Lisa Joyce, MA, LPC
5527 N. Union Blvd., Suite 203 Colorado Springs, CO 80918
Office (719)598-0982 Fax (719)264-7618 www.lisajoycelpc.com

FAMILY THERAPY--NEW CLIENT INFORMATION

Primary Client Name: _____ Sex: ☐M ☐F
DOB: _____ **SSN**: _____
Address: _____
City, State, Zip Code: _____

	Okay to contact you at this number?	Okay to leave a message?
Home Phone: _____	☐Yes ☐ No	☐Yes ☐ No
Cell Phone: _____	☐Yes ☐ No	☐Yes ☐ No

I give permission to leave messages with the following person(s) in the event that I am unable to take your call. Please note the Name, Relationship, and any alternate contact numbers. If none, then please note N/A and date and sign.

_____
_____

_____ _____
Client/Parent Signature **Date**

Your provider is happy to correspond via email, but it is important to know that there is no way to guarantee confidentiality when using unencrypted email addresses. If you wish to be able to communicate with your therapist via email, please provide your email address.
Email Address:
_____
Would you like to receive appointment reminders via email? ☐Yes ☐No

Preferred method of communication: ☐Home # ☐Cell phone # ☐Text msg. ☐Email

Current Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other: _____

If client is a Minor:
Parent/Guardian Name: _____ *DOB:* _____
Address (if different than client): _____
Home Phone: _____ *Cell Phone/Work Phone:* _____
Email Address: _____
Are there custody orders related to this child? __Yes ___No
If yes, who has medical decision making responsibility? _____

Emergency Contact:
Name: _____ Relationship to Client: _____ Phone Number: _____
Address: _____City, State, Zip Code _____

Other Family Members Attending Therapy:
Name: _____ DOB: _____ Relationship to client: _____
Address (if different from client):_____
City/State/Zip code:_____ Phone number: _____

Name: _____ DOB: _____ Relationship to client: _____
Address (if different from client):_____
City/State/Zip code:_____ Phone number: _____

Name: _____ DOB: _____ Relationship to client: _____
Address (if different from client):_____
City/State/Zip code:_____ Phone number: _____

Primary Insurance Information:
Insurance Provider: _____ Policy Holder: _____ DOB: _____
Policy Holder SSN: _____ Client's Relationship to Policy Holder: _____
Member ID #: _____ Group/Plan: _____
Deductible: _____ Met for this year? ☐Yes ☐ No Coinsurance: _____ Copay: _____

Secondary Insurance Information:
Insurance Provider: _____ Policy Holder: _____ DOB: _____
Policy Holder SSN: _____ Client's Relationship to Policy Holder: _____
Member ID #: _____ Group/Plan: _____
Deductible: _____ Met for this year? ☐Yes ☐ No Coinsurance: _____ Copay: _____

Please briefly describe what brings you to counseling?

_____
_____
_____
_____

HISTORY
Name and Phone Number of Primary Care Physician for each participating family member:

_____

Name and Phone Number of current Psychiatrist, if any, for each participating family member:

_____

May this provider communicate with your Physician and/or Psychiatrist regarding your treatment needs, progress and recommendations? ☐Yes ☐No

Any current or past significant health issues for any family member? _____

_____

Are you or any participating family members currently taking any medication? ☐Yes ☐No
If so, please list the family member's name, medications and dosage.

_____
_____

Have you attended counseling in the past? ☐Yes ☐No If yes, when and with whom?

_____
_____

Have you or any participating family member had any recent history of suicidal or homicidal thoughts? ☐Yes ☐No
If yes, explain: _____

_____

Any history of suicide attempts in family? ☐Yes ☐No Who? When? _____

Do you or any participating family member have any history of self harming behaviors? ☐Yes ☐No
If yes, ☐Current ☐Past Explain: _____

_____

Do you or any participating family member have any history of addictions? (alcohol, drugs, gambling, sex, etc) ☐Yes ☐ No If yes, explain: _____

_____

☐Current addiction issues ☐Past addiction issues only

Lisa Joyce, MA, LPC
Counseling and Consulting
5527 N. Union Blvd., Suite 203 Colorado Springs, CO 80918
Office (719)598-0982 Fax (719)264-7618 www.lisajoycelpc.com

CLIENT DISCLOSURE STATEMENT AND CONSENT TO TREAT

PSYCHOTHERAPY
Psychotherapy services vary depending on the client's needs, personality and the particular issue being addressed. There are different methods that may be used to address different issues. Therapy is different from other healthcare services in that it requires a very active effort on the client's part. Therapy can have benefits and risks. There are no guarantees on how therapy will impact a client.

REGULATION OF PSYCHOTHERAPISTS
The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The regulatory boards can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. 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 masters degree in their profession and have two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctorial supervision. A Licensed Social Worker must hold a masters degree in social work. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified. Any complaints filed with DORA must be done within 7 years of your last appointment or for minors, within 7 years of their 18th birthday (up to 12 years max) as your records are only retained for that length of time.

CLIENT RIGHTS AND IMPORTANT INFORMATION
1. You are entitled to receive information from me about my methods of therapy, the techniques I use, and the duration of your therapy. Please ask if you would like to receive this information. You are also entitled to information regarding fees for therapy.
2. You can seek a second opinion from another therapist or terminate therapy at any time.
3. In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Department of Regulatory Agencies.
4. Generally speaking, information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and the therapist cannot disclose the information without the client's consent. There are several exceptions to confidentiality which include: (1) I am required to report any suspected incident of child abuse or neglect to law enforcement; (2) I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (3) I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental disorder; (4) I am required to report any suspected threat to national security to federal officials; and (5) I may be required by Court Order to disclose treatment information.
5. Under Colorado law, C.R.S. § 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information. If you request treatment information from me, I may provide you with a treatment summary, in compliance with Colorado law and HIPAA Standards.

CONSULTATION AND COVERAGE
Lisa Joyce, MA, LPC operates as a collaborative group practice with multiple clinicians. To ensure the highest level of treatment and availability for our clients, we do provide crisis coverage for each other and regularly participate in professional consultation. All of our therapists are held to the same confidentiality restrictions as required by law.

PROFESSIONAL FEES
Regular fee for services is $120 for the initial intake session, $100 per individual session (45-60 minutes) or couples/family session (45-55 minutes). All fees are due at the time services are rendered and a $35 fee will be assessed for any returned checks. Clients will also be responsible for a fee of $75 if they request that their therapist complete any disability related paperwork. Lisa Joyce, MA, LPC reserves the right to refuse services if your account is past due. Lisa Joyce, MA, LPC also reserves the right to use the services of a collection agency for collection of fees on delinquent accounts, and only information pertinent to fee collection will be disclosed. A $50 fee will be assessed for any missed appointments or group sessions if the client fails to cancel the appointment with at least 24 hours notice, unless due to an emergency. This fee is NOT billable to insurance and is the client's responsibility.

COURT DIRECTED TREATMENT OR EVALUATIONS, TESTIMONY AND COURT REPORTS
If your treatment is related to court involvement, or you are planning to request that your treatment information be provided to the court, there are additional things you need to be aware of. If you are COURT ORDERED to participate in treatment or evaluation, your compliance with treatment can be released to the court without further release from you. If you are not court ordered to attend treatment, but would like Lisa Joyce, MA, LPC to submit treatment reports to the court, or provide court testimony on your behalf, you (if individual therapy) or ALL FAMILY MEMBERS (if family therapy) must sign a release of information. Any report writing will be billed to you at a rate on $200 per hour, and is not covered by insurance. If your counselor is requested to testify, or required to respond to a subpoena for testimony, you will be charged $200 per hour, which will be billed for the entire amount of time required to include

court preparation, travel time, time waiting in court, and time testifying. For these requests, Lisa Joyce, MA, LPC requires that you have a signed credit card authorization on file to cover all costs.

APPOINTMENTS AND CANCELLATION POLICY
Current clients are welcome to schedule their own appointments either by phone, email, or online via our website at www.lisajoycelpc.com. All clients are expected to provide at least 24 hours notice if you need to cancel or change an appointment. If you fail to provide 24 hours notice, you will be assessed a $50 missed appointment fee. This fee is strictly enforced and must be paid before your next scheduled appointment.

Because of the importance of a client's commitment to their own treatment and out of respect for our therapists, clients who fail to provide 24 hours notice for cancellations or who fail to attend their appointments with no notice more than two times in any 60 day period may have services discontinued through Lisa Joyce, MA, LPC and be referred out to another provider or agency.

CONTACTING YOUR THERAPIST AND EMERGENCIES
Due to the nature of the business, your therapist may not be immediately available by telephone. Clients are always welcome to leave a message on the confidential voicemail, which is checked frequently. If it is more urgent, clients may contact their therapist via cell phone (listed at the top of this form). If it is an emergency and you are unable to reach your therapist or cannot wait for a return call, clients should contact the local crisis center at 635-7000 or call 911.

INFORMATION SHARING IN FAMILY THERAPY
Lisa Joyce, MA, LPC conducts family therapy with an understanding and agreement that your counselor will not be asked or expected to keep secrets between family members. To that extent, if it is determined that it would be beneficial for any family members to meet with your counselor individually as part of treatment, it must be understood that this will not constitute and individual therapy relationship with any expectation of confidentiality from the family therapy setting, and information shared in an individual setting will be used as deemed therapeutically beneficial as part of the treatment of the family as a whole.

If at any time there is a request made for release of family therapy records, all individuals participating in family therapy must sign a release of information before records can be released.

CONSENT TO TREAT

I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree (or agree for my child) to undertake therapy with Lisa Joyce, MA, LPC. I accept financial responsibility for all services rendered, and for any no show or late cancellation fees incurred by me (or my child).

All Clients 15 or older:

_____ _____
Client Signature (15 or older) Date

_____ _____
Client Signature (15 or older) Date

_____ _____
Client Signature (15 or older) Date

If clients is 14 or younger:
Children's Names: _____
_____I attest that I have legal custody and authority to consent to treatment on behalf of my children listed above. (Biological parents that are married, no legal determination of decision making/custody, legal determination of FULL medical decision making responsibility, etc.)
_____I attest that I have JOINT MEDICAL DECISION MAKING, shared with my children's other parent.
If joint decision making, it is recommended that authorization for treatment be obtained from both parents.
Other Parent Name: _____
Other Parent Address: _____ Phone:_____
_____I attest that I am not these children's parent, but have been granted legal authority to consent to treatment for this child (e.g. Social Services Representative). Custody vests with : _____

_____
Parent/Guardian Name (Print) Signature Date

_____
Parent/Guardian Name (Print) Signature Date

NOTICE OF PRIVACY RIGHTS (HIPAA)

I received a copy of this statement and have received the agency's Notice of Privacy Rights.

_____ _____

Client/Parent Signature Date

_____

Client Representative (sign, print, and list relationship to client)

INSURANCE/COMMUNITY RESOURCE/AGENCY BILLING

If you are using your insurance benefits or other community resource for the services being provided by Lisa Joyce, MA, LPC, please be aware that certain Protected Health Information must be released to your insurance company in order to submit billing claims, and that your insurance company may request supporting documentation including your diagnosis and treatment notes. It is the client's responsibility, not the providers, to verify insurance coverage and limitations (such as number of allowed sessions). Clients are responsible for any claims that are denied or otherwise not covered by insurance.

I agree to the release of Personal Health Information to my current insurance provider (name of carrier: _____) for the purpose of claims and billing. If I change insurance, this consent will continue for the new carrier unless I specifically revoke consent.

_____ _____

Client/Parent Signature Date

APPOINTMENTS AND CANCELLATION POLICY

Current clients are welcome to schedule their own appointments either by phone, email, or online via my website at www.lisajoycelpc.com. All clients are expected to provide at least 24 hours notice if you need to cancel or change an appointment. ***If you fail to provide 24 hours notice, you will be assessed a $50 missed appointment fee. This fee is strictly enforced and must be paid before your next scheduled appointment.***

If you miss your appointment and normally have a standing appointment time, be aware that you may lose that time slot. This is particularly important to remember if you have a high demand time slot, such as afterschool or evenings. Likewise, if I have a waiting list, more than 2 late cancellations or missed appointments may result in your slot being given away and you may have to go back on the waiting list before you can be rescheduled.

This cancellation policy applies for individual, family and group appointments. For group members, if you miss more than 2 consecutive groups, your slot in the group may be filled. Any late cancellation fees must be paid before any further appointments will be rescheduled. Payments can be made through my website www.lisajoycelpc.com

I have been advised of the late cancellation and missed appointment policy and agree to abide by this policy.

_____ _____

Client/Parent Signature Date

Credit Card Authorization

It is requested that all clients keep a credit card on file to cover session fees, co-pays and deductibles. Session fees and no-show/late cancellation fees will typically be charged to the card within a week of when the service was provided or as soon as claim is processed by your insurance company.

If you choose not to keep a card on file, all copays and missed appointment fees must be paid before your next appointment. Fees can be paid in person or by credit card through my website www.lisajoycelpc.com.

Credit Card Information

Cardholder Name: _____

Card Type: ☐Mastercard ☐Visa ☐Other: _____

Card #: _____ Exp. Date: ____/____

Billing Zip Code: _____ CVV code (on back of card): _____

If you would like a copy of your receipt emailed to you, please list your email address:

_____

I authorize Lisa Joyce, MA, LPC to retain my card information for the purpose of payment for ongoing therapeutic services, no show/late cancellation fees, and any fees that are not reimbursed by my insurance carrier. I understand that my payment method can be discontinued or changed at any time by notifying your therapist by email or in writing. I know that if my credit card is declined, I am obligated to arrange an alternate method of payment for services rendered.

Cardholder Signature: _____ Date: _____

HIPAA Omnibus Notice of Privacy Practices
Revised 2013

(Effective as of 3/26/2013)

Lisa Joyce, MA, LPC
5527 N. Union Blvd., Suite 203
Colorado Springs, CO 80918
719-598-0982

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

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

During the process of providing services to you, LISA JOYCE, MA, LPC will obtain, record, and use mental health and medical information about you that is protected health information. Ordinarily, that information is confidential and will not be used or disclosed, except as described below.

I. USES AND DISCLOSURES OF PROTECTED INFORMATION

A. General Uses and Disclosures Not Requiring the Client's Consent. LISA JOYCE, MA, LPC will use and disclose protected health information (PHI) in the following ways.

1. ***Treatment.*** Treatment refers to the provision, coordination, or management of health care [including mental health care] and related services by one or more health care providers. For example, LISA JOYCE, MA, LPC's staff involved with your care may share your information to plan your course of treatment, coordinate care and consult with other staff, your primary care physician, psychiatrist or another provider to whom you have been referred to ensure the most appropriate methods are being used to assist you.

2. ***Payment.*** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, LISA JOYCE, MA, LPC will use your information to develop accounts receivable information, bill you, and with your consent, provide information to your insurance company for services provided. The information that identifies you, as well as your diagnosis, type of service, date of service, provider name/identifier, and other information about your condition and treatment.

3. ***Health Care Operations.*** Health Care Operations refers to activities undertaken by LISA JOYCE, MA, LPC that are regular functions of management and administrative activities. These activities include, but are not limited to, quality assessment, employee review, training of counseling/social work students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to counseling/social work students that see patients at our office. We may also call you by name in the waiting room when your counselor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

4. ***Contacting the Client.*** LISA JOYCE, MA, LPC may contact you to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.

5. ***Required by Law.*** LISA JOYCE, MA, LPC may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

6. ***Health Oversight Activities.*** The Center will disclose protected health information to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, regulatory programs or determining compliance with program standards.

7. ***Crimes on the premises or observed by LISA JOYCE, MA, LPC's Personnel.*** Crimes that are observed by LISA JOYCE, MA, LPC's staff, that are directed toward staff, or occur on LISA JOYCE, MA, LPC's premises will be reported to law enforcement.

8. ***Business Associates.*** Some of the functions of LISA JOYCE, MA, LPC's practice are provided by contracts with business associates. For example, some administrative, clinical, quality assurance, billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services. In those situations, protected health information will be provided to those contractors as is needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.

9. ***Research***. LISA JOYCE, MA, LPC may use or disclose protected health information for research purposes if the relevant limitations of the Federal HIPAA Privacy Regulation are followed. 45 CFR § 164.512(i).

10. ***Involuntary Clients.*** Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.

11. ***To Notify and/or Communicate with your Family.*** Unless you tell us you object, we may use or disclose your health information in order to notify your family or assist in notifying your family, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in any communication with your family and others.

12. ***Record Storage.*** LISA JOYCE, MA, LPC maintains client health records electronically. All protected health information is stored on a secure, HIPAA compliant storage database. Any potential breaches to the security of the electronic records will be reported to clients.

13. ***Emergencies.*** In life threatening emergencies, LISA JOYCE, MA, LPC staff will disclose information necessary to avoid serious harm or death.

B. Client Authorization or Release of Information.

1. LISA JOYCE, MA, LPC may not use or disclose protected health information in any other way without a signed authorization or release of information. When you sign an authorization, or a release of information, it may later be revoked, provided that the revocation is in writing. The revocation will apply, except to the extent LISA JOYCE, MA, LPC has already taken action in reliance thereon.

2. No uses or disclosures may be made without an individual authorization for a purpose that is not explicitly described in the NPP.

3. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

II. YOUR RIGHTS AS A CLIENT

The following are statements of your rights with respect to your protected health information.

A. **You have the right to inspect and copy your protected health information (fees may apply) –** Pursuant to your written request**,** you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

B. **You have the right to request a restriction of your protected health information –** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician/counselor/social worker <u>is not</u> required to agree to your requested restriction except if you request that the physician/counselor/social worker not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

C. **You have the right to request to receive confidential communications –** You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

D. **You have the right to request an amendment to your protected health information –** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

E. **You have the right to receive an accounting of certain disclosures –** You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

F. **You have the right to receive notice of a breach** – We will notify you if your unsecured protected health information has been breached.

G. **You have the right to obtain a paper copy of this notice** from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

III. ADDITIONAL INFORMATION

A. **Privacy Laws**. The Center is required by State and Federal law to maintain the privacy of protected health information. In addition, LISA JOYCE, MA, LPC is required by law to provide clients with notice of its legal duties and privacy practices with respect to protected health information. That is the purpose of this Notice.

B. **Terms of the Notice and Changes to the Notice**. LISA JOYCE, MA, LPC is required to abide by the terms of this Notice, or any amended Notice that may follow. The Center reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all protected health information that it maintains. When the Notice is revised, the revised Notice will be posted in the Center's service delivery sites and will be available upon request.

C. **Complaints Regarding Privacy Rights.** If you believe LISA JOYCE, MA, LPC has violated your privacy rights, you have the right to complain to Center management. To file your complaint, call **Lisa Joyce at 719-598-0982**. You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 515F, HHH Bldg., Washington, D.C. 20201. It is the policy of the Center that there will be no retaliation for your filing of such complaints.