# 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 Please review it carefully.**

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 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_____

To_____ Info_____ Date_____ By_____

**ASSOCIATES FOR PSYCHOTHERAPY & EDUCATION**
**924 INDIANA AVE**
**PUEBLO, COLORADO 81004**
**719-564-9039**

# IMPORTANT INFORMATION FOR MEDICAID MEMBERS

## As a Medicaid Member, you have the right to:

- Be treated with respect, dignity and regard for your privacy;
- Be free from discrimination on the basis of race, religion, gender, age, disability, health status, or sexual orientation;
- Get information on treatment options in a way that is easy to understand;
- Take part in decisions made about your health care. This includes the right to refuse treatment, except as required by law;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
- Ask for and get a copy of your medical record. You may ask for it to be changed or corrected;
- Have an independent advocate;
- Ask that we include a specific provider in our network;
- Get a second opinion;
- Receive culturally competent services;
- Get interpreter services if you have disabilities or if you do not speak English;
- Be told if your provider stops seeing members or has changes in services;
- Tell others your opinion about our services. You can tell regulatory agencies, the government, or the media without it affecting how we provide covered services;
- Get medically necessary mental health care services according to federal law;
- Be free to use all of your rights without it affecting how you are treated; and
- Be free from sexual intimacy with a provider.
    - If this happens, report it to the: Colorado Department of Regulatory Agencies (DORA). Phone: 303-894-7788 or write to: DORA, 1560 Broadway, Suite 1350, Denver, CO 80202

## As a Medicaid Member, you have the Responsibility to:

- Learn about your mental health benefits and how to use them
- Be a partner in your care. This means:
    - Following the service plan you and your therapist have agreed on
    - Participating in treatment and working toward the goals of your service plan
    - Taking medications as agreed upon between you and your prescriber.
- Tell your therapist or if you do not understand the service plan, if you do not agree with the plan, or if you want to change it.
- Give your therapist or doctor the information s/he needs to provide good care. This includes signing releases of information so that your providers can coordinate your care.
- Come to your appointments on time. Call the office if you will be late or if you can't keep the appointment.
- Cooperate with ValueOptions, the Medicaid contractor that works with your provider. You may call ValueOptions at 1-800-804-5008 for questions about choosing a provider or making your first appointment.
- Let us know when you change your address or phone number, and when you have lost or renewed your eligibility for Medicaid.
- Treat others with courtesy and respect as you want to be treated.

**Advance Directives:**

Even though ValueOptions and your therapist provide mental health services, federal law requires that we tell adult patients about Colorado laws relating to your right to make health care decisions and Advance Directives. Your provider will provide mental health care whether or not you have an advance directive.

**What is a Medical Advance Directive?** Advance Directives are written instructions that express your wishes about the kinds of medical care you want to receive in an emergency. In Colorado, Medical Advance Directives include:

- **Medical Durable Power of Attorney:** This names a person you trust to make medical decisions for you if you cannot speak for yourself.
- **Living Will:** This tells your doctor what type of life supporting procedures you want and do not want.
- **Cardiopulmonary Resuscitation (CPR) Directive of "Do Not Resuscitate Order":** This tells medical personnel not to revive you if your heart or lungs stop working.

Your provider will ask you if you have an Advance Directive. If you wish, your provider will put a copy of your Advance Directive in your medical file. If a medical provider does not follow your Advance Directive, you may call the Colorado Department of Public Health and Environment at 303-692-2980.

For more information about Advance Directives, talk with your **P**rimary **C**are **P**hysician (PCP). To get a copy of ValueOptions' policy on Advance Directives, call the Office of Member and Family Affairs at 303-432-5956 or 1-866-245-1959.

**Well-Child Exams (EPSDT)**

For clients under the age of 21, we are required to ask if any mental health issues were identified in the last medical visit or well-child exam. We want to address the issues that were identified and coordinate care with your primary care physician (PCP). Your provider will ask you to sign a release of information.

If your child has not had a well-child exam within the last year, your therapist will recommend that you schedule an appointment. If you do not have a PCP or you want a new PCP, you may contact Health Colorado for assistance in Denver **303-839-2120; o**utside of Denver **1-888-367-6557 (**The call is free.); TTY**: 1-888-876-8864.**

Client Name _____

Member/Or Guardian signature _____

Provider signature _____

Date _____

# 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

_____

form date 6-2012

Name _____

DOB _____

# MEDICAID 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: _____

**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: _____

**Cancellation and Missed Appointment Policy**

Associates for Psychotherapy understands emergencies, but my appointment time is reserved especially for me. I understand that you request at least 24 hours notice if I am unable to keep any of my scheduled appointments. Repeated "no-show" appointments could result in a referral back to Colorado Health Networks for assignment to another practitioner.

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: _____

(PLEASE CONTINUE ON BACK SIDE)

Name _____

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.

**Consent for Treatment**

INITIAL HERE: _____ 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.

_____ _____
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

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**

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)*

# 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



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