

Running Creek Counseling

18425 Pony Express Drive, Suite 203, Parker, CO 80134 Telephone (303)805-1218 Fax: (303) 805-3679
www.rccounseling.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

DISCLOSURE STATEMENT

Kelly Baker, CAC III #6748
Shawn E. Griffin, MS, LPC, #2327
Nanci Gonzales, MA, LPC #3256, CACIII #3108,
Michael Lyons, MA, listed in unlicensed psychotherapist
Sylvia E. Moore, MSC, listed in unlicensed psychotherapist in database
Alana Rumley, BA, CAC III #2432

1. Running Creek Counseling is located at 18425 Pony Express Dr., Parker, CO 80134, (303) 805-1218. Psychotherapists at Running Creek Counseling are graduate students in psychology or counseling or postmasters clinicians working towards Colorado mental health licensure. The psychotherapists are under the clinical supervision of licensed mental health professionals. Everyone fifteen or older must sign a disclosure statement. This disclosure statement contains the policies and procedures of Running Creek Counseling and is HIPAA compliant. No medical or psychotherapeutic information, or any other information related to your privacy, will be revealed without your permission unless mandated by Colorado law {42 U.S.C. 290dd-3& 43 U.S.C. 29033-3 for federal laws, 42 CFR Part 2 for regulations and Health Insurance Portability and Accountability Act of 1996 (HIPAA)}. You, as a client, may revoke your consent to treatment, release of confidential information, or disclosure in writing at any time during psychotherapy according to 45 CFR 164.508(b)(5).

ABOUT MY CLIENT RIGHTS:

The Colorado Department of Regulatory Agencies (DORA) has the general responsibility of regulating the practice of licensed psychologists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, certified school psychologists, and unlicensed individuals who practice psychotherapy. The agency within DORA that has responsibility specifically is the Mental Health Section, 1560 Broadway, Suite #1370, Denver, CO 80202, (303) 894-7766. While all of our counselors are regulated by the Department of Regulatory Agencies (DORA), Running Creek Counseling Services is also licensed by the Division of Behavioral Health (DBH). Clients are encouraged to resolve any grievances through our internal process, by they may call DBH at any time with concerns. Division of Behavioral Health, 3824 West Princeton Circle, Denver, CO 80236-3111, phone number (303)866-7400. Clients may also contact the Office for Civil Rights, U.S. DHHS, 1961 Stout Street - Room 1426, Denver, CO 80294, (303) 844-2024 if you feel your rights have been violated.

2. Client Rights and important information:
 - a. You are entitled to receive information from each therapist about methods of therapy, the techniques used, the duration of your therapy (if it can be determined), and the fee structure. Please ask if you would like to receive this information.
 - b. You are entitled to request restrictions on certain uses and disclosures of protected health information as provided by 45 CFR 164.522(a), however RCCS is not required to agree to a requested restriction.
 - c. You are entitled to receive confidential communications of protected health information.
 - d. You are entitled to inspect and copy protected health information as provided by 45 CFR 164.522; amend protected health information (164.526); receive an accounting of disclosures protected health information; and obtain a paper copy of this notice upon your request.
 - e. You can seek a second opinion from another therapist or terminate therapy at any time.
 - f. In a professional relationship (such as psychotherapy), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs it should be reported to DORA at (303) 894-7766.
 - g. Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the therapist is a certified school psychologist, a licensed social worker, a licensed marriage and family therapist, a licensed professional counselor, a licensed psychologist, or an unlicensed psychotherapist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent.

Information disclosed to a licensed clinical social worker, an unlicensed psychotherapist, a licensed marriage and family therapist, a licensed professional counselor, or a licensed psychologist is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

However, there are legal exceptions to the general rule of legal confidentiality. These legal exceptions include: intent to harm others or yourself; abuse or suspected abuse of children, and possibly the abuse of the elderly or others unable to care for themselves; neglect or suspected neglect of children; subpoenaed testimony in criminal court cases and orders to violate privilege by judges in child-custody, divorce and other court cases. Also, be aware that, except in the case of information given to a licensed psychologist, legal confidentiality does not apply in a criminal or delinquency proceeding. There are other exceptions, such as threats to national security under the federal Patriot Act, which will be identified to you as the situations arise during therapy.

3. Persons with a limited ability to pay for psychotherapy services may use the option of receiving services from students or interns. The rate for psychotherapy services will be negotiated based on the average annual income of the client and the ability of the client to pay. If clients use Running Creek Counseling's clinical services, they agree for the clients and their minor children to be observed by Running Creek Counseling staff and students and possibly videotaped. Signing this disclosure statement for you and/or minor children under your legal guardianship or legal custody authorizes staff and interns to observe in the same room and possibly videotape the psychotherapy sessions. Psychotherapy fees and treatment are based on a 45 to 50 minute clinical hour instead of a 60 minute clock hour.

AS A PSYCHOTHERAPY CLIENT:

1. I understand that RCCS may contact me to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
2. I understand that court testimony on my/our behalf is charged at a higher rate including testimony related matters like case research, report writing, travel, depositions, actual testimony and cross examination time and courtroom waiting time. Signing this disclosure statement gives permission for my psychotherapist(s) to release confidential information in courtroom testimony and written reports to the Court.
3. I understand that there may be times when my psychotherapist(s) may need to consult with a colleague or another professional, like an attorney, about issues raised by me in therapy. My confidentiality is still protected during consultation by my psychotherapist and the professional consulted. Signing this disclosure statement gives my psychotherapist(s) permission to consult as needed to provide professional services to me as a client.
4. I understand in marriage and family counseling, my psychotherapist(s) hold(s) a "NO SECRETS" policy. All members of the couple or family system are treated equally and "secrets" are not kept by the psychotherapist(s) that require differential or discriminatory treatment of family members. I understand that any information shared in individual therapy MUST be also shared in couple or family therapy to insure this "NO SECRETS" policy. Signing this disclosure statement affirms permission to share this confidential information.
5. I understand my psychotherapist(s) provides non-emergency psychotherapeutic services by scheduled appointment. If my psychotherapist(s) believe(s) my psychotherapeutic issues are above her or his level of competence, or outside of his or her scope of practice, he or she is legally required to refer, terminate, or consult. If, for any reason, I am unable to contact my psychotherapist(s) by telephone, (303) 805-1218, and I am having a true emergency, I will call 911 or check myself into the nearest hospital emergency room. In the case of an after hours, non-life threatening, clinical emergency I may call the agency cell phone (720) 940-5628 to contact an on-call clinician.
6. I understand that I have any questions or would like additional information, I may feel free to ask during the initial session and any time during the psychotherapy process. By signing this disclosure statement I also give permission for the inclusion of my partners, spouses, significant others, parents, legal guardians, or other family members in psychotherapy when deemed necessary by myself or my psychotherapist(s). They will also have to sign separate disclosure statements.

7. **I understand that I am legally responsible for payment for my psychotherapy services, if, for any reason, my insurance company, HMO, third-party payor, etc. does not compensate my therapist. I also understand that signing this form gives permission to my psychotherapist to communicate with my insurance company, HMO, third-party payor, collections agency or anyone connected to my psychotherapy funding source. Failure to pay will be a cause for termination of psychotherapy services.**

8. I understand this form is compliant with HIPAA regulations and no medical or psychotherapeutic information, or other information related to my privacy, will be released without permission unless mandated by Colorado law as described in paragraph 1 of this document. Consistent with HIPAA guidelines authorization for release and consent for treatment will be automatically revoked one year after the signing date.

9. **CLIENT SIGNATURE, ACKNOWLEDGEMENT, AGREEMENT, AND CONSENT**

I have read the preceding information and understand my rights as a client. By signing below I acknowledge my understanding and agree to all the terms discussed in this disclosure statement. By signing this disclosure statement, I also agree to permit consultation and I provide release for my psychotherapist(s) to seek consultation with the agency that referred me and/or my minor children, other psychotherapists or professionals as the need arises. I also consent for me, my minor child, and/or any of my minor children to be observed in the same room and/or videotaped during psychotherapy by Running Creek Counseling staff, students, trainees, and/or treatment team members. I also affirm, by signing this form that I am the legal guardian and/or custodial parent with legal right to consent to treatment for any minor child or children for whom I am requesting psychotherapy services here at Running Creek Counseling. This disclosure statement will be automatically revoked one year after signing in compliance with HIPAA guidelines.

Client Signature

Date

Primary Psychotherapist

Date

Running Creek Counseling

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FINANCIAL POLICY AND PATIENT AGREEMENT

FINANCIAL/INSURANCE ISSUES: As a courtesy I will bill your insurance company, HMO, responsible party payer for you, if you wish. We ask that at each session you pay your co-pay or full fee. If you do not know your co-pay amount, we will collect \$20.00 until that amount has been verified an adjustment will be made. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds \$300.00 we will need to ask that you pay for services when rendered. After 60 days, any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to my collections agency, the client or responsible party will be held responsible for any collection fee charged to my office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to Running Creek Counseling.

Lastly if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be charged \$60 for each missed appointment. Exceptions can be made and will be at the provider's discretion in the following circumstances: true emergencies, sudden illness or severe adverse weather conditions. Insurance carriers will not pay for missed appointments and they will be the patient's responsibility. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask.

If you are not using your insurance, payment of fees is due at the time of service. The fee for individual psychotherapy is _____ per 50 minute session. A complete fee schedule will be made available to you if you would like a copy. Acceptable forms of payment are cash, personal check and Visa/Mastercard. Payment not made at the time of service is considered past due when the patient leaves the facility.

Regarding insurance, the patient must recognize that he/she is responsible to pay the full amount for all services unless the Practice has an agreement with the patient's insurance carrier. The patient is responsible to make available to the Practice complete insurance information for accurate filing of claims. Insurance information includes 1) Any necessary referrals for primary and secondary insurance coverage, and 2) All identification and benefits cards and documents. **The patient agrees that if the insurance company denies benefits for any reason, or if no payment is received from the insurance carrier within 30 days as designated by Colorado law, then the patient is responsible for the full amount of the bill immediately.**

By this agreement, the patient also authorizes the exchange of information relating to care and claims with the patient's insurance company(s), and authorizes insurance payment to be made directly to the Practice for services provided under the patient's insurance agreement and otherwise payable to the patient.

Please pay all fees due before the start of the session. Thank you.

PATIENT AGREEMENT: I have read and understand the Financial Policy above and agree to the terms stated.

Patient or Legal Guardian's Signature

Patient's Printed Name

Date

Patient's Birthdate

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Patient Information

Patient's Name _____ Home Phone _____

Address _____ Work Phone _____

City _____ State _____ Zip _____ Cell Phone _____

E-mail _____

Patient's Birthdate _____ Gender _____ Male _____ Female _____ SSN _____

If minor, parent's name(s) _____

Primary Care Physician _____ Referred By _____

EMERGENCY

Contact _____ Phone _____

Relationship _____

For marriage/couples counseling, you MUST list your spouse's information

Partner's Name _____ Birthdate _____ SSN _____

CONSENT FOR TREATMENT OF CHILDREN AND ADOLESCENTS:

I/We consent that _____ may be treated as a client or clients of Running Creek Counseling.

Signature(s) _____ Date _____

Policyholder's Name _____ Birthdate _____

Address _____ SSN _____

Insurance Company _____ Policy # _____

Insurance Company Address _____

Insured's Employer & Address _____

Insured's Work Phone # _____

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except in a) criminal and delinquency matters and except for the other areas as provided in Colorado Revised Statutes 12-43-218. b) information shared with your insurance company to process your claims, c) where you sign a release to have specific information shared, d) if you provide information that informs me that you are in danger of harming yourself or others. If an emergency arises for which the client or their guardian feels immediate attention is necessary, the client or the guardian understands they are to contact the emergency services in the community for those services. All Running Creek Counseling staff will follow those emergency services with standard counseling and support to the client or the client's family.

Signature(s) _____ Date _____

Primary Psychotherapist _____ Date _____