Jennifer Kane, LCSW, MA
Insight Counseling Center, 190 E. 9th Avenue, Suite 290, Denver, CO 80203
Email: JKane@InsightCounselingCenter.com Cell: 303-517-2776

Intake Form Date: ______________

**BASIC INFORMATION**: The following information is confidential unless otherwise mandated by law. Please be aware there is a risk that an unintended third-party may access information shared by electronic transmissions such as email and cell phone. By allowing Jennifer Kane to contact you by email or phone you are consenting to receive electronic communications and understand the risks involved.

Name: ____________________________________ Employer: ________________________________________

Home Address: Street_____________________ Occupation: _____________________________________

City__________________________ Zip_________ Work Address Street:_____________________________

Work Phone: _____________________________ OK to leave message?** ____yes ____no

Home Phone: ____________________________ OK to leave message?** ____yes ____no

Cell/Alt. Phone #: _________________________ OK to leave message?** ____yes ____no

Birth date: _________________________

Email Address:____________________________________

Marital Status: □ Single □ Married or Civil Union □ Separated □ Divorced □ Living Together

Partner's Name (if being seen as a couple)___________________________ Cell#____________________

Partner's address _________________________________________ Email address________________________

Others living in the home:

Name __________________________________ Relationship__________________________________

Name ___________________________________ Relationship __________________________________

Name ___________________________________ Relationship __________________________________

**IN CASE OF AN EMERGENCY ,** I authorize Jennifer Kane/Insight Counseling to contact the following person(s)

Name__________________________ Relationship_________________ Phone (___)_____________

Address: Street: ______________________ City/State:_____________ Zip Code: ________________

**INSIGHT COUNSELING CENTER PAYMENT and CANCELLATION POLICY**

Payment in full (or co-payment for insurance) is required at the end of each session. Cancellations later than 24 hours before a scheduled session will be billed at 50% of the agreed rate for private pay clients and a flat fee of $70 for clients using insurance. You may pay in cash, check, or credit card on file after any session. If you are seeing me as part of your employer's EAP, please provide the employee or authorization number before our first session and at the start of any subsequent number of sessions.

Client Signature ______________________________ Date ______________________________

**EAP (Employee Assistance Plan) INFORMATION**

Authorization number or employee number ________________________________________

Number of sessions per authorization _____________ Dates valid _____________________

**PRIMARY INSURANCE INFORMATION**

Insured 's full name and address: ______________________________________________________

Insured's birthdate and/or social security number: ______________________________________

Insured's employer ___________________________________ Phone _________________________

Insurance Company Name _______________________________________________________________

Plan Name ______________________________ Insured's ID#________________________________

Policy Group # _______________________Client co-pay _____________ Deductible ___________

**How did you get referred to/learn about Insight Counseling Center's services?**

_____________________________________________________________________________

**Previous Counseling/Treatment:**

(Who) _____________________________ (Where) ________________ (When) ______________________

How was it helpful or what did you learn?

(Who) _____________________________ (Where) _________________(When) ______________________

How was it helpful or what did you learn?

## CURRENT CONCERNS AND RESOURCES

**CONCERNS & GOALS:** What brings you to counseling / therapy? What do you hope to accomplish?

**SUPPORT & RESOURCES:** (family, friends, support groups, spiritual or religious communities, etc.)

**Is there anything else about your health, mental health, or current situation that you would like me to know that might be important to our work together?**

## HEALTH

### Medical Information

Primary Care Physician: ______________________________ Date of Last Visit: ___________________

Address: ____________________________________________ Medical Issues: _____________________

List all of the prescription and over-the-counter drugs you are taking

Check and describe the following, with dates, as they apply to you:

_____ Current / chronic medical conditions / infectious diseases

Explain:

_____ Recent weight changes: _______ lbs. in _____ weeks/months? Intentional?

_____ Serious illnesses / injuries / traumas

Explain:

_____ Surgeries / hospitalizations (medical / psychiatric) ________________________________________________________

**Rate your current distress level for each symptom / concern that applies to you, using the scale below:**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| None | Very little | Mild | Moderate | Considerable | Severe | Maximum |

_____ Depression

_____ Hopelessness

_____ Anxiety

_____ Panic attacks

_____ Withdrawn behavior

_____ Social Anxiety

_____ Loss of / increased appetite

_____ Mood swings

_____ Anger / rage

_____ Fearfulness

_____ Guilt

_____ Suicidal thoughts

_____ Suicidal actions

_____ Homicidal thoughts / actions

_____ Obsessive thoughts ___________________

_____ Compulsive behaviors _________________

_____ Paranoid thoughts / behaviors

_____ Hallucinations (audio / visual)

_____ Memory problems (short term / long term)

_____ Concentration / lack of focus

_____ Perfectionism

_____ Health concerns

_____ Hormonal / endocrine imbalances

_____ Self esteem concerns

_____ Grief / losses (identify) _________________

_____ Loss of meaning in life

_____ Alcohol / other drug abuse (self)

_____ Alcohol / other drug abuse (who?) _________

_____ Nicotine addiction – amt. _______________

_____ Caffeine addiction – amt. _______________

_____ Eating disorders

_____ Compulsive gambling

_____ Pornography

_____ Sexual addiction

_____ Computer / internet addiction

_____ Other addictions (identify) ______________

_____ Communication problems

_____ Sexual problems

_____ Marital / relationship conflicts

_____ Domestic violence

_____ Blended family problems

_____ Conflict with parents

_____ Conflict with siblings

_____ Conflict with children

_____ School / work conflicts

_____ Emotional abuse ( past current)

_____ Physical abuse ( past current)

_____ Sleep problems (describe)

___________________________________________________________

_____ Other (describe)

___________________________________________________________

_____ Sexual abuse (past / current)

_____ Legal problems

_____ Financial problems

_____ Job / employment problems

## Substance Abuse Information

List all of the prescription and over-the-counter drugs you are taking :

| | FIRST USE | # DAYS PER WEEK | LAST USED |
|---|---|---|---|
| **Beer** | | | |
| **Liquor** | | | |
| **Wine** | | | |
| **Marijuana** | | | |
| **Cocaine/crack** | | | |
| **Methamphetamine** | | | |
| **Heroin** | | | |
| **Prescription Pain killers** | | | |
| **PCP, LSD** | | | |
| **Ecstasy** | | | |
| **Other** | | | |

Have you ever felt like you should cut down on your drug or alcohol use?

Has a friend or relative expressed concerns about your use?

Have you ever felt guilty about your drinking or drug use?

Have you ever had to take a drink or use a drug the next day to steady your nerves?

Are you a recovering alcoholic or a recovering drug addict?

Is there a history of problems with drug or alcohol use in your family?

**To be completed by adolescents (12 yrs to 17 yrs)**

Have you ever used alcohol or drugs before or during school?

Have you ever missed school (or been truant) because of use or just to use?

Have you ever avoided non-users?

How often do you get drunk/high? ___________________________

About how often do you use more than one drug when you get high? _____________

Is there a history of problems with drug or alcohol use in your family?

_________________________ _________________________ _________________________

Client Signature Parent/Legal Guardian Signature Date of Signature

**DISCLOSURE STATEMENT**
Welcome to Insight Counseling Center. We want your experience here to be positive and growth promoting. Following is some information about Insight Counseling Center's policies and procedures and HIPAA compliancy. Please take your time, read this carefully, and ask if you have any questions. Everyone fifteen (15) years and older must sign this disclosure. No medical or psychotherapeutic information, or any other information related to your privacy, will be revealed without your permission unless mandated by Colorado law and Federal Regulations (42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164).

## 1.General Information about Your Therapist

Ms. Jennifer Kane, LCSW, MSW, MA
190 E. 9TH Avenue, Suite 290, Denver, CO 80203
Website: InsightCounselingCenter.com
Email: JKane@InsightCounselingCenter.com

### Education

| | |
|---|---|
| Master of Social Work | University of Denver, 1998 |
| Master of the Arts (English Literature) | Emory University, Atlanta, GA 1982 |
| Bachelor of Arts *Phi Beta Kappa* | Emory University, Atlanta, GA 1982 |

### Professional Training and Experience

| | |
|---|---|
| Psychotherapist at Insight Counseling Center | January 2018 to present |
| Psychotherapist at Wellmind & Associates | Littleton, CO May-August, 2017 |
| Social Work Intern, Rose Medical Center | Denver, 1997 |
| Child/teen social worker/intern , Children First | Denver, 1996 |
| Co-facilitator, "Subsequent Pregnancy after Loss" | Rose Medical Center, Denver, 1998 |
| Therapy Intern, Maria Droste Counseling Center | Denver, 1997-1998 |
| EFT (Emotionally Focused Therapy) Externship | Denver, May 2017 |
| EFT Core Skills Advanced Training | Palo Alto, CA Sept. 2017-May 2018 |
| Cognitive Behavioral Therapy training certificate | Denver, November 2018 |
| Discernment Therapy for Couples training | Denver, 2017 |
| Mindfulness Based Stress Reduction workshops | Shambala, June 2015, Denver, 2017 |

**2. Mental Health Regulation and Types of Licenses and Registration.** Levels of Psychotherapy Regulation in Colorado include **Licensing** (requires minimum education, experience, and examination qualifications), Certification (requires minimum training, experience, and for certain levels, examination qualifications), and Registered Psychotherapist (does not require minimum education, experience, or examination qualifications.) All levels of regulation require passing a jurisprudence take-home examination. The practice of licensed, certified, or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Professions and Occupations, Department of Regulatory Agencies. The Colorado Board of Licensed Professional Counselor Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800; DORA_MentalHealthBoard@state.co.us and the State Board of Addiction Counselors can also be reached the same way. As to the regulatory requirements applicable to mental health professionals: a **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-masters supervision.**

**3. Information about Therapy and Fees**. 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. You may also revoke your consent to treatment, release of confidential information or disclosure in writing and given to your therapist at anytime.

You are entitled to request restrictions on certain uses and disclosures of protected health information as provided by 45 CFR 164.522(a), however I am not required to agree to a restriction request. Please review the Notice of Privacy Policies for more information.

**Length of therapy varies**, depending on the nature of the problem and the desired level of change of the client. While some issues may be resolved within a few sessions, deep level change often takes time. **No one can guarantee the outcome of therapy**. Therapy depends on the fit between client, therapist, and therapeutic method and is **dependent on the client's motivation and willingness to experience the anxiety of the change process**. Please feel free to discuss with me at any time your goals for therapy and any thoughts or questions you have about the work we are doing together. If at any point you would like to try another approach, please feel free to talk with me about this and I will be happy to provide appropriate services or referrals.

Insight Counseling **provides therapeutic services by scheduled appointment only and does not provide emergency/crisis counseling**. In the event you are unable to reach me at the number I provided to you, and you are having a true medical or psychiatric emergency, notify 911 immediately, go to the nearest emergency room, or call Colorado's Crisis Hotline (844) 493-8255, and then notify me. If you seek after hours and/or emergency treatment from any counseling agency center, hospital, or emergency room, you will be solely responsible for any fees due. If you leave me a voicemail, I will return your call by the end of the next business day, excluding holidays and weekends.

My current reduced fee for self-pay individual psychotherapy is $90 per clinical hour. You will be charged for missed individual sessions ($45) unless you give me 24 hours notice/one business day notice, excluding emergencies. Please see the Fee Agreement for more details. If you are using your insurance or employee assistance plan for payment, you are responsible for contacting that agency and for any co-pay or deductible payments. You will be charged a flat fee of $70 for missed sessions which we are unable to bill to your insurance company unless you give me 24 hours notice/one business day, excluding emergencies.

If your therapeutic issues are above my level of competence or outside the scope of my practice, I am legally required to refer, terminate or consult.

**4. Prohibited Relationships**. In a professional relationship, sexual intimacy is never appropriate, is unethical, is illegal, and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder listed above.

**5. Confidentiality**. 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 or in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates if the psychotherapist is a Licensed Psychologists, Licensed Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified and Licensed Addiction Counselors, or a Registered Psychotherapist. There are exceptions to this confidentiality, some of which are listed in C.R.S.§ 12-43-218 and the Notice of Privacy Rights you were provided, as well as other exceptions in Colorado and Federal law. If a legal exception arises during therapy, if feasible, you will be informed accordingly. You should be aware that provisions concerning disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in C.R.S § 13-90-107. Some of the exceptions to confidentiality are as followed:

· I am required by law to report suspected child abuse and/or neglect, without an investigation, to the proper authorities.

· I am required to report any suspected incident or imminent risk of elder abuse and/or exploitation of an at-risk elder, age 70 years or older, to law enforcement which may include contacting law enforcement to perform a wellness check for the person of concern.

· If I determine, in my sole discretion, that you are a serious harm/danger to yourself or others, I may be required to take action, such as seek hospitalization without your consent or contact law enforcement.

· I am required to report any suspected threat to national security to federal officials

· I am required to report any threats against specific locations and/or entities, including those identifiable by their association with a specific location or entity such as mosques, synagogues, churches, schools, theaters, workplaces, etc. to appropriate authorities or to warn the party, location, or entity you threatened.
· I may be required by Court Order to disclose confidential information
· If I am unable to collect my agreed upon fee, I may send your name and address to a collection agency or seek the assistance of the Court. Only the minimum amount of information will be disclosed to collect my fee and I will notify you prior to sending the information to the collections agency by contacting you at your last known address.
· If you file an official complaint or a lawsuit against me, according to Colorado law, I may disclose confidential information.
· As a standard of practice, I may seek consultation from another professional, such as another mental health professional or an attorney, about issues raised by you in therapy. However, your confidentiality is still protected and only the minimum amount of information necessary to consult will be disclosed. Signing this disclosure statement gives me permission to consult as needed to provide professional services to you. You will need to sign a separate Release of Information for any discussion or disclosure of your protected health information to another professional besides an attorney that I retain.
· Clerical persons hired by me may have access to limited confidential information. This information is protected from further disclosure and is used solely for administrative and billing purposes.
· In couples counseling or where the consent of both parents/legal guardians are required to treat a minor child, both spouses and/or parents/legal guardians will be required to sign a release of information prior to any disclosure.
· There may be other exceptions to confidentiality as provided by HPIAA regulations and other Federal and/or Colorado laws and regulations
· Due to the public nature of social media, and my primary role of confidentiality as a mental health provider, I will not accept personal Facebook, LinkedIn, Twitter, Instagram and/or other friend/connection/follows requests via any form of social media. As such, any request will be denied in order to maintain professional boundaries. By signing this disclosure statement you agree not to discuss, comment, as questions, contact, and/or otherwise communicate with me regarding therapeutic issues via any social media platform. If you have a therapeutic question/issue, by signing this disclosure statement you agree to contact me through the mode you consented to and not through social media.

**6. Teletherapy**. In general, I do not provide teletherapy, which is therapy conducted over telephone or video chat, as a primary method of therapy. If you are a current client or have special circumstances, please discuss your request with me... In addition, due to the risks of third-parties gaining access to confidential information, all communications via email and text should be limited to administrative purposes and not used as an avenue for therapy. Confidentiality extends to communications by text, email, telephone, and/or other electronic means. However, I cannot guarantee that those communications will be kept confidential and/or that a third-party may not access our communications. Even though I may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by a third-party.

**7. Electronic Communications**. By signing this disclosure statement, you consent to receiving appointment reminders, information about treatment alternatives, and/or other health-related benefits and services that may be of interest to you. Appointment reminders and other information will be provided in accordance with the Consent for Communication of Protected Health Information by Unsecure Transmissions. If you choose to initiate communication by an electronic mode that you have not specifically consented to in the Consent Form, you will need to amend the Consent Form so that I may communicate with you by that electronic mode.

**8. Electronic Records.** I may keep and store records for each client electronically on my laptop, desktop computer, or mobile devices. In order to maintain security and protect the record, I employ the use of firewalls, antivirus software, passwords that are changed regularly, and encryption methods to protect the electronic devices from unauthorized access. I can also remotely wipe out data on mobile devices if the mobile device is lost, stolen, or damages. Insight Counseling Center also has entered into a Business Associates Agreement with email.1and1.com, the email service provider Insight Counseling Center uses. Because of this Agreement, email.1and1.com is obligated by federal law to protect these backups from unauthorized use or disclosure. Email.1and1.com may store the

records on a cloud-based backup which means the backups are stored on computers that are connected to the internet. These computers are kept in secure data centers, where various security measures are used to maintain the protection of the computer from physical access by unauthorized persons.

**9. Discontinuation of Therapy.** Should you choose to discontinue therapy for more than sixty (60) days by not communicating with me, your treatment will be considered "terminated." You may be able to resume therapy after the sixty (60) day period by discussing your decision to resume therapy services with me. Ability to resume therapy after sixty (60) days will depend upon my availability and will be within my sole discretion. This disclosure statement will remain in effect should you resume therapy if one (1) year has not elapsed since your last session. You may be asked to provide additional information to update your client record. By signing this disclosure statement you understand "discontinuing therapy" means that you have not had a session with me for at least sixty (60) days, unless otherwise agreed to in writing.

**10. HIPAA.** This form is compliant with HIPAA regulations and no medical or therapeutic information or other information related to your privacy, will be released without permission unless mandated by Colorado law as described in this form and the Notice of Privacy Policies and Practices. Consistent with HIPAA guidelines, authorization for release and consent for treatment will be automatically revoked one year after the signing date. You understand and acknowledge that you have received Insight Counseling Center's Notice of Privacy Policies and Practices.

**11. Extraordinary Events**. In the case that I become disabled, die, or am away on an extended leave of absence (hereinafter "extraordinary event,") the following Mental Health Professional Designee will have access to my client files. If I am unable to contact you prior to the extraordinary event occurring, the Mental Health Professional Designee will contact you. Please let me know if you are not comfortable with the below listed Mental Health Professional Designee and we will discuss possible alternatives at this time.
NAME: Beth Barta, Insight Counseling Center
ADDRESS:
930 Logan Street
Denver, Colorado 80203
TEL: 303-246-3219
CREDENTIALS: Licensed Clinical Social Worker, #992831; Certified Addictions Counselor Level III, #6135
The purpose of the Mental Health Professional Designee is to continue your care and treatment with the least amount of disruption as possible. You are not required to use Mental Health Professional Designee for therapy services, but Mental Health Professional Designee can offer you referrals and transfer your client record, if requested.

My signature below affirms that the preceding information has been provided to me in writing by my primary therapist, or if I am unable to read or have no written language, an oral explanation accompanied the written copy. I understand my rights as a client/patient and should I have any questions, I will ask my therapist.

______________________________ ______________
Print Client Name Client Date of Birth

______________________________ ______________
Client or Responsible Party's Signature Date

______________________________ ______________
Print Client Name Client Date of Birth

______________________________ ______________
Client or Responsible Party's Signature Date

# FEE AGREEMENT

**STANDARD FEE FOR SERVICES**

I understand that the standard fee for services for individual, couple, and family psychotherapy is $90.00 per 50-minute session. Any additional non-standard services will be charged a different fee. You will be notified in writing of these additional non-standard services and the fee, should the need for such services arise.

A fee will be charged for all other auxiliary services including mental health evaluations, progress reports, collateral contacts, or any other report or services made at the request of the client. Fees for auxiliary services will be agreed upon in writing prior to commencement of such services. Also, a fee will be charged at the session rate on a pro-rated basis for phone calls longer than ten (10) minutes. Any court testimony, appearances, or other requests for legal services such as: testimony related matters like case research, report writing, travel, depositions, actual testimony, cross examination time, and courtroom waiting time will be charged at a rate of $500 per hour with a deposit of $500.00. The higher rate also includes attorney fees I may incur in preparing for the requested legal services.

**Your fee/co-payment is due in full at each session unless you and I agree to alternative arrangement for payment in writing. Have your cash or pre-written check ready prior to the beginning of each session.** I also understand that if my situation changes – at any point – that I am invited to re-negotiate this fee with my therapist. In other words, at no time should my decision to participate in therapy be contingent on my ability to pay. I understand that unless another payment schedule is specifically arranged and agree to in writing; the standard fee for services applies. Any revisions to these standard fees for services are indicated on the reverse.

All accounts that are not paid within thirty (30) days from the date of service shall be considered past due. If your account is past due, please be advised that I may be obligated to turn past due accounts over to a collection agency or seek collection with a civil court action. By signing below, you agree that I may seek payment for your unpaid bill(s) with the assistance of a collections agency. Should this occur, I will provide the collection agency or Court with your Name, Address, Phone Number, and any other directory information, including dates of service or any other information requested by the collection agency or Court deemed necessary to collect the past due account. I will not disclose more information than necessary to collect the past due account. I will notify you of my intention to turn your account over to a collection agency or the Court by sending such notice to your last known address.

**PAYMENT AGREEMENT**

I understand that if I am paying privately I will pay for all services provided either for myself or for my designee, (name) ____________________, (relationship) ____________________, at the conclusion of each session on the day the services are provided.

I understand that if I am not able to honor my financial commitment that this may be grounds for conversing therapeutically about financial issues, renegotiating my therapeutic contract, exploring alternative options, and/or terminating from treatment. I understand that if I am not able to make a payment after a particular session that I may ask my therapist for an extension for one week. I agree to make every effort to remit payment within that time frame. I also understand that I may not have more than two unpaid sessions accumulated at any one time. If this should happen I understand that I will need to speak with my therapist in order to negotiate the next steps.

I understand that I may pay with cash, personal checks, or money orders, however, should my personal check be returned due to insufficient funds, I will be assessed a $25.00 service charge and I will be requested to pay with cash, or money order thereafter. I realize that while my signature does not bind me to therapy, it does make me responsible for all charges incurred prior to my termination.

**MISSED SESSION POLICY**

I understand that I will be charged $45 for any missed appointments ("no-shows") or appointments cancelled with less than 24 hours notice, with NO EXCEPTIONS. I further understand that most third party payment sources, such as victim compensation funds and insurance companies, do not pay for missed sessions and thus I am solely responsible for these fees.

**LIMITATIONS OF CONFIDENTIALITY**

I understand that if I am providing payment for a non-minor designee, I may not have legal access to any kind of privileged and confidential information about that individual including assessment information, diagnostic information, or therapeutic progress. By contrast, I do understand that if another party, such as an insurance company, is providing payment for my therapeutic services, I authorize that individual or institution to be informed of my presence in treatment, details of my diagnoses and care, and/or my discharge from treatment. I also understand that there are further limitations to confidentiality discussed in the *Disclosure Statement or* other agreements and am aware of these constraints. **I also understand that signing this form gives permission to**

**my therapist to communicate with my insurance company, HMO, third-party payor, collections agency or anyone connected to my therapy funding source. I understand that my insurance company may request information from my therapist about the therapy services I received which may include but is not limited to: a diagnosis or service code, description of services or symptoms, treatment plans/summary, and in some cases my entire client file. I understand that once my insurance company receives the information I or my therapist have no control of the security measures the insurance company takes or whether the insurance company shares the required information. I understand that I may request from my therapist a copy of any report he submits to my insurance company on my behalf.**

**USING INSURANCE OR THIRD PARTY PAYMENT SOURCES**

I understand and recognize that I am actively participating and investing in the therapeutic process. By taking responsibility for payment of my therapy services I am able to maintain a direct relationship with this investment. **I understand that I am legally responsible for payment for my therapy services. If for any reason, my insurance company, HMO, third-party payor, etc. does not compensate my therapist; I understand that I remain solely responsible for payment.** I understand that *Insight Counseling Center* recognizes that I may wish to use an in or out-of-network insurance plan, EAP program, Health Savings Account, cafeteria plan, victim compensation program, or other such third party payer. If I should choose to use a third party payment source, I understand that I am still responsible for direct payment to *Insight Counseling Center* and that no guarantees can be made in terms of my reimbursement by the third party payment source. *Insight Counseling Center* will work with me as much as possible to facilitate this process.

I understand that if I use insurance or another type of third party payment source that I authorize *Insight Counseling Center* to release and/or exchange any pertinent information with such entities in order to utilize these benefits. I understand that most third party payment sources, such as insurance companies, do not pay for missed sessions and thus I am solely responsible for these fees.

**REVISIONS TO FEE SCHEDULE**

I understand that if I am committed to starting counseling at *Insight Counseling Center* and am not able to pay the full standard fee; my therapist will work with me on finding an adjusted fee within his/her sole discretion. I understand that should my insurance benefits lapse, expire, or otherwise end, that I will continue pay the same fee as if my insurance coverage were still in place.

**FEE SCHEDULE ADJUSTMENTS**

The following reflects the adjusted fee schedule my therapist and I have agreed to:

$ 90  Full Fee for Individual Psychotherapy, Couple, or Family Therapy

$____ co-pay per session for Clients Using Insurance

$ 45 No-Show or Late Cancellation Other for Private Pay Clients

$70 No-Show or Late Cancellation Fee for Clients Using Insurance

______________________________________________

**I have read the preceding information and I agree to the aforementioned terms:**

Client Name: ____________________________________________________________

Client Signature: ___________________________________ Date: __________________

Parent/Legal Guardian: ________________________________ Relationship: ___________

Therapist Name:

Therapist Signature:__________________________________ Date: __________________

# CONSENT FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION BY UNSECURE TRANSMISSIONS

**This consent form is for the communication of Protect Health Information ("PHI") that Insight Counseling Center may transmit without the written authorization of the client as described in the Uses and Disclosure section of its Notice of Privacy Policies.**

I, ________________________, hereby consent and authorize Insight Counseling Center to communicate my PHI through the following unsecure transmissions (please initial all your choices):

________ Cellular/Mobile Phone this includes text messaging. Cell Phone Number: ____________________________

________ Unsecured Email address: __________________________ Send Receive

_________Counselor's Email: djohnson@insightcounselingcenter.com Send Receive)

Please Check One: Work Personal

________ Appointment/Scheduling Reminder via email and/or telephone

________ Other Media: (Please describe: ________________________________)

________ I do not wish to have my PHI transmitted electronically

Should we agree to communicate by the approved communications listed above, i.e. text, email, telephone, or any other electronic method of communication, confidentiality extends to those communications. However, Insight Counseling Center cannot guarantee that those communications will remain confidential. Even though Insight Counseling Center may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by an unintended third-party. There is never a 100% guarantee information will remain confidential when transmitted electronically.

I, _________________, understand that Insight Counseling Center may use and disclose the following PHI without my written authorization. However, I consent to Insight Counseling Center transmitting the following PHI by the above selected electronic communications (please initial all your choices):

________ Information related to scheduling/appointments

________ Information related to billing and payments

________ Information related to your mental health treatment (this may contain personal materials, forms, suggested articles, homework, etc.)

________ Information related to Insight Counseling Center's operations

________ In accordance with an Authorization for Release of Information signed by me

________ Other Information; Please Describe: ____________________________

I further understand that if I initiate communication via electronic means that I have not specifically consented to in this form, I will need to amend this consent form so that my counselor/therapist may communicate with me via that method.

_________________________________ ______________

Signature of Client/Parent/Legal Guardian DATE

**NOTICE OF PRIVACY POLICIES AND PRACTICES: HOW MEDICAL AND MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED & HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY**

Given the nature of Insight Counseling Center's work, it is imperative that it maintains the confidence of client information that it receives in the course of its work. Insight Counseling Center is a mental health counseling practice that provides mental health services. The practice works solely to provide the best counseling treatment options to its clients. Insight Counseling Center prohibits the release of any client information to anyone outside immediate staff, employees, interns, and/or volunteers except in limited circumstances in accordance with this Notice of Privacy Policies and Practices. Discussions or disclosures of protected health information ("PHI") within the organization are limited to the minimum necessary that is needed for the recipient of the information to perform his/her job. Please review this Notice of Privacy Policies and Practices ("Notice of Privacy Policies"). It is the policy of Insight Counseling Center to:

1. fully comply with the requirements of the HIPAA General Administrative Requirements, the Privacy and Security Rules;
2. provide every client who receives services at Insight Counseling Center with a copy of this Notice of Privacy Policies;
3. ask the client to acknowledge receipt when given a copy of this Notice of Privacy Policies;
4. ensure the confidentiality of all client records transmitted by facsimile;
5. obtain from each client an informed Authorization for Release of Protected Health Information form when required.

Insight Counseling Center is required to follow all state and federal statutes and regulations including Federal Regulation 42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164, governing testing for and reporting of TB, HIV AIDS, Hepatitis, and other infectious diseases, and maintaining the confidentiality of PHI.
PHI refers to any information that is created or received by Insight Counseling Center, and relates to an individual's past, present, or future physical or mental health or conditions and related care services or the past, present, or future payment for the provision of health care to an individual; and identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. PHI includes any such information described above that Insight Counseling Center transmits or maintains in any form, this includes Psychotherapy Notes. HIPAA and federal law regulate the use and disclosure of PHI when transmitted electronically.
Effective April 14, 2003. If you have any questions or requests about this Notice, please contact Beth Barta at 303.246.3219.
Insight Counseling Center is required by State and Federal law to maintain the privacy of protected health information. In addition, the Practice is required by law to provide clients with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to your mental health information, and to request that you sign the attached written acknowledgement that you received a copy of this Notice. This Notice describes how the Practice may use and disclose your protected health information. This Notice also describes your rights regarding your protected health information and how you may exercise your rights. "Protected Health Information, PHI", is information the Practice has created or received about your physical or mental health condition, the health care we provide to you, or the payment for your health care; and identifies you or could be reasonably used to identify you. It includes your identity, diagnosis, dates of service, treatment plan, and progress in treatment.

**USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

**Permissible Uses and Disclosures Not Requiring Your Written Authorization** Your mental health information may be used and disclosed in the following ways.

- **Treatment:** Your mental health information may be used and disclosed in the provision and coordination of your healthcare. For example, this may include coordinating and managing your health care with other health care professionals. Your mental health information may be used and disclosed when I consult with another professional colleague, or if you are referred for medication, or for coverage arrangements during my absence. In any of these instances only information necessary to complete the task will be provided.
- **Payment:** Your mental health care information will be used to develop accounts receivable information, to bill you, and with your consent to provide information to your insurance company or other third party payer for services provided. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnosis, dates and type of service, and other information about your condition and treatment, but will be limited to the least amount necessary for the purposes of the disclosure.
- **Health Care Operations:** Your mental health information may be used and disclosed in connection with our health care operations, including quality improvement activities, training programs and obtaining legal services. Only necessary information will be used or disclosed.
- **Required or Permitted by Law:** Your mental health care information may be used or disclosed when I am required or permitted to do so by law or for health care oversight. This includes, but is not limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when there is a legal duty to warn or to take action regarding imminent danger to others; (d) when the client is a danger to self or others or gravely disabled; (e) when a coroner is investigating the client's death; or (f) to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, or regulatory compliance.
- **Contacting the Client:** You may be contacted to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.

- **Crimes on the premises or observed by the provider:** Crimes that are observed by the therapist or the therapist's staff, crimes that are directed toward the therapist or the therapist's staff, or crimes that occur on the premises will be reported to law enforcement.
- **Business Associates:** Some of the functions of the practice may be provided by contracts with business associates. For example, some of the billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services. In those situations, protected health information will be provided to those contractors as is needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.
- **Involuntary Clients:** Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.
- **Family Members:** Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of the discussion. However, if the client objects, protected health information will not be disclosed.
- **Emergencies:** In life threatening emergencies the practice will disclose information necessary to avoid serious harm or death.

**Uses and Disclosures Requiring Your Written Authorization or Release of Information**
Except as described above, or as permitted by law, other uses and disclosures of your mental health information will be made only with your written authorization to release the information. When you sign a written authorization, you may later revoke the authorization in writing as provided by law. However, that revocation may not be effective for actions already taken under the original authorization.

**Psychotherapy Notes:** Psychotherapy notes are maintained separate from your mental health record. These notes will be used only by your therapist and disclosure will occur only under these circumstances: (a) you specifically authorize their use or disclosure in a separate written authorization; or (b) the therapist who wrote the notes uses them for your treatment; or (c) they may be used for training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills; or (d) if you bring a legal action and we have to defend ourselves; and (e) certain limited circumstances defined by the law.

## YOUR RIGHTS AS A CLIENT

**Additional Restrictions:** You have the right to request additional restrictions on the use or disclosure of your mental health information. However, the clinician does not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. Ask your clinician for the Request Form for Protected Health Information.

**Alternative Means of Receiving Confidential Communications:** You have the right to request that you receive communications from the practice by alternative means or at alternative locations. For example, you may request that bills and other correspondence be sent to an address other than your home address. Ask your clinician for the Request Form.

**Access to Protected Health Information:** You have the right to inspect and obtain a copy of your protected health information in the mental health and billing record. However, any psychotherapy notes are for the use of your therapist, and are treated differently. If it is thought that access to your mental health records would harm you, your access may be restricted. Ask your clinician for the Request Form for PHI and the appeal process.

**Amendment of Your Record:** You have the right to request an amendment or correction to your protected health information. If the clinician agrees that the amendment or correction is appropriate, the Practice will ensure the amendment or correction is attached to the record. An appeal process is available if the clinician determines the record is accurate and complete as is. Ask your clinician for the Request Form PHI and the appeal process available to you.

**Accounting of Disclosures:** You have the right to receive an accounting of certain disclosures the practice has made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment, or health care operations. In addition, the accounting does not include disclosures made to you, disclosures authorized by you, or disclosures made prior to April 14, 2003. Other exceptions will be provided to you, should you request an accounting. Ask your clinician for the Request Form.

**Right to Revoke Consent or Authorization:** You have the right to revoke your consent or authorization to use or disclose your mental health information, except for action that has already taken place under your consent or authorization.

**Copy of this Notice:** You have a right to obtain a copy of this Notice upon request.

The Practice is required to abide by the terms of this Notice, or any amended Notice that may follow. The Practice reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that it maintains. When changes are made, the revised Notice will be posted at the Practice's office and copies will be available upon request.

If you believe the Practice has violated your privacy rights, you may file a complaint to Beth Barta. You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 515F, HHH Bldg., Washington, D.C. 20201. It is the policy of the Practice that there will be no retaliation for your filing of such a complaint

# Credit Card Authorization:

Please complete this form even if you will not be charging your sessions on a regular basis. Missed appointments and returned checks will automatically be charged to this credit account.

Cardholder Name: ______________________________________________

Name as it appears on Credit Card: __________________________________

Billing Address: __________________________________________

Email Address: _______________________________________

Credit Card Type: Circle: Visa MasterCard Discover HAS Other

Credit Card Number: __________________________________________

Expiration Date: _____________________________________________

CID (3-4 digit code on back): ____________________________________

***Please initial each section:***

_____I authorize Insight Counseling Center to process my credit card for payment of services on a recurring basis for all scheduled appointments including missed appointments, late cancellations, and returned checks.

_____I understand that I will be charged a 4% convenience fee for the extra time it takes to process credit card payments. Further, I understand that cash and check are preferred types of payments.

____I may cancel this authorization at any time by contacting Insight Counseling Center. This authorization will remain in effect until cancelled or services are terminated.

______________________________ _____________

Signature Date

Jennifer Kane, LCSW, EFT certification candidate

Insight Counseling Center

190 E. 9th Avenue, Suite 290, Denver, CO 80203

**Videotaping of Therapy Sessions**

As a best practice, Emotionally Focused Couples Therapists often videotape sessions, however ONLY with clients' consent. My subsequent review of a videotaped session allows me to more deeply explore the dynamics and events that occur during your session and prepare more fully for your next session. This process often expedites the progress made in session, allowing clients to experience change and growth more quickly. You are not charged for the additional time I spend reviewing the videotape. On occasion, I will review the tape with a supervisor, supervision group or certification team to gain additional insight in order to best support your therapy. I absorb all professional fees associated with such consultations. All persons viewing the tape will be bound by the same confidentiality requirements as I am. The tapes are stored in a secure, password protected location and will be erased in a timely manner. At times it may also be necessary for further training purposes for the therapist to transcribe (write out) the recorded session for supervisor learning, development and/or certification. The transcription of the session will not contain any identifying information and may be sent to a supervisor or group of supervisors for review of the counselor's skills. By signing this form, you are consenting to allow your therapy session to be videotaped and transcribed by your counselor and understand the purpose of doing so. You are able to withdraw this consent at any time.

Client Signature Date

Client Signature Date

Provider Signature Date