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 Signature____ Date_______________

ASSOCIATES FOR PSYCHOTHERAPY AND EDUCATION, PC
CONFIDENTIAL CLIENT INFORMATION

Client Information

Name ____

Home Address ________________________________

City ____________________ State _______ Zip ________

Home phone__________________

Work phone__________________ Cell ________________

May we call or leave a message at home / cell? YES NO

May we call or leave a message at work? YES NO

Email address___________________________________

Date of Birth ________________ Age _____ Sex _____

Social Security No. ______________________________

Level of Education _______________________________

Responsible Party Information

Name ____________________________________

Home Address ______________________________

City __________________State_____Zip________

Home phone _______________

Work phone_______________ Cell______________

Relationship to Client: Parent _ Spouse _ Other _

Referral Source _____________________________

For Minors: Name(s) of Custodial Parent(s)

Guardian(s):________________________________

____

____

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_____

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

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 ____________

Form Date 12-13
Rev. 10-20-11

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

______________________ Date

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

____

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 ____

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

CHILD HISTORY FORM for clients < 18 y.o **(MEDICAID)** **DATE**________________

(To be completed by parent or legal guardian)

CHILD'S NAME: ____________________________ DOB: ______________ Medicaid ID #_______________

****DEVELOPMENTAL/MEDICAL HISTORY****

Please check all the following that were problems at pregnancy, delivery or in the first three (3) years of life.

	Toxemia		Late to walk
	Jaundice		Late to talk
	Premature		Late to potty train
	Low birth weight		Problems with verbal skills
	Prenatal/perinatal drug/alcohol exposure		
	Developmental disabilities/organic conditions (please identify)		

During the first three years of life were there any major changed in the home?_______________________

____

____

Has your child ever had any unusual accidents? ________________________________

____

____

Has he/she ever been physical/sexually abused or neglected? ________ Please list when, where to what extent and if it was reported to appropriate agency or required medical attention. ______________________

____

____

Please check all the following significant medical problems that your child has experienced:

	Meningitis		Seizures
	Repeated ear infections		Repeated high fever
	Surgeries (list type, age of child, date(s) length of hospital stay		

____

____

Other ____

____

What was the date of your child's last physical exam? ___________________________

Please list any medications your child is currently taking: (include name of doctor, dose, frequency and effectiveness)____

____

Continue on back →

CHILD'S NAME: ________________________________ DOB: ________________ Medicaid ID #____________

Who is your child's doctor? ____

What are your child's physical activities, hobbies, interests and strengths ______________________________

____

EDUCATIONAL HISTORY/INTELLECTUAL DISABILITY

Present grade: ________________ School: ____

Has he/she ever had academic problems or received special education services? ____________________________________

____

Has he/she ever had behavioral problems? ____

Does he/she have difficulty making friends?____

FAMILY HISTORY

Was the child adopted? ________________ At what age? _________________ Has he/she ever been in foster care or taken care of by relatives? ____________ Why? ________________________________

Does he/she have contact with biological father? ________________ Biological mother? _________________

Briefly describe relationship with present guardians: ____

____

List all siblings and ages (and anyone else in the home): ______________________________________

____

Any conflict with siblings? ______ Describe: ____

Have any other of your children had similar problems? __________ How did you handle it? ________________

____

What kind of discipline do you use? ____

Is it effective? ____

Provide any additional information you feel is important: ____

____

____

Individual providing information/Relationship ____

________________________________ ______________________________ ____________

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

____ Date: __________________

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

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

Date: ____________________

RE: _____________________

Medicaid #: _______________

Dear Dr. _________________ ,

Enclosed you will find a copy of the release of information signed by the above-named child's parent or guardian giving me permission to communicate with you.

The above-named child has entered into psychological counseling with me. Due to the type of insurance s/he has (i.e. Medicaid), I am required to document that an Early Periodic Screening and Diagnostic Tool (EPSDT) has been completed by his/her Primary Care Physician (PCP).

You may either call me at 564-9039 and leave a message as to whether the EPSDT has been completed (it is **not necessary to send the EPSDT**) or complete the following and either **FAX** it back to me at 561-8752, or mail a copy to me at the following address:

Associates for Psychotherapy & Education, PC
924 Indiana Ave
Pueblo, CO 81004

Doctor's Information: Please circle the appropriate response. Thank you!

Yes An EPSDT was completed by me on the following date:

Date: _________________________

No I have not completed an EPSDT on the above-named child.

______________________ ______________________

Doctor's Signature or Initials Date

Sincerely,

_____________________ ____________________

Marsha Phelps, M.A., LPC Tim Kelley, MA, LPC

Form date 11-13

ASSOCIATES FOR PSYCHOTHERAPY & EDUCATION, PC

CONSENT FOR TREATMENT OF MINOR
(UNDER AGE 15)

Child's Name ____

DOB: __________________

I/We ____
Name(s) of Parent(s)/Guardian

am/are the legal custodial parent(s) of _____________________________________
Name of Child

and give my/our permission to Associates for Psychotherapy to provide psychological services to my/our child.

____ ______________
Signature of Parent/Guardian Date

____ ______________
Signature of Parent/Guardian Date

____ ______________
Witness Date

Form 2/03