



# Client Information

Revised 07/25/25

Client ID #: \_\_\_\_\_ Date: \_\_\_\_\_

Last Name:	First Name:	
Alias/Preferred Name/Preferred Pronoun:	Have you ever been seen here before? <input type="checkbox"/> No <input type="checkbox"/> Yes, if so when?	
SS#:	DOB:	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Transgender: MTF <input type="checkbox"/> FTM <input type="checkbox"/>
Mailing Address, City, State, ZIP:		Physical Address, City, State, ZIP:

<b>Contact Preference:</b>	Home Phone: _____
<input type="checkbox"/>	Cell Phone: _____
<input type="checkbox"/>	Email: _____
<input type="checkbox"/>	Text Message: _____
<input type="checkbox"/>	Message Phone: _____
<input type="checkbox"/>	Don't contact me

**\*Emergency Contact Info(optional):**  
 Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_  
 Phone#: \_\_\_\_\_

**Parent/Guardian #1**  
**If the above client is under the age of 18, do you have legal custody of the client ?** Yes or No

Last Name:	First Name:	Middle Initial:	Relationship to Client:
Aliases: _____	Sex: Please circle one Male   Female   Transgender		SS#: _____
			DOB: _____
Mailing Address: _____			
Home Phone Number: _____		Cell Phone Number: _____	

**Parent/Guardian #2**  
**If the above client is under the age of 18, do you have legal custody of the client? Yes or No**

Last Name:	First Name:	Middle Initial:	Relationship to Client:
Aliases: _____	Sex: Please circle one Male   Female   Transgender		SS#: _____
			DOB: _____
Mailing Address: _____			
Home Phone Number: _____		Cell Phone Number: _____	

**Client#:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**ARE YOU EMPLOYED? – CHECK ALL THAT APPLY:**

- Employed Full Time (35 + hours a week)  
  Employed Part Time (less than 35 hrs a week)  
  Unemployed  
  Student  
 Disabled  
  Active Military  
  Supported Employment  
  Inmate  
  Volunteer  
  Retired  
  Other \_\_\_\_\_

**PLEASE TELL US YOUR MARITAL STATUS:**

- Married  
  Divorced  
  Separated  
  Domestic Partnership  
  Never Married  
  Widowed

**PRIMARY LANGUAGE:**

- English  
  Spanish  
  Other \_\_\_\_\_

**PLEASE TELL US YOUR RACE:**

- Native American/Alaskan Native  
  African American  
  Asian  
 Native Hawaiian/Pacific Islander  
  White/Caucasian  
  Declined to Answer

**PLEASE TELL US YOUR ETHNICITY:**

- Non-Hispanic  
  Hispanic (Mexican)  
  Hispanic (Puerto Rican)  
  Hispanic (Cuban)  
  Hispanic Other  
 Declined to Answer

**PLEASE TELL US YOUR EDUCATIONAL BACKG ROUND:**

- High School Diploma /GED  
  College Degree  
  Doctoral Degree  
  Master’s Degree  
 Some College  
  Grade 1-12  
  Kindergarten  
  Pre-K or below

**SEXUAL ORIENTATION:**

- Bisexual  
  Gay/Lesbian  
  Heterosexual/Straight  
  Other \_\_\_\_\_  
  Declined

**DO YOU OR HAVE YOU EVER SMOKED TOBACCO:**

- Every Day Smoker  
  Heavy Tobacco User  
  Former Smoker  
 Light Tobacco Smoker  
  Never Smoked

**CURRENT LIVING ARRANGEMENTS:**

- Alone  
  Child(ren)  
  Father  
  Foster Parents  
  Guardian  
  Mother  
 Partner/Significant Other  
  Relatives (kin)  
  Sibling(s)  
  Spouse  
  Unrelated Person

**CURRENT RESIDENT CODE:**

- Assisted Living  
  ATU, Adults Only  
  Boarding Home (Adult)  
  Jail  
 Foster Home (Youth)  
  Group Home (Adult)  
  Halfway House  
  Homeless  
 Independent Living  
  Inpatient  
  Nursing Home  
  Residential Facility  
 Sober Living  
  Supported Housing (section 8, vouchers)

**HANDICAP:**

- Cognitive  
  Developmental  
  Limitation  
 Physical  
  Sensory  
  Other \_\_\_\_\_

**VETERAN:**

- No  
  Yes



# Household Financial Information (HFI)

Revised 11/22/24

Client#: \_\_\_\_\_ Date: \_\_\_\_\_ Staff Initials: \_\_\_\_\_

Last Name:		First Name:	
Address:			
Phone Number:	Date of Birth:	Social Security #	
Insurance Company: Please provide copy of both sides of insurance card			
Policy # / Subscribers SS# if VA insurance:			Group #

## Household Income Verification

I would like to speak with someone regarding Sliding Fee Information.

The below household financial information is an estimate of your annual income.

Number of Adults in household \_\_\_\_\_ Number of Children under 18 in household \_\_\_\_\_

Income Source	Income 1	Income 2	Income 3	Subtotal
Employment				
Unemployment				
Social Security				
Disability				
Other Sources of Income (e.g. TANF, SNAP, AND)				
Total:				

Please provide verification for the above income as follows:

- If you or anyone in your household is employed, please provide a copy of paystubs supporting your most recent 30 days of employment. If self-employed, please provide your most recent Income Tax Return and supporting Form 1099, if applicable, along with a year-to-date Profit & Loss statement.
- If you or anyone in your household is receiving Unemployment, Social Security, Disability, or TANF, please provide award letters for these sources of income.

**My household has no current source of income and /or benefits. I agree to bring Proof of Income as soon as I become employed or proof of benefits or other sources of income as they are obtained.**

I attest that the information I have provided on this form is true and accurate, to the best of my knowledge, as of the date this form was signed. I agree to provide updated insurance and financial information should anything change in the future. I understand that I will be required to provide an update to this form at least annually.

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



Please turn in the first 3 pages of the completed intake packet to the front desk. Then continue to work on the remainder of the paperwork unless you have questions and staff will assist.



# Medical Questionnaire

Revised 08/27/2025

Client#: \_\_\_\_\_ Date: \_\_\_\_\_

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Doctor Name: \_\_\_\_\_ Medical Clinic: \_\_\_\_\_

Clinic Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

(Note: If you do not have a doctor or clinic, your clinician can assist you in finding a new primary care physician.)

Do you currently take prescription narcotics?  Yes  No If yes, please describe: \_\_\_\_\_

Other medications and dosages prescribed by a doctor: \_\_\_\_\_

Medications I am **allergic** to: \_\_\_\_\_ Other allergies: \_\_\_\_\_

**Date of last physical or well-child exam:** \_\_\_\_\_ Current Height: \_\_\_\_\_ Current weight: \_\_\_\_\_

Were any mental health concerns identified during the physical or well child exam/EPSTD (Early & Periodic Screen & Diagnosis & Treatment)?  Yes  No  Unknown

**MEDICAID RECIPIENTS AGED 21 OR UNDER** should have a medical screen called the EPSTD completed every year by Public Health or by your physician. Your provider can answer questions about the EPSTD.

**ADVANCE DIRECTIVES** (advance directives are not required for children/adolescents < 18yo):

Do you have a living will, medical power of attorney, CPR Directive, or psychiatric advance directive (WRAP plan)?

Yes  No Information may also be found at

<https://www.caringinfo.org/planning/advance-directives/by-state/colorado/>

**FAMILY HISTORY:** Please list any major health problems or causes of death in family members:

\_\_\_\_\_

Please list any significant medical issues you are dealing with at this time:

\_\_\_\_\_

Of those conditions listed above, please identify any that are not being treated at this time:

\_\_\_\_\_

**Are you at risk for HIV/AIDS?**  Yes  No

(Risk includes using injected drugs, sharing needles or drug paraphernalia, having multiple sex partners or homosexual partners without using condoms 100% of the time, having sex with someone who is HIV+ or was prostituting, receiving transfusions)

**Are you at risk for tuberculosis?**  Yes  No

(Risk includes having had a positive skin test for TB, having contact with an infected person, coughing that will not stop for 3 weeks or more, swollen but non-tender lymph nodes, weight loss without trying, recurrent fevers or night sweats, having been homeless or living in a shelter)

**I am requesting a referral for further education and/or testing for either TB, HIV or AIDS.**  Yes  No

The Agency will make suggestions for further medical testing or treatment, based on this information, if our medical staff suspect health problems may be complicating one's mental health condition or negatively affecting treatment. The individual is responsible for his/her own medical care.

**Client ID #:** \_\_\_\_\_ **Client Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*In response to increasing rate of Hepatitis B and C, sexually transmitted diseases, TB, and HIV, all clients in substance abuse treatment programs licensed by the Colorado Alcohol and Drug Abuse Division (ADAD) must complete this screening.*

*I understand that my responses to this screen are protected under federal and state regulations governing confidentiality (42 CFR, Part 2, HIPAA, CRS 25-4-1402), and cannot be disclosed without my written consent except as permitted or required by law. I have read and understand the above.*

*Client Signature:* \_\_\_\_\_

**PART 1**

1. **Yes No** Did you have a blood transfusion (including during childbirth or surgery) or organ transplant prior to 1992?
2. **Yes No** Have you ever been or are you now on long-term Hemodialysis (blood-cleansing)?
3. **Yes No** Have you received any blood clotting factor made prior to 1987?
4. **Yes No** Have you ever been stuck by a needle or sharp object that may have been contaminated with Hepatitis-C infected blood?
5. **Yes No** Were you born to a mother who had Hepatitis?
6. **Yes No** Have you ever had symptoms of liver disease or any abnormal liver function / enzyme tests?
7. **Yes No** Have any of your sexual partners been infected with Hepatitis B or C?

*If "yes" to any question above, please see your counselor for a Hepatitis screening/testing referral.*

8. **Yes No** Have you received a tattoo or body piercing in unsanitary conditions?

*If "yes" to Question 8, please see your counselor for an infectious disease screening/testing referral.*

9. **Mark all of the following that apply to you now or applied in the past:**

- Close** contact with active TB
- A medical condition that increases risk of TB (e.g., HIV, other immune disorders, diabetes, silicosis (black lung), bleeding or clotting disorders, specific malignancies, kidney failure, etc.)
- Abnormal chest x-ray showing fibrotic lesions
- Resident or employee in a high risk setting (e.g., correctional facility, nursing home, mental institution, homeless shelter, residential care facility, etc.)
- Health care worker or volunteer who serves high-risk clients
- Foreign-born person who arrived in the US within the last 5 years from countries with a high rate of TB (e.g., most countries in Africa, Asia, Latin America, Eastern Europe, and Russia)
- History of inadequately treated TB

*If any of the above are marked, please see your counselor for a TB screening referral.*

10. **Yes No** Have you had a cough for more than 3 weeks?
11. **Yes No** Have you coughed up blood or colored mucous?
12. **Yes No** Do you have swollen, non-tender lymph nodes?
13. **Yes No** Have you ever has a prolonged loss of appetite or unexplained weight loss of 10 pounds or more?
14. **Yes No** Have you had any recurrent fevers or heavy night sweats for more than three weeks?

*If "yes" to any of the above, please see your counselor for an immediate referral for TB screening and treatment.*

Client ID #: \_\_\_\_\_ Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

**PART 2**

1. Have you had 2 or more sexual partners in the last 10 years?  
Yes (5) No (0)
2. Have you had anal sex with any partner in the last 10 years?  
Yes (10) No (0)
3. How often have you used a condom during anal sex in the past 10 years?  
Never (20) Sometimes (15) Always (10) No anal sex (0)
4. Have you ever had a sexually transmitted disease e.g., gonorrhea, syphilis, chlamydia, genital warts (HPV) genital herpes, hepatitis?  
Yes (15) No (0)
5. In the past 10 years, have you ever given money or drugs to someone to have sex with you?  
Yes (10) No (0)
6. Have you ever had sex with someone so they would give you money or drugs?  
Yes (20) No (0)
7. Have you ever injected street drugs, steroids, or vitamins with a needle?  
Yes (30) No (0)
8. Have any of your sexual partners in the past 10 years ever injected street drugs, steroids, or vitamins with a needle?  
Yes (30) No(0) Don't know (15)
9. Have any of your sexual partners in the past 10 years been men who have had sex with other men?  
Yes (30) No (0) Don't know (15)
10. Have any of your sexual partners in the past 10 years ever had a sexually transmitted disease (see list in question 4)?  
Yes (30) No (0) Don't know (15)

**Add all the numbers next to your answers IN Part 2.**

**My Score is \_\_\_\_\_**

**Scoring guide:**

0-29 Indicates **low risk** for acquiring/transmitting HIV. You do not need to be further evaluated unless it is indicated by other information you provided, or you desire testing.

30 to 119 Indicates **medium risk** for acquiring/transmitting HIV and Hepatitis. You should receive further evaluation, and appropriate referrals should be provided by your counselor.

120 or higher Indicates **high risk** for acquiring/transmitting HIV and Hepatitis. You should contact your physician, the Colorado Department of Public Health and Environment (1-303-692-2759), or your local county health department, for further evaluation and follow-up.

*NOTE: If you answered "yes" to Question 7, testing for HIV and Hepatitis B and C is strongly encouraged, as behaviors associated with injection drug use place you at an increased risk for acquiring/transmitting these infections.*

**FOR COUNSELOR USE ONLY:**

\_\_\_\_\_ At risk for TB (based on any positive response to Part 1, Questions 9-14)

\_\_\_\_\_ At risk for HIV. Risk is \_\_\_\_\_ medium or \_\_\_\_\_ high (based on score of \_\_\_\_\_)



Consent for Behavioral Health Treatment
Acknowledgement of Receipt of Client
Rights & Responsibilities
Revised 7/23/2025

Client#: \_\_\_\_\_ Date: \_\_\_\_\_

Please Initial below

CLIENT RIGHTS AND RESPONSIBILITIES: I was given a copy of the Clients Rights. I have had a chance to review it and ask questions. I understand my rights and responsibilities. I may speak with the client advocate for more information.

ACKNOWLEDGEMENT OF PRIVACY NOTICE: I was given a copy of the current Notice of Privacy Practices to include information regarding 42 CFR Part II. The Notice tells me about how the Agency may use or disclose information about me to others. I may speak to the Quality Improvement Department for more information.

FINANCIAL AGREEMENT: I was given information about the fees for my care. I have had a chance to review it and ask questions. I request that my insurance company, funding source, or Medicaid benefits pay all claims directly to the Agency. I understand I must pay for services according to my agreement with the Business Office at the time of service. The Agency may stop treating me if I don't pay. I may speak to the Business Office about payment arrangements.

RIGHT TO COMPLAIN: I was given information about how to file a complaint or object to decisions made by the Agency as to my services. I may refer to the Notice of Privacy Practices or the Client Rights for additional information. I may make a complaint without jeopardizing my care. Client records may not be maintained after the 7-year period for purposes of filing a complaint C.R.S. §12-43-214.

PSYCHIATRIC ADVANCE DIRECTIVES: I was given a handbook which explains Psychiatric Advance Directives. I may use the document to tell the staff in advance what care I want to receive if I cannot participate in my care. I may speak to my clinician or the client advocate to obtain more information about advance directives.

CONSENT TO TREAT: I have been given enough information about the Agency's policies to make an informed decision about treatment. I freely consent to all terms. Treatment will have a greater chance of success when I participate fully and cooperate with professional recommendations. I may revoke this consent in writing at any time. If I do so, treatment with the Center will end.

FOLLOW UP CONTACT SURVEYS: The Agency or their representatives may contact me during or after my treatment to learn how I am doing and if I was satisfied with the services I received. I may choose to participate in these surveys, or not, without jeopardizing my care.

EPSDT/Well Child Checks: I have been given information about the well-child exam or was given a referral to a medical professional regarding a well child check for my minor child.

CO CRISIS SERVICES: If you are experiencing a mental health crisis, you may call a crisis clinician at (719) 589-3671 during or after normal business hours. You may also contact the Colorado Mental Health Line by calling or texting 988, or live chat at 988colorado.com.

Emergency Procedures: In the event of a medical emergency at any SLVBHG building, staff will call 911. At the beginning of every telehealth session, the client will be asked about their location in case a telehealth emergency or contact is lost and the provider cannot reach the client via telephone. In this case, the provider will call Emergency Services, who will be sent to the individual's location for a welfare check.

Please check one of the following:

- I give SLVBHG permission to communicate with me via email or text. I also understand that use of electronic communication means that my confidentiality cannot be assured according to HIPAA regulations.
I decline to give SLVBHG permission to communicate with me via email or text.

I have reviewed and understand the discharge/ no show policy below.

- SLVBHG's general policy on no show appointments and discharge policy is to administratively discharge clients who are not engaging in treatment, have two or more consecutive no show appointments or who have not met with their provider in 45 days. SLVBHG will make every attempt to outreach and re-engage client into services, however if this occurs you may be discharged if contact is not made.

Client Printed Name

Date

Client/Guardian/Representative Signature

Guardian/ Representative's Relationship to Client

Revocation of Consent:

Client Signature: \_\_\_\_\_

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

<b>Client Name:</b>	<b>Client ID:</b>	<b>Phone Number:</b>
<b>Location of Patient:</b>	<b>Date of Birth:</b>	<b>Date Consent was Discussed:</b>

I give my consent for Teletherapy treatment to be provided to me or my dependent. I understand that Teletherapy is the online delivery of mental health therapy services via two-way video conferencing (audio and video). Teletherapy sessions are very similar to mental health sessions with one major exception. Instead of sitting in the same room, therapists interact with clients via live video conferencing. I realize that no guarantees can be made as a result of treatment, however clients can get the same type of counseling they could receive in person. Teletherapy services work through encrypted HIPAA compliant video software that allows the client (“you”) to connect with your therapist through electronic means. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client’s identification and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information. The laws that protect the confidentiality of my medical information also apply to teletherapy. All teletherapy exchange is confidential unless disclosure about child abuse or harm to self or others arises then I am mandated to report.

Teletherapists must uphold boundaries and make sure safety measures are in place so they do not ensue liability for texts exchanged. I, as a client, will assume the risk if I choose to text a teletherapist personal information on this unencrypted platform. Teletherapist will uphold boundaries by limiting text use for appointment coordination only and will not answer or send texts after hours. Teletherapists should have an automated message indicating they are out of office and emergency numbers if a client is in crisis.

The event of any adverse or unexpected reaction to treatment that may occur during or after your teletherapy encounter, you should immediately notify your primary clinician to plan arrangements to speak to the emergency services clinician on call.

I have read this document, understand what Teletherapy is and consent to participate in teletherapy sessions under the conditions described in this document.

I am aware I may refuse this process and that I may revoke this teletherapy consent at any time by requesting a change in service.

Client/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client name (Please print): \_\_\_\_\_

SLVBHG PROVIDERS		
Aaliyah Duran, MA, LPC	Donald Tietsema, PMHNP-BC	Mary Lambert, LPC
Adela Valencia-Lucero, MA	Donna Nelson, MD	Mary Lynnette Tracey, MSN, APRN, PMHNP-BC
Adriana Frazier, APN-CNS, RXN	Emily Kreissler, LPC	Marcia Candy, LPC, LAC
Albert Gonzales, LPC, LAC	Fanny Guyton, CAS	Matthew Harris, LPC
Amanda Martinez, BA-CIT	Frances Echeverria, LCSW	Melissa Marquez, LCSW
Angelica Vazquez, LCSW	Gavin St. Cyr, MA Intern	Michael Benavidez, MA
Anna Chavez-Sandoval, LPC, LAC	Hillary Nipple, LCSW	Mikyla Hernandez, MA
Ashley Pacheco, LPC	Ivonne Alvarado, MRC	Natalie Williams, CAS
Ashley Sasser, LPC	Jamie Bogner, LPC	Patricia Albert, LPC
Autumn Setzler, LPC	Jazmin Vigil, LPC, LAC	Rick Esquibel, CAS
Bonnie Ortega, LPC, CAS	Jeffery Wallace, MD	Roberta DeSalvo, MS, LPCC
Breanna Mosco, MA, LPC	John Ryan, LPC, LAC	Sandra Romero, MS, ACC
Bridgett McCarroll, MA Intern	Katy Plumb, MA	Sarah Jennings, LPC, LAC
Brittney Siler, MA, CAS	Korissa Roesch, LCSW	Susan Travers, MS
Carmen Ramos, MA	Leah Romero, MSW, CAS	Tasha Martinez, LPC
Charles Wright, LPC	Lindsey Renner, MSN, APN, RXN, FNP-C	Vanessa Thong, MA
Chastidy Chacon, LPC	Lynne Jacobson, DNP, FNpc, PMHNP-BC	Veronica Trujillo, LPC, LAC
Consuelo Contreras, MPA, CAS	Mackenzie Browning, BS	Whitney Glenn, LPC
Cynthia Stone, LPC	Stephanie Atkins, BA	Jason Chacon, BA
Lisa Mortensen, BS	Ronnie Herrera, BA	Jadenn Gurule, BA



**Form Must be Complete & Legible, or it will be returned**  
**This document is required to complete the Application for Treatment.**

Interstate Compact Unit  
 940 N Broadway  
 Denver, CO 80203  
 303.763.2408  
 DOC\_interstatetreatment@state.co.us

## Client Questionnaire

The following questionnaire must be completed by all adult clients seeking admission to this program for specific treatment needs as required by Colorado law. Refusal to cooperate or failure to provide complete or accurate information, including failure to sign a release of information to the referring criminal justice agency, may result in a denial to attend the treatment program by the Interstate Compact Administrator under the authority of C.R.S 17-27.1-101.

Client Name: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ Place of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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

1. Are you, or will you be under the supervision of a probation or parole officer in Colorado? YES  or NO
2. For DUI Offenders only: Are you seeking education or treatment for the sole purpose of restoring your driving privileges as the result of an alcohol or drug related driving offense in another state, but are not under court order to do so? YES  or NO
3. Do you have court ordered treatment conditions as part of an alternative sentence outside of the State of Colorado? YES  or NO
4. Are you under probation or parole supervision in any other state? YES  or NO

**If YES to questions 3 or 4 above, please answer the following questions(5-7) and complete Form A, Form B, a release of information, and provide any court or diversion order. Submit all forms and documentation back to your intended treatment provider. In addition, you may also be required to appear at a law enforcement agency for fingerprinting and photographing.**

5. In what state was the crime committed? \_\_\_\_\_
6. Who are you to report the treatment to? \_\_\_\_\_  
 (Example: Court, Judge, Probation or Parole officer, etc.)
7. Name, address, and phone number of your \_\_\_\_\_  
 Probation Officer, Parole Officer, Judge, \_\_\_\_\_  
 or diversion officer who oversees your \_\_\_\_\_  
 case/supervision. \_\_\_\_\_

Form C





# ROI (Release of Information)

Authorization to Send, Receive &/or Exchange Healthcare Information  
Revised 1/17/2025

There are Colorado Laws about your right to privacy. The Agency must protect information about your health & treatment (42 CFR, Part 2, CRS 25.1, HIPAA CFR 160, 164). Information about you cannot be given to other people or agencies without your written permission, except when the law allows it. Substance use information & HIV/AIDS information is especially protected.

Client's Name: \_\_\_\_\_ Client#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Organization/ Individual Name: \_\_\_\_\_ Relation to Client: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax/Email: \_\_\_\_\_

**The information to be disclosed:**

- |   |  |
|---|--|
| <input type="checkbox"/> Assessment/Evaluations<br><input type="checkbox"/> Billing Information<br><input type="checkbox"/> Treatment Information<br><input type="checkbox"/> HIV/AIDS Status<br><input type="checkbox"/> Legal Information<br><input type="checkbox"/> Monthly Reports/ MH only<br><input type="checkbox"/> Medication Info-MH only<br><input type="checkbox"/> Educational Information<br><input type="checkbox"/> Scheduling/Appointments<br><input type="checkbox"/> Other: _____ | <input type="checkbox"/> Substance use: (e.g. monthly progress report, discharge, UA, staffing clinical progress, attendance, diagnosis, DUI Level I & II status, medications, TMS hours etc.)<br>_____<br>_____<br>_____<br>Substance use request needs to be specific, "How much and what kind of information" in order to release any information 42 CFR Part 22018 |
|---|--|

**The information will be used for the following purposes:**

- |   |  |
|---|--|
| <input type="checkbox"/> Additional Evaluation/Treatment<br><input type="checkbox"/> Client Request<br><input type="checkbox"/> Representative/Guardian's Request<br><input type="checkbox"/> Multi-Agency Coordination | <input type="checkbox"/> Obtaining Resources/Benefits<br><input type="checkbox"/> Reports to Court/Other Agencies<br><input type="checkbox"/> Treatment/Payment/HCO<br><input type="checkbox"/> Other: _____ |
|---|--|

**Other Important Information:**

- I do not have to sign this document to get treatment at the Agency unless treatment is required by a court or another official.
- This permission will expire in two (2) years, 60 days after my treatment ends, or I revoke it in writing. I understand the Agency cannot take back any information given out before I revoked permission.
- Copies of this form may be used in place of the original signatures received by fax or email will be accepted.
- By signing this ROI, I consent for the disclosure and redisclosure of records
- The Agency cannot promise that people who get this information will keep it private. They may or may not have to follow the privacy laws. If the information is about substance use or HIV/AIDS, the people who get it are not permitted to re-release it to anyone subject to Federal laws.

**SIGN BELOW FOR PERMISSION TO RELEASE INFORMATION INDICATED ABOVE:**

> **Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 Guardian/Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Guardian/Representative's Relationship to Client: \_\_\_\_\_

**OFFICE USE ONLY BELOW:**

**REVOCATION OF AUTHORIZATION TO SEND, RECEIVE AND/OR EXCHANGE HEALTHCARE INFORMATION**

I hereby revoke the authorization signed by me on \_\_\_\_\_, and submitted to the Agency. I understand that this request does not apply to any disclosures: 1) already made in reliance upon my previous authorization, 2) made for the purpose of obtaining insurance, or 3) made as required by law.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Guardian/Representative: \_\_\_\_\_ Date: \_\_\_\_\_  
 Guardian/Representative's Relationship to Client: \_\_\_\_\_ Date: \_\_\_\_\_



# ROI (Release of Information)

(Only clients with an SUD DX)  
Rocky Mountain Health Plans Behavioral  
Health Network / Behavioral Health  
Administration  
Revised 07/07/2025

Client#: \_\_\_\_\_ Date: \_\_\_\_\_

Client's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

San Luis Valley Behavioral Health Group must protect information about your health and treatment. (42 CFR Part 2, CRS25.1, HIPAA CFR 160, 164). Information about you cannot be given to other people or agencies without your written permission, except when the law allows it. Substance abuse information and HIV or AIDS information is especially protected.

### Permission To Exchange Healthcare Information Specifically For Medicaid, Non-Insured, and Underinsured Billing

Name of Person(s)/Organization: Rocky Mountain Health Plans  
Behavioral Health Administration

The information to be used or disclosed will include: Billing Information

The information will be used for the following purposes: Treatment, Payment or Healthcare Operations

#### Other Important Information:

1. I do not have to sign this document to get treatment at the Behavioral Health Group, however, I understand that my signature is required for reimbursement for my services from Medicaid.
2. This permission will expire in two (2) years, unless my treatment ends or I revoke it in writing. I may take back my permission at any time. I understand the Agency cannot take back any information given out before I revoked permission.
3. Copies of this form may be used in place of the original. Signatures received by fax will be accepted.
4. The Agency cannot promise that people who get this information will keep it private. They may or may not have to follow the privacy laws. If the information is about substance abuse or HIV/AIDS, the people who get it are not permitted to re-release it to anyone subject to Federal laws.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Guardian/Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Guardian/Representative's Relationship to Client: \_\_\_\_\_

### REVOCATION OF AUTHORIZATION TO SEND, RECEIVE AND/OR EXCHANGE HEALTHCARE INFORMATION

I hereby revoke the authorization signed by me on \_\_\_\_\_, and submitted to the San Luis Valley Behavioral Health Group, releasing information to the following:

Name of Person(s)/Organization: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

I understand that this request does not apply to any disclosures:

1. Already made in reliance upon my previous authorization,
2. Made for the purpose of obtaining insurance, or,
3. Made as required by law.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Guardian/Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Guardian/Representative's Relationship to Client: \_\_\_\_\_



## Disclosure Statement

PG. 1 of 2  
Revised 07/28/2025

Client#: \_\_\_\_\_ Date: \_\_\_\_\_

### We Want You to Be Informed

San Luis Valley Behavioral Health Group is providing this disclosure in accordance with CRS §12-43-214. The practice of licensed or registered personnel in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. Questions or complaints may be addressed to the Department of Regulatory Agencies:

The Board of  
Examiners  
1560 Broadway,  
Suite 1350  
Denver, CO 80202  
[www.colorado.gov/dora-dpo](http://www.colorado.gov/dora-dpo)

1. As to the regulatory requirements applicable to mental health professions: a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's degree in their profession and have two years of post-master's supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed 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. A Psychiatrist or Nurse Practitioner must hold an advanced degree and training in their profession in addition to being a credentialed/ licensed health care practitioner.
2. A Certified Addiction Technician (CAT) must be a high school graduate, and complete required training hours and 1,000 hours of supervised experience. A Certified Addiction Specialist (CAS) must hold a bachelor's degree in a clinical behavioral health concentration, complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's degree and meet the CAS requirements.
3. You are entitled, to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy, if known, and the fee structure.
4. Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality to include when a therapist suspects child, elder, or dependent - adult abuse or anytime when a client poses imminent danger to themselves or others. Client's will be informed if a report is to be made.



**Disclosure Statement**  
PG. 2 of 2

**Client#:** \_\_\_\_\_ **Date:** \_\_\_\_\_

5. Mental health professionals are required to maintain records of the people they serve. Records for adults shall be retained for seven (7) years from the date of discharge and records for individuals who are less than eighteen (18) years old when admitted shall be retained until the individual is twenty-five (25) years old. Client records may not be maintained after the 7-year period for purposes of filing a complaint. (C.R.S. § 12-43-214).

Client's may seek a second opinion from another therapist or terminate therapy at any time in a professional relationship. Sexual intimacy is never appropriate and should be reported to Department of Regulatory Agencies, the board that licenses, registers, or certifies the licensee registrant or certificate holder.

**I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the client's responsible party.**

X _____	X _____
Print Client's Name	Date
X _____	X _____
Client's Signature/Parent/Guardian or Authorized Representative	Relationship/ Capacity to client

SLVBHG PROVIDERS		
Aaliyah Duran, MA, LPC	Donald Tietsema, PMHNP-BC	Mary Lambert, LPC
Adela Valencia-Lucero, MA, LPC	Donna Nelson, MD	Mary Lynnette Tracey, MSN, APRN, PMHNP-BC
Adriana Frazier, APN-CNS, RXN	Emily Kreissler, LPC	Marcia Candy, LPC, LAC
Albert Gonzales, LPC, LAC	Fanny Guyton, CAS	Matthew Harris, LPC
Amanda Martinez, BA-CIT	Frances Echeverria, LCSW	Melissa Marquez, LCSW
Angelica Vazquez, LCSW	Gavin St. Cyr, MA Intern	Michael Benavidez, MA
Anna Chavez-Sandoval, LPC, LAC	Hillary Nipple, LCSW	Mikyla Hernandez, MA
Ashley Pacheco, LPC	Ivonne Alvarado, MRC	Natalie Williams, CAS
Ashley Sasser, LPC	Jamie Bogner, LPC	Patricia Albert, LPC
Autumn Setzler, LPC	Jazmin Vigil, LPC, LAC	Rick Esquibel, CAS
Bonnie Ortega, LPC, CAS	Jeffery Wallace, MD	Roberta DeSalvo, MS, LPCC
Breanna Mosco, MA, LPC	John Ryan, LPC, LAC	Sandra Romero, MS, ACC
Sheila Lavadour, MA, LPCC	Katy Plumb, MA	Sarah Jennings, LPC, LAC
Brittney Siler, MA, CAS	Korissa Roesch, LCSW	Susan Travers, MS
Carmen Ramos, MA	Leah Romero, MSW, CAS	Tasha Martinez, LPC
Charles Wright, LPC	Lindsey Renner, MSN, APN, RXN, FNP-C	Vanessa Thong, MA
Chastidy Chacon, LPC	Lynne Jacobson, DNP, FNPc, PMHNP-BC	Veronica Trujillo, LPC, LAC
Consuelo Contreras, MPA, CAS	Mackenzie Browning, BS	Whitney Glenn, LPC
Cynthia Stone, LPC		



**42 CFR PART 2-CONFIDENTIALITY OF  
SUBSTANCE USE DISORDER DISCLOSURE**  
Revised 6/19/24

**Client Name:** \_\_\_\_\_ **Client #:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Code of Federal Regulations (CFR) Part 2 serves to protect patient records created by federally assisted programs for the treatment of substance use disorders (SUD). Strict confidentiality protections mean that clients may share information about past and current substance use without worrying that it will be used against them or exposed. SLVBHG may not reveal that a client is involved with any substances or substance treatment unless:

1. Client has consented in writing on a Release of Information form; or
2. For internal program communications; or
3. The disclosure is allowed in response to a valid Court Order; or
4. The disclosure is made to medical personnel in a medical emergency; or
5. The disclosure is made to personnel for research, audit, or program evaluation purposes; or
6. You commit or threaten to commit a crime either at the program or against any person who works for the program; or
7. To report suspected child or elder abuse; or
8. In the event of a stated or implied threat of suicide; or
9. You make a direct threat of homicide where there is “duty to warn” the intended victim.

When client information is released to another agency or person, it is accompanied by a written statement that the information disclosed is protected by federal law 42 CFR Part 2, which prohibits the receiving agency or person from making any further disclosure of the record unless permitted by the written consent of the individual whose information is being disclosed.

My signature below indicates that I have reviewed, understand and accept the Colorado Federal Regulation exceptions.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_