

## SCA INTAKE DOCUMENTS

Thank you for your interest in Southwest Counseling Associates. This package contains all the documents you would typically receive when you arrive for your first session with an SCA therapist. Some of them are for your records; others request information and/or your signature for our records.

The documents are as follows:

- **Disclosure and Consent Form:** This is a sample only, and is not intended for your signature. Each therapist has a unique disclosure and consent form. You will need to sign the therapist's personalized form in order to begin therapy. To access that form, go to the therapist's page in the Clinical Staff section of this website and click the button at the bottom of the page.
- **SCA Policy and Procedure for Patient Emergencies:** Explains how to reach your therapist or access other assistance if you are in a crisis that threatens your safety. *This document is for your records.*
- **Insurance Information/Authorization and Release:** Requests specific information regarding your insurance provider, and your signature on the Authorization and Release portion. This enables SCA to bill your insurance provider for our services to you. Without your information and signature, SCA will have to bill you directly. *You must sign this form in the presence of the SCA receptionist or your therapist.*
- **Patient Information:** Requests basic information such as date of birth, contact information, spouse and emergency contacts, and reasons for seeking therapy. *You may fill out this form prior to your first visit to SCA.*
- **The Importance and Value of Personality Assessment:** Explains the benefits of personality assessment for effective, cost-effective therapy. By signing it, you are not committing yourself to any kind of testing; you simply acknowledge that you understand the value of testing, and that if you choose to receive testing, you will pay any costs that your insurance does not pay.
- **Receipt of Notice of Privacy Practices:** Asks for your signature acknowledging that you have received our Notice of Privacy Practices, also included in this document package. *This fulfills a federal HIPAA requirement, and must be completed before therapy can proceed.*
- **Notice of Privacy Practices:** Explains detailed policies that SCA follows to protect your privacy. *Federal law requires us to provide this information and obtain proof that you have received it before we can begin therapy.*

We appreciate your attention to these documents. If you have any questions, contact us:

Phone: 303-730-1717

Fax: 303-730-1531

Email: [sca@southwestcounseling.com](mailto:sca@southwestcounseling.com)

**SAMPLE ONLY  
DO NOT SIGN**

Southwest Counseling Associates  
141 West Davies Avenue  
Littleton, Colorado 80120  
303.730.1717

## **DISCLOSURE AND CONSENT FORM**

Southwest Counseling Associates is committed to quality time-effective treatment for all clients regardless of age, race, sex, or religious affiliation. Professional Christian counseling and the use of spiritual resources are available for clients who request it.

### **PAYMENT POLICIES**

Our fees are based on forty-five/fifty (45-50) minute sessions. Your therapist is (*Therapist's Name*) and the per-session fee is (*therapist's fee*). Phone consultations are your responsibility and are billed in 15-minute increments. All calls over five minutes will be billed accordingly.

Our policy is that each person receiving counseling or testing services will pay for such services at the time the professional services are rendered. If there is partial insurance coverage, a co-pay will be due at the time of services. In cases in which children of divorced parents are receiving services, all fees due must be paid at the time of service by the accompanying adult. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days of billing date. A \$35 administrative fee will be charged on all checks that are returned.

If there are expenses due to legal action leading a therapist to consult with attorneys, you will be responsible for all fees, including but not limited to phone calls, written reports, or court appearances.

### **CANCELLATIONS/MISSED APPOINTMENTS**

We understand that at times, it is necessary to cancel an appointment. We **request that any changes or cancellations be made at least 24 hours in advance**. If there should be a need to cancel a Monday appointment, that cancellation would need to be made **by the Friday before the appointment**. **Any appointments or cancellations with less than 24 hours notice will be charged the regular per-session rate**. If the therapist determines it is an emergency, the charge can be waived. Most insurance providers do not cover missed appointment charges.

### **DISCLOSURE REGARDING DIVORCE AND CUSTODY LITIGATION**

If you are involved in divorce or custody litigation, the therapist role is not to make recommendations to the court concerning custody or parenting issues. By signing this Disclosure Statement, you agree not to subpoena your therapist(s) to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that your therapist(s) write any reports to the court or to your attorney, making recommendations concerning custody. The court can appoint professionals, who have no prior relationship with family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interests of the family's children.

### **REGULATION OF PSYCHOTHERAPISTS**

The practice of licensed or registered persons and Certified School Psychologists in the field of psychotherapy is regulated by the Department of Regulatory Agencies. **The regulatory boards can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800**. The regulatory requirements for mental health professionals include the following:

1. A Licensed Clinical Social Worker, a Licensed Marriage and Family therapist, and a Licensed Professional Counselor must hold a masters degree in their profession and have two years of post-masters supervision.
2. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.
3. A Licensed Social Worker must hold a masters degree in social work.
4. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.
5. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1000 hours of supervised experience.
6. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelors degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience.
7. A Licensed Addiction Counselor must have a clinical masters degree and meet the CAC III requirements.
8. A Registered Psychotherapist is listed in the State's Database and is authorized by law to practice psychotherapy in Colorado, 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.

**CLIENT RIGHTS AND IMPORTANT INFORMATION**

1. You are entitled to receive information from your therapist about methods of therapy, the techniques used, the duration of your therapy, and your therapist's fee. Please ask if you would like to receive this information.
2. You may seek a second opinion from another therapist or terminate therapy at any time.
3. In a professional relationship (such as your relationship with your therapist), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should immediately be reported to the Board that licenses, certifies or registers the therapist.
4. The information provided by the client during therapy sessions is legally confidential in the case of licensed marriage and family therapists, social workers, professional counselors, and psychologists; licensed or certified addiction counselors; and registered psychotherapists, except as provided in section 12-43-218 and the HIPAA Notice of Privacy Rights you were provided. Certain legal exceptions will be identified by the licensee, registrant, or certificate holder should any such situation arise during therapy.
5. There are several exceptions to confidentiality which include:
  - (a) Your therapist is required to report any suspected incident of child abuse or neglect to law enforcement;
  - (b) Your therapist is required to report any serious threat of imminent physical violence against a specific person or persons, including those identifiable by their association with a specific location or entity;
  - (c) Your therapist is required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental disorder;
  - (d) Your therapist is required to report any suspected threat to national security to federal officials;
  - (e) Your therapist may be required by Court Order to disclose treatment information;
  - (f) Your therapist is required to report suspected neglect, abuse, or exploitation of elderly individuals; and
  - (g) SCA as an organization considers it an ethical obligation to report mistreatment, neglect, or exploitation of at-risk adults. This includes suspected and/or observed incidents that involve adults who are at-risk due to physical or mental causes.

**SUPERVISION**

As part of our commitment to quality care, all therapists participate in individual and group supervision. *(Therapist's Name)* receives direct and regular supervision by *(name of therapist's supervisor/group supervisor)* a staff member with SCA. In order to provide thorough, competent supervision and quality care, the supervisor may, at times, determine that it is valuable for a session to be video or audio taped. In that event, you will be informed of such and asked to sign a consent form before any taping is done.

**AUTHORIZATION FOR TREATMENT**

I have read this disclosure. I have been given my therapist's biography and am aware of my therapist's degrees and credentials. I understand the conditions as stated above, and I agree to receive counseling with my therapist under these conditions.

\_\_\_\_\_  
Client's name if different than the Guarantor

\_\_\_\_\_  
Signature of Client or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Spouse (when in joint therapy)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

***Please go to your therapist's page in the Clinical Staff section to get his/her individualized disclosure and consent form.***

## Southwest Counseling Associates

Thank you for selecting Southwest Counseling Associates! We will strive to provide you with the best possible care. To help us meet your needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us.

Date: \_\_\_\_\_

Account# \_\_\_\_\_

Therapist: \_\_\_\_\_

SCA \_\_\_\_\_ CBH \_\_\_\_\_ Waiver \_\_\_\_\_

### Patient Information

Name \_\_\_\_\_ DOB \_\_\_\_\_ M \_\_\_ F \_\_\_

SS# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone# \_\_\_\_\_ Cell # \_\_\_\_\_

Are you a full time college student? Yes \_\_\_ No \_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone# \_\_\_\_\_ ext: \_\_\_\_\_

Church \_\_\_\_\_ Member \_\_\_ Attender \_\_\_

Denomination \_\_\_\_\_ Pastor \_\_\_\_\_

Name of Your Physician: \_\_\_\_\_ Phone# \_\_\_\_\_

### Insurance Policy Holder or Responsible Adult Information

Relationship to Patient: \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ M \_\_\_ F \_\_\_

SS# \_\_\_\_\_

Address Same As Patient? Yes \_\_\_ No \_\_\_

If different \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone# \_\_\_\_\_ Cell # \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone# \_\_\_\_\_ ext: \_\_\_\_\_

**Please complete both sides of this sheet**

### Spouse Information

(Either of Patient or Policy holder)

Relationship to Patient: \_\_\_\_\_  
Name \_\_\_\_\_ DOB \_\_\_\_\_ M \_\_\_ F \_\_\_  
SS# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone# \_\_\_\_\_ Cell # \_\_\_\_\_  
Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone# \_\_\_\_\_ ext: \_\_\_\_\_

### In Case of Emergency Contact

Name \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Reason for seeking therapy:

\_\_\_\_\_  
\_\_\_\_\_

What do you hope to accomplish from therapy:

\_\_\_\_\_  
\_\_\_\_\_

List all previous therapists and counseling experiences:

\_\_\_\_\_  
\_\_\_\_\_

Have you formally terminated therapy with your previous therapist?

Yes \_\_\_ No \_\_\_ N/A \_\_\_

If you have formally terminated therapy with your previous therapist, are you willing to sign a release of information? Yes \_\_\_ No \_\_\_ N/A \_\_\_

# Southwest Counseling Associates

## Client Insurance Information

### INSURANCE INFORMATION

Many insurance policies provide partial to total coverage for mental health services. Your insurance is a contract between you and your insurance company; it is not an agreement between the insurer and our agency. This means that your account with SCA is your responsibility regardless of insurance coverage that may exist. With the exception of contracted Managed Care Organizations, payment is expected at the time of service. Clients with contracted managed care plans agree to pay in full any amount due for co-pays or deductibles as well as all non-covered services including, but not limited to, testing, educational resources, and telephone consultations. Frequently these charges are not covered by insurance and therefore are the client's responsibility.

Due to the changes in health care, it is necessary to obtain insurance information on all of our clients.

Name of Insurance Company: \_\_\_\_\_

Their Address: \_\_\_\_\_

Their Phone #: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Policy Holder's SS It: \_\_\_\_\_

ID #: \_\_\_\_\_ Group Policy it: \_\_\_\_\_

Does your policy, provide mental health coverage? Yes  No

### AUTHORIZATION AND RELEASE

I authorize the release of any medical or other information necessary to process claims incurred at Southwest Counseling Associates. I understand that information requested by my insurance provider may include treatment plans, progress reports, and/or case notes. I also request payment of government benefits or payment of medical benefits to Southwest Counseling Associates.

I agree that payments will not be delayed or withheld because of any insurance coverage. It is understood that all proceeds of insurance payments are assigned to SCA, where applicable, until remaining charges have been paid. It is also understood that SCA will not assume responsibility for the collection of insurance payments. Accounts with no financial activity for 30 days may be sent to a collection agency.

### MEDICAID POLICY

Unfortunately SCA cannot work with any client covered under Medicaid. Due to the rules with Medicaid, we cannot work with any client under any condition including self-pay, reduced rate, 3<sup>rd</sup> party payment, other insurance company coverage, or even pro bono. If at any point of your treatment with us at SCA you do begin to be covered under Medicaid, please inform your therapist immediately. We will then seek to advise you of organizations in this area who might potentially work with you, but we will need to responsibly terminate treatment with you in a timely manner in order to not violate Medicaid rules.

I have read, understand, and agree to abide by the above statement. I agree to discuss with my SCA therapist(s) any questions or concerns I might have regarding SCA's Medicaid policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

SOUTHWEST COUNSELING ASSOCIATES  
141 West Davies Avenue, Suite 105  
Littleton, Colorado 80120  
(303) 730-1717

### SCA Policy and Procedure For Patient Emergencies

Southwest Counseling Associates offers a paging service for emergencies that occur **during non-office hours**. This service is provided for those patients who, because of an emergency or crisis, need to get in touch with their therapist or one of the associates here at SCA. Regular office hours are 8:00 a.m. to 7:00 p.m., Monday through Thursday and 8:00 a.m. to 5:00 p.m. on Friday (these hours may be subject to change). If there is a problem you need to discuss with your therapist before your next scheduled appointment, please call the office and leave a message. There is a voice mail service that will take your message during the lunch hour and after regular business hours.

An emergency or crisis is a situation or incident that occurs in which you cannot wait until office hours to talk with your therapist. This would include suicidal or homicidal thoughts and plans, or anxiety attacks that render you nonfunctional. In other words, situations that are **life threatening**. If these situations arise during non-office hours, please call 303-730-1717 and follow the voice mail instructions. Give your name, phone number, and the name of the therapist you are seeing. Please give the number of where you can be reached and **not** a pager number. If you are calling from a phone that does not receive calls from blocked numbers, please note the procedure listed below that will allow blocked numbers to get through temporarily. If you lose this information sheet, you can call the Operator for assistance. Sometimes the therapists must return emergency calls from home, and it is the policy of the SCA Board that therapists do **not** give out their home number. Either your therapist or one of the SCA clinical staff members will get back to you. Do not use this number for cancellations or appointment changes.

If, for some reason, you are unable to reach your therapist and/or an SCA clinical staff member and if it is a life or death emergency, you are encouraged to call 911.

To turn off your Anonymous Call Rejection, pick up the receiver and dial \*87 (1187 on rotary phones). A stutter dial tone will confirm that you have turned the service off. To turn Anonymous Call Rejection back **on**, pick up the receiver and dial \*77 (1177 on rotary phones). The service will remain on until you choose to turn it off. A stutter dial tone will confirm that you have turned the service on.



## Initial Assessment

Welcome to Southwest Counseling Associates (SCA). We appreciate you selecting our clinic for your counseling and mental health services.

When a person comes in for counseling or psychiatry services, he or she may be experiencing a wide variety of concerns. An important part of our treatment involves assessment and clarification of these concerns. Much of this assessment is done by *clinical interview* in your initial session(s). During the interview process, you (the client) are able to inform your provider of stressful events you have been through, challenging circumstances in your life presently, and how life stressors are affecting you and hindering your overall wellness.

In addition to the clinical interview, *testing* is a valuable tool that enables your provider to better understand the complexities of your situation in an efficient manner. *Diagnostic testing* helps both you and your provider identify and understand your symptoms—i.e., problems in behavior, emotions, physical functioning, and relationships. This testing also clarifies how you as an individual tend to experience stress. *Personality testing* helps you and your therapist identify your strengths and preferences, and gives you a common language for discussing these during the course of therapy. An important goal of counseling is to help clients understand and maximize their strengths in a way that helps them cope with problems, achieve their potential, and improve their quality of life. In sum, testing helps clarify both problems and strengths.

Since 1986, it has been our experience that the combination of clinical interviewing and testing is the most effective way to assess clients for the purposes of accurate diagnosis and effective treatment planning. Testing is both cost-effective and time-effective in that it helps us gain a wide range of information in a short period of time. We have found that it would typically take a minimum of four to five counseling sessions in order to obtain the amount of information provided by one or two testing instruments. Your provider will talk with you about which test(s) would be most beneficial given your presenting concerns and goals, and will inform you of the cost of these tests. ***Please note that insurance companies typically do not pay for testing—and thus you would be personally responsible for making the payment in full.***

Based on the results of initial testing, your provider may determine that additional, more specialized tests are indicated. If this is the case, your therapist will explain to you the need for additional testing, and will clarify the time and costs involved.

If you have questions about assessment and testing, please do not hesitate to ask your provider. By signing below, you are acknowledging that you have read and understood this document. Your signature does NOT commit you to testing.

Name of client (print): \_\_\_\_\_ Today's Date: \_\_\_\_\_

Legal Guardian (print, if applicable): \_\_\_\_\_

Signature of Client or Guardian: \_\_\_\_\_



**SOUTHWEST COUNSELING ASSOCIATES**  
**NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL (including mental health) INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice is effective as of October 13, 2003.

We are required by law to maintain the privacy of protected health information, and must inform you of our privacy practices and legal duties. You have the right to obtain a paper copy of this Notice upon request.

We are required to abide by the terms of the Notice of Privacy Practices that is most current. We reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that we maintain. The revised Notice will be posted in the waiting room and on our web site. You may request a copy of the revised Notice at any time.

We have designated a Privacy Officer to answer your questions about our privacy practices and to ensure that we comply with applicable laws and regulations. The Privacy Officer also will take your complaints and can give you information about how to file a complaint.

Our Privacy Officer is Doug Feil, MS, LPC. You can contact the Privacy Officer at 303-730-1717 ext. 219. Our Security Officer is Charity Barone, MA, LPC. You can contact the Security Officer at 303-730-1717 ext. 249.

**Use and disclosure of your protected health information that we may make to carry out treatment, payment, and health care operations.**

We may use information in your record to provide treatment to you. We may disclose information in your record to help you get health care services from another provider, a hospital, etc. For example, if we want an opinion about your condition from another professional, we may disclose information to the professional to obtain that consultation.

We may use or disclose information from your record to obtain payment for the services you receive. For example, we may submit your diagnosis with a health insurance claim in order to demonstrate to the insurer that the service should be covered.

We may use or disclose information from your record to allow "health care operations." These operations include activities like reviewing records to see how care can be improved, contacting you with information about treatment alternatives, and coordinating care with other providers. For example, we may use information in your record to train our staff about your condition and its treatment.

Southwest Counseling Associates (SCA) may also contact you to remind you of appointments and to tell you about treatments or other services that may be of benefit to you.

## **Your rights**

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions.

You have a right to receive confidential communications from us. For example, if you want to receive bills and other information at an alternative address, please notify us.

You have a right to inspect the information in your record, and may obtain a copy of it. This may be subject to certain limitations and fees. Your request must be in writing.

If you believe information in your record is inaccurate or incomplete, you may request amendment of the information. You must submit sufficient information to support your request for amendment. Your request must be in writing. SCA is not required to amend your record if it is determined that the record is complete and accurate.

You have the right to request an accounting of certain disclosures made by us. This request must be made in writing.

You have the right to complain to us about our privacy practices (including the actions of our staff with respect to the privacy of your health information). You have the right to complain to the Secretary of the Department of Health and Human Services about our privacy practices. You will not face retaliation from us for making complaints.

Except as described in this Notice, we may not make any use or disclosure of information from your record unless you give your written authorization. You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by us before the revocation. In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization.

You have the right to obtain another copy of this notice upon request.

## **Use or disclosure of your protected health information that we are required to make without your permission**

In certain circumstances, we are required by law to make a disclosure of your health information. For example, state law requires us to report suspected child abuse or neglect. Also, we must disclose information to the Department of Health and Human Services, if requested, to prove that we are complying with regulations that safeguard your health information.

If you receive mental health care, including treatment for substance abuse, information related to that care may be more protected than other forms of health information. Communications between a psychotherapist and patient in treatment are privileged and may not be disclosed without your

permission, except as required by law. For example, psychotherapists still must report suspected child abuse, and may have to breach confidentiality if you appear to pose an imminent danger to yourself or others, in order to reduce the likelihood of harm to you or others.

**Use or disclosure of your protected health information that we are allowed to make without your permission**

There are certain situations where we are allowed to disclose information from your record without your permission. In these situations, we must use our professional judgment before disclosing information about you. Usually, we must determine that the disclosure is in your best interest, and may have to meet certain guidelines and limitations.

We may use or disclose information from your record if we believe it is necessary to prevent or lessen a serious and imminent threat to the safety of a person or the public. We may report suspected cases of abuse, neglect, or domestic violence involving adult or disabled victims.

We may assist in health oversight activities, such as investigations of possible health care fraud.

We may disclose information from your record as authorized by workers' compensation laws.

We may disclose information from your record if ordered to do so by a court, grand jury, or administrative tribunal. Under certain conditions, we may disclose information in response to a subpoena or other legal process, even if this is not ordered by a court.

We may disclose information from your record to a law enforcement official if certain criteria are met. For example, if such information would help locate or identify a missing person, we are allowed to disclose it.

If you tell us that you have committed a violent crime that caused serious physical harm to the victim, we may disclose that information to law enforcement officials. However, if you reveal that information in a counseling or psychotherapy session, or in the course of treatment for this sort of behavior, we may not disclose the information to law enforcement officials.

We may use or disclose information from your record for research under certain conditions.

Under certain conditions, we may disclose information for specialized government purposes, such as the military, national security and intelligence, or protection of the President.

*Crimes on the premises or observed by SCA staff.* Crimes that are observed by SCA staff, that are directed toward staff, or occur on SCA's premises will be reported to law enforcement.

## **CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE CONSUMER INFORMATION**

Federal law and regulations protect the confidentiality of alcohol and drug abuse consumer records. Generally, SCA may not disclose to a person outside SCA that any information identifying a client as an alcohol or drug abuser, unless:

- 1) The client consents in writing; OR
- 2) The disclosure is allowed by a court order; OR
- 3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the federal law and regulations by SCA is a crime. Suspected violations may be reported to the United States Attorney in the District of Colorado.

Federal law and regulations do not protect any information about suspected child abuse or neglect being reported under Colorado law to appropriate state or local authorities.

**Southwest Counseling Associates**  
**RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Patient Name: \_\_\_\_\_ Given to patient on: \_\_\_\_\_  
I acknowledge that I have received Notice of the Privacy Practices of SCA.

\_\_\_\_\_  
Signature of Patient or Personal Representative      Date

\_\_\_\_\_  
Signature of Patient or Personal Representative      Date

Relationship of Personal Representative to the Patient: \_\_\_\_\_

+++++  
**For office use only**

Modified version given: \_\_\_\_\_ Version/Effective Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Personal Representative      Date

Relationship of Personal Representative to the Patient: \_\_\_\_\_