EMPOWER
CENTERS OF EXCELLENCE IN FAMILY BEHAVIORAL HEALTH

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LEGAL FORMS

Thank you for choosing the **EMPOWER**: *Centers of Excellence in Family Behavioral Health*. The following packet is designed to provide you information about **EMPOWER** and our multi-disciplinary behavioral health services. All **EMPOWER** providers are committed to our patients' rights of information regarding our policies including confidentiality, consent and administrative services. In keeping with this policy, we have listed below our various office policies for your information. Reading and signing these forms establishes our contract for behavioral health services. Please read these forms thoroughly and bring copies to your first visit at our center.

NEW PATIENT FORMS PACKET:

The following packet contains legal documents that are required by healthcare governing agencies in Colorado and across the United States. Please review and sign these forms prior to your first appointment at **EMPOWER** Centers. Your clinician will be available to explain the contents and answer questions at your first appointment. The packet includes the following documents:

- Disclosure Statement (pages 2 – 3)
- Consent for Treatment (pages 4 – 5)
- HIPAA Acknowledgment (page 6)
- Electronic Payment Authorization (page 7)

FACILITY POLICIES:

I agree to give **EMPOWER** permission to correspond with us by letter/telephone to check on progress after discharge.

I/We have willingly placed ourselves in **EMPOWER** programs and authorize its clinicians to act in our best interests; perform any treatment deemed indicated and appropriate.

I/We understand that **EMPOWER** clinicians will not get involved in any legal proceedings of any kind including but not limited to custody disputes and divorce proceedings.

I/We do also hereby state that this agreement and contract is to be in effect for our lifetime and that even after death this contract shall stay in effect.

I attest that I have read reviewed, understood and agreed to abide by all of the included policies, disclosures and acknowledgments:

Signature of Patient or Parent/Legal Guardian_____ Date_____

Printed Name of Patient or Parent/Legal Guardian_____ Date_____

DISCLOSURE STATEMENT

Address:

EMPOWER: Centers of Excellence in Family Behavioral Health
6530 S. Yosemite St. Suite #210
Greenwood Village, CO 80111
Ph: 720-778-4077 Fax: 720-778-4078

Full Name and Credentials of Providers:

- Mary Nord Cook, MD (Licensed, Board Certified, Child & Adolescent Psychiatrist / #33979)
  Medical Doctorate, University of Michigan, 1993
- Kym Spring-Thompson, PsyD, IMH-E® (IV-C) (Licensed, Clinical Child Psychologist / #3555)
  Doctorate of Psychology, University of Denver, 2009
- Jaimelyn Roets, LCSW (Licensed Clinical Social Worker / LCSW-1415)
  Master of Arts in Social Work, University of Michigan, 2006
- Ashley M. Steppig, MSW, LSW (Master's of Social Work, Licensed Social Worker)
- Mariah Stuart, MSW (Master's of Social Work / NLC-106587)
  Master of Arts in Social Work, University of Denver, 2016
- Armann Heshmati, LMFT (Licensed Marriage & Family Therapist / LMFT-789)
  Master of Arts in Marital & Family Therapy, University of San Diego, 2002
- Anne Bliss Niess, LPC-C (Licensed Professional Counselor Candidate / LPCC-14890)
  Master of Arts in Counseling, Pacifica Graduate Institute, 2016
- Barry McCoy, LCSW (Licensed Clinical Social Worker / CSW9924754)
  Master of Arts in Social Work, University of Illinois, 1987
- Angelica Abston, LPC (Licensed Professional Counselor / LPC-12027)
  Master of Arts in Clinical Mental Health Counseling, Denver Seminary, 2012

(The providers listed above are all licensed professionals in the State of Colorado)

Regulation of Psychotherapists:

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 regulatory boards can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, 303.894.7800. As to the regulatory requirements applicable to mental health professionals:

a. 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 a registration from the state.

b. Certified Addiction Counselor I (CAC I) must be a high school graduate, complete required training hours and 1,000 hours of supervised experience.

c. Certified Addiction Counselor II (CAC II) must complete additional required training hours and 2,000 hours of supervised experience.

d. Certified Addiction Counselor III (CAC III) must have a Bachelor's degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience.

e. Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements.

f. Licensed Social Worker must hold a Master's degree in social work.

g. 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.

h. 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.

i. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.

Client Rights:

a. 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. (Please see Consent for Treatment)

b. You can seek a second opinion from another therapist or terminate therapy at any time.

c. 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.

d. 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 several exceptions to confidentiality which include: (1) I am required to report any suspected incident of child or elder abuse or neglect to law enforcement; (2) I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (3) I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental disorder; (4) I am required to report any suspected threat to national security to federal officials; (5) I may be required by Court Order to disclose treatment information and other exceptions as noted in the HIPAA Notice of Privacy Rights you were provided as well as exceptions in Colorado and Federal law. If a legal exception arises during therapy, if feasible, you will be informed accordingly. The Mental Health Practice Act (CRS 12-43-101, et seq.) is available at: http://www.dora.state.co.us/mentalhealth/Statute.pdf.

e. Under Colorado law, C.R.S 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information. If you request treatment information from me, I may provide you with a treatment summary, in compliance with Colorado law and HIPAA Standards.

Disclosure Regarding Divorce and Custody Litigation:

If you are involved in a divorce or custody litigation, my role as a therapist is not to make recommendations to the court concerning custody or parenting issues. By signing this Disclosure Statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that I write any reports to the court or to your attorney, making recommendations concerning custody. The court can appoint professionals, who have no prior relationship with family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interest of the family's children.

I have read the preceding information, it has also been provided verbally and I have been offered a copy. I understand my rights as a client or as the client's responsible party.

Signature of Patient or Parent/Legal Guardian_____Date_____

Printed Name of Patient or Parent/Legal Guardian_____Date_____

CONSENT FOR TREATMENT:

The clinicians at **EMPOWER** have been trained in a variety of evidence-based treatments and will determine which approaches and techniques would most benefit you (if adult) and/ or your child, teen & family. After your initial evaluation, your clinician will be able to discuss types and average duration of treatment for conditions that are similar to yours or your child's. You have the right to ask and learn about the techniques and approaches offered by your clinician; you are also entitled to a second opinion. Please ask your clinician if you would like referral information to seek a second opinion. You may also terminate treatment at any time without penalty as participation in treatment is voluntary.

CONFIDENTIALITY:

Generally, information provided by a patient during therapy sessions is legally confidential. **EMPOWER** clinicians and staff will not inform others that you and/or your child, teen or family is in therapy; session content will remain confidential. The only time confidentiality may be broken is if one or more of the following exceptions/conditions apply:

- If you and/or your child/teen pose a physical danger to yourself or others.
- If you and/or your child/teen discloses he or she has been physically or sexually abused, or experienced neglect or has witnessed domestic violence.

If any of the above are disclosed in session, we are mandated by Colorado Law to report such information to the appropriate State Protective Agency. Also, it is important to know and understand that your information may be shared with other **EMPOWER** providers and administrators for the purposes of case consultation, coordination of care and administrative functions. By your signature below you authorize and release your clinician to provide this information to the **EMPOWER** group as a whole.

TECHNOLOGY:

By your signature below, you authorize **EMPOWER** to contact you by phone using the number you provide at your or your child/teen's initial evaluation. Email is not the most confidential mode of communication and therefore we rely solely on face to face, telephone and written documentation for exchanging patient healthcare information.

SESSIONS:

Please arrive 5 minutes early for sessions. Sessions will end at the designated time in the event of a patient late arrival. Clinicians are only required to wait 15 minutes past the scheduled start time for an appointment before a no-show/missed appointment will be billed.

CANCELLATIONS:

We understand that you may need to cancel and/or reschedule an appointment. It is helpful for us to know if you will not be coming, so we ask that you give us 24 hours' notice for any change or cancellation. Within a calendar year, we will afford you one missed appointment at no charge. **The second missed appointment will be billed at 50% rate and after that, any late cancellation (less than 24 hours' notice) or missed appointment will be charged the full session rate.**

EMERGENCY SERVICES:

You may call **720-778-4077** with any questions, during normal business hours, which are:

- **Mon-Thurs: 9:30 am – 5:30 pm & Fri: 9:30 am – 3:00 pm**
- **After hours, you may leave a voicemail, which will be answered w/in 1 business day.**

- **EMPOWER is NOT a 24-hr center & is not staffed to manage unscheduled visits.**
- **In an emergency, please call 911 on go to your nearest emergency room.**

FINANCIAL TERMS:

Your designated payment type will be used to process payment for all clinical services rendered. The following forms of payment are accepted through the practice: **Visa, MasterCard, and Discover (Credit or Debit).** Cash & Personal Checks are acceptable as well, but are preferred on an as needed basis. Please make checks payable to **EMPOWER Centers**. *There is a $35 returned check fee for any check that we are unable to process due to insufficient funds. All payments are due at the time of service.*

Monthly Statements:

On the 6th of each month, you will automatically receive an insurance-ready statement via email. You must authenticate the email address you provided to receive statements. If you are seeking reimbursement from a healthcare plan privately, you may use this statement to do so.

EMPOWER offers a wide range of services including diagnostic evaluations, individual therapy, family therapy, group therapy, psychosocial skills building workshops and medication consultations and management. Fees for these services are listed below:

Masters or Doctorate Level Clinician (PsyD, PhD, LCSW, LMFT, LPC)	
☐ **99442** Phone Consultation (> 14 minutes)	$35
☐ **90832** Psychotherapy, Brief (30 minutes)	$95
☐ **90834** Psychotherapy, Standard (50-60 minutes)	$150
☐ **90847** Family/Couples Therapy w/ pt (50-60 minutes)	$165
☐ **90846** Family/Couples Therapy w/o pt (50-60 minutes)	$165
☐ **90839** Crisis Intervention (First 60 minutes)	$200
☐ **90840** Crisis Intervention (Each additional 30 minutes)	$100
☐ **90853** Group Therapy, Single Therapist (90 minutes)	$115
☐ **90849** Multi-family Workshop (90 minutes)	$135
☐ **90791** Diagnostic Evaluation (90 minutes)	$300

Board Certified Child & Adolescent Psychiatrist (MD or DO)	
☐ **99205** Diagnostic Evaluation w/ Medical Services (90 minutes)	$425
☐ **99204** Diagnostic Evaluation w/ Medical Services (60 minutes)	$350
☐ **99212** Medication Evaluation & Management (20-30 minutes)	$185
☐ **99213** Medication Evaluation & Management (45-50 minutes)	$275
☐ **99214** Medication Evaluation & Management (50-60 minutes)	$325
☐ **99215** Medication Evaluation & Management (60-75 minutes)	$375
☐ **99442** Child Psychiatry (MD) Phone Consultation (5-15 minutes)	$55
☐ **99443** Child Psychiatry (MD) Phone Consultation (16-30 minutes)	$110
☐ **99445** Child Psychiatry (MD) Phone Consultation (31-45 minutes)	$175

Signature of Patient or Parent/Legal Guardian_____ Date_____

Printed Name of Patient or Parent/Legal Guardian_____ Date_____

NOTICE OF PRIVACY PRACTICE

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. You have a right to a copy of this notice.

- We have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
- The law permits us to use or disclose your health information to those involved in your treatment.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to the insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may call to remind you of your appointments. If you do not answer the phone, we may leave this information on your answering machine or with the person who answers the telephone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law
- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.
- You have the right to transfer copies of your health information to another practice. With your written consent we will mail or fax copies of your records to another practice.
- You have the right to see and receive a copy of your health information, with a few exceptions. A written request regarding the information you want to see is required. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
- You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing.
- We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add the new information.
- If we change any of the details of this notice we will notify you of the changes in writing.
- You may file a complaint with the Department of Health and Human Services, 200 Independence Ave, SW Room 509F, and Washington, DC 20201. You will not be retaliated against for filing a complaint.
- This notice goes into effect as of August 2015.

Acknowledgment: I have read/received a copy of EMPOWER's notice of privacy practices.

Signature of Patient or Parent/Legal Guardian_____Date_____

Printed Name of Patient or Parent/Legal Guardian_____Date_____

ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the card you wish to use for all services rendered through this practice. Charges for services rendered will be deducted from the card designated below at the time services are rendered. We accept: Visa, MC and Discover.

Client Information:

Client Name: _____ Date of Birth: _____

Address: _____ City_____ State: _____ Zip: _____

Home Number: _____ Mobile Number: _____ Email: _____

Billing Information:

Please indicate the information associated with the debit card you wish to use. ☐ I prefer to use a credit card.

Name on Card:_____ ☐ Billing Card Address Same as Client (may skip down to email)

Address: _____ City _____ State: _____ Zip:_____ Email: _____

I authorize all service fees to be deducted from the card ending in __ __ __ __ (last four digits of the card)

Please enter the CVV code __ __ __ (three digits on back of card)

I authorize the use of this card for all services and fees at the time they are rendered for the following parties:

Full Name(s) _____ _____ _____ _____

I understand that this form authorizes my provider to charge this card for varying session types, across multiple dates of service. ***By authorizing use of this card, and signing this electronic payment authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.

Cardholder Signature:_____ Date: _____

Payments processed by Therapy Partner. Therapy Partner is a registered ISO/MSP of Fifth Third Bank, Cincinnati, OH and HSBC Bank USA National Association, Buffalo, NY.

Debit Card Information: ☐ I prefer to use a credit card.

Please provide your payment information below. The card information you provide on this form will be destroyed once your information has been securely encrypted and stored.

Card (circle one): Visa MasterCard Discover

Card Number: __ __ __ __- __ __ __ __-__ __ __ __-__ __ __ __ Expiration Date: __ __/__ __

PLEASE NOTE: If using an HSA Card/Account as primary card for payment, you are required to provide a secondary form of payment in the event the HSA Card/Account is declined.

Back Up Card (*Required if using HSA as primary*) (circle one): Visa MasterCard Discover

Card Number: __ __ __ __- __ __ __ __-__ __ __ __-__ __ __ __ Expiration Date: __ __/__ __