DEAR CLIENT:

I am pleased that you have selected me as your psychotherapist. In order to give you the best service, and to meet the legal requirements of the State of Colorado, I would like to provide you with the following information:

* My professional background includes: a Bachelor’s Degree from the Western Michigan University in Kalamazoo in 1994; a Masters Degree in Counseling Psychology and Counselor Education from the University of Colorado in 1998; and a Certification as a Guidance Counselor from Johnson State College in 2000. I am trained in EMDR II and Divorce and Child Custody Mediation. I am a Licensed Professional Counselor in the State of Colorado (License # 3954).

* The practice of both licensed and unlicensed persons in the field of psychotherapy is regulated by the Department of Regulatory Agencies, Division of Registrations. Any questions, concerns, or complaints regarding the practice of mental health may be directed to the Department of Regulatory Agencies, Division of Registrations, 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800.

* You are entitled to receive information at any time about methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure. You may seek a second opinion from another therapist or may terminate therapy at any time.

* Dual roles, exploitation, and sexual intimacy are never appropriate in a professional relationship and should be reported to the Office of Professional Regulations.

*CONFIDENTIALITY:* The information provided by you as a client during therapy session is legally confidential in the case of licensed marriage and family therapists, clinical social workers, professional counselors, psychologists, and certified school psychologists. The limits of confidentiality are set by law. If I am directed by a judge in a court of law to reveal information, then I must do so. Legal confidentiality does not apply in criminal or juvenile delinquency proceedings. If you provide me with information about child abuse or abuse of the elderly, I must report that information immediately. If you tell me that you intend to harm someone else or yourself, I am required by law to reveal that information to the authorities and to the individual who may be harmed. In addition, I am required to work with you closely to preserve your safety.

*INSURANCE AND FEES:* If you are utilizing insurance, I am requesting your permission to provide your insurance company or its representatives with any information concerning your diagnosis and treatment or for the individual for whom you are the legal guardian. This information may include (but is not limited to) information about diagnosis, treatment, insurability, and peer review for the purpose of determining continued insurance support.

Some health insurance companies will reimburse clients for my counseling services and some will not. In addition, most will require that I diagnose your mental health condition and indicate that you have an “illness” before they will reimburse you. Some conditions for which people seek counseling do not qualify for reimbursement. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis I plan to render before I submit it to the health insurance company. Any diagnosis made will become a part of your permanent insurance records.

My fee is $110.00 for a 50 minute session. I ask that you pay me at the beginning of each session. Cash or check payment is acceptable. There will be a $25.00 charge for checks drawn on insufficient funds. Charges for my services include office appointments and crisis phone sessions. Additionally, I reserve the right to use a collection agency to
collect fees that are more than 120 days past due, unless we have agreed on an alternative payment plan. Please contact me at least 24 hours ahead of time if you need to cancel an appointment. Without this notice, you will be charged $50 for the first missed appointment and $100 any additional appointments missed.

**How to Reach Me:** You can reach me by leaving a message on my voice mail at (303) 437-1351. In the event of a psychiatric emergency, please leave me a message on my voicemail indicating that you are in a state of emergency, and, in addition, call 911 or your nearest hospital.

**Feedback** Your input in your treatment is invaluable. Please keep me informed in terms of what you feel works for you/does not work for you in our sessions. Please give me feedback about anything about our work together that causes you distress or makes you feel uncomfortable. You are welcome and encouraged to ask questions about my theory of psychotherapy, any of my policies, your bill, or any other concerns that arise. The better informed you are, the more effective our work together will be.

Sincerely,

Judy Innes, M.A.

I have read and I understand the information outlined in this Informed Consent Form. I have had my questions answered to my satisfaction. I have received a copy of this form for my own records.

I hereby acknowledge that I have received the provider’s Notice of Privacy Rights.
Consent to Release of Information
If prescribed RX by PCP or Psychiatrist

I ___________________________ consent to have the following information:

- Diagnosis
- Treatment Plan
- Treatment Plan Update(s)
- Psychiatric Records
- Psychological Assessments

Released between:

Judy Innes, MA, LPC
545 Collyer Street
Longmont, Colorado 80501
Office (303) 437-1351
Fax (720) 494-1855

And:

This disclosure is for the purpose of _____ Treatment, _____ Payment, _____ Operations, _____ the release of Psychotherapy Notes, or _____ Other. If “the release of Psychotherapy Notes or Other” is checked, regardless of whether additional purposes are also checked, this form is a HIPAA compliant Authorization. As such, the Practitioner may not condition treatment, payment, enrollment in a health plan, or eligibility for health plan benefits on your signing your authorization. This form has not been conditioned unless one of those two blanks has been checked. Also, if this is an Authorization, the Practitioner must provide you with a copy.

This consent applies from ____________ until termination of treatment.

Client Signature ___________________________________________ Date ________________

Parent/Guardian if client is a minor ___________________________________________ Date ________________

Witnessed ___________________________________________ Date ________________
HIPAA Notice of Privacy Practices

This document contains information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides privacy protections and client rights with regard to the use and disclosure of your protected health information for the purposes of treatment, payment, and health care operations. If you have any questions about the information contained in this document, please ask and I will be happy to answer them for you.

THIS NOTICE DESCRIBES HOW MEDICAL/HEALTH INFORMATION (INCLUDING MENTAL HEALTH INFORMATION) ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I respect my clients’ confidentiality and only release information in accordance with state and federal laws and the ethics of the psychotherapy profession. This notice describes my policies related to the use and disclosure of clients’ health information.

Use and Disclosure of Protected Health Information
Providing treatment services, collecting payment, and conducting healthcare operations are necessary activities for quality care. I use and disclose the minimum necessary health information about you for these purposes, as allowed by state and federal law.

1.) Treatment: I may use and disclose health information to provide, manage, and/or coordinate care and to consult with other professionals. For example, I may share relevant information to facilitate appropriate emergency coverage by another professional in my absence.

2.) Payment: I may use and disclose your health information to obtain payment for services that I provide to you. For example, I may share information to verify insurance and coverage and to process claims and collect fees.

3.) Healthcare Operations: I may use and disclose your health information as part of my internal healthcare operations. For example, I may share information for the purpose of reviewing treatment procedures and records to assure quality, for training purposes, and for licensing and/or business activities.

Other Uses and Information Disclosed Without Your Consent
In compliance with state and federal law, the following information may be disclosed without your consent:

1.) Mandated Reporting: I may disclose health information about you related to the suspicion of child and/or elder neglect and/or abuse.

2.) Emergencies: In emergency situations, I may disclose health information to prevent serious harm and/or death to yourself or others.

3.) Criminal Activity and/or Danger to Others: I may disclose health information if a crime is committed on premises or against any personnel/staff, or if I believe there is someone who is in immediate danger.

4.) Appointment Scheduling/Client Contact: I may use information you provide to contact you to schedule or remind you of appointments or to discuss treatment services.

5.) National Security, Intelligence Activities, and Protective Services to the President and Others: I may disclose health information to authorized federal officers as authorized by law in order to protect the President or other national figures, or in cases of national security.

6.) Judicial and Administrative Proceedings: I may disclose your health information in the course of judicial or administrative proceedings in response to a valid court order or other lawful process.
Client Rights

1.) Right to Inspect and Copy: You have a right to look at or get copies of your health information, with limited exceptions (i.e., psychotherapy notes). Your request must be made in writing. If you request a copy of your record, a reasonable charge may be made for costs incurred.

2.) Right to Amend: You have the right to request that I amend your health information. Your request must be made in writing, and it must explain why the information should be amended. I have the right to deny your request if I believe the information contained in your record to be accurate and complete. If denied, you have the right to file a disagreement statement.

3.) Right to Accounting Disclosures: You have the right to receive a list of instances in which your health information has been disclosed for purposes other than treatment, payment, or healthcare operations. This accounting does not include disclosures made to you or disclosures pursuant to a signed authorization to release information.

4.) Right to Request Restrictions: You have a right to request a restriction or limitation on the health information used or disclosed about you. For example, you may request that information not be disclosed to an insurance carrier, in which case you would be responsible for payment in full for services provided. Your request must be made in writing. While I am not obligated to agree to your request, I will consider the request very seriously. If I agree to the restriction/limitation, I will abide by our agreement unless the information is needed in an emergency or required by law (for examples, please see the section above entitled, Other Uses and Information Disclosed Without Your Consent).

5.) Right to Request Confidential Communications: You have the right to request that I contact you regarding health matters in a certain way or at a certain location. For example, you may request that I only contact you through your cell phone number, or only at work. I will make every attempt to accommodate reasonable requests.

6.) Right to Obtain a Paper Copy of this Notice/Changes in Notice: You have the right to receive a paper copy of this notice and any amended notice. I reserve the right to change my privacy practices provided such changes are permitted by applicable law. Before the effective date of a material change, however, I will make a new notice available to you at my place of practice.

8.) Right to Release your Health Information: You have the right to request that certain health information be released at your request by signing an authorization to release information. You may revoke a written authorization for release of information at any time; this request must be made in writing, and will be effective only for disclosures that have not already been completed.

7.) Right to Complain: If you believe your privacy rights have been violated, you have the right to file a complaint with me, or you may file a complaint with the United States Department of Health and Human Services. No retaliation will be made against you if you choose to file a complaint.

This notice is effective October 1, 2005.

I understand and agree to all of the above information. A copy of this information has been given to me for my records.

__________________________________________________________________________
Client (or Guardian) Signature                          Date

__________________________________________________________________________
Client (or Guardian) Printed Name                          Date

__________________________  __________________________
Judy Innes, MA, LPC.                           Date
Payment in full (if self pay or using my services as an out of network provider) or copays/deductibles (if I am an in network provider with your insurance company) is due at time of services.

Your insurance will be billed on your behalf. Any uncovered services, including, but not limited to: copayments, coinsurance, or deductible for scheduled and kept appointments, sessions cancelled without 24-hour notice, telephone consultations over 10 minutes, reports prepared outside of appointments and records review. These fees will be billed to the credit card supplied below. By signing this form I am agreeing to have my credit card charged the full rate of $110 for any session cancelled with less than 24 hour notice.

This agreement shall remain in existence as long as I am a patient of Judy Innes, M.A. or until I provide a written retraction of this agreement.

Receipts of credit card charges will be available upon request.

Please circle payment method: Visa Mastercard Discover American Express

Patient Name: ___________________  Account # ____________________

Card #: ___________________  Date of First Appt. ____________

Expiration Date: ______________

Three numbers on back of card: _____________

Card Holder Name and Address the card is billed to:

__________________________________  Card Holder Phone #:

__________________________________  __________________________________

I ____________________________ agree to allow Judy Innes, M.A. to keep my credit card on file. I hereby authorize Judy Innes, M.A. or designated staff to bill my credit card for services rendered.

__________________________________  Date

Cardholder Signature