SAN LUIS VALLEY
Behavioral Health Group
Dedicated to Hope, Healing and Recovery

Client Demographics

Client ID: _____

Date: _____

Client Information

Last Name:	First Name:
Alias/Preferred Name/ Pronoun:	Gender (Sex at Birth): Male_____ Female_____
SS#:	DOB:
Mailing Address:	
Physical Address:	
Contact Preference: Primary Phone: _____ Secondary Phone: _____ Email: _____ Message Phone: _____ **Appointment Reminder Type:** Phone Call____ Text (cell phone only) ____ Email____	

Referral Source

☐ Individual (self, family, friend) ☐ Employer ☐ School ☐ Crisis System ☐ Social Services Agency, County SS ☐ Civil Commitment ☐ STIRRT	☐ Other Healthcare Provider (e.g. medical) ☐ Behavioral Health Care Provider ☐ Non- DUI Criminal Justice (Probation, Parole, etc.) ☐ Own Path	☐ DUI/DWI Criminal Justice (Court, Juvenile, etc.) ☐ Other Community Referral ☐ Unknown ☐ Problem Solving Court ☐ I Matter ☐ BHASO Care Navigation

Employment Status

☐ Employed Full Time ☐ Employed Part Time ☐ Unemployed/Looking ☐ Unemployed, not looking ☐ Supported Employment	☐ Homemaker ☐ Student ☐ Retired ☐ Disabled ☐ Inmate	☐ Military ☐ Volunteer ☐ Not Applicable ☐ Unknown

Marital Status

☐ Divorced ☐ Domestic Partnership ☐ Married, Separated	☐ Married ☐ Never Married	☐ Unknown ☐ Widowed

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Client ID: _____

Date: _____

Primary Language

- ☐ Asked but Unknown
- ☐ Cantonese
- ☐ Cherokee
- ☐ Declined
- ☐ Dutch
- ☐ English
- ☐ German
- ☐ Italian
- ☐ Other Communication
- ☐ Other Native American
- ☐ Other
- ☐ Polish
- ☐ Russian
- ☐ Sign Language
- ☐ Spanish
- ☐ Unknown
- ☐ Vietnamese

Ethnic Origin

- ☐ Cuban
- ☐ Mexican/ Mexican American
- ☐ Other Hispanic
- ☐ Puerto Rican
- ☐ Decline to Answer
- ☐ Doesn't claim to be Hispanic

Race (check all that apply)

- ☐ American Indian
- ☐ Asian
- ☐ Black African American
- ☐ Hawaiian/ Pacific Islander
- ☐ White/ Caucasian
- ☐ Declined to Answer

Sexual Orientation

- ☐ Asexual
- ☐ Bisexual
- ☐ Declined
- ☐ Gay/Lesbian
- ☐ Heterosexual
- ☐ Other
- ☐ Pansexual
- ☐ Queer
- ☐ Questioning/not sure

Gender Identity

- ☐ Unknown
- ☐ Decline to Answer
- ☐ Female (Cisgender)
- ☐ Male (Cisgender
- ☐ Non-Binary
- ☐ Other
- ☐ Transgender (FTM)
- ☐ Transgender (MTF)
- ☐ Two-Spirit

Education

- ☐ Less than Kindergarten
- ☐ Kindergarten
- ☐ Up to Grade #_____
- ☐ Grade 12 or GED
- ☐ Some College
- ☐ College Degree
- ☐ Master's Degree
- ☐ Doctoral Degree

Smoking Status

- ☐ Current Every Day Smoker
- ☐ Current Some Day Smoker
- ☐ Former Smoker
- ☐ Heavy Tobacco Smoker
- ☐ Light Tobacco Smoker
- ☐ Never Smoked
- ☐ Smoker, Current Status Unknown
- ☐ Unknown If Ever Smoked

Living Arrangements

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

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Client ID: _____

Date: _____

Current Resident Code

☐ Assisted Living	☐ Homeless	☐ Residential Treatment/Group
☐ Correctional Facility/Jail	☐ Independent Living	☐ Sober Living
☐ Foster Home (Youth)	☐ Inpatient	☐ Supported Housing
☐ Halfway House	☐ Nursing Home	☐ Unknown

Veteran

☐ Yes ☐ No

Handicap or Disabilities (Check all that apply)

☐ Attention Deficit Disorder	☐ Developmental Disability	☐ Psychiatric
☐ Autism	☐ Down Syndrome	☐ Seizure disorder / Epilepsy
☐ Blind/Vision Loss	☐ Learning Disability	☐ Significant speech impairment/ non-verbal
☐ Cerebral Palsy	☐ Non-ambulatory	
☐ Deaf/Hearing Loss	☐ None	☐ Traumatic Brain Injury (TBI)
☐ Developmental Delay	☐ Other Neurological	

Emergency Contact Information (Optional)

Name:	Phone #:	Relationship to Client:

Parent / Guardian #1

Last Name:	First Name:	
DOB:	Phone Number:	Relationship to Client:
Address:		

Parent / Guardian #2

Last Name:	First Name:	
DOB:	Phone Number:	Relationship to Client:
Address:		

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Household Financial Information (HFI)

Client ID: _____

Last Name:	First Name:
Insurance Company: (Please provide copy of both sides of insurance card)	
Policy #	Group #

Insurance Subscribers Information (Complete only if different from client)

Name:	Social Security #	Date of Birth

Household Income Verification

☐ **I would like to speak with someone regarding payment assistance options.**

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

Number of Adults in household_____ Number of Children under 18 in household_____

Annual household income _____

Income Source (Please check all that apply)

Wages___ Public Assistance☐ Retirement/Pension___ Disability ___ Other_____

☐ **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.**

Please provide verification for the above income as follows:

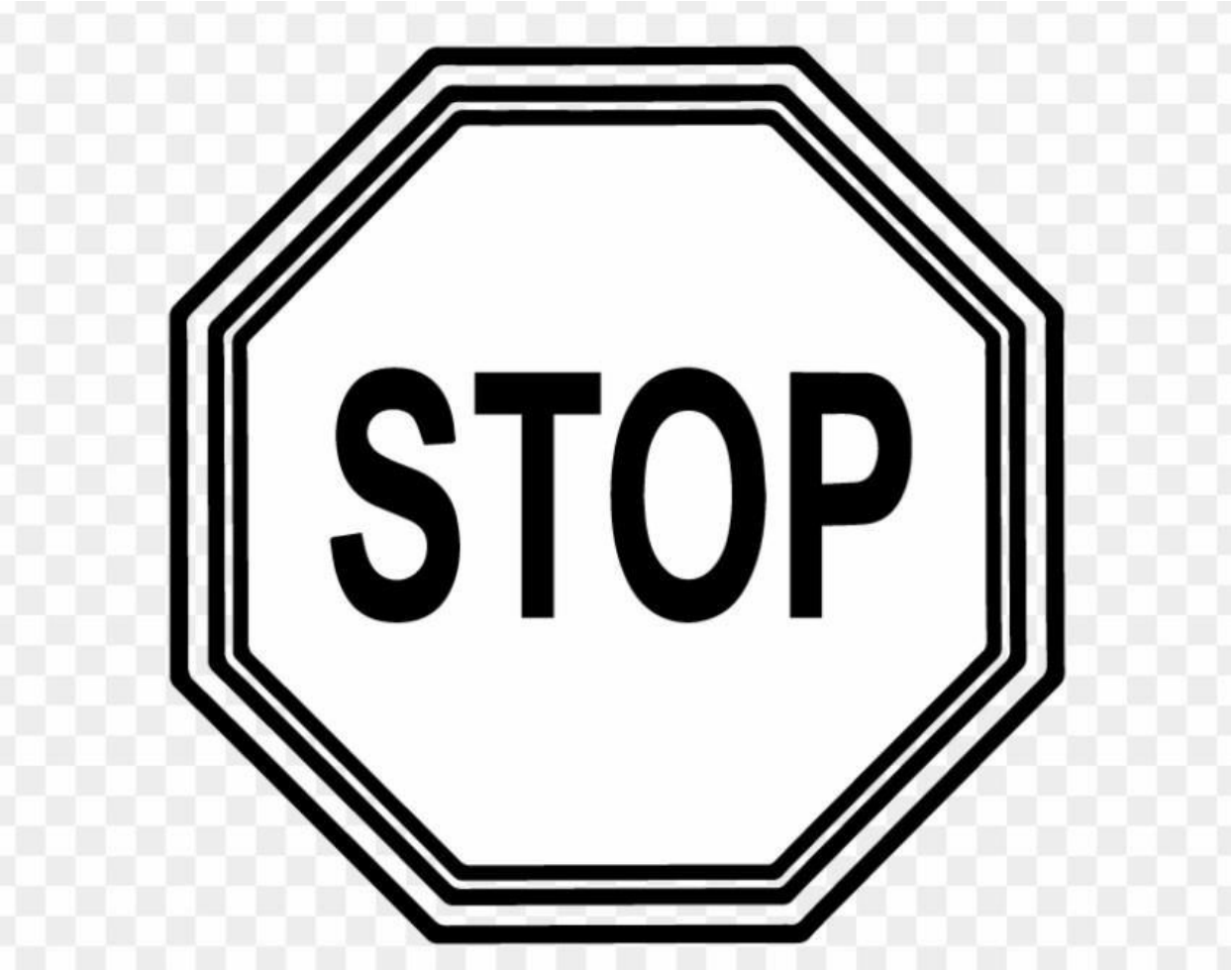
- If you or anyone in your household is employed, please provide a copy of paystubs supporting your most recent 30 days of employment. If self-employed, please provide your most recent Income Tax Return and supporting Form 1099, if applicable, along with a year-to-date Profit & Loss statement.
- If you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

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.

Sign here _____ _____ _____

Client/Guardian/Representative Signature | Relationship to Client | Date

Email Completed Form To Eligibility@slvbhg.org



Please turn in the first 4 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.

San Luis Valley
Behavioral Health Group
Dedicated to Hope, Healing, and Recovery

Client ID: _____

Client Name:_____

Infectious Disease Screen

(Complete for 12 years of age and older)

All responses are confidential and used only to support the client's health and safety.

1. **Are you currently pregnant?**
   ☐ Yes ☐ No ☐ Decline to answer

2. **Do you plan or wish to become pregnant within the next 12 months?**
   ☐ Yes ☐ No ☐ Unsure ☐ Decline to answer

3. **Would you like information or a referral for contraceptive or family planning services?**
   ☐ Yes ☐ No ☐ N/A

4. **Have you ever been diagnosed with or exposed to any of the following?**
   ☐ HIV/AIDS
   ☐ Tuberculosis (TB)
   ☐ Hepatitis A
   ☐ Hepatitis B
   ☐ Hepatitis C
   ☐ Other infectious disease
   ☐ None reported
   ☐ Decline to answer

5. **Do you believe you are currently at risk for any infectious diseases or need medical follow-up/testing?**
   ☐ Yes ☐ No ☐ Unsure

6. **Would you like assistance or referral for medical, infectious disease, or dental care services?**
   ☐ Yes ☐ No

7. **Referral/Follow-Up Completed:**
   ☐ Education provided
   ☐ Referral made
   ☐ Declined referral
   ☐ Not indicated

Sign here _____ _____

Client/Guardian/Representative Signature Date

Relationship to client: _____

Staff Signature:_____Date: _____

SAN LUIS VALLEY
Behavioral Health Group
Dedicated to Hope, Healing and Recovery

Consent for Treatment & Client Rights

Client ID: _____

Client Name:_____

Please check to provide consent

_____**CLIENT RIGHTSANDRESPONSIBILITIES:** I was given a copy of the Client's 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.

_____**ACKNOWLEDGMENT 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. Client information may be used without an ROI for the following purposes: treatment, payment, and health care operations.

_____**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. 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 7 years for purposes of filing a complaint, C.R.S. §12-43-214.

_____**PSYCHIATRIC ADVANCE DIRECTIVES:** I was given a handbook that 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 treatment decision. 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 UPCONTACT 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 I was given a referral to a medical professional regarding a well-child check for my minor child.

_____**Telehealth Consent:** I agree to receive teletherapy services for myself or my dependent. I understand that teletherapy is mental health care provided online using secure audio and video. I agree that sessions will not be recorded without everyone's consent. I understand I am responsible for having a private space for sessions, and my provider will use reasonable privacy protections on their end."

Please check one of the following:

☐ I permit SLVBHG to communicate with me via email or text. I also understand that the 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 have not met with their provider in 45 days. SLVBHG will make every attempt to reach out and re- engage the client into services; however, if this occurs, you may be discharged if contact is not made.

Sign here _____ _____

Client/Guardian/Representative Signature Date

_____

Relationship to Client

Office Use Only:

Revocation of Consent: Client Signature:_____ Date: _____

SAN LUIS VALLEY
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Artificial Intelligence (AI)
Disclosure and Consent

Client ID: _____

Our agency may use **Eleos AI** to assist your clinician with documentation by recording and/or transcribing psychotherapy sessions and preparing draft clinical notes.

Your licensed clinician remains responsible for all aspects of your care. Your clinician reviews and approves all AI-generated documentation before it becomes part of your clinical record.

In accordance with Colorado law (HB26-1195):

- AI is used only to support documentation and administrative tasks.
- AI does not independently provide psychotherapy, counseling, diagnosis, treatment recommendations, or treatment planning.
- AI cannot engage in therapeutic communication with you unless your clinician is actively participating in real time.
- If you do not consent to AI recording or transcription, or if you later withdraw your consent, you will continue to receive psychotherapy services.

Consent

I understand that Eleos AI may be used to record and/or transcribe my psychotherapy sessions for documentation purposes. I have had the opportunity to ask questions, and my questions have been answered.

☐ **I CONSENT** to the use of Eleos AI for recording and/or transcription of my psychotherapy sessions.

☐ **I DO NOT CONSENT** to the use of Eleos AI for recording and/or transcription of my psychotherapy sessions.

Sign here

_____ _____
Client/Guardian/Representative Signature Date

Relationship to Client_____

Staff Signature:_____Date: _____

COLORADO
Department of Corrections
Division of Adult Parole

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

Revised March 2024

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

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. _____

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ROI (Release of Information)

Authorization to Send, Receive &/or Exchange Healthcare Information

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: _____

Person or Organization Receiving Information

This section refers to the person or organization to whom your information will be released.

Organization/Individual Name: _____ Relation to Client: _____

Address: _____ Phone #: _____ Fax/Email: _____

The information to bedisclosed:

- ☐ Assessment/Evaluations
- ☐ Billing Information
- ☐ Treatment Information
- ☐ HIV/AIDS Status
- ☐ Legal Information
- ☐ Monthly Reports/ MH only
- ☐ Medication Info-MH only
- ☐ Educational Information
- ☐ Scheduling/Appointments
- ☐ Other: _____
- ☐ Substance use: (e.g. monthly progress report, discharge, UA, staffing clinical progress, attendance, diagnosis, DUI Level I & II status, medications, TMS hours etc.)

The information will be used for the following purposes:

- ☐ Additional Evaluation/Treatment
- ☐ Client Request
- ☐ Representative/Guardian's Request
- ☐ Multi-Agency Coordination
- ☐ Obtaining Resources/Benefits
- ☐ Reports to Court/Other Agencies
- ☐ Treatment/Payment/HCO
- ☐ 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:

Sign here _____ _____

Client /Guardian/Representative Signature Date

Relationship to Client: _____

As a client you have the right to revoke/cancel this form by filling out a "Revocation of ROI" form. Please call 719-589-3671 to request this form and you can either come by any office in person to sign or it can also be sent to you via email for your signature.

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Disclosure Statement

Client ID: _____

Client Name: _____

PROVIDER NAME: _____

EDUCATION, DEGREE, CERTIFICATES & SPECIALTIES: _____

PROVIDER'SSUPERVISOR (Name & credentials): _____

SUPERVISOR CONTACT INFORMATION: _____

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 Mental Health Licensing Section of the Division of Professions and Occupations, 1560 Broadway, Suite 1350 Denver, CO 80202,** DORA HOME | Department of Regulatory Agencies.

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 Social Worker must hold a master's degree in social work. 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. 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.

A Certified Addiction Technician (CAT) must have a high school diploma or GED, complete required courses, pass the required exams, and complete 1,000 hours of clinically supervised work experience. A Certified Addiction Specialist (CAS) must hold a bachelor's degree in an approved behavioral health specialty clinical behavioral health concentration, complete required courses, pass the required exams, and complete a total of 2,000 hours of clinically supervised work experience (1,000 direct clinical hours beyond the CAT). A Licensed Addiction Counselor must have a clinical master's degree, meet all the CAS requirements, complete required courses, pass the required exams, and complete a total of 3,000 clinically supervised hours (2,000 direct clinical hours).

We provide services in accordance with the following guidelines:
A client is entitled to receive information about the methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure.

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. The client will be informed if a report is to be made.

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 7 years for purposes of filing a complaint. (C.R.S. § 12-43-214).

Clients 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 the Department of Regulatory Agencies, the board that licenses, registers, or certifies the licensee, registrant, or certificate holder.

By signing this form, you acknowledge that you have received a copy of this document that includes your assigned provider's name and their degree, credentials, license, experience, and or training.

Sign here **Client Signature**_____Date: _____

Guardian Signature_____Relation to client:_____Date: _____