclosed to any individual or agency without your written consent.

However there are exceptions to the general rule of confidentiality. These exceptions include, but are not limited to:

- **The receipt of a legitimate subpoena**
- **In the event of a medical emergency**
- **The receipt of information that suggests child abuse or neglect, or any other illegal activity has occurred.**
- **If you represent a danger to yourself or others. This includes suicidal and/or homicidal threats that indicate a future threat to you or another individual's personal safety.**
- **Information disclosed for the purpose of clinical supervision or case management with other staff members.**

If you have any questions or would like additional information, please feel free to ask. I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and other New Mexico regulations, and cannot be disclosed without my written consent unless as otherwise provided for in the regulations. I have read and understand my rights as a client, including certain exceptions to the general rule of confidentiality listed above.

Client Signature Date

Parent or Guardian Signature (for minors only) Date

Therapist Signature Date



Client Notice of Rights/Confidentiality Form

As a client of Higher Ground Counseling you have the following rights regarding the confidentiality of your personal information and communications with Higher Ground Counseling staff and volunteers:

1. The information that you provide to Higher Ground Counseling will be kept confidential to the greatest extent allowed by law.
2. You may choose what information you want to provide to Higher Ground Counseling. You will not be denied access to services if you choose to not provide certain identifying information.
3. The information that you provide to Higher Ground Counseling including your name, address, phone number, and other personal information will not be shared with other individuals or agencies without your permission.
4. Higher Ground Counseling staff may be required by law to report certain situations even if you don't give them permission to share or report the situations, such as suspected child abuse or neglect. Other situations can be: threats to self or others, elder or at-risk adult abuse, commission of a crime or a civil claim against clinicians with Higher Ground Counseling. Staff and advocates will inform you of any reporting requirements prior to having conversations with you and will tell you when they must make a report and what information will be shared. Even when these reports are made Higher Ground Counseling should not share information beyond what is required by law.
5. After your intake with Higher Ground Counseling you may choose to be referred to other agencies for additional help and support.
6. You can decide how much or how little of your personal information Higher Ground Counseling will or will not be shared with each partner agency. You will be told, in general, what each partner's obligations are to keep your information confidential. If you choose to have Higher Ground Counseling share some of your personal information with an agency we partner with, you will be told exactly *how* and *what* information will be shared. If you later decide that you don't want the information you have provided to be shared with any of Higher Ground Counseling partners, let us know and we won't share any more information with those partners.

Client: I, _____, on this date, _____, have received notice of my rights to confidentiality.

Date: _____



Credit/Debit Card Payment Consent Form I authorize Darren McKinnis/DBA Higher Ground Counseling to charge my credit/debit card for:

- A cancellation fee of \$85 (individual) or \$125 (couple) for any appointment that was not cancelled in concurrence with the cancellation policy, (24 hour notice).
- A balance due if payment is not made for a session (credit card will be charged immediately after the session).
- A balance overdue by 30 days
- This agreement applies to both individual sessions and couples sessions.

Client Name:

Print Last Name First Name(s) Middle Initial

Name on Card (if different):

Type of Card: __ Visa __ MasterCard __ AMEX

Expiration Date: _____ (month /year)

Card Number: _____ - _____ - _____ - _____

CVV Number: _____

Card Holder's Billing Address for Card Statements:

Street City State Zip Code

The receipt of the charged services can be emailed to:

If I have questions about these charges, I agree to contact Darren McKinnis at Higher Ground Counseling. I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by Higher Ground Counseling.

Card Holder's Signature: _____ Date: _____