**Phil Stone LCSW**
4 WEST DRY CREEK CIRCLE 2ND FL LITTLETON CO 80120
Phone: 720-619-0968 Web: Philjstone.com

# Patient Registration Form

**Therapist:** PHIL STONE LCSW

## Patient Demographic Information

## Diagnosis Code:

| Patient Name: | Social Security #: |
|---|---|
| Address: | Date of Birth: |
| | Gender: |
| Cell Phone: | Messages OK? ❑ YES ❑ NO |
| Work Phone: | Messages OK? ❑ YES ❑ NO |
| Other Phone: | Messages OK? ❑ YES ❑ NO |
| Email Address: | Primary Physician: |
| Primary Physician: | Psychiatrist (if any): |
| Emergency Contact Person: | Emergency Contact Phone: |
| How did you hear about us? | Marital Status: |

**Responsible Party is the person who will be paying the per-session fee for services (leave blank if same as patient)**

| Responsible Party: | Cell Phone: |
|---|---|
| Responsible Party Address: | Work Phone: |
| | Other Phone: |
| Relationship to Patient: | Responsible Party SSN: |

## Insurance Information

| Primary Insurance: | Policy Holder Name: |
|---|---|
| Insurance Company Address: | Policy Holder Date of Birth: |
| | Identification Number: |
| Insurance Company Phone: | Policy/Group Number: |
| Primary Insured's Employer: | Policy Holder SSN: |

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## Secondary Insurance Information

| | |
|---|---|
| **Secondary Insurance:** | **Policy Holder Name:** |
| **Insurance Company Address:** | **Policy Holder Date of Birth:** |
| | **Identification Number:** |
| **Insurance Company Phone:** | **Policy/Group Number:** |
| **Secondary Insured's Employer:** | **Policy Holder SSN:** |

## Authorization Information – Please call and Verify Your Benefits

| | |
|---|---|
| **Primary Insurance:** | **Phone#:** |
| **Visits Authorized:** | **Copay:** |
| **Member ID#:** | **Group Number:** |
| **Authorization #:** | **Client Number:** |

By signing below, I agree to the following: (1) I understand that the client is ultimately responsible for the cost of all services rendered. (2) As a service to me, Westside Behavioral Care, Inc. may bill my insurance company on my behalf. However, I am responsible for verifying insurance coverage and obtaining any necessary pre-authorization. If I fail to do so, I will pay the provider's full customary fees for all services rendered. (3) I authorize the release of any information necessary to process insurance claims (4) I authorize my insurance company to pay Westside Behavioral Care, Inc. directly for the services provided to the client. (5) I will pay the appropriate co-payment or co-insurance to the provider at the time service is rendered. (6) I understand that I will be billed for missed appointments that are not cancelled at least 24 hours in advance and that I am responsible for paying those charges.

| | |
|---|---|
| **Patient Name:** | **Social Security #:** |
| **Address:** | **Date of Birth:** |
| | **Gender:** |
| **Cell Phone:** | **Messages OK?** ❑ **YES** ❑ **NO** |
| **Work Phone:** | **Messages OK?** ❑ **YES** ❑ **NO** |
| **Other Phone:** | **Messages OK?** ❑ **YES** ❑ **NO** |
| **Email Address:** | **Primary Physician:** |
| **Primary Physician:** | **Psychiatrist (if any):** |
| **Emergency Contact Person:** | **Emergency Contact Phone:** |
| **How did you hear about us?** | **Marital Status:** |

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**Responsible Party is the person who will be paying the per-session fee for services (leave blank if same as patient)**

| | |
|---|---|
| **Responsible Party:** | **Cell Phone:** |
| **Responsible Party Address:** | **Work Phone:** |
| | **Other Phone:** |
| **Relationship to Patient:** | **Responsible Party SSN:** |

## Insurance Information

| | |
|---|---|
| **Primary Insurance:** | **Policy Holder Name:** |
| **Insurance Company Address:** | **Policy Holder Date of Birth:** |
| | **Identification Number:** |
| **Insurance Company Phone:** | **Policy/Group Number:** |
| **Primary Insured's Employer:** | **Policy Holder SSN:** |

## Secondary Insurance Information

| | |
|---|---|
| **Secondary Insurance:** | **Policy Holder Name:** |
| **Insurance Company Address:** | **Policy Holder Date of Birth:** |
| | **Identification Number:** |
| **Insurance Company Phone:** | **Policy/Group Number:** |
| **Secondary Insured's Employer:** | **Policy Holder SSN:** |

## Authorization Information / Benefits Info

| | |
|---|---|
| **Primary Insurance:** | **Phone#:** |
| **Deductible** | |
| **Co-Insurance** | |

| **Out of Pocket Maximum** | |
|---|---|
| **Co Pay** | |
| **Authorization #:** | |

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| **Client Signature**<br>Typing your name is equivalent to signature | |
|---|---|
| **Date:** | |

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## RECEIPT OF CONSENTS / POLICIES AND PROCEDURES

Please sign below that you have reviewed the Consents, Disclosures, and Policies Forms.

______________________________________________________

PATIENT NAME PRINTED

______________________________________________________

SIGNATURE Typing your name is equivalent to signature DATE/TIME

If you are consenting to therapy for a minor, please sign below:

______________________________________________________

PARENT/GUARDIAN NAME PRINTED RELATIONSHIP TO PAIENT

______________________________________________________

SIGNATURE Typing your name is equivalent to signature DATE/TIME

empathy
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# Credit / Debit Card Payment Consent Form

| | |
|---|---|
| **Client Name:** | |
| **Card Number:** | |
| **Name on Card:** | |
| **Good Through:** | |
| **CCV: (3 digit code on back)** | |
| **Zip Code of the Card:** **(Your Home Zip Code)** | |

I authorize ______Phil Stone LCSW______ to charge my credit/debit/health account card for professional services 24 hours before our scheduled appointment. If I do not cancel before 24 hours, I recognize that ______Phil Stone LCSW______ will charge my card as a late cancel or no show if I do not show up for the appointment. I will be billed for a charge of ($50 – Individual $75 – Couples $25 - Group).

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

| | |
|---|---|
| **Client Signature** Typing your name is equivalent to signature | |
| **Date:** | |

Please sign below that you have reviewed the Consents, Disclosures, and Policies Forms.

________________________________________________________

PATIENT NAME PRINTED

________________________________________________________

SIGNATURE Typing your name is equivalent to signature DATE/TIME

If you are consenting to therapy for a minor, please sign below:

________________________________________________________

PARENT/GUARDIAN NAME PRINTED RELATIONSHIP TO PAIENT

________________________________________________________

SIGNATURE Typing your name is equivalent to signature DATE/TIME

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| **Client Name:** | |
|---|---|
| **Card Number:** | |
| **Name on Card:** | |
| **Good Through:** | |
| **CCV: (3 digit code on back)** | |
| **Zip Code of the Card:** <br> **(Your Home Zip Code)** | |

I authorize ______Phil Stone LCSW______ to charge my credit/debit/health account card for professional services 24 hours before our scheduled appointment. If I do not cancel before 24 hours, I recognize that ______Phil Stone LCSW______ will charge my card as a late cancel or no show if I do not show up for the appointment. I will be billed for a charge of ($50 – Individual $75 – Couples $25 - Group).

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

| **Client Signature** <br> Typing your name is equivalent to signature | |
|---|---|
| **Date:** | |

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# Consent, Disclosure, & Policies Form

Welcome to Phil Stone LCSW and Emp3thy Counseling. We are required by the State of Colorado and the Department of Regulatory Agencies to share the following information with you to help establish the understanding and trust essential to a therapeutic relationship. Please provide the requested information and read these documents carefully, as they contain important information about our practice, policies, and how your mental health information can be used and disclosed. Please note any questions or concerns that you have—you may discuss these with your therapist at any time. After you sign the enclosed documents, they will constitute a binding agreement between you, and your therapist Phil Stone LCSW.

**SPECIAL INSTRUCTIONS REGARDING CHILDREN & TEENS IN THERAPY:** Any child under the age of fifteen (15) years of age must have a parent or legal guardian consent to the mental health services to be provided. Parents of teens 15-18 may also consent to mental health services on behalf of their child (this is the recommended course of action if parents are paying for the services and/or if they want to communicate with the therapist about the services provided). Any child fifteen (15) years of age or older may sign the below form and consent to mental health services without the consent of a parent or legal guardian. If the parent or legal guardian is consenting to the mental health services, the required disclosures shall be made to the parent or legal guardian. If the child is consenting to mental health services, the required disclosures shall be made to the child. If a parent or legal guardian is consenting to mental health services for his/her minor child, and the parent or legal guardian is divorced or separated, the parent is required to provide a copy of the Court Order and/or Custody Agreement that grants the parent or legal guardian authority to consent to mental health services. Failure to provide a copy of the Court Order or Custody Agreement will result in immediate termination of therapy. **It is solely your responsibility to provide this information to your therapist.**

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## PART 1: INFORMED CONSENT

As a collaborative process, therapy requires your very active effort, honesty, and openness in order to achieve desired changes. You may also be contacted periodically by Phil Stone LCSW to get feedback on the quality of services you are receiving. You may always request that Phil Stone LCSW not contact you to receive feedback on the quality of services you receive.

The process of engaging in therapy can result in your experiencing considerable emotional discomfort. Your therapist may challenge your perceptions or propose ways of handling situations that can cause you to feel some distress. Attempting to resolve therapeutic issues may result in changes that were not originally intended. Therapy may also result in decisions that may be positive for one family member, but could be viewed negatively by another. Change will sometimes be easy and swift; other times it will be slow and even frustrating. There is no guarantee that therapy will yield the intended results. At all times, it is your decision whether to pursue the suggestions made by your therapist. It is always your responsibility, not your therapist's, to make decisions regarding relationships such as cohabitation, marriage, divorce, separation, reconciliation, custody, etc.

You are entitled by law to receive information about the methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure. During the course of therapy, your therapist at Phil Stone LCSW is likely to draw on various therapeutic approaches according, in part, to the problem that is being treated and the therapist's assessment of what will best benefit you. Within a reasonable period of time after the initiation of treatment, your therapist will be able to offer you some impressions of what your therapy will include. You should also make your own assessment about whether you feel comfortable working with your therapist. If you have any questions about the process of therapy, please let your therapist know directly.

The most common reason for ending therapy is that a client's concerns have been addressed. You are entitled to end therapy or seek a second opinion from another therapist at any time. Most clients find it helpful to have one or two sessions to bring closure to therapy and discuss the therapeutic process. These sessions can help prevent future problems. Therapy can also end when your challenges lie beyond the limits of your therapist's ability to help. If this becomes apparent to your therapist at any point, your therapist is legally required to refer, terminate, or consult, and will discuss this with you, offer you appropriate referrals, and end treatment.

**By signing this document**, you affirm your understanding that should you discontinue therapy for more than 60 days without written notice to PHIL STONE LCSW, your treatment will be considered "terminated." You may resume therapy anytime after the 60-day period by communicating your decision to resume therapy services to PHIL STONE LCSW. This document may remain in effect should you resume therapy if one (1) year has not elapsed since your last session. However, you may be asked to re-sign this document or provide additional information to update your client records and/or sign new forms. "Discontinuing therapy" means that you have not had a session with your therapist for at least sixty (60) days.

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# PART 2: DISCLOSURE STATEMENT (Degrees & Licensing)

**Phil Stone:** *Degrees:* University of Louisville, Kent School of Social Work MSW 1996. Indiana University B.A. in Telecommunications. *License:* Licensed Clincial Social Worker: CSW 00000427. 10 Day Intensive Training University of Washington 2007. Transactional Analysis Training 1997-1997, Chapel Hill NC.

**Regulation of Psychotherapists in Colorado:** The Colorado Department of Regulatory Agencies (DORA), Division of Professions and Occupations ("DOPO") has the general responsibility of regulating the practice of licensed psychologists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, certified school psychologists, and unlicensed individuals who practice psychotherapy. The agency within DORA that has responsibility specifically is the Mental Health Section, 1560 Broadway, Suite #1350, Denver, CO 80202, (303) 894-2291;

DORA_MentalHealthBoard@state.co.us. Specifically the State Board of Marriage and Family Therapist Examiners regulate Licensed Marriage and Family Therapists; the State Board of Social Work Examiners regulates Social Workers; and the State Board of Licensed Professional Counselor Examiners regulates Licensed Professional Counselors and all State Boards may be reached at the address listed above. Clients are encouraged, although not required, to resolve any grievances through our internal process.

Levels of Regulation Include: licensing (requires minimum education, experience, and examination qualifications), Certification (requires minimum training, experience, and for certain levels, examination qualifications), and Registered Psychotherapist (does not require minimum education, experience, or examination qualifications.) All levels of regulation require passing a jurisprudence take-home examination. The following are the requirements for each type of Mental Health Professional: *Certified Addiction Counselor I (CAC I)* must be a high school graduate, complete required training hours and 1,000 hours of supervised experience. *Certified Addiction Counselor II (CAC II)* must complete additional required training hours and 2,000 hours of supervised experience. *Certified Addiction Counselor III (CAC III)* must have a bachelor's degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience. *Licensed Addiction Counselor* must have a clinical master's degree and meet the CAC III requirements. *Licensed Clinical Social Worker* must hold a masters degree in social work. *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. *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-doctoral supervision. Registered psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.

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# PART 3: PAYMENT POLICIES

**PAYMENT AND FEES:**

- **Phil Stone:** $100 per 45-minute session (prorated at $25 for each additional 10 minutes)
- ***You are expected to pay the full fee (as listed above) at each session, unless other arrangements have been made. If longer sessions occur, the fee will be prorated for each additional 10 minutes, as indicated above*.All payments should be made directly to *Phil Stone LCSW.*** Credit Card information collected over the phone when you scheduled your first appointment may be used to collect payment after your session, or in the event of a late cancelation/no-show.
- Additional services will also be prorated at the fees listed above. Such additional services may include, but are not limited to, preparation of reports, correspondence, travel time, and phone calls lasting over 10 minutes. Acceptable forms of payment are cash, check, or any major debit/credit card. If your check bounces, you will be charged an additional $10 to cover bank fees. Please notify your counselor if any problem arises regarding your ability to make payments. **Any court/legal appearances will be billed at $300 per hour, which includes but is not limited to:** testimony related matters like case research, report writing, travel, depositions, testimony, cross examination time, and courtroom waiting time.

**Cancellation and No-Shows:** Since your appointments involve the reservation of time specifically for you, and out of respect for your therapist, a minimum of 24 hours' notice is required for rescheduling or canceling an appointment, excluding emergency situations. **Anytime you fail to attend a scheduled appointment without giving any notice of cancellation, you will be charged the full fee amount of your session. The first session that is missed by cancelling within the 24-hour window will be charged a $50 fee. After that, a full fee will be charged for each cancellation within the 24-hour window**. Repeated cancellations (more than two) without the required 24 hours' notice may result in the termination of therapy. Multiple no-shows will result in the termination of therapy. Although PHIL STONE LCSW may send clients email reminders about upcoming appointments, this is done as a courtesy and only if you consent to receive such communications via email. It remains your sole responsibility to keep track of and attend all scheduled therapy appointments, whether or not you receive the email reminder.

**Overdue Payment:** If your account is more than 30 days overdue and suitable arrangements have not been agreed to, PHIL STONE LCSW may become obligated to turn past due accounts over to collection agencies or small claims court (If such legal action is necessary, the costs of bringing that proceeding will be included in the claim). PHIL STONE LCSW will provide the collection agency/ Court with information requested by the collection agency/Court necessary to collect the past due account.

**Third Party Payments (by Clergy or other family members):** When clergy or other family members offer to pay, in full or in part, for the services you receive at PHIL STONE LCSW, you may be asked to make a copayment at the time of each session. **If the third party is unable to pay for any reason, you remain personally responsible for the full fee. Any cancellation/no-show fees will be charged directly to you.** If you do not have a co-payment, PHIL STONE LCSW will still collect your credit/debit card information before or at the first session to enable timely payment for any cancellation/no-show fees. If a third party is making a payment on your

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behalf, Phil Stone LCSW will not disclose confidential information to the third party without your written consent.

**Insurance:**

As Phil gets credentialed with all the major medical insurances we are offering an introductory Co-Pay only program to begin therapy. Once Phil is credentialed with all the major medical insurances, we will then put in an Authorization for Outpatient Therapy. Note: Phil is currently paneled with Cigna and can process these claims as usual.

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# PART 4: OFFICE POLICIES

**Phone Contact:** It is PHIL STONE LCSW's policy to try to return all telephone messages by the following business day, although that may not always be possible. Our therapists check their messages a few times a day, though rarely during non-business hours. They may not be available to converse or check messages on weekends, holidays, and when they are out of town. Messages left during these times will be returned in a prompt manner when the therapist returns to work. PHIL STONE LCSW only provides non-emergency services by scheduled appointment. *<u>**Please note that therapeutic calls lasting 10 minutes or longer are billed pro-rated at the regular fee**</u>**.**

**Teletherapy:** Phil Stone LCSW will provide Tele-Therapy or Video Therapy upon your request (via Phone, FaceTime, V-See or Skype). This can be an effective alternative to save in travel time. State of Colorado Law requires that the first session be in person and every session thereafter can be Tele-Therapy. Note: Your Insurance may or may not reimburse for this service and as a result it may become a Private Pay arrangement of a discounted rate of $75 per 45 minute hour.

**Texting/Messaging Policy:** Phil will allow for brief Text messages regarding re-scheduling appointments or business matters. For secure Text Messaging Options, Phil will be getting set up on TalkSpace.com in the near future (a membership driven unlimited texting site).

**Email Policy:** Please use discretion in deciding whether to communicate with your therapist via email. PHIL STONE LCSW cannot be held responsible for any information lost in transit or viewed by a third party. Email should *only* be used for brief, general questions (e.g., questions regarding billing or advance scheduling of appointments). Hence, therapeutic issues, emergencies, sensitive personal information, and cancellations should all be communicated to your therapist <u>only over the telephone or in person</u>. Although confidentiality cannot be guaranteed when using email communications, confidentiality will extend to information obtained through email communication.

**Social Media Policy:** Please do not request your therapist and/or PHIL STONE LCSW to "follow" or "friend" you etc. via any social media. Any such request will be denied in order to maintain professional boundaries. Do not use wall postings, @replies, or other means of engaging with your therapist and/or PHIL STONE LCSW in public online if you have an already established client/therapist relationship with a therapist at PHIL STONE LCSW. Engaging in this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. Although PHIL STONE LCSW may have a business Facebook Page, Blog, or other business social media accounts, there is no requirement that you "like" or "follow" PHIL STONE LCSW on social media. If you choose to "like", "follow", or post comments on PHIL STONE LCSW's social media accounts/blog, there is the chance that others will see your name associated with PHIL STONE LCSW. Any comments you post regarding therapeutic work between you and your therapist will be deleted as soon as possible after PHIL STONE LCSW becomes aware of such posts. By signing this form, you agree that you will refrain from discussing, commenting, and/or asking therapeutic questions via any social media platform. You agree that will not use social media to communicate any therapeutic comments and/or questions to PHIL STONE LCSW therapists.

**Emergencies:** Phil Stone LCSW does not provide emergency care or crisis services. Our therapists are often not immediately available by telephone. They do, however, check periodically for telephone messages. *If you need to talk to someone immediately and are having an emergency,* **call 911** or the 24-hour Rocky Mountain Crisis Center at **1-844–493–TALK** (8255)**,** or **go to your nearest hospital emergency room.** You are solely responsible for all costs arising from such care.

**Litigation Limitations:** If you are involved in divorce/custody litigation, your therapist's role is not to make recommendations to the court concerning custody or parenting issues. The court can appoint professionals to conduct an investigation/evaluation and make recommendations to the court in the best interest of your children. Any request to testify / participate in any litigation will be charged directly to the client/s at $250/hour, as stated previously.

**Electronic Records:** Phil Stone LCSW may keep and store records for each client electronically on PHIL STONE LCSW's computers and some mobile devices. In order to maintain security, Phil Stone LCSW employs the use of passwords and encryption methods to protect computers from unauthorized access. In addition, Phil Stone LCSW may also use electronic backup or storing systems either by using external hard drives, thumb drives or similar methods, or on a cloud-based service. The cloud-based records system PHIL STONE LCSW uses is therapynotes.com. This is to help prevent the loss or damage of records. PHIL STONE LCSW maintains the security of these backup devices through HIPAA compliant encryption and passwords. The cloud-based backup and storing systems means that the backups are stored on computers that are connected to the internet. In order to maintain security of these backups PHIL STONE LCSW has employed the following procedures: (1) Entered into a HIPAA Business Associates Agreement with the cloud-based company. Because of this Agreement, the company is obligated by federal law to protect these backups from unauthorized use or disclosure; (2) The computers on which these backups are stored are kept in secure data centers, where various security measures are used to maintain the protection of the computers from physical access by unauthorized persons; (3) The company employs various security measures to maintain the protection of these backups from unauthorized use or disclosure; (4) Other individuals may have access to these backups such as Company's workforce members in order to maintain the system itself, and federal law protecting the backups extends to these workforce members.

**Maintenance of Client Record**
As a client, you may request a copy of your Client Record at any time. In accordance with the Rules and Regulations outlined by DORA, PHIL STONE LCSW will maintain your client record (consisting of disclosure statement, contact information, reasons for therapy, notes, etc.) for a period of seven (7) years after the termination of therapy or the date of our last contact, whichever is later. PHIL STONE LCSW cannot guarantee a copy of your Client Record will exist after this seven-year period.

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# PART 5: CONFIDENTIALITY

Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the therapist is a certified school psychologist, a licensed social worker, a licensed marriage and family therapist, a licensed professional counselor, a licensed psychologist, or a registered psychotherapist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent. Information disclosed to a licensed marriage and family therapist, a licensed social worker, a licensed professional counselor, a licensed psychologist, a registered psychotherapist, or a certified/licensed addition counselor is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

**Exceptions to this general rule of confidentiality** are in C.R.S. §12-43-218. Such situations in which the law requires disclosure include, but are not limited to the following:

1. Your therapist is required to report any suspected incident of child abuse or neglect to law enforcement and/or the appropriate agency.
2. Your therapist is required to report any suspected abuse or exploitation of an at-risk elder or the imminent risk of abuse of exploitation.
3. Your therapist is required to report any threat of imminent physical harm by a client, including the harm to a child, to law enforcement and to the person(s) threatened.
4. Your therapist is required to initiate a mental health evaluation of a client who is imminently dangerous to self or others, including the harm of a child, or who is gravely disabled as a result of a mental disorder.
5. Your therapist is required to report if he/she determines you are a danger to yourself or others, including those identifiable by their association with a specific location or entity.
6. Your therapist is required to report any suspected threat to national security to federal officials.
7. Disclosure may be required pursuant to Court Orders. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the therapy records and/or testimony by your therapist.
8. Disclosure may be required during the course of supervision or consultation, the investigation of a complaint or civil suit filed against your therapist or PHIL STONE LCSW, or if otherwise ordered by a court of competent jurisdiction.
9. Your therapist will advise you of other situations where the law requires disclosure, should the situation arise. Provisions concerning disclosure of confidential communications do not apply to any delinquency or criminal proceedings, except as provided in C.R.S. §13-90-107

**You should also be aware of the following additional Confidentiality Policies of Phil Stone LCSW:**

- **Consultation:** In order to provide the best possible therapy treatment, your therapist consults on occasion with other professionals, such as an attorney or supervisor, concerning his/her clients. In addition, the therapists at PHIL STONE LCSW may consult with each other. The same confidentiality laws listed above bind all professionals with whom your therapist consults. The minimum amount of information necessary to consult will be disclosed. Signing this form gives your therapist permission to consult as needed to provide professional services to you. **Consultation with Psychiatrists/Medical Professionals:** If a psychiatrist or other medical professional is also seeing you for issues regarding or relating to your mental health, it is PHIL STONE LCSW's policy to require a written authorization for your therapist to exchange information regarding your mental health treatment. If this is not a suitable arrangement for you, your therapist will assist you by offering referrals for you to be seen elsewhere.
- **In couples & family therapy, when different people are seen individually,** your therapist will use his/her clinical judgment when revealing information disclosed in individual

sessions. Should you reveal a "secret" to your therapist that you refuse to disclose to the others, and harms the therapeutic process, your therapist will terminate therapy.

- **In accordance with Colorado Law (C.R.S. § 14-10-123.8), if therapy is provided for a minor child/children,** parents or other guardians, who have been allocated parental responsibilities, shall not be denied the right to mental health treatment information concerning their minor children, unless the courts have restricted access to such information, or unless otherwise restricted by the rules and regulations of the state of Colorado. If you request treatment information from PHIL STONE LCSW, your therapist may provide you with a treatment summary, in compliance with Colorado law and HIPAA standards. Pro-rated fees may be charged for the time spent preparing such reports. **You agree, by signing this form, to keep your therapist informed of any proceedings or supplemental court orders and/or custody agreements that affect your parenting rights, custody arrangements, and decision-making authority.** Failure to do so may result in termination of therapy. It is solely your responsibility to provide this information to your therapist.
- If you see someone you know in the waiting room, please respect their confidentiality.
- Considering all of the above exclusions, upon your written request Phil Stone LCSW will release information to any agency/person you specify unless your therapist and/or PHIL STONE LCSW concludes that releasing such information might be harmful. Records will only be released to outside parties when PHIL STONE LCSW is authorized to do so, in writing, by every member of the couple/family in treatment legally able to execute a waiver.
- This form is compliant with HIPAA regulations and no medical or therapeutic information or other information related to your privacy, will be released without permission unless mandated by Colorado law as described in this form and the "Notice of Privacy Policies and Practices and Compliance with HIPAA Regarding Confidentiality of Client Records and Dissemination of Information." Consistent with HIPAA guidelines authorization for release and consent for treatment will be automatically revoked one year after the signing date. **You acknowledge that you have received Phil Stone LCSW's Notice of Privacy Policies and Practices and Compliance with HIPAA Regarding Confidentiality of Client Records and Dissemination of Information.**
- *By signing this form, you hereby consent and authorize* PHIL STONE LCSW to communicate your protected health information through the following non-secure transmissions: (1) Cellular/Mobile Phone (this includes SMS); (2) Unsecured Email as listed on PHIL STONE LCSW's New Client Information Form (this will allow PHIL STONE LCSW to send you appointment reminders and/or homework assignments). Should you communicate by the methods listed above, i.e. telephone, email, text or any other electronic method of communication, confidentiality extends to those communications. However, PHIL STONE LCSW cannot guarantee that those communications will remain confidential. Even though PHIL STONE LCSW may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by an unintended third-party. By signing this form, you acknowledge your understanding that PHIL STONE LCSW may use and disclose the following protected health information without your written authorization: (a) Information related to scheduling; (b) Information related to billing and payments; (c) Information related to your mental health treatment (this may contain personal materials, forms, suggested articles, homework, etc.); (d) Information related to PHIL STONE LCSW's operations.

***My signature below*** *affirms my informed and voluntary consent to enter therapy (and/or have my child/children enter therapy), and that I have read and understand the preceding information, including the office policies and procedures and the nature of confidentiality in therapy. I affirm that the information provided on the New Client Information Form is true and accurate, including (if applicable) all information about third parties who may be helping with payments. I have had an opportunity to ask questions and have had my questions answered satisfactorily. I affirm that prior to becoming a client of Phil Stone LCSW, I was given sufficient information to understand the nature of therapy, including the possible risks and benefits. I understand that I have full access to*

*this form online at coloradocounselingcenter.com/forms. I acknowledge that if I wish to have a copy of the signed document, I may request one in writing at any time. I understand that I can ask questions and raise concerns about the treatment at any time and that I may terminate therapy at any time by providing written notice to Phil Stone LCSW. Therapy shall be terminated upon receipt of my written notice.*

**RECEIPT OF CONSENTS / POLICIES AND PROCEDURES**

Please sign below that you have reviewed the Consents, Disclosures, and Policies Forms.

____________________________________________________________

PATIENT NAME PRINTED

____________________________________________________________

SIGNATURE Typing your name is equivalent to signature DATE/TIME

If you are consenting to therapy for a minor, please sign below:

____________________________________________________________

PARENT/GUARDIAN NAME PRINTED RELATIONSHIP TO PAIENT

____________________________________________________________

SIGNATURE Typing your name is equivalent to signature DATE/TIME