REGISTRATION FORM (PLEASE PRINT)

Please circle one:
George Richard Athey, MD, PhD; Scott Gregory, LMFT; Marta McKay, LPC, CAC III; Tiffany Nerguizian, LPC
Affiliates: Ashley Williams, PhD; Jennifer Wilson, PhD

Patient's Name _____ _____/_____/_____ ____-____-_____
First M.I. Last Date of Birth (mm/dd/yyyy) SSN

Home Address _____
Street address Apt # City State Zip code

Home phone_____ Work_____ Cell_____

Email address _____

Sponsor/Primary Insured_____ _____/_____/_____ ____-____-_____
First M.I. Last Date of Birth (mm/dd/yyyy) SSN

Full address if different from patient's _____

Employer _____ Occupation _____

Relationship _____ Home Phone _____Work_____Cell _____

If patient is a child, other parent name: _____ Phone _____

Address, if different _____

Legal Guardian (or custodian) _____ Relationship _____ Type of custody _____

Emergency contact name & phone _____
(If patient is a child, someone other than the adult regularly bringing the child)

Referred by _____**Address** _____**Phone**_____

Primary Care Physician _____**Addr**_____**Phone**_____

Appointment reminders

Home email _____ **Alternate email** _____

Text to #_____ **OR Call to #**_____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance

Insurance Company_____ **Telephone number**_____

Subscriber ID _____ **Group #** _____ **Employer**_____

Secondary Insurance: We no longer bill for secondary insurance. If you have a second insurance, please let your provider know and we will provide a Statement of Service for you to submit to that company.
Copay and Deductible payments are expected at the time of service.
PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD AND I.D.

I acknowledge the above information to be complete and accurate as of this date and agree to update this information whenever changes occur.

_____

Signature of Patient (18 years or older) or Authorized Signature of Parent/Guardian/Responsible Party/Witness **Date**

AUTHORIZATIONS, RELEASES, AND SIGNATURES

(INITIAL EACH BOX AND SIGN AT BOTTOM AFTER READING)

George Richard Athey, MD, PhD; Scott Gregory, LMFT; Marta McKay, LPC, CAC III; Tiffany Nerguizian, LPC
Affiliates: Ashley Williams, PhD; Jennifer Wilson, PhD

Patient Name:_____ Patient Date of Birth:_____

_____1. AUTHORIZATION FOR EVALUATION/TREATMENT

I hereby authorize above provider to evaluate and administer treatment necessary or advisable for the above named patient, and I have legal responsibility to give such authorization.

_____2. RELEASE OF INFORMATION TO HEALTH CARE PROVIDERS

Above provider is authorized to release all or part of the patient's medical record including psychiatric and substance abuse records to HEALTHCARE PROFESSIONALS (i.e. physicians, hospitals, agencies, providers, therapists, etc.) involved in provision of direct or emergent care. Above provider is further authorized to release such information as may be necessary, or required by applicable law (see HIPAA Privacy Notice).

_____3. RELEASE OF INFORMATION FOR INSURANCE CLAIMS

Above provider is authorized to release all or part of the patient's medical record to any person or corporation which is or may be liable for any part of the charges, including but not limited to, hospital or medical service companies, insurers, compensation carriers, government agencies, or collection agencies when necessary. It is understood that a photo copy of this form is a valid authorization for release.

_____4. ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment of any insurance benefits arising from policies insuring the patient or any party liable to the patient, directly to Above provider. I understand that I am financially responsible for any charges not covered by this assignment.

_____5. FINANCIAL RESPONSIBILITY

In consideration of the services to be rendered to the patient by Above provider, the undersigned guarantees payment of any amount due. I assume financial responsibility for the expenses of the above named patient including fees for missed or inappropriately cancelled appointments, including the first appointment.

_____6. PATIENT INFORMATION SHEET

I acknowledge that I have been given a copy of the New Patient Information Sheet and have read and understand my rights and responsibilities as a patient, parent/guardian, or responsible party as outlined therein.

_____7. HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of a copy of the HIPAA Notice of Privacy Practices. I have read and understood these notices and have had opportunity to ask questions concerning these.

_____8. CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, have received a copy of the foregoing and being the patient, guarantor, or being duly authorized by the patient, do agree and accept these terms.

Signature Printed Name Relationship to Patient Date

These authorizations and releases will remain in effect until revoked in writing, or until future date listed here:

Colorado Centers for Neuropsychiatry & Behavioral Care
4760 Flintridge Dr., Ste. 250, Colorado Springs, CO 80918
George Richard Athey, MD, PhD; Scott Gregory, LMFT; Marta McKay, LPC, CAC III; Tiffany Nerguizian, LPC
Affiliates: Ashley Williams, PhD; Jennifer Wilson, PhD

PATIENT FINANCIAL RESPONSIBILITIES

(INITIAL EACH BOX AND SIGN AT BOTTOM AFTER READING)

Due to changes in insurance processing, reduction in contracted fee schedules, and increased cost in overhead, the following administrative changes are necessary for our office:

_____1. Each patient will be allowed one “no show” or “late cancellation” exemption per calendar year for follow-up appointments. Intakes (first time appointments) are not eligible for the exemption waiver. A minimum of two working/business days are needed in order to cancel or change an appointment without accruing a charge on your account (Business days are Mon – Fri, 9 a.m. – 5 p.m.). No additional appointments will be scheduled with either your prescriber or your therapist until this is paid.

_____2. Each No show or late cancellation after the first exemption will be billed at $75.00 for any/all follow-up appointments. Any missed appointment for any reason after the first exemption will be billed. If the initial intake appointment is missed, a $150.00 charge will be billed which must be paid prior to scheduling the next intake appointment.

_____3. After three (3) No shows or late cancellations in a calendar year, there will be a consideration of transferring your care and no longer providing services to you.

_____4. The full co-pay or co-insurance is DUE AT THE TIME OF YOUR APPOINTMENT. If it is not paid before leaving the office and a bill must be sent to your home, then you will incur a $10 office administrative fee which will be charged to your account.

_____5. Any unpaid balances after a 90-day billing cycle will incur a $10 office administrative fee which will be charged to your account.

We are sorry to have to make these changes, but financially we must do this if we are to remain in business. If any of these changes cause you undo financial hardship, please discuss this with your provider personally.

Printed Patient Name	Signature	Date

Legal Guardian Printed Name	Signature	Date

New Patient Information Sheet (Rights and Responsibilities)

(Please <u>read carefully</u> as these statements are legally binding concerning your care)

George Richard Athey, MD, PhD; Scott Gregory, LMFT; Marta McKay, LPC, CAC III; Tiffany Nerguizian, LPC Affiliates: Ashley Williams, PhD; Jennifer Wilson, PhD

(719) 574-6562 (Main Office) **or 719-268-6992** (Dr. Athey)

1. Your health and well being are the reason for your therapy. You will be actively involved in your treatment plan and encouraged to ask questions, dialogue and provide feedback to optimize your therapy experience. Prior to each appointment, feel free to write down issues that you would like to discuss. By making the most of your scheduled appointment time we reduce time dealing with medication refill issues, insurance issues, or non-emergency therapeutic issues by phone after the appointments.

2. Please be prepared to keep all of your scheduled appointments in order to ensure quality care. Your concerns and medication refill issues can be most quickly addressed in this manner.

3. Your treatment is confidential. There are limits to your confidentiality if you become in imminent danger to yourself or others and then only minimal information is shared to facilitate the safety of yourself and others. It is in your best interest to authorize the release of information to your primary care doctor and insurance company for continuity of care and for payment.

4. **<u>CANCELLATIONS:</u>** If it is necessary to cancel an appointment, **<u>YOU MUST CALL 48 BUSINESS HOURS IN ADVANCE OF THE SCHEDULED APPOINTMENT TIME</u>**. **<u>IF YOU DO NOT CALL 48 BUSINESS HOURS AHEAD, YOU WILL BE CHARGED $150.00 FOR AN INITIAL ASSESSMENT AND $75.00 FOR A MISSED APPOINTMENT</u>**. No additional appointments will be scheduled until these charges are paid.

5. Any **insurance** questions can be directed to 719-574-6562. We will help you with your insurance company at your request, either to bill or to obtain approval (**<u>authorizations</u>**) for your treatment sessions. Please pay for any co-payments or deductibles at the time of service. You should understand that you are personally responsible for the entire bill and filing of insurance is done as a convenience for you. You understand that you are giving permission to submit a claim for insurance and that in doing so you are giving permission to send personal information to the insurance company including, but not limited to, diagnosis and treatment.

6. Please be responsible that your account does not become delinquent. If you have financial concerns, please address these early in treatment with your therapist or with our patient care coordinator. You should understand that if you have an unpaid balance that can not be worked out with CCNBC or Behavioral Care, then you give permission for information concerning bills, treatment, diagnosis, and personal information necessary for collection to be released to a court, attorney, or collection agency.

7. If you need to contact us urgently you may call **719-574-6562**. We are not always available immediately and in the case of a life threatening **<u>emergency</u>** where immediate care is needed, **call 911 or go to the nearest emergency room**. The number one concern is your (or your child's) health and safety. If you do not feel safe call or get additional help.

8. If you are taking medication, you agree to take medication only as prescribed and not to ingest any alcoholic beverages or illicit drugs. For **refills** please call at least 3 business days in advance so that the refills may be called, mailed, or faxed into your pharmacy. It greatly facilitates refills if you call the pharmacy requesting a refill and the pharmacy will then contact us with your refill request. **Stimulant medications** require an office visit and written prescription every 30 days and no mailed, phoned or faxed prescriptions are allowed.

9. Please be mindful of the fact that an **initial appointment** is 45 minutes to 1 hour and may take more than one appointment for a complete evaluation. **Follow-up appointments** are either 10-15 minutes for medication management alone, or 20-25 or 40-50 minutes in length for therapy or medication management with some additional evaluation and therapy. Longer times may be needed for certain therapies or in special cases and may require additional fees that may not be paid by your insurance.

10. You should know that we have an International Certified, Insured Therapy Dog named Lovey in our office. If you or your child is afraid of dogs, please let us know this prior to your appointment so appropriate arrangements can be made.

11. **Requests** for letters and reports, extensive review of other records, visits to school or attendance at other meetings, and frequent or extended phone calls will likely not be paid by insurance and the time will be **billed directly to you**. Reports or extended phone calls are a **minimum of $25 and time is billed at $160/hr**. Please be courteous to your health care provider as well as to other patients and be on-time and prepared for each appointment.

12. If you are seeking counseling or medication evaluation services for your minor child/children and the parent or legal guardian is divorced, you must provide legal documentation along with the intake packet clarifying the legal guardianship status for minor children.

****Please sign the **Authorizations, Releases, and Signatures Form** as the authorization of your consent for evaluation and mental health treatment and acknowledgement that you have received, read, and understand these Rights and Responsibilities.
(Rev. 7/17)

Release of Information or Authorization

Please circle one:

George Richard Athey, MD, PhD; Scott Gregory, LMFT; Marta McKay, LPC, CAC III; Tiffany Nerguizian, LPC Affiliates: Ashley Williams, PhD; Jennifer Wilson, PhD

4760 Flintridge Dr., Ste. 250, Colorado Springs, CO 80918
(719) 574-6562 (Main Office) **or 719-268-6992** (Dr. Athey) Fax (719) 570-0386

Name:_____ Birth Date:_____
Address:_____
Phone:_____ Social Security Number:_____

The purpose of this form is to release Health Care Information to be **____sent to, ____received from, or ____two way communication**, both verbal and written, between above provider, and the following health care / mental health / substance abuse / educational agencies or providers:

Person/Agency	**Address**	**Phone**

For the purpose(s) of (specify): __Continuity of care __Treatment __ Therapy __ Payment or Financial Operations

Special information being requested includes (specify, including dates if applicable)

_____

_____

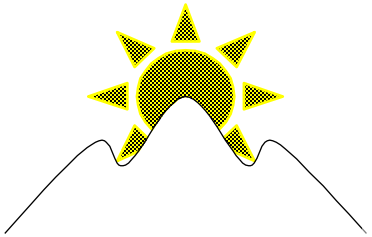
- If "treatment", "payment", or "operations" is checked, this form is a "release" of information and if I refuse to sign it, Dr. Athey can withhold treatment, payment, enrollment, or other eligibility benefits.
- Please see the HIPAA Notice of Privacy Practices for this office which was provided to you at registration for your rights concerning release of protected information.
- If this is an authorization the above provider will provide me with a copy if I so request.
- I understand that, unless lined through, information to be released / authorized may include information regarding the following condition(s):
  - Drug Abuse Psychiatric Conditions / Treatment
  - Alcoholism HIV / Auto Immune Deficiency Syndrome (AlDS)
- I understand that by releasing this information to other parties, it may not be protected by the HIPAA regulations.
- I understand that I may revoke this release / authorization at any time by giving written notice to the above provider, except to the extent that action has already been taken to comply with it. Without such revocation, this release / authorization **will expire on / / (date), or if left blank, one year from the date of my signature**, or as of the action or event of _____.

_____

Signature of patient **Print Name** **Date**

_____

Signature of Parent/Legal Representative **Print Name** **Relationship to Patient** **Date**



4760 Flintridge Drive, Suite 250
Colorado Springs, CO 80918
(719) 574-6562
fax 570-0386

Colorado Center for Behavioral Care

Instructions: *Please complete all sections to the best of your ability. This will significantly help quicken the intake process. You may decline to answer any question, though this may inhibit your overall treatment process. All information herein is privileged under state and federal law. Please refer to your mandatory disclosure document for info on privilege and exceptions to privilege.*

Patient Name	Date of Birth	Age	Gender
Date	Referred by		

History of presenting problem

What brought you here today?

What led up to this decision?

Are there specific stressors/life events that may have triggered your situation?

How long has this lasted?

How bad or intense has it been?

Have you experienced this before? If so, when and how did you handle it?

Have you ever seen a therapist or psychiatrist before, either as an inpatient or outpatient client? If so, who, when, why, and did you feel it worked?

Have you ever taken psychotropic medications (medications to address mental health issues) before? If so, what, when, how much, and did you feel it worked?

Medical History

Date of last physical exam or visit to your physician?

Date of last physical exam or visit to your psychiatrist?

Are you on any current medications? If so, what, for how long, how much, why, and who prescribed them?

Are you allergic to any medications? If so, what?

Have you or anyone in your family ever had the following? If so, write their name and relationship to you (e.g., Grandfather on Mom's side).

Hypothyroidism	Diabetes		Hypoglycemia	Traumatic Brain Injury	Other? (Please write in box)
	Type I	Type II			

Major Depression	Bipolar Disorder	ADHD	Schizophrenia	Substance or Alcohol Abuse	Anxiety (if so, write in write in box)	Personality Issues	Traumatic Stressor

Other: _____

Symptom Checklist for Patient

	Circle All That Apply						**Write out Answer**		
Sleep Quality	Too little		Just Right		Too much		Average number of hours per night		
If problems, are they with getting to sleep, staying asleep, waking up, or other?									
							Comments		
Energy Level	Too little		Just Right		Too much				
Concentration/Focus	Too little		Just Right		Too much				
Memory	Poor or worse than before		Just Right		Excellent				
Appetite	Too little		Just Right		Too much				
Guilt	Too little		Just Right		Too much				
Body Movement	Fidgety/hyper		Just right		Couch potato				
Hallucinations	None	Hear things	See things	Feel things	Taste things	Smell things	They command me to do things like ….		
Mood	Sad	Happy	Up and down	Unpredictable	Irritated	Angry	Anxious or fearful	Flat or restricted	Elated or Manic

If anxious, angry or irritated mood, when does that occur? What does it look like? What are the triggers?								
Body Aches and Pain	Headaches	Migraines	Stomach Aches	Diarrhea	Nausea	Vomiting	Rashes	Other?

Suicidal Thoughts or Actions	Never	In the past but not now	Wish I were dead but wouldn't do it	Pretty Strong Feelings	Scared for my own safety
Homicidal Thoughts or Actions	Never	In the past but not now	Wish someone dead but wouldn't do it	Pretty Strong Feelings	Scared for their safety

Other symptoms that I should know about?

Therapist Observations or Comments (For Therapist to Complete This Section)

Family History

(May include family that raised you; current or past significant relationships; family history of physical, emotional abuse and alcohol or drug dependency; significant life events; marital issues; education; social support; interest/leisure activities; work; or other significant information.)

Developmental History

(May include any information from your past that is important. May be replaced by expanded developmental questionnaire if patient is a child or adolescent.)

Alcohol or Drug Use History

	Have you ever used or abuse this?	If so, over the past year…how often?	How much at a time?	Age of first use?	Date of last use?	Have you ever experienced shakes, blackouts, hallucinations, convulsions, or delirium tremors due to your use of this?	Has this use ever led to problems with the legal system, friends, your health, the military, your spouse or family, work, or school?	If treatment was sought for this, what was it? (E.g., AA, therapy, CD treatment, etc…) (Please write in name of treatment)
Alcohol								
Stimulants like Meth								
Cocaine								
Pain Pills								
Tranquilizers								
Narcotics								
Sleeping Pills								
Marijuana								
Hallucinogens								
‘Downers’								
Huffing agents								
Other? (Please write in name)								

Strengths based approach

What are your strengths as a person?

What are your weaknesses or areas for improvement as a person?

What do you want to get from therapy?

Is there anything else that I would benefit from knowing about you, your family or your past?

Thank you for your openness and honesty completing this form. The questions are difficult, but very important to successful treatment.

PATIENT'S PLEASE STOP HERE

Mental Status Screening

Appearance	☐ Well Groomed ☐ Disheveled ☐ Eccentric ☐ Inappropriate ☐ Dirty
Attitude	☐ Cooperative ☐ Uncooperative ☐ Guarded ☐ Suspicious ☐ Belligerent
Alertness	☐ Alert ☐ Drowsy ☐ Lethargic
Motor Activity	☐ Normal ☐ Increased ☐ Decreased
Mood	☐ Normal ☐ Euthymic ☐ Elevated ☐ Depressed
Affect	☐ Appropriate ☐ Positive ☐ Irritable ☐ Tearful ☐ Anxious ☐ Angry ☐ Blunt/Flat ☐ Labile ☐ Other:
Speech	☐ Normal ☐ Over talkative ☐ Under Talkative ☐ Loud ☐ Soft ☐ Pressured ☐ Slowed ☐ Slurred ☐ Other:
Thought Process	☐ Appropriate ☐ Delayed Responses ☐ Blocking ☐ Circumstantial ☐ Perseverative ☐ Loose ☐ Flight of Ideas ☐ Incoherent ☐ "Magical" Quality ☐ Other:
Thought Content	☐ Appropriate ☐ Ideas of Reference ☐ Grandiose ☐ Delusional ☐ Obsessive ☐ Paranoid ☐ "Magical" Quality ☐ Floridly Psychotic ☐ Other:
Hallucinations	☐ None ☐ Auditory ☐ Visual ☐ Tactile ☐ Olfactory ☐ Gustatory ☐ Command in Nature Comments:

Summary Statement or Conclusions of Therapist

Practice of
George Richard Athey, MD, PhD; Scott Gregory, LMFT; Marta McKay, LPC, CAC III; Tiffany Nerguizian, LPC
Affiliates: Ashley Williams, PhD; Jennifer Wilson, PhD

Please read this Notice, ask questions if it is not clear, sign the signature form indicating your understanding of these statements.

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date (July 1, 2004)

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. If you have any questions about this notice, please contact: 719-574-6562 or 268-6992

This notice describes the privacy practices at our office. We are required by law to:*
Maintain the privacy of protected health information
Give you this notice of our legal duties and privacy practices regarding your health information
Follow the terms of the notice currently in effect.

•

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

Described as follows are the ways we may use and disclose your health information. Except for the following purposes we will use and disclose your health information only with your written permission. You may revoke such permission at any time by writing to Your provider.

Treatment. We may use and disclose your health information for your treatment and to provide you with treatment-related health care services. For example, we may disclose your health information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose your health information so that others or we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give information to your health plan so that they will pay for your treatment.

Health Care Operations. We may use and disclose your health information to evaluate and improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or a health plan that is evaluating our care. We may also share information with others that have a relationship with you for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services. We may use and disclose your health information to contact you and remind you of your appointment, to tell you about treatment alternatives or health-related benefits and services you could use.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share your health information with a person involved in, or paying for, your care (such as your family or a close friend). We may notify your family about your location or condition or disclose such information to an entity assisting in disaster relief.

Research. We may use and disclose your health information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for

the same condition. Before we do so, the project needs to go through a special approval process. Even without special approval, we may permit researchers to look at records to help identify patients who may be included in their research, as long as they do not remove or copy any of your health information.

As Required by Law. We will disclose your health information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose your health information when necessary to prevent a serious threat to the health and safety of you, another person, or the public. Disclosures will be made only to someone who can prevent the threat.

Business Associates. We may disclose your health information to our business associates that perform functions on our behalf or provide us with services if necessary. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose the information for any other purpose than appears in their contract with us.

Military and Veterans. If you are a member of the armed forces, we may release your health information as required by military command authorities. If you are a member of a foreign military we may release your health information to the foreign military command authority.

Worker's Compensation. We may release your health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your health information for public health activities to prevent or control disease, injury or disability. We may use your health information in reporting births or deaths, suspected child abuse or neglect, medication reactions or product malfunctions or injuries, and product recall notifications. We may use your health information to notify someone who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. If we are concerned that a patient may have been a victim of abuse, neglect, or domestic violence we may ask your permission to make a disclosure to an appropriate government authority. We will make that disclosure only when you agree or when required or authorized to do so by law.

Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law. These may include audits, investigations, inspections, and licensure. These activities are necessary to for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose your health information in response to a court or administrative order. We may disclose your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release your health information request by law enforcement official if
1) there is a court order, subpoena, warrant, summons or similar process;
2) if the request is limited to information needed to identify or locate a suspect, fugitive, material witness, or missing person;
3) the information is about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain your agreement;

4) the information is about a death that may be the result of criminal conduct;
5) the information is relevant to criminal conduct on our premises; and
6) it is needed in an emergency to report a crime, the location of a crime or victims, or the identity, description, or location of the person who may have committed the crime.

Coroners, Medical Examiners, and Funeral Directors. We may release your health information to a coroner, medical examiner, or funeral director to identify a deceased person or cause of death, or other similar circumstance.

National Security and Intelligence Activities. We may disclose your health information to authorized federal officials for intelligence and other national security activities authorized by law.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or in custody we may disclose your information 1) for the institution to provide you with health care, 2) to protect your health and safety or that of others, and 3) for the safety and security of the institution.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect and Copy. You have the right to inspect and copy your medical and billing records by written request to your provider in the group, except for restricted mental health information.

Right to Amend. You have the right to request an amendment to your records by written request to Your provider.

Right to an Accounting Of Disclosures. You have a right to an accounting of certain disclosures by written request to Your provider.

Right to Request Restrictions. You have the right to request restriction or limitation on your health information used for treatment, payment or health care operations. You may request us to limit disclosure to someone involved in your care or in payment for your care (such as a spouse) by written request to Your provider. We are not required to agree with your request, but we will try to comply.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You can ask, for example, that we contact you only by mail or at work. Your written request must specify how or where you wish to be contacted and be addressed to Your provider. We will accommodate reasonable requests. You give us the right to contact you by phone and leave phone or voicemail messages unless you specifically exclude this right.

CHANGES TO THIS NOTICE

We may change this notice and make it effective for medical information we already have about you as well as new information. The current notice will be posted and available at all times. You have a right to request a paper copy of the current notice at any visit or by written request to Your provider.

Your provider,

4760 Flintridge Drive, Suite, 250
Colorado Springs, CO 80918
719-574-6562 (main office) or 268-6992 (Athey)

Ashley A. Williams, Ph.D.
4760 Flintridge Drive # 125
Colorado Springs, CO 80918
(719) 231-9609
(719) 570-0386 (FAX)

DISCLOSURE AND CONSENT TO SERVICE

CLIENT: _____ DATE: _____

Client Date of Birth: _____
Client Telephone Number: _____
Client Address: _____
Parent/Guardian: _____
Parent/Guardian Telephone Number: _____

All mental health professionals are required by law to provide the following information to each client (or their legal guardian) during the initial client contact, except in cases of emergencies and court ordered situations:

1) Clinician/Degree: Ashley A. Williams, PhD Psychologist's License #0003680
Business Address: 4760 Flintridge Dr
Colorado Springs, CO 80918
Business Telephone: 719-231-9609

2) 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, CO 80202, 303.894-7800. The Regulatory requirements for mental health professionals provide that a Licensed Clinical Social Worker, a Licensed Marriage and Family therapist, and a Licensed Professional Counselor must hold a master's degree in in their profession and have two years of post-master's supervision.

A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a master's degree in social work.

A 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.

A Certified Addiction Counselor 1 (CAC I) must be a high school graduate, and complete required training hours and 1000 hours of supervised experience.

A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelor's degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience.

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

A Registered Psychotherapist is listed in the State's Database and is authorized by law to practice psychotherapy I 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.

3) Core clinical psychological services offered are psychological assessment and psychotherapy. There are no physically invasive procedures offered by psychologists working at the Colorado Center for Behavioral Care. Feel free to ask any questions about techniques used, the duration of the procedure, and the reason for any of the policies outlined at any time. Clinical psychology is not an exact science; it depends on the full participation of the client and his/her support system.

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

5) In a professional relationship, sexual contact is never appropriate and should be reported to the grievance board.

6) Confidentiality: Information you may provide during therapy or consultation sessions is legally confidential. There are certain exceptions to confidentiality. Primarily, these include the following:

    a. A judge's order, in a court of law, to reveal information.

    b. If you provide your clinician with information about child or elder abuse, or that you intend to harm yourself or someone else, she or he is required by law to reveal that information to the appropriate authorities or individuals.

    c. If your clinician determines that a warning is necessary to avert imminent threat of harm to self or others, or certain other conditions, she or he is required by law to reveal that information to the appropriate authorities or individuals.

    d. Other exceptions will be identified if they occur during treatment.

7) Cancellations: Due to changes in insurance processing, reduction in payments under the Affordable Care Act, and increases in overhead, the following administrative policies are necessary for our office:
    a. Each client will be allowed one no show or late cancel per year. A minimum of one working day is needed to cancel or change appointments.
    b. Each no show after the first will be billed at the full fee for that visit. Any missed appointment for any reason after the first will be billed.
    c. After three no show or late cancel appointments in a year, there will be a consideration of no longer providing services to the client.
    d. The full copay or co-insurance is due at the time of your appointment. If it is not paid before leaving the appointment and a bill must be sent to the home, then there will be a $10.00 office administration fee added to the bill.

    We are sorry to have to make these changes, but financially must do this if we are to stay in business. If any of these changes causes you financial hardships, please discuss this with us personally.

8) Dr. Williams is not able to provide emergency or crisis services. If you have an emergency, please go to the nearest hospital, emergency room, or mental health crisis canter (635-7000). If you anticipate or are experiencing acute distress, you and your therapist may decide to schedule extra sessions and/or plan to have a brief phone consultation.

9) When the client and/or the clinician determine that the client is no longer in need of therapy, a step-down treatment will begin (e.g., weekly treatment to bi-weekly treatment to monthly) prior to the termination of services. The clinician will work with other provider agencies to transfer information to allow for continuity of care for the client in cases when that is needed.

10) 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 plans. By signing this Disclosure Statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; you also agree not to request that I write any reports to the court or to your attorney regarding making recommendations concerning custody. The court can appoint professionals whose job is to conduct investigations or evaluations for the court concerning parental responsibilities or parenting time in the best interest of the family's children.

11) Patient Record Retention Policy

    For the treatment of adults, records will be kept for seven (7) years after treatment ends or following our last session, but I may not retain them after seven years. For the treatment of minors, records will be kept for seven (7) years, commencing on the last date of treatment or for seven (7) years from the date when the minor reaches 18 years of age, whichever comes later. In no event am I required to keep these records for longer than 12 years.

I have been informed of my clinician's degree, credentials, and license status. I have read the preceding information and understand my rights as a client. I understand that I have the right to terminate or revoke services at any time. Also, I understand that this consent will be automatically rescinded in one year her HIPPA regulations. I hereby consent to consultation, evaluation, and treatment by clinically qualified staff at Colorado Center for Behavioral Care.

Client Signature: _____

Parent/Guardian Signature: _____

Clinician Signature: _____

Date: _____