789 Sherman Street
Suite 440
Denver, CO 80203

613 Walnut Street
Boulder, CO 80302

5370 Manhattan Circle
Suite 203
Boulder, CO 80302

2975 Valmont Rd
Suite 320
Boulder, CO 80301

Client Information:

Client Name: ____ Date: ______________

Address: ________________________________ City: ______________ State: _______ Zip: __________

Date of Birth: ____________________

Home Phone: ______________________ Cell: ___________________ Work: ____________________

Email Address: ____

Employer/School: ____

Employer/School Address: ____

Responsible Party:

If you are the parent or legal guardian of a client who is under the age of 15, please complete the following with your information. If you are over the age of 15, please proceed to the next section.

Name of Parent(s) or Legal Guardian(s): ____

Address: ________________________________ City: ______________ State: _______ Zip: __________

Date of Birth: ____________________

Home Phone: ______________________ Cell: ___________________ Work: ____________________

Email Address: ____

Employer/School: ____

Employer/School Address: ____

Emergency Contact Information:

Name: ____ Relationship to Client: _______________

Address: ________________________________ City: ______________ State: _______ Zip: __________

Home Phone: ______________________ Cell: ___________________ Work: ____________________

Who Were You Referred By?

□ Website- which one? ____________________ □ Physician □ Family/Friend □ Counselor □ School □ Church

□ Psychology Today □ Other_______________________

May we contact someone to thank them? Yes No

Name of Physician:

Name: _________________________________ Phone: _____________________

May I contact your Physician for continuity of care? Yes: ________ No: ___________

FFC Therapist: _____________________

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Clinical/Psychosocial History

Client marital status: __________________________ **Gender**: ____________________________

Names and ages of Immediate Family Members:

____

____

Currently a Student? Yes_____No _____ **Current Occupation:** ____

Partner's Occupation:____

Client's spiritual/religious involvement, interests, commitments, etc.

____

____

Client's cultural involvement, interests, commitments, etc.

____

____

Describe why you are seeking counseling at this time?

____

____

What are your current symptoms and how long have you been concerned about them?

____

What goals do you hope to achieve from therapy?

1.____

2.____

3.____

4.____

Medical and Psychiatric History: (please list dates and reason why) Include major illnesses, surgeries, hospitalizations, accidents, injuries and traumas

____

____

Current and or past substance abuse (include tobacco, illicit, prescribed & OTC substance):

____

____

Current Medications: Please list medication and reason for being on medication

____

Allergies (include medication allergies):

____

Developmental Issues/Pregnancy:

____

FAMILY PSYCHIATRIC HISTORY

List family members, conditions, hospitalizations and diagnosis:

____

____

COUNSELING HISTORY

Have you ever consulted a therapist before? Yes _____ No_____ If so When? _________________________

How long? ____________ Briefly state the reasons you sought counseling at that time? ________________

____

What was helpful in your past counseling experiences? ______________________________________

____

Have you recently or in the past thought about suicide? Yes_______ When____________________ No_________

Have you ever attempted suicide? Yes____ No____

If your answer is yes to either of these questions, please describe what treatment you have had:

____

____

STRENGTHS

How do you reduce your stress? ____

____

What are your strengths and the strengths of your family? ____________________________________

____

Additional Information:

Consent for Treatment

I voluntarily consent to participate in mental health and/or substance abuse services with Foundations Family Counseling, PLLC.

Financial Agreement

Standard Service Fees:

Please review the rates for the following services.

- Individual Counseling (50 minutes): $140
- Individual Counseling (90 minutes): $210
- Phone Consultations: $140
- Emergency or After-Hours Consultations: $140
- Consultation and Correspondence Rate: $140 per hour
- Group Rate: $80
- Psychological Assessment: Determined on case by case basis
- Couples and Family Counseling (50 minutes): $140
- Couples and Family Counseling (50 minutes): $210

If a report or consultation with an outside party is requested. I understand I will be billed for any time needed to prepare documentation or to conduct an in-person or phone consultation. My therapist's standard service fee will apply.

Discount Rates:

If you are currently receiving a rate reduction which has been previously arranged by your therapist, please enter this rate here: _____________. This corresponds to a _______% discount.

Cancellation Policy:

In the event you need to cancel an appointment, please provide notice to your therapist within 24 hours of your scheduled appointment time. If you cancel less than 24 hours before your scheduled appointment, you will be charged a fee of $______. If no notice is given at all, your therapist's standard service fee as agreed upon in this disclosure will be assessed for that session.

Insurance:

The use of insurance is determined by you and your therapist. If your therapist is not on your insurance panel, an insurance-ready statement will be emailed to you at the end of each month detailing any direct payments you have made to the practice. These statements can be used to initiate the reimbursement process privately through your insurance company if you choose.

Policy for Non-Payment:

In the event billing efforts fail, delinquent accounts may be subject to collections. This therapist will make every attempt to develop a payment plan with any client struggling to pay a past due balance prior to sending a balance to collections.

I certify the information provided above is accurate to the best of my knowledge. I understand and agree to the proceeding Financial Agreement and Consent for Treatment. I also authorize any service fees to be deducted from the form of payment designated on this form. Should any of the information provided change, I agree to update my provider as soon as possible.

____ ________________

Signature of Client (Legal Guardian if Client is a Minor) Date

Additional Fees

Many fees associated with therapy are not covered by insurance companies. Fees usually not included in insurance coverage will be charged out of pocket at the following rates:

Correspondence:

Item	Minimum	Rate
Letters to insurance agencies (other than normal claim processing)	(minimum $20)	$140/Hour
Correspondence (non-court related)	(minimum $20)	$140/Hour
Case Summaries	(minimum $20)	$140/Hour
Release of information for case notes	(minimum $20)	$140/Hour

School:

Item	Rate
School staffing (hour or part of hour)	$140/Hour
Consulting with Educational Personnel (no charge for one hour per month)	$140/Hour
Reports	$140/Hour
Travel to Schools (door to door)	$140Hour

Consulting:

Item	Rate
Consulting with other therapists (billed a minimum of fifteen minutes)	$140/Hour

Court: ($500 deposit required prior to service)

Item	Rate
Depositions (hour or part of hour)	$210/Hour
Consulting with attorneys (billed a minimum of fifteen minutes)	$210/Hour
Phone Testimony to Court (minimum of one hour)	$210/Hour
Court Preparation	$210/Hour
Subpoena to appear in court and/or testimony (hour or part of hour)	$210/Hour
Cancelled court appearance, less than 24-hour notice	$140
Travel to court (door to door)	$140/Hour

Please sign and date below indicating you have been provided accurate information and understand the limits of these charges and billing information.

Signed: ____ Date____________________

Client Signature (Legal Guardian if Client is a Minor)

Signed: ____ Date ____________________

Therapist Signature

ELECTRONIC PAYMENT AUTHORIZATION Please indicate the card you wish to use for all services rendered through this practice. Charges for services rendered will be deducted from the card designated below at the time services are rendered. We accept: Visa, MC and Discover.

Client Information:
Client Name: ____ Date of Birth: _________________

Address: ______________________________ City_____________________ State: _______ Zip: ____________

Home Number: _____________________ Mobile Number: ___________________

Email Address (for statements): ____

Billing Information:
Please indicate the information associated with the credit card you wish to use, if different from client information.

Name on Card:____

Address: ______________________________ City_____________________ State: _______ Zip: ____________

Authorization:
I authorize all service fees to be deducted from the card ending in ________________ (last four digits of the card)

I authorize the use of this card for all services and fees at the time they are rendered for the following parties:
Full Name(s):

____

I understand that this form authorizes my provider to charge this card for varying session types, across multiple dates of service. By authorizing use of this card, and signing this electronic payment authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.

Cardholder Signature____ Date __________________

Payments are processed by Therapy Partner. Therapy Partner is a registered ISO/MSP of Fifth Third Bank, Cincinnati, OH and HSBC Bank USA National Association, Buffalo, NY.

- -

Credit Card Information:

Please provide your payment information below. The card information you provide on this form will be destroyed once your information has been securely encrypted and stored.

Card (circle one): Visa MasterCard Discover

Card Number: ____ Expiration Date: ____________________

Please enter the CVV code _____________ (last three digits on back of card)

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Insurance Information and Agreement if Applicable

FILL OUT ONLY IF INSURANCE WILL BE BILLED DIRECTLY; NOT FOR REIMBURSEMENT OR OUT-OF-NETWORK PURPOSES

INSURANCE INFORMATION

NAME OF CLIENT: ____________________________________ CLIENT'S DATE OF BIRTH: ____________________

NAME OF INSURED MEMBER (if different than client): ____

INSURED MEMBER'S DATE OF BIRTH (if different than client): ____

NAME OF INSURANCE COMPANY: ____

INSURED MEMBER'S ID #:____

INSURED MEMBER'S GROUP #____

PHONE # OF INSURANCE COMPANY: ____

ADDRESS OF INSURANCE COMPANY: ____

____

ADDRESS TO SEND CLAIMS (if different than above):____

____

SECONDARY INSURANCE (if any) –Name, address and phone number of Insurance Plan, Name of Insured, Insured's DOB, Employed Company Name:

____

____

____

If services are to be billed to an insurance company, I authorize the release of any medical or other information necessary to process this claim. I further understand that I am liable for charges in the event of a claims denial. I agree to provide any necessary forms or documentation to assist in settling my account.

____ ____________________

Client Signature (Legal Guardian if Client is a Minor) Date

____ ____________________

Therapist Signature Date

Foundations Family Counseling Unsecured Communications Consent Form

Foundations Family Counseling requires consent from clients to communicate with you and, if necessary, with other providers, business associates, or workforce members of Foundations Family Counseling via unencrypted technological correspondence regarding your protected health information, billing information and statements through Therapy Partner, and appointment times and dates. Technological correspondence may include emails, text messages, shared informational spreadsheets, fax correspondence, and cloud storage systems. If a client is paying for services through insurance, or attempting to be reimbursed for services through insurance, potential unsecured correspondence with insurance clearinghouses may also occur. It is the policy of Foundations Family Counseling that all phones, laptops, desk computers, physical files and case notes, and email addresses be password protected to ensure to our ability the protection of your information.

The purpose of this consent form is to notify the individual of the risks associated with unencrypted correspondence. There is some level of risk that information sent via unencrypted correspondence will be vulnerable to unauthorized access as servers and communications companies have unlimited access to information sent between devices that utilize these services. There is also some level of risk that unencrypted correspondence will be accidentally delivered to a mistaken email address, phone number, or fax number. If you consent to and request to receive information individually, and also consent to and request the unencrypted correspondence of information between business associates and other workforce members of Foundations Family Counseling regarding your protected health information, Foundations Family Counseling is not responsible for unauthorized access of protected health information while in transmission based on the individual's request and consent. Further, Foundations Family Counseling is not responsible for safeguarding information once delivered to the individual, business associate or other workforce member of Foundations Family Counseling.

The client also acknowledges that creating a payment account with Therapy Partner may occasionally result in unencrypted correspondence regarding your statements being sent to you, a business associate, or other workforce member of Foundations Family Counseling, and by signing this consent form, you agree and request to receive this type of correspondence and agree and request to this type of correspondence between business associates and workforce members of Foundations Family Counseling. If you do not request and consent to this, the client must use an alternate system of out of pocket payment.

I have been informed of the potential risks involved in both sending and receiving unencrypted technological correspondence regarding my protected health information. I have read the preceding information and I understand my rights as a client/patient.

I understand that if I refuse to sign this agreement, my therapist will be unable to continue my services with Foundations Family Counseling, as this facility uses unencrypted email correspondence for billing purposes.

By signing this form, you consent and request to unsecured technological correspondence between your provider and yourself (the individual), business associates, and other Foundations Family Counseling workforce members.

____

Client Signature (Legal Guardian if Client is a Minor) Date

____

Therapist Signature Date

Foundations Family Counseling Social Media Policy

The purpose of this form is to provide information about the social media conduct policy of Foundations Family Counseling. Please read it to understand how we will respond to various interactions that may occur between Foundations Family Counseling therapists and clients on the Internet.

If you have any questions about this document, please discuss them with your therapist.

Friending, Fanning, and Likes

The policy of Foundations Family Counseling is for therapists to neither accept nor solicit friend, fan, or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, Instagram, etc). It is our belief that clients as friends or contacts on these sites can compromise your confidentiality. It may also blur the boundaries of the therapeutic relationship. Please also be aware that if you "like" any Facebook posts that your therapist keeps for his/her professional practice, it may compromise your confidentiality as a client. If you have questions about this, please bring them up with your therapist.

We believe having clients as social media contacts creates a greater likelihood of compromised client confidentiality, and we feel it is best to be explicit to all who may view social media sites and pages that they will not find client names unless that client has willingly posted or "liked" something of their own volition. In addition, the American Psychological Association's Ethics Code prohibits soliciting testimonials from clients. We feel that becoming a social media contact comes too close to the boundary of an implied request for a public endorsement of our practice.

Following

Many therapists publish blogs on professional websites and post psychology news on Twitter. If you use an easily recognizable name online, be aware that following these blogs or Twitter streams may compromise your confidentiality.

Note that if you choose to follow your therapist, your therapist will not follow you back. The policy of Foundations Family Counseling is for therapists to only follow other health professionals on Twitter and to not follow current or former clients on blogs or Twitter. Our reasoning is that casual viewing of clients' online content outside of the therapeutic relationship can be inappropriate. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with your therapist, please bring them into your session where you can view and explore them together, during the therapy hour.

Social Media to Contact Foundations Family Counseling

Please be aware that using any means of public communication from a social networking site such as Twitter, Facebook, or LinkedIn to contact your therapist 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. In addition, be aware that your therapist will not respond to public communications via social networking sites. If you need to contact your therapist, please do so by phone, email, or text.

Business Review Sites

You may find our therapy practice on sites such as Yelp, Psychology Today, Good Therapy, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find your therapist or Foundations Family Counseling on a listing on any of these sites, please know that this listing is NOT a request for a testimonial, rating, or endorsement from you as a client. If you choose to contribute to a business review site forum, be aware that this may compromise your confidentiality as a client.

____

Client Signature (Legal Guardian if Client is a Minor) Date

____

Therapist Signature Date

Foundations Family Counseling Transport of information Policy

The policy of Foundations Family Counseling is to accept the use of personal laptops, cell phones, iPads, tablets, and any other portable electronic device for the recording and storage of case notes and other identifying client information. Because of this, your therapist may transport your information by moving these devices to and from the office in their vehicles. They may also transport your physical client file to and from the office in their vehicles.

With the transport of these materials, there is a level of risk involved to your file or the device which contains your information, which includes loss of information due to technical corruption or failure, hacking via malicious software or unauthorized access, and loss of information due to theft, misplacement, or accidental destruction.

We take these risks very seriously and value your confidential information and privacy as a priority. The policy of Foundations Family Counseling is for all information kept on electronic devices to be password protected, and for all physical files to be stored in a locked location both at the office and elsewhere when in the possession of your therapist. Your information will never be transported carelessly or with unnecessary risk.

By signing this form you authorize your therapist to transport your files to and from the office as necessary.

❑ ____

Client Signature (Legal Guardian if Client is a Minor) Date

❑ ____

Therapist Signature Date

Disclosure Statement

Colorado Law requires that the following information be provided to all clients.
The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed social workers, licensed professional counselors, licensed marriage and family therapists, licensed school psychologists practicing outside the school setting, and unlicensed individuals who practice psychotherapy.

The agency within the Department that has responsibility specifically for licensed and unlicensed psychotherapists is:

Department of Regulatory Agencies
Mental Health Section
1560 Broadway, Suite 1350
Denver, CO 80202
(303) 894-7766

If there are any complaints or concerns regarding the practice of mental health, please direct them to the above listed department. Any person who alleges that a mental 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. Pursuant to law, this practice will maintain records for a period of seven years commencing on the date of termination of services or on the date of last contact with the client, whichever is later. When the client is a child, the records must be retained for a period of seven years commencing either upon the last day of treatment or when the child reaches eighteen years of age, whichever comes later, but in no event shall records be kept for more than twelve years.

A separate addendum to this disclosure, which identifies your therapist's training and license, will be provided to you.

You are entitled to receive information from me regarding methods, techniques, fee structure and duration (if known) of the sessions. You have the right to seek a second opinion from another therapist or terminate therapy at any time.

The information provided by you during counseling is legally confidential except as required by law and 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. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent. There are exceptions to the rule of confidentiality that can be explained and will be identified to you should any situations arise during therapy. Some of these exceptions are listed in section C.R.S. 12-43-218 and C.R.S. 27-65-102(4.5) and in the Notice of Privacy Rights you were provided. In general, the exceptions include a "danger to yourself or others" as in the case of child abuse, suicide, gravely disabled C.R.S 27-65-102(9); under a court order; or in response to any legal action taken by you against this agency. You should also be aware that provisions concerning disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in section 13-90-107 C.R.S. C.R.S. 18-6.5-108 requires the reporting of abuse and exploitation of elders, 70 years of age or older.

In the event that the therapist becomes concerned about a client's safety or welfare, it is policy that the therapist be allowed to request a welfare check through law enforcement.

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.

You should know that supervisors and other therapists detailed on the attached addendum may provide supervision and/or consultation to each other. As such information regarding your case may be made available to staff and contractors of Foundations Family Counseling as is warranted for administrative and/or clinical care coordination.

As to the regulatory requirements applicable to mental health professionals: 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-doctoral supervision. A Licensed Social Worker must hold a masters degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor 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 bachelors 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 masters 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. However, the registered psychotherapist is 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

I understand I am responsible for all fees agreed to in the financial agreement. Fees are due upon receipt of services, and should billing attempts fail, delinquent accounts will be turned over to a collection agency.

I have been informed of my therapist's degrees, credentials and licenses. I have read the preceding information and I understand my rights as a client/patient.

❑ I, ______________________________, have received a copy of both the Foundations Family Counseling Disclosure Statement and Notice of Privacy Practices.

❑ ____ ____
Client Signature (Parent or Guardian for a minor) Date Therapist Signature Date

Credentials, Education, Degrees, and Associations

Whitney Sundquist Jose, MA, LPC, RPT-S
-Master of Counseling Psychology and Counseling Education
-Eye Movement Desensitization and Reprocessing (EMDR) Certified
University of Colorado at Denver
-Colorado Licensed Professional Counselor #3321
-Registered Play Therapist Supervisor # S-1260

Clinton J. Nunnally, MA, LPC
-Master of Counseling
-ACA: American Counseling Association
-Prepare/Enrich Certified
Denver Seminary
- Beyond Consequences Certified Instructor
- Clinical Faculty at Denver Seminary Graduate School in Counseling
- Colorado Licensed Professional Counselor #5581

Brandon Smith, LCSW, RPT
-Master of Social Work
-C.D.E School Social Work
Smith College School of Social Work
- Colorado Licensed Clinical Social Worker #992892
- Colorado Association for Play Therapy (CAPT)

Nicole Sidebottom, MA, LPC
-Master of Counseling
-ACA: American Counseling Association
-Colorado Licensed Professional Counselor #6381
Denver Seminary
-PREPARE/ENRICH Certified

Liliana Baylon, MS, MFTC
- M.S. in Counseling/Marriage, Family, and Child Therapy #13358
- Gottman Bring Baby Home Educator
- Independent Facilitator of the Becoming a Love and Logic Parent Curriculum
- Completed Level 2 Training in Gottman Method Couples Therapy
- EMDR Trained
- Certified Play Therapist
University of Phoenix
- APT: Association for Play Therapy Member
- ACA: American Counseling Association
- AAMFT: American Association for Marriage and Family Therapy
- EMDR International Association
- Alternatives for Families – CBT
- Gottman Seven Principles Program Educator

Briana Hutchinson, MA, LPC
- Colorado Licensed Professional Counselor #6196
- National Certified Counselor
Denver Seminary
-PREPARE/ENRICH certified
-ACA: American Counseling Association

Rachelle Schieffer, MS, LPC, ATR-BC
- Colorado Licensed Professional Counselor, #2972
- Board Certified and Registered Art Therapist, #02-114
- EMDR Trained
Emporia State University
- Eye Movement Desensitization and Reprocessing (EMDR) trained
- American Art Therapy Association

Ashley Banister-Riley, MA, NCC
- ACA: American Counseling Association Member
- Colorado Counseling Association Member
Denver Seminary
- TREM (Trauma Recovery and Empowerment Model) Certified
- CAC II

Heather Menzie, MA, LPC, RYT-500
- Masters in Transpersonal Counseling Psychology - Wilderness Therapy Concentration
- Colorado Licensed Professional Counselor # 11210
- EMDRIA Member
Naropa University and College of William and Mary
- EMDR Therapy
- RYT 500 (Yoga Therapist)

Mikey Brackett, MA, NCC
- Masters of Arts in Counseling
- Nationally Certified Counselor
- Prepare Enrich Certified
Denver Seminary
- AACC: American Association of Christian Counselors
- Play Therapist
- Equine Assisted Counseling Therapy

Jennie Tuttle Baughn, MA, NCC
- ACA: American Counseling Association Member
- Colorado Licensed Professional Counselor, #13408
University of Colorado Denver
- Masters of Counseling Psychology - Clinical Mental Health Emphasis

Alison Cotter, MA, LPC, NCC
- Licensed Professional Counselor, #12873
- National Certified Counselor
- ACA: American Counseling Association Member
Denver Seminary
- Masters of Arts in Clinical Mental Health Counseling
- APT: Association for Play Therapy Member
- CAPT: Association for Play Therapy Board Member

Brenda A. Newton MA, NBCC
- LPC Candidate
University of Colorado Denver
- Masters of Counseling Psychology

Lisa Firle, MA, LPC, NCC
- Colorado Licensed Professional Counselor, #105368
- EMDR Trained
Denver Seminary
- Masters of Counseling Psychology

Hannah Salander, MA, LPC
- Colorado Licensed Professional Counselor, #13532
- EMDR Therapy
- Art Therapy
Naropa University
- Masters of Counseling Psychology

NOTICE OF PRIVACY PRACTICES
Effective Date: March 26, 2013

THIS NOTICE DESCRIBES HOW MEDICAL, UNCLUDING MENTAL HEALTH, INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. During the process of providing services to you, the provider 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 in the specific regulatory exceptions described below. Note that the term "individual" refers to the patient or client, and the terms "Foundations Family Counseling" and "provider" may be used interchangeably.

What is "medical information?"
The term "medical information" is synonymous with the terms "personal health information" and "protected health information" for purposes of this Notice. It essentially means any individually identifiable health information (either directly or indirectly identifiable), whether oral or recorded in any form or medium, that is created or received by a health care provider (me), health plan or other **and** relates to the past, present or future physical or mental health or condition of an individual (you); and the provision of health care (e.g. mental health) to an individual (you); or the past, present or future payment for the provision of health care to an individual (you).

I am a mental health care provider and I create and maintain treatment records that contain individually identifiable health information about you. These records are generally referred to as "medical records" or "mental health records" and this notice among other things concerns the privacy and confidentially of those records and the information contained therein.

I. Uses and Disclosures of Protected Information

A. General Uses and Disclosures Not Requiring the Individual's Consent. Practitioner will use and disclose Protected Health Information 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, your provider may use your information to plan your course of treatment and consult with professional colleagues to ensure the most appropriate methods are being used to assist you.
2. Payment. Payment refers to the activities undertaken by a health care provider, including a mental health provider, to obtain or provide reimbursement for the provision of health care. Your provider will use your information to develop accounts receivable information, bill you, and with your consent, provide information to your insurance company or other third-party payers for services provided. The information provided to insurers and other third-party payers may include 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. If you are covered by Medicaid, information will be provided to the State of Colorado's Medicaid program, including but not limited to your treatment, condition, diagnosis and services received.
3. Health Care Operations. Health Care Operations refers to activities undertaken by Foundations Family Counseling that are regular functions of the management and administrative activities. For example, Foundations Family Counseling may use or disclose your health information in monitoring service quality, staff training and evaluation, medical reviews, obtaining legal services, auditing functions, compliance programs, business planning and accreditation, certification, licensing and credentialing activities.
4. Contacting the Individual. Foundations Family Counseling may contact you to remind you of appointments and to tell you about treatments and other services that may be of benefit to you.
5. Required by Law. Foundations Family Counseling will disclose Protected Health Information when required by law or necessary for health care oversight. This includes, but is not limited to when (a) reporting child abuse or neglect; (b) a court-ordered release of information; (c) there is a legal duty to warn or take action regarding imminent danger to others; (d) the individual is a danger to self or others or gravely disabled; (e) a coroner is investigating the individual's death; or (f) 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 or regulatory compliance.
6. Crimes on the Premises or Observed by the Provider. Crimes that are observed by Foundations Family Counseling staff, crimes that are directed towards Foundations Family Counseling staff or crimes that occur on the premises will be reported to law enforcement.

7. Business Associates. Some of the functions of your provider may be provided by contracts with business associates. For example, some of the 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 he Protected Health Information privacy of the Protected Health Information released to them.
8. Research. Foundations Family Counseling may use or disclose Protected Health Information for research purposes if the relevant limitations of the Federal HIPAA Privacy Rule are followed. 45 C.F.R. § 164.512(i).
9. Involuntary Treatment. Information regarding individuals 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.
10. Family Members. Except for certain minors, incompetent individuals or involuntarily treated individuals, Protected Health Information cannot be provided to family members without the individual's consent. In situations where family members are present during a discussion with the individual, and it can be reasonably inferred from the circumstances that the individual does not object, information may be disclosed in the course of that discussion. However, if the individual objects, Protected Health Information will not be disclosed.
11. Emergencies. In life threatening emergencies Foundations Family Counseling will disclose information necessary to avoid serious harm or death.

B. Statements That Certain Uses and Disclosures Require Authorization. Foundations Family Counseling must obtain your Authorization or Consent to Release Information in order to use or disclose your Protected Health Information as follows: (1) for marketing purposes; (2) to sell your Protected Health Information to a third party; and (3) most uses and disclosures of your psychotherapy notes.

C. Individual Authorization or Release of Information. Your provider may not use or disclose Protected Health Information in any other way than set forth in this notice without a signed authorization. When you sign an Authorization or Consent to Release Information, it may later be revoked, provided that the revocation is in writing. The revocation will apply except to the extent Foundations Family Counseling has already taken action in reliance thereon.

II. Your Rights as an Individual

A. Access to Protected Health Information. You have a right to inspect and obtain a copy of the protected health information Foundations Family Counseling has regarding you, in the designated record set, by making a specific request in writing. If records are used or maintained as electronic health record, you have a right to receive a copy of the protected health information maintained in the electronic health record in an electronic format. This right to inspect and copy is not absolute- in other words, I am permitted to deny access for specified reasons. For instance, you do not have this right of access with respect to my "psychotherapy notes." The term "psychotherapy notes" means notes recorded (in any medium) by a health care provider who is mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's medical (includes mental health) record. The term excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. There are other limitations to this right, which will be provided to you at the time of your request, if any such limitation applies. To make a request, ask your provider.
B. Amendment of your Record. You have the right to request that your provider amend your protected health information in his/her records by making a request to do so in writing that provides a reason to support the requested amendment. Your provider is not required to amend the record if it is determined that the record is accurate and complete. There are other exceptions, which will be provided to you at the time of your request, if relevant, along with the appeal process available to you. To make a request, ask your provider.
C. Accounting of Disclosures. You have the right to receive an accounting of certain disclosures Foundations Family Counseling has made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment or health care operations. In addition the accounting does not include disclosures made to you, disclosures made pursuant to a signed Authorization, or disclosures made prior to April 14, 2003. There are other exceptions that will be provided to you, should you request an accounting. To make a request, ask your provider.

D. Additional Restrictions. You have the right to request additional restrictions on the use or disclosure of you protected health information. Unless you pay for your services out of pocket, your provider does not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. If you pay for a service out of pocket, you are permitted to demand that information regarding the service not be disclosed to your health plan or insurance. To make a request, ask your provider. If a request is granted, Foundations Family Counseling will maintain a written record of the agreed upon restriction.

E. Alternative Means of Receiving Confidential Communications. You have the right to request that you receive confidential communications of protected health information from your provider by alternative means or at alternative locations. There are limitations to the granting of such requests, which will be provided to you at the time of the request process. To make a request, ask your provider.

F. Marketing. Foundations Family Counseling engages in marketing and will obtain your authorization before we use your Protected Health Information to contact you with you marketing communications.

G. Breach Notification. In the event of any breach of your unsecured Protected Health Information, Foundations Family Counseling will notify you of such breach within sixty (60) days of the date your provider learns of the breach.

H. Copy of this Notice. You have a right to obtain another copy of this notice upon request.

III. Additional Information

A. Privacy Laws. Foundations Family Counseling is required by State and Federal law to maintain the privacy of protected health information. In addition, Foundations Family Counseling is required by law to provide individuals 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. Foundations Family Counseling is required to abide by the terms of this Notice, or any amended Notice that may follow. Foundations Family Counseling 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 Foundations Family Counseling's office(s) and will be available upon request.

C. Complaints Regarding Privacy Rights. If you believe your privacy rights may have been violated either by your provider or by those who are employed by Foundations Family Counseling, you may file a complaint with your provider by providing a writing that specifies the manner in which you believe the violation occurred, the approximate date of such occurrence, and any details that you believe will be helpful. You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to

Regional Manager, Office for Civil Rights
U.S. Department of Health and Human Services
999 18th Street, Suite 417
Denver, Colorado 80294
Phone: (800) 368-1019
Fax: (303) 844-2025
TDD: (800) 537-7697

Neither employees of Foundations Family Counseling nor your provider will retaliate against you in any way for filing a complaint with your provider or with the Secretary. Complaints to the Secretary must also be filed in writing and notice must be given to Foundations Family Counseling if such a complaint is filed.

D. Contact Information. If you have questions about this Notice or desire additional information about your privacy rights, please contact our Privacy Officer at:

Whitney Sundquist-Jose
789 N Sherman St., Ste 440
Denver, Colorado 80203
(303) 393-0085 x89

E. Effective Date. This Notice is effective July 28, 2015.