Krupnick Counseling Associates **CONFIDENTIAL** **CHILD/ADOLESCENT Intake Information**

CONTACT INFORMATION

Child/Adolescent Legal Name: ______________________ **DOB:** ________

Client's Preferred Name: ______________________ **Preferred Pronoun** He ☐ She ☐ ------- ☐

Mailing Address: ____
City Zip Code

		OK to call/email		OK to leave a message	
Home Phone #:	________________	Yes ☐	No ☐	Yes ☐	No ☐
Parent Cell #:	________________	Yes ☐	No ☐	Yes ☐	No ☐
Parent Email:	________________	Yes ☐	No ☐		
Adolescent Phone #:	________________	Yes ☐	No ☐	Yes ☐	No ☐
Adolescent Email:	________________	Yes ☐	No ☐		

1st Parent's Name: ____
Address, Phone & Email (if different from above)

2nd Parent's Name: ____
Address, Phone & Email (if different from above)

Name(s) of Parent(s) with Legal Custody: ______________________________

Describe Custody Arrangements (if applicable): ______________________________

HOUSEHOLD INFORMATION

Family Members:

Name	Age	Relationship	Grade/Occupation	Living at home?

CANCELLATION POLICY

If you need to cancel an appointment, kindly give us a minimum of a 24 hour notice. Exceptions will be made when circumstances exist such as illness or when weather conditions make it impossible to get to your appointment. Insurance companies do not reimburse us for missed appointment and late cancellations. You will be billed directly. The missed appointment/late cancellation is billed at the reduced rate of $85.00.

As a courtesy and to assist our clients in remembering their appointments our office does offer appointment reminders. Please complete the APPOINTMENT REMINDER section if you would like to receive appointment reminders.

Adolescent Signature: ______________________ **Date:** ____________

Parent Signature: ______________________ **Date:** ____________

APPOINTMENT REMINDERS

Would you like to receive appointment reminders for future appointments? Please select only <u>one</u> option.

- ☐ No, I do not wish to receive appointment reminders
- ☐ Yes, Please call the following phone number:____________________ It is ok to leave a message.
- ☐ Yes, Please email my reminder to:____

Appointment reminders are offered as a courtesy & based on staffing availability. We will make every effort to provide the requested reminder, however, we are not responsible for deleted messages, disconnected or wrong phone numbers, mechanical/phone line failures, full voicemail boxes, or other unforeseen events that would prevent you from receiving the reminder. Not receiving a reminder regarding an appointment does not absolve your responsibility in terms of our missed appointment / no show policy.

***Please initial here that you have read this statement:*____________________________**

COMMUNICATION by Email & Other Non-Secure Means

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Krupnick Counseling Associates (KCA) there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with a KCA therapist
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

If there are people in your life that you don't want accessing these communications, please talk with your KCA therapist about ways to keep your communications safe and confidential.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS
This Consent is Optional

I, ____________________________________ , consent to allow Krupnick Counseling Associates to use unsecured email messaging to transmit to me the following protected health information: **(mark only those you authorize)**

- ☐ Information related to scheduling of appointments
- ☐ Appointment reminders
- ☐ Information related to billing and payment
- ☐ Completed forms, including forms that may contain sensitive, confidential information
- ☐ Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment
- ☐ My health record, in part or in whole, or summaries of material from my health record
- ☐ Customer Service Satisfaction Survey
- ☐ Other information per my request. Describe:________________________________

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

______________________________________ ______________________________________

Client Signature: **Date:**

Therapist Signature:____

INSURANCE INFORMATION

Co-payments and allowable rates prior to deductibles being met are due at the time of your visit

Will we be billing insurance on your behalf? **Yes** ☐ **No** ☐

If yes, please complete the following section about your insurance and carefully read our billing agreement.

Policy Holder's Name: ______________________ **Policy Holder's DOB:** ______________

Policy Holder's Social Security #: ______________________ **Insurance Company:** ____________

Policy Holder's Mailing Address: ____

Insurance ID #: ______________ **Policy Holder's Employer:** ______________________

Do you have a deductible? Yes ☐ No ☐ **If yes, do you believe you have met your deductible?** Yes ☐ No ☐

What is your co-pay, or patient portion amount?______________________________

Please list the name(s) of all individuals who have permission to make billing inquiries on this account (spouse, 2nd parent, etc):

*****ALL INFORMATION MUST BE COMPLETED ABOVE IN ORDER TO BILL INSURANCE*****

You are responsible for understanding the provisions of your health insurance plan and coverage. As a courtesy our billing office will contact your insurance provider and conduct a benefit check. We will provide you with this information at the second visit. Please bear in mind that, ultimately, carrier adjudications after the visits determine financial responsibilities. Health insurance is a contract between you and your insurance company and you are responsible for any services that are rendered on your behalf if your insurance company does not compensate us for those services. In addition, signing this form gives us permission to communicate with your insurance company regarding payment. Your insurance company may request information about the services we provide, including but not limited to a diagnosis, description of services or symptoms, treatment plan or summary, and in some cases, your entire file. Once your insurance company receives this information, we have no control over the security measures they use to protect the information or whether the insurance company shares the information. In these situations, we will try to release the minimum information necessary in response to requests from your insurance company.

Copayments are due at the time of service.

Collection procedures will be initiated when payments are past due. This may involve using a collection agency or filing a claim in small claims court. In collection situations, we will make all efforts to release the minimum information necessary to proceed with collections or a claim, which will include the client name, dates, times, and the nature of services, and the amount due. Before we engage a collection agency, we will provide you with written notice of our intent to do so, sent to your last address we have on record, and give you an opportunity to make payment arrangements. The responsible party agrees to pay all collection fees, including attorney fees, court costs and other expenses incurred in the collection of delinquent accounts.

I have read, understand and consent to assignment of authorized health insurance benefits by my health insurer to Krupnick Counseling Associates for services furnished to me or my dependents.

Patient Name (Please print clearly): ______________________________

______________________________ ______________________

Parent/Guardian Signature **Date**

____

Parent/Guardian Printed Name

OFFICE STAFF INITIALS:______________________

FEE SCHEDULE & COLLECTION POLICIES

Fee Schedule

Initial assessment or extended session	$150.00	Psychotherapy	$140.00
Reduced Private Pay Rate(no insurance billing)	$85.00	Missed appointment/late cancel(s)	$85.00

Other services that require more than 15 minutes are billed directly to you(NOT COVERED BY INSURANCE) at the rate of $150.00 per hour. These services include:

1. Telephone/Email Consultations
2. Review of records such as prior treatment reports, custody evaluations and the like.
3. Reports, testing, and letters to others (which are only provided at your written request).
4. Expert testimony for depositions and/or court appearances, including travel and preparation time if necessary. 50% of anticipated fee for these services must be paid one week in advance

Collection Policies

Financial Responsibility for Minors: We realize that many families are in a state of change. Divorced, separated, single parent and blended families are common. In many of these families the question of who is responsible for the children's medical bill is uncertain. **The policy of our office is that the parent who requests treatment for the child is responsible for all fees incurred.** However, our office is happy to work with families who would like to put two forms of payment on file when sharing the financial responsibility for co-payment and session fees.

Collection Procedures: Collection procedures will be initiated when payments are 60 days past due. This may involve using a collection agency or filing a claim in small claims court. In collection situations, we will make all efforts to release the minimum information necessary to proceed with collections or a claim, which will include the client name, dates, times, and the nature of services, and the amount due. Before we engage a collection agency, we will provide you with written notice of our intent to do so, sent to your last address we have on record, and give you an opportunity to make payment arrangements. The responsible individual agrees to pay all collection fees, including attorney fees, court costs and other expenses incurred in the collection of delinquent accounts.

_______________________________ _______________________

Parent/Guardian Signature **Date**

Financial Security: Office policy requires clients to keep a credit card on file. Under HIPAA, we are under strict rules and guidelines in terms of protecting client privacy and the credit card is considered protected health information. We treat your financial information with the same respect and privacy guidelines as your medical records.
We assure you that we will only bill your credit card in the following situations:

1. You instruct us to bill your credit card for any outstanding balance.
2. Your balance is 60 days past due.

PLEASE PRINT CLEARLY

Name of cardholder: ______________________________

Name of patient: ______________________________

Credit card number: ______________________________

Visa / MasterCard / Discover

Expiration Date: ________________ **Billing Zip Code:** ________

By signing below, I, the cardholder or authorized signatory, authorize payment on this credit card to Krupnick Counseling Associates, as explained above, and agree to all terms and conditions as set out above.

Authorized Signature: ________________________ **Date:** ____________

Automatic Payment Express for your convenience:

If you would like us to charge the credit card listed above for your payment/co-payment(s) Please notify your therapist and sign the payment authorization below. After each session we will charge the credit card listed above for payment amount due. A receipt will be placed in your chart and available at your next session.

Payment Authorization: ________________________ **Date:** ____________

Therapist Signature:________________________________

MEDICAL INFORMATION / MENTAL HEALTH HISTORY

Presenting Problem: ______________________________
What brings you here now?

How long has the problem persisted? ______________________________

Is the presenting issue affecting any of the following areas? ☐ Handling everyday tasks ☐ Work/School ☐ Health ☐ Relationships ☐ Self Esteem ☐ Legal Matters ☐ Finances ☐ Housing ☐ Parenting ☐ Other

Please list any previous counseling experiences (Counselor's name, dates, what helped, what did not work): ____________

____

____

____

Has child/adolescent been hospitalized for psychiatric reasons? If so, for what, where and when?

____

____

Name of Child's School: ______________________________

Teacher / Grade: ______________________________

Does your child have an IEP/504/Special Education? If so, for what? ______________________________

Name of counselor/psychologist who coordinates IEP/504/special education recommendations: ____________

Who are your child's physician(s)?

Primary Care Physician: ______________________________

Psychiatrist: ______________________________

Other: ______________________________

Who referred you? ______________________________

If you would like for your child's therapist at Krupnick Counseling Associates to communicate with your child's school, teacher, psychiatrist, primary care physician or other healthcare provider please complete a release of information. The release of information is the last page of this packet/document. A release of information must be completed for each individual listed above that you would like KCA to coordinate care with.

If your child is 15 years of age or older than both you and your child will need to sign the release of information.

Current Illnesses: ______________________________

____

Current Medications: ______________________________

____

Emergency Contact Name & Phone #: ______________________________

____

KRUPNICK COUNSELING ASSOCIATES
MANDATORY DISCLOSURE STATEMENT

(required by C.R.S. 12-43-214)

Elizabeth Lewis, MA

Licensed Professional Counselor, Colorado #0014948

Masters in Counseling: Wilderness Therapy, Naropa University

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, certified and licensed addiction counselors, and unlicensed individuals who practice psychotherapy. The agency within the Department that has responsibility specifically for licensed and unlicensed psychotherapists is the: Department of Regulatory Agencies, Mental Health Section, 1560 Broadway, Suite 1350, Denver, CO 80202, (303) 894-7766, DORA_MentalHealthBoard@state.co.us

Levels of regulations of mental health professionals in Colorado include licensing (requires minimum education, experience, and examination qualifications), certification (requires minimum training, experience, and for certain levels, examination qualifications), and registration (does not require minimum education, experience, or training). All levels of regulation require passing a jurisprudence take-home examination.

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' 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 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 I (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 registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required.

You are entitled to receive information about the methods of assessment and psychotherapy, the techniques used, the duration of the therapy (if known), and the fee structure. Please carefully review our financial and procedural policies. You may seek a second opinion from another therapist or terminate therapy at any time. 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, at the address/phone number/email address listed above.

Generally speaking, the information provided by and to a client during therapy is legally confidential, and the therapist cannot be forced to disclose information 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. There are exceptions to this confidentiality, some of which are provided in sections C.R.S. 12-43-218, 18-6.5-108, in the Notice of Privacy Practices you were provided, as well as other exceptions in Colorado and Federal law. If a legal exception arises during therapy, you will be informed accordingly, if feasible. The following are some exceptions to confidentiality:

1. You sign a release of information form giving permission for the therapist to provide specified information about your treatment to a particular individual or agency.
2. The therapist reasonably suspects or has proof of child abuse and/or neglect.
3. The therapist reasonably suspects or has proof of abuse, neglect, and/or exploitation of elderly individuals.
4. You are in imminent danger of harming yourself and/or others, including those identifiable by their association with a specific location or entity. In this situation, your therapist is required to disclose such information to the appropriate authorities and/or to warn the party, location, or entity you have threatened.
5. Therapist testimony is subpoenaed in a court case or court ordered by a judge.
6. You file a suit or grievance against the therapist.
7. The therapist is being reviewed by the Mental Health Section of the Division of Registrations.

Krupnick Counseling Associates (KCA) works with a medical biller. In accordance with HIPAA, for billing purposes only, pertinent information is disclosed to the biller, including name, demographic and contact information, diagnoses, social security number, and any similar information required by your insurance company or reimbursement program. KCA has entered into a Business Associates Agreement with *Professional Billing Office*.

There may be times when your therapist needs to consult with a colleague or another professional such as an attorney or supervisor, about issues raised by you in therapy. Your confidentiality is still protected during consultation by your therapist and the professional consulted. Only the minimum amount of information necessary to consult will be disclosed. Signing this disclosure statement gives your therapist permission to consult as needed to provide professional services to you as a client. You will need to sign a separate Authorization for Release of Information for any discussion or disclosure of your protected health information to another professional besides an attorney retained by your therapist.

When working with a minor, information regarding the child's progress will be provided to the parent(s) or guardian(s) upon request, but specific information provided during therapy by the minor is protected by law. If the minor is fifteen (15) years of age or older, it is at the therapist's discretion to advise parents of the services given or needed by the minor.

If you are consenting to the treatment of a minor child, you will be required to provide a copy of the most recent Court Order Custody Agreement and/or Parenting Plan, if applicable, that gives you the authority to consent to the treatment of the child. By signing this form, you agree to keep your child's therapist informed of any supplemental court order or other proceedings that impact your parental rights, custody arrangements, or decision-making authority. Failure to produce the Court Order will prohibit the therapist from seeing the minor child. If there is joint medical decision-making authority for your child, we will require both parents to consent to treatment and will not proceed until such consent is obtained.

It is beyond the scope of our practice to provide custody recommendations, and any such request will be denied. The Court can appoint professionals who have the expertise to make such recommendations. By signing below, you agree not to subpoena our records or ask your child's therapist to testify in court or to provide letters or documentation expressing an opinion about custody or visitation. Despite this, a Court may still require your child's therapist to testify or to provide treatment information to an evaluator. We will comply with these requests as legally required and you will be required to compensate your child's therapist for time spent providing these services as indicated in the "Professional Fees" section above.

In the course of treatment with your child, your child's therapist may involve other family members in your child's treatment. However, please remember that the client is your child, not the other family members of the child. Any meetings with you or other family members will be documented in your child's records. These notes will be available to anyone who has legal access to your child's treatment record.

Therapy is most effective when there is a trusting relationship between the therapist and the client. Privacy is important in establishing trust and as a result, it is often important for child or adolescent clients to have a level of privacy around the therapy. It is our policy to provide parents with general information about their child's treatment, but not to share specific information disclosed during therapy. This includes behaviors that you may not approve of but which do not place your child at imminent risk or danger. If your child's therapist ever feels that your child is in danger, they may communicate this information to you. If the therapist feels your child is in imminent danger, they will communicate this. If you have questions about the types of information your child's therapist will share, you can feel free to ask hypothetical questions about situations that they may or may not disclose to you.

Although you may have the legal right to access any written record we keep, by signing this agreement you are agreeing that your child or adolescent should have privacy around their therapy and you agree not to request access to your child's full record.

In therapy where a family or a couple is the "client", the therapist holds a "no secrets" policy. Please be aware that information you choose to share with your therapist, in this context, that is particularly pertinent to all participating members of the family may come out in counseling. This pertains to all face-to-face, written, and phone conversations and messages. If your therapist meets with one or multiple members of the family in individual sessions, the contents of those meetings may be shared with the non-attending members, if the therapist determines that the information must be disclosed for therapy to be effective. Should you feel it is necessary to disclose something in this context that you wish to be kept confidential, your therapist can refer you to another therapist who can treat you individually. Your therapist cannot release the record from couples/family therapy without authorization from all participating members of the family.

KCA therapists provide non-emergency psychotherapeutic services by scheduled appointment only. If your therapist believes your psychotherapeutic issues are outside his/her level of competence or scope of practice, the therapist is legally required to refer, terminate, or consult. If, for any reason, you are unable to contact your therapist by telephone, and you are having a true physical or mental health emergency, please dial 911, go to your nearest emergency room, or call Colorado's Crisis Hotline (844) 493-8255. If you seek afterhours treatment from any counseling agency, center, emergency room, hospital or similar facility, you are solely responsible for any fees due.

MANDATORY DISCLOSURE STATEMENT continued..

In the case that your therapist becomes disabled, dies, or is away on an extended leave of absence, another therapist at KCA will have access to your client files. If your therapist is unable to contact you prior to such an event occurring, KCA will contact you. KCA will arrange for another therapist in the practice to continue your treatment, or to offer you referrals and transfer your client record, if requested.

Paper patient records are kept in locked file cabinets at KCA. Currently, Colorado law requires that we maintain our records for a period of seven (7) years commencing on the date of termination of services or the date of last contact with the client, whichever is later. When the client is a child, the records must be maintained for a period of seven years commencing either upon the last day of treatment or when the child reaches 18 years of age, whichever comes later, but in no event shall records be kept for more than 12 years. After this time, your records will be destroyed. If you would like further information about the maintenance of your records, please ask.

Any person who alleges that a mental health professional has violated the licensing laws related to the maintenance of records of a client eighteen years of age or older, must file a complaint or other notice with the licensing board within seven years after the person discovered or reasonably should have discovered this.

Although confidentiality extends to electronic communications, KCA cannot guarantee that those communications will be kept confidential and/or that a third party may not access the communications. Even though KCA utilizes current encryption methods, firewalls, and back-up systems to help secure communications, there is a risk that the electronic or telephone communications may be compromised by a third party. Faxes can easily be sent erroneously to the wrong address. NEVER use email or text for emergencies.

If you have questions or would like more information, please ask at any time.

I have read the preceding information and it has also been provided verbally if I am unable to read or have no written language. I understand my rights as a client or guardian of a client. By signing below I acknowledge my understanding and agree to all the terms discussed in this disclosure statement. 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.

Client(s) Name(s):____

Client or Parent/Guardian Signature:_________________________________ Date:___________

_________________________________ Date:___________

Therapist Signature:____ Date:___________

KRUPNICK COUNSELING ASSOCIATES
500 Kimbark Street, Suite 200, Longmont, CO 80501
303-651-1515

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY RIGHTS

Name of Client: ____

I hereby acknowledge that I have received a copy of the provider's Notice of Privacy Rights.

____ ____________________________
Client Signature Date

If not the client please print your name and state your legal authority to sign for the client:

____

____

●●● For Provider/Therapist Use Only ●●●

The Notice of Privacy Rights was presented to the client or legal guardian today, but the client or legal guardian did not sign this acknowledgement because:

_________ The client refused to sign

_________ The legal guardian refused to sign

_________ The client or legal guardian was incapable of signing

_________ Other reason:_______________________________

Signature of provider: ____ Date: __________________

Krupnick Counseling Associates

500 Kimbark Street, Suite 200, Longmont, CO 80501
303.651.1515 / info@krupnickcounseling.com

PRIVACY NOTICE

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 our Privacy Officer, Kehle Griego, at 303-651-1515 or Kehle@workwiseeap.com. You may also view this policy on our website: www.krupnickcounseling.com. **The following information will cover YOUR RIGHTS / YOUR CHOICES / OTHER DISCLOSURES**

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.

We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
You can request an accounting of the time we've shared your health information for six years prior to the date you ask. The accounting will not include disclosures pertaining to specific treatment, payment and health care operations. We will provide one accounting per year for free but will charge a reasonable, cost based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

Choose someone to act for you
We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
You can complain if you feel we have violated your rights by contacting us using the information on page 1.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave., SW, Washington, DC 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
-Share information with your family, close friends, or others involved in your care

-Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we **never** share your information:
Marketing purposes/Sale of your information.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you
We can use your health information and share it with other professionals who are treating you if you sign a release or if we feel you are in danger. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?
We are allowed or required to share your information in other ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

OUR USES AND DISCLOSURES continued….

Help with public health and safety issues
We can share health information about you for certain situations such as: Preventing disease, Reporting suspected abuse, neglect, or domestic violence, Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research. Any information shared would **not include identifying information.**

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director with a valid court order.

Law enforcement, and other government requests
We can use or share health information about you with:
Law enforcement, in cases where safety is a concern.
Law enforcement, when presented with a valid court order.
Health oversight agencies for activities authorized by law.
Under valid court order for special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Other Disclosures Permitted by Colorado Law:

Maintenance of your safety and others' safety
We can share certain health information about you in order to maintain your safety and/or others' safety should your treatment provider determine that you present an imminent danger to yourself or to an identified other person(s).

Respond to lawsuits or complaints
If you file a lawsuit or licensing board complaint about your care, and/or if a review of your care is conducted by a licensing board/professional organization, certain disclosures of health information are permitted

Business Associates
We may enter into contracts with business associates that are outside entities to provide billing, legal, auditing, and practice management services. In those situations, protected health information will be provided to those contractors as needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released or accessed by them.

Special Notes Regarding the Privacy Policies of Krupnick Counseling Associates and WorkWise Employee Assistance Program:
We will only share information about your treatment without authorization from you (including your identity) under the following conditions:
1.) We are required by law and professional ethics to report possible child abuse and/or neglect. Depending on the circumstances, reports are made to the appropriate law enforcement agency or the county social services department.

2.)We report suspected elder abuse to the relevant adult protective services agency.

3.) In cases where we are concerned about the immediate safety of clients or others, we take whatever action we deem appropriate, including contact with hospitals and law enforcement agencies.

4.) We are required by law to report danger to a place/location

5.) We are required by law to release treatment records if we receive a valid Court Order to do so, or to challenge the Court Order for certain specific reasons.

6.) Limited information about your treatment needs may be shared with your health insurer in order for treatment to be authorized and paid for.

Uses and disclosures requiring authorization
We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when we are asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We will also obtain an authorization from you before using or disclosing PHI in a way that is not described in this Notice. You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extend that (1) We have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- If you have any questions about these policies or any issues covered by the federal government's privacy notice, please speak with your therapist, our Privacy Officer (Kehle Griego), or our director, Louis Krupnick.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.Effective Date of This Notice: 10/31/2018

500 Kimbark Street, Suite 200, Longmont, CO 80501
T 303.651.1515 F 720.652.0408
E info@krupnickcounseling.com

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Client Name: ______________________________ Date of Birth: ______________

I authorize the persons, agencies, or institutions listed below to release verbal and/or written information concerning my current and/or prior medical or psychological treatment. The purpose of this release is to insure continuity of care, to aid in effective treatment, and/or to allow for consultation between professionals. I release the persons, agencies, or institutions from any and all liability for providing such information:

I authorize:	To release to:

_____ **Initial here** if you are authorizing the parties listed above to exchange information for the purposes outlined.

Please check the types of information/records you would like to have disclosed:

- Mental health treatment records/information
- Medication records
- Medical treatment records/information
- Psychological reports (including testing)
- Hospital intake/discharge summaries
- Substance abuse treatment records/information
- HIV/AIDS treatment records/information

The purpose of this disclosure is:

____

I wish to restrict my entered above in the following specific ways:

____

____

By signing below, I certify that this request has been made voluntarily, and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization in writing, at any time, except to the extent that action has already been taken to comply with this. A legible copy of this signed Authorization (e.g., transmitted via facsimile) may be used with the same effectiveness as an original. Unless the purpose of this Authorization is to determine payment of a claim or benefits, my treatment or payment for my treatment cannot be conditioned on the signing of this authorization. I understand that the information that is disclosed may be subject to redisclosure by the recipient, and is no longer protected under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

This Authorization expires one year from the date of signature below.

______________________________ ______________________________

Signature of Client Date Signature of parent/guardian Date
(if applicable)

____

Signature of witness Date

Revocation (if applicable): I hereby revoke the above Authorization.

____

Signature Date