ASSOCIATES FOR PSYCHOTHERAPY & EDUCATION, PC
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information <u>Please review it carefully.</u>

The Health Insurance Portability and Accountability Act of 1996, (HIPAA), effective April 14, 2003, mandates that health care providers inform individuals of their rights with regard to Protected Health Information, (PHI) (information that is personally identifiable; your name, address, phone number, social security number, etc.). To this end we have listed below the individuals who have access to your PHI and the circumstances in which we would use or disclose your PHI:

Associates for Psychotherapy & Education, PC (any and all employees) will use and disclose PHI for the following reasons:

1. With consent from the Client or Parent should the client be a minor.
2. Where legal regulations explicitly demand disclosure without the client's consent. *Client is a danger to self or others, in the case of known or suspected child abuse or neglect, we may inform law enforcement officials, (i.e., Police, Sheriffs Dept., Department of Social Services) and when ordered to by a court order, court ordered subpoena, administrative tribunal, (social security admin).*
3. With your consent we will share information to coordinate your care with your primary care physician.
4. At your request we will send service information and diagnosis to your insurance company for claims payment. We will also abide with Quality Assurance practices of the insurance company if we send in claims to them.
5. At your request we will send information regarding your services to your attorney or other selected individual.
6. In the case of a mandatory employee assistance referral we will, with your consent, send compliance information to the appropriate person at work.
7. The department of Health & Human Services (HHS) can view your PHI as a part of a compliance audit with the HIPAA standards.

Associates for Psychotherapy & Education, PC (any and all employees) **will not** use or disclose PHI for monetary gain from advertising or marketing or as a part of independent or cooperative research.

The following are your rights to your PHI in our office:

1. Right of Notice – You have the right to read this privacy notice and know how Associates for Psychotherapy & Education, PC uses the clients' PHI, .
2. Right to Protect – You have the right to control the use of your PHI. HIPAA dictates that if you don't wish to give consent for disclosure of your PHI we will not take action against you.
3. Right to Access – You have the right to look at your PHI.
4. Right of Accounting – You get to know where your PHI goes.
5. Right of Amendment – You have the ability to request that the health care provider amend or modify the PHI.

Ironically, HIPAA also mandates that you be informed that Associates for Psychotherapy is not required to honor the previous requests. We will make every effort to comply with your requests.

Signature below indicates that I have read and understand My HIPAA privacy rights. Additional information is available to further explain your rights should you need additional assistance. Ask for and review it if you need additional explanation of your rights.

CLIENT COPY form date 7-04*

MENTAL HEALTH PROFESSIONAL'S DISCLOSURE

1. The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The Department of Regulatory Agencies can be reached at 1560 Broadway, Suite 1550, Denver, CO 80202, 303-894-7855. As to the regulatory requirements applicable to mental health professionals:
   - ✓ Registered psychotherapist is a psychotherapist 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 registration from the state.
   - ✓ Certified Addiction Counselor I (CACI) must be a high school graduate, complete required training hours and 1,000 hours of supervised experience.
   - ✓ Certified Addiction Counselor II (CACII) must complete additional required training hours and 2,000 hours of supervised experience.
   - ✓ Certified Addiction Counselor III (CACIII) must have a bachelors degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience.
   - ✓ Licensed Addiction Counselor must have a clinical masters degree and meet the CAC III requirements.
   - ✓ Licensed Social Worker must hold a masters degree in social work.
   - ✓ 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.
   - ✓ 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.
   - ✓ A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.
2. 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. You can seek a second opinion from another therapist or terminate therapy at any time.
3. In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.
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, some of which are listed in section 12-43-218 of the Colorado Revised Statutes, and the HIPAA Notice of Privacy Rights you were provided as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report suspected child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly. Mental Health Practice Act (CRS 12-43-101, et seq.) is available at http://www.dora.state.co.us/mentalhealth/Statute.pdf.

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.

_____ _____

Client's or Responsible Party's Signature Print Client's name

_____ If signed by Responsible Party, state relationship to client and authority to consent: _____

Date _____

Name _____ DOB _____

CLIENT RIGHTS AND RESPONSIBILITIES

Treatment Philosophy-Explanation of Brief Therapy

Brief therapy is goal-directed, problem-focused treatment. This means that treatment goal/ goals are established after a thorough assessment. All treatment is then planned with the goal(s) in mind and progress is made toward meeting the goal(s) in a time efficient manner. I will take an active role in setting and achieving my treatment goals. My commitment to this treatment approach is necessary for me to experience a successful outcome. If I ever have any questions about the nature of the treatment or care, I will not hesitate to ask.

INITIAL HERE: _____

Limits of Confidentiality Statement

All information between practitioner and client is held strictly confidential. There are legal exceptions to this:

1. The client authorizes a release of information with a signature.
2. The client's mental condition becomes an issue in a lawsuit.
3. The client presents as a physical danger to self.
4. The client presents as a danger to others.
5. Child abuse and/or neglect are suspected.
6. The violation of psychotherapy licensing laws is suspected.

In the latter three cases, the practitioner is required by law to inform potential victims and legal authorities so that protective measures can be taken. All written and spoken material from any and all sessions is confidential unless written permission is given to release all or part of the information to a specified person, persons, or agency. If group therapy is utilized as part of the treatment, details of the group discussion are not to be discussed outside of the counseling sessions.

INITIAL HERE: _____

Release of Information

I authorize release of routine information to my insurance company for claims, certification, case management, quality improvement, and benefit administration, understanding that information may be shared with other therapists at Associates for Psychotherapy for emergency on-call purposes and clinical supervision.

INITIAL HERE: _____

Consent for Telehealth Services

I agree to receive telehealth services telephonically, via doxy.me or zoom during a time of crisis or if an occasion arises where it's inconvenient to attend sessions.

INITIAL HERE: _____

After Hours Access:

An on-call practitioner is available after hours to handle current client's urgent calls. By calling the main office number after hours, I will be instructed how to contact the on-call practitioner.

INITIAL HERE: _____

Financial Terms: Cash payment, Deductibles and Co-payments

Associates will send claims to my primary insurance company, at no charge. A charge of $55.00 will be assessed for missed appointments or appointments canceled with less than 24 hours notice. Emergency cancellations will be assessed a $25.00 "time lost amount". Office services including phone calls will be charged at the same rate as my therapist's fee for service. The above fees are not covered by insurance plans. I am responsible for obtaining prior authorization for treatment from my insurance carrier when necessary. I am responsible for co-payment and deductibles as set by my benefit plan. I authorize Associates for Psychotherapy to send claims to and receive payment from my insurance plan for all current and future claims. Should my account become delinquent, I authorize a reasonable collection fee on any unpaid balance. Co-payment amounts are set by my benefit plan. Payment is due and payable at each appointment. A $5.00 billing fee will be charged if my portion is not paid at time of service. **I understand that the information I receive regarding insurance coverage for my services (including copayment/coinsurance) is an estimate based on information received from my insurance company. Should the actual claims payment amount be different from this estimate, I agree that I am responsible to pay any additional amount.** I understand that I

Name _____

will be told of any costs for services beyond or outside of insurance benefits, or for special modalities of treatment not covered by benefit plan. A written agreement will be signed between this office/ practitioner and me. This agreement will outline the understanding of what service is not a covered benefit. If I change insurance coverage, it is my responsibility to inform this office. If at any time during treatment I become ineligible for insurance coverage, I will notify the office and become responsible for any balance due.

INITIAL HERE: _____

Cancellation and Missed Appointment Policy

Associates for Psychotherapy understands emergencies but, my appointment time is reserved especially for me. I understand that I will be charged for missed or canceled appointments if I give less than 24 hours notice. Repeated "no-show" appointments could result in a referral back to the insurance company for assignment to another practitioner. My insurance will not be billed for missed or canceled appointments.

INITIAL HERE: _____

Case Closure

Please note that your file may be closed if we do not have any contact with you for 90 days. Feel free to contact us if future services are desired.

INITIAL HERE: _____

Appeals and Grievances

Associates for Psychotherapy therapists' goal is to provide the best service appropriate to your needs. Any time I have questions, comments or complaints about services, I can feel free to contact Dr. Annette Long, Clinical Director of Associates for Psychotherapy & Education at 924 Indiana Ave Pueblo, CO 81004. The practice of psychotherapy is regulated by the Department of Regulatory Services, and questions or complaints may also be addressed to them at 1560 Broadway, Suite 1550, Denver 80203, 303-894-7855.

INITIAL HERE: _____

I also understand that I may submit a complaint (a Grievance) to Associates for Psychotherapy at any time to register a complaint about my care or I may send the complaint directly to my insurance company. Associates for Psychotherapy has access to information and forms to facilitate this.

INITIAL HERE: _____

Consent for Treatment

I authorize and request my practitioner carry out psychological exams, treatment and/or diagnostic procedures, which now, or during the course of my treatment, become advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psycho-therapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me.

INITIAL HERE: _____

_____ _____

Client/Guardian Signature Date

General Consent for Child or Dependent Treatment

I am the legal guardian or legal representative of the client and on the client's behalf legally authorize the practitioner/group to deliver mental health care services to the client. I also understand that all policies described in this statement apply to the client I represent.

_____ _____

Client Name Client Social Security #

_____ _____

Signature of Legal Guardian/Legal Representative Date

_____ _____

Therapist Signature Date

ASSOCIATES FOR PSYCHOTHERAPY AND EDUCATION, PC

CONFIDENTIAL CLIENT INFORMATION

Client Information	Responsible Party Information
Name _____	Name _____
Home Address _____	Home Address _____
City _____ State _____ Zip _____	City _____State_____Zip_____
Home phone_____	Home phone _____
Work phone_____ Cell _____	Work phone_____ Cell_____
May we call or leave a message at home / cell? YES NO	Relationship to Client: Parent _ Spouse _ Other _
May we call or leave a message at work? YES NO	Referral Source _____
Email address_____	For Minors: Name(s) of Custodial Parent(s)
Date of Birth _____ Age _____ Sex _____	Guardian(s):_____
Social Security No. _____	_____
Level of Education _____	_____

INSURANCE INFORMATION

Name of Policy Holder_____Policy Holder's SSN(REQUIRED)_____

Policy Holder's Employer _____

Primary Insurance Co _____ Member ID#_____ GROUP# _____

Secondary Insurance Co _____ Member ID# _____ GROUP# _____

OFFICE USE ONLY

Intake Date: _____ **Discharge Date**: _____

Received Therapist Information ____Yes ____No Signed Mental Health Disclosure ____Yes ____No

Diagnosis: _____

Other Contact Name _____ Phone # _____

_____ Phone # _____

Therapist: _____

Information Released

To_____ Info_____ Date_____ By_____

To_____ Info_____ Date_____ By_____

To_____ Info_____ Date_____ By_____

ASSOCIATES FOR PSYCHOTHERAPY AND EDUCATION, PC

924 INDIANA AVE.
PUEBLO, CO 81004

NO SHOW / CANCELLATION/LATE POLICY

When we schedule your appointment, this is your time that has been reserved with your therapist. In order to provide the best care and service to our clients, we ask that you notify us 24 hours in advance to cancel and/or reschedule your appointment.

You will be charged a $55.00 fee for missed appointments or appointments cancelled with less than 24-hour notice and a $25.00 "time lost amount" for emergency cancellations.

After 3 NO-SHOWS OR CANCELLATIONS, you may be discharged from our care as a direct result of being "non-compliant to treatment."

If you are a new or established client and are late 15 minutes or more than your scheduled appointment time, the remainder of your appointment time will be considered a complete session.

We value our client/therapist relationship and will do everything we can to accommodate you and to achieve a positive outcome at our office.

I have read this carefully. I understand the above policy and agree to be bound by this policy.

Signature	Relationship to patient	Date

Therapist's Signature	Date

Form date 4-2020

Associates for Psychotherapy & Education

Child/Adolescent Screen

Today's date_____

Client_____ Age_____ Date of Birth_____

Sex_____ Grade in School_____ Ethnic Background (optional)_____

Person completing form_____ Relationship_____

What is the PROBLEM(S) that motivated you to seek therapy?

Does your child have, or have you ever suspected this child has, any of the following (please check those that apply)?:

_____ Attention Deficit Disorder (ADD, ADHD)
_____ Fetal Alcohol Syndrome
_____ Hearing problems
_____ Memory problems
_____ Motor skills (coordination) problems
_____ Sleep problems
_____ Problems with bowel or bladder
_____ Use of alcohol, drugs, or cigarettes
_____ Learning problems (school failures)
_____ Attachment Disorder
_____ Eyesight problems
_____ Speech problems
_____ Mental slowness or retardation
_____ Eating problems
_____ Phobias (severe fears)
_____ Allergies

_____ Presence or history of medical problems, head injury, high fevers, seizures, unconsciousness, etc., please circle & explain:_____

_____

_____ History of any type trauma (emotional or physical), please explain:_____

_____

_____ Exposure to violence, please explain:_____

_____ Problems with development, please explain:_____

_____

Did the mother or this child have problems during gestation or birth?_____

Is there anything odd, that you don't quite understand about this child?_____

_____

Has this child had problems getting along with people?____ If yes, please explain:_____

_____

Do teachers report that there are problems at school?____ If yes, please explain:_____

_____

Who lives in the same household with this child?_____

_____

What does this child do for fun?_____

How do you describe this child to people?_____

_____

Has this child/adolescent been seen in counseling?_____

Is there a family history of any mental disorders, addictions, developmental problems, legal problems,or any other problem that may have an impact on this child's development or life?____ If yes, please circle & explain:_____

_____

Is there anything else that you feel would be helpful for the counselor to know, so that they can more fully help this child/adolescent?_____

_____

Therapist Signature_____

ASSOCIATES FOR PSYCHOTHERAPY HEALTH CARE COORDINATION

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO PRIMARY CARE PHYSICIAN

Name: _____ DOB: _____

I hereby authorize the release of information listed below which may pertain to my medical history or treatment, including information relating to my mental health and/or substance abuse diagnosis or treatment to my primary care physician:

Physician Name _____

Address _____

Phone Number _____ Fax _____

I understand the purpose of the release is to permit my primary care physician to monitor and coordinate all care, which I may receive from specialists. This authorization is effective when signed, and may be revoked by me at any time, except to the extent action has been taken. If not earlier revoked, it shall automatically terminate in one year. Information authorized by this release will be provided to the authorized recipient only. I understand that additional information may be provided to this recipient only with signed consent from me, and further that I have a right to a copy of this authorization upon request.

_____ _____ _____

Signature of Client (15 years & older) Signature of Parent or Legal Guardian Date

_____

Signature of Witness

OFFICE USE

Dear Primary Care Physician:

I have seen your patient for services at Associates for Psychotherapy. The following information about the patient may be helpful for you in managing the patient's medical care.

Diagnosis: _____

_____

_____

Treatment Goals: _____

_____

_____

Additional Information: _____

_____

If you need additional information, contact me at Associates for Psychotherapy and Education 924 Indiana Ave. Pueblo, CO 81004, 719-564-9039, fax 719-561-8752.

It is a pleasure to assist you in the care of your patient.

_____ _____ _____

Name of Therapist Signature Date

1/15

NOTICE: FEDERAL LAW PROHIBITS FURTHER DISCLOSURE OF THIS INFORMATION (42 C.F.R., PART 2)

ASSOCIATES FOR PSYCHOTHERAPY & EDUCATION, PC
CONSENT FOR TREATMENT OF A MINOR
(UNDER AGE 12)

Child's Name: _____

DOB: _____

In the state of Colorado a minor under the age of 12 years needs the consent of the parent (if said parent has full decision-making) or both parents or guardian in order to seek voluntary outpatient counseling services for the minor child. It is **the responsibility of the parent who is scheduling** the counseling to notify the other parent with joint decision-making rights and obtain their signature below **prior** to the first session. A current copy of any and all court documents pertaining to the custody/guardianship/decision-making of the child in the case of separation and divorce will be provided to Associates **prior** to the first counseling session. Documents may be delivered in person, faxed to (719) 561-8752 or emailed to help@aforp.com. If both parents share joint custody or joint decision-making for the child **both parents** will be required to sign a consent for treatment.

If Associates does not have appropriate written consent **prior** to the first session, we will be unable to see the child.

Please fill in your name, check the appropriate line and sign and date below.

I _____ am
(Parent's Name—Please Print)

____ The only surviving biological parent

____ The biological parent with full decision-making (documents must be provided to substantiate this statement **prior** to the first session)

____ The legal guardian (documents must be provided to substantiate the statement **prior** to the first session)

____ One of two biological parents (the other parent must also sign below **prior** to the first session)

_____
(Other Parent's Name—Please Print)

of _____ and give my permission to Associates
(Child's Name)
For Psychotherapy to provide mental health/psychological services to my child.

_____ _____
(Signature of Parent/Guardian) (Date)

_____ _____
(Signature of Parent/Guardian) (Date)