Grand Junction
Wellness Center, LLC

Agreement for Confidentiality of Individual Treatment

I understand that it is Dr. Michael Olson's role to provide therapeutic services so that I might feel better and/or improve my functioning, especially as it relates to my family. Dr. Olson's role is not intended to gather information for the courts or to make judgments related to my family.

Therefore, I agree that I will not call upon Dr. Olson to provide treatment records or to testify in a future divorce or custody action. I understand that courts can appoint professionals who have had no prior contact with my family to conduct independent evaluations and make recommendations to the court.

I understand that it is Dr. Olson's policy to have no court involvement in my case because that could harm our professional relationship and the ability to achieve my goals. My goals include resolving personal concerns so that I might preserve my marriage and/or be a better parent. Since I need to speak freely, my spouse is also agreeing never to ask Dr. Olson to testify or have his records of my treatment in court.

By signing this form we are both agreeing not to use any of my therapeutic intervention records or testimony in any future court proceedings.

Signed:
_____Date_____

Signed:
_____Date_____

Grand Junction
Wellness Center, LLC

Confidentiality Contract for Marital or Couple Therapy

This contract is an agreement between the interested parties that neither party shall for any reason attempt to subpoena my testimony or my records to be presented in a deposition or court hearing of any kind for any reason, such as a divorce case.

Both parties acknowledge that the goal of psychotherapy, either individual or marital or couples therapy, is for the sole purpose of the amelioration of psychological distress and that the process of psychotherapy depends on trust and openness during the therapy sessions.

Therefore it is understood by both parties that if they request my services as a psychotherapist, they are expected not to use information given to me during the therapy process against the other party in a judicial setting of any kind, be it civil, criminal, or circuit.

The signatures below reflect that the parties agree to the terms set forth above.

Signed & Dated_
_____

Signed &
Dated_____

Signed &

Dated_____

Grand Junction
Wellness Center, LLC

THERAPIST-CLIENT SERVICE AGREEMENT

Welcome to Grand Junction Wellness Center! This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOTHERAPY SERVICES: Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first 2 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, we will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with your therapist and team. If you have questions about any of our procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

APPOINTMENTS: Appointments will ordinarily be 45-50 minutes in duration, typically once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone.

If you need to cancel or reschedule a session, we ask that you provide 24 hour notice. Without adequate notice you will be responsible for the full session fee as described herein.

PROFESSIONAL FEES: The standard fee is $155.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Other arrangements can include a third-party payor (will require a release/consent for sending an invoice/request for payment for services). Payment may be made by Venmo (e-payment), check, cash, or credit card.

In addition to weekly appointments, it is my practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

INSURANCE: I do not accept or bill insurance. If requested, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

PROFESSIONAL RECORDS: I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in an encrypted/password protected file. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

CONFIDENTIALITY: My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

PARENTS & MINORS: While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

CONTACTING ME: The best number to reach me is 281-979-5482 by call or text. My private practice is after 5PM M-F so my availability and timeliness of response may be limited during the day 8:00-5:00PM M-F but I will try to respond as soon as I can. If you have an emergency or need immediate assistance, call 911 or seek help at your nearest emergency room/hospital. My clinic does not provide emergency/crisis services.

SCOPE OF PRACTICE: I am not a medical professional and do not have the license or authority to prescribe medications. Any discussion of medications is intended to support your treatment plan with your prescribing medical professional. We have psychiatric nurse practitioners that work in our office location and with appropriate release of information, can collaborate with them to optimize care as indicated.

BOARD REGULATION

Your therapist will attend to any concern or complaint that you may have about psychotherapy or you may file a complaint by contacting the Mental Health Grievance Board at: Department of Regulatory Agencies, Mental Health Section, 1560 Broadway, Suite 1340, Denver, CO 80202, (303) 894–7766.

OTHER RIGHTS
If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

CONSENT TO PSYCHOTHERAPY
Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

_____
Signature of Patient or Personal Representative

_____
Printed Name of Patient or Personal Representative

_____

Date _____

Description of Personal Representative's
Authority:_____

Notice of Privacy Policies

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Confidentiality

As a rule, I will disclose no information about you, or the fact that you are my patient, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship (by signing the attached general consent form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me.

II. “Limits of Confidentiality”

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization

There are some important exceptions to this rule of confidentiality – some exceptions created voluntarily by my own choice, [some because of policies in this office/agency], and some required by law. If you wish to receive mental health services from me, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together.

I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

· Emergency: If you are involved in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.

· Child Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required by State law to report the matter immediately to the child protective services (CPS) or relevant state agency.

· Adult Abuse Reporting: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by State law to immediately make a report and provide relevant information to the Adult Protective Services (APS).

· Court Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so you can file a motion to quash (block) the subpoena

· Serious Threat to Health or Safety: By law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety.

· Workers Compensation: If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

· Records of Minors:

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission. [This sentence is now required under the HIPAA "Final Rule."]

III. Patient's Rights and Provider's Duties:

· Right to Request Restrictions-You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.

· Right to Receive Confidential Communications by Alternative Means and at Alternative Locations — You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voicemail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

· Right to an Accounting of Disclosures – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as

described in section III of this Notice). On your written request, I will discuss with you the details of the accounting process

. · Right to Inspect and Copy – In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.

· Right to Amend – If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted to me. In addition, you must provide a reason that supports your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

· Right to a copy of this notice – You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

EFFECTIVE DATE: _____

Patient's Acknowledgement of

Receipt of Notice of Privacy Practices

Please sign, print your name, and date this acknowledgement form.

I have been provided a copy of Dr. Olson's Notice of Privacy Practices."

We have discussed these policies, and I understand that I may ask questions about them at any time in the future.

I consent to accept these policies as a condition of receiving mental health services.

Signature:

_____

Printed Name:

_____

Date: _____

Grand Junction
Wellness Center, LLC

Couple Informed Consent Form

We understand that couples therapy begins with an evaluation of our relationship, past and present. While Dr. Olson is deciding whether he/she is the appropriate therapist for us, we will decide whether we wish to begin couples therapy with him/her. We understand that because of the commitment of time and money, plus the potential impact on us and others (see below), it is important to make an informed choice for a couples therapist.

We have read and understand the potential limits of confidentiality, including those imposed by Dr. Olson's policies and by state law, and we have received a copy to keep. *[If we have dependent children, we have read and understood the potential limits of confidentiality regarding access to records in child custody cases].*

We understand that information discussed in couples therapy is for therapeutic purposes and is not intended for use in any legal proceedings involving the partners. We agree not to subpoena Dr. Olson to testify for or against either party or to provide records in a court action.

We understand all policies as described on the PATIENT INFORMATION sheet and accept them as conditions for entering into couples therapy with Dr. Olson.

We have been given the opportunity to ask questions and discuss confidentiality and disclosure policies with Dr. Olson. We understand that while working as a couple, anything either of us might say to Dr. Olson individually, whether by phone or in an individual session, will be held confidential and will not be shared with the spouse/partner without the individual's consent.

We agree to share responsibility with Dr. Olson for the therapy process, including goal setting and termination. By entering into couples therapy, we accept that we both understand that working toward change may involve experiencing difficult and intense feelings, some of which may be painful, in order to reach therapy goals. We understand that the changes one or both of us make will have an impact on our partner and on others around us. We accept that such changes can have both positive and negative effects and agree to clarify and evaluate potential effects of changes before undertaking them. *[This is especially true if we have dependent children.]*

We agree to pay for all services provided by Dr. Olson. By signing below, we agree to accept mental health services from Dr. Olson and accept responsibility for payment for such services.

Patient_____ Date_____

Patient_____ Date_____

Grand Junction
Wellness Center, LLC

Informed Consent Form: Child Therapy: Separated/Divorced Parents

Separated/Divorced Parents' Agreement Form

I have brought my child _____, age _____, to Dr. Michael Olson for evaluation and/or treatment. I understand that Dr. Olson's patient is my child – not me, any other sibling, or my spouse. This is true no matter who pays Dr. Olson for the evaluation/treatment of my child.

I understand that Dr. Olson's primary responsibility is my child's best interest and that he may decide to involve me in my child's evaluation/treatment at her sole discretion. I understand that if payment is not received promptly for services rendered by Dr. Olson to my child, the services may be suspended or terminated at his sole discretion, pursuant to the ethical guidelines governing psychological care.

I understand that Dr. Olson is not agreeing to be an expert witness or to testify on my behalf or on the behalf of any other individual other than my child at any deposition, court proceeding, or in any other way. I understand that he may or may not meet with me, my attorney, or any other party or attorney in any custodial or divorce proceeding at her sole discretion. Dr. Olson may also charge for the receipt of any correspondence or acceptance of any telephone calls, other than those directly from the court or counsel for my child.

I have read the above paragraphs and understand them. By signing below, I agree to the above.

Signature _____ _____

Date _____ _____

Signature _____ _____

Date _____ _____

Signature _____ _____

Date _____ _____