***Kristin Spiegel, LCSW, RPT***
***270 East 8th Avenue, Suite 201***
***Durango, CO 81301***
***970-749-6139***

**Client Information:**

Name_____ D.O.B: _____

Mailing Address _____

City_____ State _____ Zip Code _____

Physical Address (if different) _____

Please list siblings, children, and/or others in the home:

| Name | Age | Relationship | Occupation/Grade |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Parent Information:**

Mother_____ D.O.B. _____

Home Phone _____ Cell Phone _____

Email _____

Father_____ D.O.B: _____

Home Phone _____ Cell Phone _____

Email _____

If divorced, what are the living and parenting time arrangements for your child? _____

_____

What are the court orders for signing permission for medical/mental health:

_____

**CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:** I/We consent that _____ maybe treated as a client by Kristin Spiegel, LCSW. At times it may be necessary to schedule appointments during school hours, I ask for your cooperation to provide the most timely treatment for you and your child.

**Signature(s)_____Date_____**

# INSURANCE INFORMATION

Insured's Name and Address _____

_____

Insured's Date of Birth_____

Insurance Plan Name or Program Name_____

Insurance Plan Phone Number (back of card) _____

Insured's I.D. Number _____ Group Number _____

Employer's Name _____

## Assignment and Release for Insurance Payments

I hereby assign all medical/insurance benefits to which I am entitled to be paid to Kristin Spiegel, for services rendered. I also authorize Kristin Spiegel, LCSW, to release all information necessary to secure payment in full.

Signature _____ Date _____

## FINANCIAL/INSURANCE ISSUES:

I will ask for full payment at the time of service or ask you to provide proof of current insurance. I will request co-pays and deductible payments as detailed in your insurance plan. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, I request that you pay the balance due at that time

Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed at the hourly rate. I sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. You may have a copy of this form if requested.

***Signature(s)_____Date_____***

***Kristin Spiegel, LCSW, RPT***
***270 East 8th Avenue, Suite 201***
***Durango, CO, 81301***
***970-749-6139***

*INFORMED CONSENT*

Thank you for choosing to work with me. Appointments will take approximately 55 minutes. I realize that starting therapy is a major decision and you may have many questions. This document is intended to inform you of my policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and I will try my best to give you all the information you need. Kristin Spiegel LCSW has earned a Bachelor of Science Degree in Therapeutic Recreation from the University of Wisconsin, La Crosse, a Masters Degree in Social Work from Colorado State University and a certification in School Psychology from University of Utah. She is licensed by the State of Colorado as Licensed Clinical Social Worker, Licensed School Social Worker and Licensed School Psychologist. She has over 20 years of clinical experience in treating children, adolescents, and families using individual and family therapy. Treatment practices, philosophy and plan imitations and risks will be discussed with you today.

**CONFIDENTIALITY AND EMERGENCY SITUATIONS:** Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or you child or children report about physical or sexual abuse; then, by Colorado State Law, I am obligated to report this to the Department of Human Services, c) where you sign a release of information to have specific information shared and d) if you provide information that informs me that you are in danger of harming yourself or others e )information necessary for case supervision or consultation and f) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community **(911**) for those services. Kristin Spiegel, LCSW will follow those emergency services with standard counseling and support to the client or the client's family.

**Signature:_____ Date:_____**

**NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS:** I/WE have read and received a copy of the, Notice of Privacy Practices, and Client Rights documents.

**Signature:_____ Date _____**

***Kristin Spiegel, LCSW, RPT***
***270 East 8th Avenue, Suite 201***
***Durango, CO, 81301***
***970-749-6139***

**COORDINATION OF TREAMENT:** It is important that all health care providers work together. As such, I would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. If you prefer to decline consent no inform will be shared.

**____You may inform my physician(s)  ____I decline to inform my physician**

PHYSICIAN NAME:_____
CLINIC:_____
ADDRESS:_____
PHONE:_____

***Signature*** _____ ***Date*** _____