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

_____

WELCOME
ASSOCIATES EAP MENTAL HEALTH DISCLOSURE

Whether you contacted EAP yourself or were referred to us by someone else, the information provided by you during counseling sessions is legally confidential unless you give specific written consent for us to release particular information. It is important to note, however, that EAP therapists are required by law to report homicidal or suicidal intent as well as indications of child sexual/physical abuse or neglect.

Our goal is to provide you with the best service appropriate to your needs. Your EAP Counselor will be conducting an evaluation and working with you to determine how best to help you with your problem. If we believe that another person, agency, or service can assist you further, we will (with your permission) refer you to them. If you choose to accept this referral, all financial arrangements are your responsibility. Associates EAP is limited to working with short-term issues. Problems that require more than a few sessions must be referred into your medical insurance. We can offer no guarantee that you can continue working with your same counselor under your insurance plan but we try to participate with as many insurance provider panels as possible.

You will receive information about your EAP counselor and about the methods of counseling. Information includes the therapist's name, educational degrees, licenses, and credentials. You may seek a second opinion from another therapist and may terminate counseling at any time.

Any time you have questions, comments or complaints about our services, please contact Dr. Annette Long, Clinical Director of Associates for Psychotherapy & Education at 924 Indiana Ave, Pueblo, CO 81004, 719-564-9039. 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 1340, Denver, CO 80203, 303-894-7766. In a professional relationship, sexual intimacy is never appropriate and should be reported to the grievance board.

Associates EAP Office practices: (Please indicate your understanding of each statement)

After Hours: An on-call therapist is available after hours to handle current client's urgent calls. By calling the main office number after hours you will be instructed how to contact the on-call therapist. Initial here: _____

Cancelations: Associates requires a minimum of 24 hour notice of intent to cancel appointment. Cancelation without this notice or failure to show for appointment will use one of your EAP sessions. Initial here: _____

Survey: I authorize Associates staff to follow up by phone or mailed questionnaire after my use of the EAP services to determine my level of satisfaction with those services. Yes ____ No _____

Privacy Policy: I have received a copy of Associates for Psychotherapy Privacy Notice. Yes ____ No _____

I have read this information and understand and approve of its content.

_____ _____
Signature of client and/or legal guardian *Date*

_____ _____
Therapist's Signature *Date* *1/05*

ASSOCIATES EMPLOYEE ASSISTANCE PROGRAM INFORMATION SHEET

Client Name_____DOB_____Age_____SSN_____

Address_____City_____State_____Zip_____

Employee Name_____ Marital Status_____

Relationship to client Self ____ Spouse ____ Parent ____

Personal Physician _____ Medical Insurance_____

Home Phone _____ cell _____

May we call/ leave you a message at home? Yes - No

Work Phone _____ May we call or leave you a message at work? Yes - No

EAP Demographic Information:

EAP Employer name _____

Primary Referral Source

_____ Self-referral
_____ Family initiated
_____ Informal suggestion from supervisor
_____ Mandatory referral from supervisor
_____ Other_____

Is your supervisor aware of your coming to Associates EAP? Yes ___ No ___ N/A ___

OFFICE USE ONLY PLEASE DO NOT WRITE IN THIS SPACE

Therapist_____ Intake date _____ Closure date_____

Diagnosis:_____

Information Released

To _____ Info _____ Date_____ By _____

To _____ Info _____ Date_____ By _____

To _____ Info _____ Date_____ By _____

NOTICE: FURTHER DISCLOSURE OF THIS INFORMATION IS PROHIBITED BY FEDERAL LAW (42 C.F.R., PART 2) Form date 10-19

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 & 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)