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.

_____ _____

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 bachelor's degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience.
   - ✓ Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements.
   - ✓ Licensed Social Worker must hold a master's 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 master's degree in their profession and have two years of post-master's 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

_____

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 ____

Signed Mental Health Disclosure ____

Received Professional's Client Rights & Responsibilities ____

Diagnosis: _____

Emergency Contact _____ Phone # _____

Therapist: _____

Information Released

To_____ Info_____ Date_____ By_____

To_____ Info_____ Date_____ By_____

To_____ Info_____ Date_____ By_____

To_____ Info_____ Date_____ By_____

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 the 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

HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM MEMBERS

Important Information about Your Rights, Responsibilities, EPSDT, and Advance Directives

As a Health First Colorado Member, you have the right to:

1. Receive a handbook and get information about your coverage, benefits and services
2. Be treated with respect and consideration for your privacy and dignity
3. Get information in a way you can easily understand. This includes language services.
4. Get information from your provider about treatment choices for your health condition
5. Be involved in all decisions about your health care and say "no" to any treatment offered
6. Not be scheduled or restrained as a punishment or to make things easier for your provider
7. Ask for and get a copy of your medical records and ask that they be changed or corrected
8. Get health care services
9. Use your rights and/or file a complaint without fear of being treated poorly
10. Any other rights guaranteed by law
11. Be free from discrimination based on race, color, ethnic or national origin, ancestry, age, Sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, disability, or health status including Acquired Immune Deficiency Syndrome (AIDS)
12. Obtain available and nearby services
13. Have an independent advocate of your choice. This is someone who can support you with your health care
14. Get a second opinion
15. Receive services that respects and knows your culture
16. Be told if your provider stops seeing members, or has changes in services
17. Tell others your view about our services
18. Be free from sexual intimacy with your 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 Health First Colorado Member, you have the responsibility to:

1. Understand your rights
2. Follow the Health First Colorado's (Colorado's Medicaid Program) handbook
3. Treat other members, your providers and staff with respect
4. Choose a provider from your plan network or call us if you want to see a different provider
5. Pay for services you get that are not covered by Health First Colorado
6. Tell your provider and Health First Colorado if you have other insurance or family or address changes
7. Ask questions when you do not understand or want to learn more
8. Tell your provider information they need to care for you, such as your symptoms
9. Take medications as prescribed and tell your provider about side effects or if your medications are not helping
10. Invite people who will be helpful and supportive to you to be included in your treatment
11. Report suspected member or provider fraud or abuse to Member Fraud at 844-475 0444 or Provider Fraud at 855-375-2500
12. Learn about your health benefits and how to use them
13. Following your treatment plan
14. Tell your PCMP, provider, or care coordinator if you do not understand your treatment plan
15. Go to your appointments on time or call your provider if you will be late or cannot keep your appointment.

Advance Directives:

You have the right to give written guidelines to health care workers about the type of health care you want or do not want. This is important if you become so ill or injured that you cannot speak for yourself. These guidelines are called Advance Directives. Advance Directives are legal papers you prepare while you are healthy. In Colorado, they include:

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

For facts about Advance Directives, talk with your primary Care Medical Provider (PCMP). Your PCMP will have an Advance Directives form that you can fill out.

Your PMCP will ask you if you have an Advance Directive and if you want a copy placed in your health record. However, you do not need to have an advance directive to get health care.

If you think that your providers are not following your Advance Directive, you can file a complaint with the Colorado Department of Public Health and Environment.

Behavioral Health Crisis Plan

Colorado does not have a law about behavioral health directives. If you have on-going behavioral health problems, it is a good idea to have a crisis plan. A crisis plan will help you have more control over decisions if you have a behavioral health crisis. You can talk with your behavioral health provider or Care Coordinator about writing a crisis plan.

Early Periodic Screening, Diagnostic Treatment Benefits

For clients under the age of 21, behavioral health providers are required to ask if any mental health issues were found in your child's last medical visit or well-child exam. If any issues were found, we want to help you coordinate care with your Primary Care Medical Provider (PCMP). 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 suggest that you schedule an appointment. If you do not have a PCMP or you want a new PMCP, you may call your RAE.

_____

Member signature

_____

Provider signature

_____

Date

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: _____

Consent for Telehealth Services

INITIAL HERE: _____ 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.

After Hours Access:

INITIAL HERE: _____ 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.

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-hour 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

INITIAL HERE: _____ 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.

(PLEASE CONTINUE ON BACK SIDE)

Name _____

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

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)_____

_____

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 (<18 y o) 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 1/15

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