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 a message at home Yes - No

Work Phone _____ May we call or leave a message for you 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

BEHAVIOR QUESTIONNAIRE SCALE

CLIENT'S NAME: _____DOB: _____ DATE: _____

Below is a list of problems and areas of life functioning in which some people experience difficulties. Place an X on the response that best describes the degree of difficulty you have been experiencing in each area during the PAST MONTH. Please respond to each item. Do not leave any blank. If there is an area that you consider to be inapplicable, indicate that it is No Difficulty.

To what extent in the past month did you experience difficulty in the area of:	No Difficulty	A Little Difficulty	Moderate Difficulty	Quite a Bit of Difficulty	Extreme Difficulty
1. Managing day-to-day life (for example, getting places on time, handling money, making everyday decisions)					
2. Household responsibilities (for example, shopping, cooking, laundry, other chores)					
3. Work (for example, completing tasks, performance level, finding/keeping a job)					
4. School (for example, academic performance, completing assignments, attendance)					
5. Financial problems					
6. Leisure time or recreational activities					
7. Adjusting to major life stresses (Example: separation, divorce, moving, new job, new school, death of family/friend)					
8. Relationships with family members					
9. Getting along with people outside of the family					
10. Isolation or feelings of loneliness					
11. Being able to feel close to others					
12. Can't make friends					
13. Frequently feel guilty					
14. Feelings of suspiciousness or mistrust toward others					
15. Being realistic about yourself or others					
16. Feeling satisfaction with your life					
17. Lack of self-confidence, feeling bad about yourself					
18. Recognizing and expressing emotions appropriately					
19. Developing independence, autonomy					
20. Apathy, lack of interest in things					
21. Depression, hopelessness					
22. Fear, anxiety or panic					
23. Confusion, concentration, memory					
24. Can't make decisions					
25. Self-harm or suicidal thoughts now or previously					
26. Disturbing or unreal thoughts or beliefs					
27. Hearing voices that others do not hear					
28. See things others do not see					
29. Mood swings, unstable moods					
30. Uncontrollable, compulsive behavior (for example, eating disorder, hand-washing, hurting yourself)					
31. Physical symptoms (for example, headaches, aches or pains, sleep disturbance, stomach aches, dizziness)					
32. Victim of physical abuse					
33. Victim of sexual abuse					
34. Sexual activity or preoccupation					
35. Drinking alcoholic beverages					
36. Taking illegal drugs, misusing drugs					
37. Controlling temper, outbursts of anger, violence					
38. Past or present legal problems					

Therapist Signature_____ **For ages 14 and older**

*NOTICE: FURTHER DISCLOSURE OF THIS INFORMATION IS PROHIBITED BY FEDERAL LAW (42 C.F.R., PART 2)*7/14

Client Name _____ DOB: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "√" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping to much	0	1	2	3
4. Feeling tired or having no energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself--or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have moving around a lot more than usual	0	1	2	3
9. Thoughts you would be better off dead or of hurting yourself in some way	0	1	2	3

Scoring Guide

FOR OFFICE CODING__0__ + _____ + _____ + _____

=TOTAL: _____

0-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Therapist Signature _____ Date _____

Client Name _____ DOB: _____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been Bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying to much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7 Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	_____ + _____	_____ + _____	_____ + _____	_____ + _____

Total Scores (*add your column scores)* =

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?
Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Therapist Signature _____ Date _____

MEDICAL HISTORY

NAME _____ Male___Female___ DOB _____ DATE _____

FAMILY PHYSICIAN _____

A. Immediate Medical History:

Are you currently being treated for any medical or surgical condition? Yes _____ No _____

If yes, please explain _____

_____

If female, are you pregnant? Yes ____ No ____

Are you taking any medications now? List dosages and frequency. _____

_____

_____

Have you ever taken the following type of medications: Antidepressants, tranquilizers, antabuse, pain or sleeping pills? Explain: _____

_____

__

Do you now have or have you ever had allergies and/or sensitivities? Please list: _____

_____

Was there ever a time in your life you were using more alcohol or drugs than was good for you? What were the social, medical and/or legal complications?

_____

_____

B. List below any significant medical illnesses, injuries, and all surgeries you have undergone. Give year and place where treated. _____

_____

_____

_____

C. List below any significant health problems of parents, grandparents, and other close relatives:

_____

_____

_____

_____

D. Date of last physical exam _____

_____ _____

Signature of Client Date

_____ _____ _____ _____

Signature of Parent or Legal Guardian Relationship Therapist's Signature Date 4/06

NOTICE: FURTHER DISCLOSURE OF THIS INFORMATION IS PROHIBITED BY FEDERAL LAW (42 C.F.R., PART 2