Picking Daisies

Coover Counseling Services, PLLC

CONSENT FORM

CONSENT FOR TREATMENT

I consent to evaluation and mental health treatment for myself, my minor child, or the ward. I am aware that care and treatment are not an exact science and acknowledge that no guarantees have been made to me as to the result of treatment. I also understand that Amanda Coover is not a crisis therapist. If you have an emergency between 6:00 PM and 10:00 Am Monday through Thursday or on Friday, Saturday, or Sunday you need to call the police (911), or go to the closest emergency room. I understand if Amanda thinks I need more intensive services I will be referred to a therapist that has the ability to provide treatment to meet those needs.

CLIENT RIGHTS

1. You have the right to terminate treatment at any time.
2. Your rights as an individual will be respected at all times without regard to race, color, creed, age, sex, or political affiliation.
3. You have the right to know the cost of your treatment.
4. You have the right to review and have your therapist review your treatment plan at any time. 5. Your right to confidentiality does not preclude your therapist from reporting information pertaining to a crime committed by you in the office or against another client in treatment with you.
6. Sexual contact between client and therapist is never appropriate.

EXCEPTIONS TO CONFIDENTIALITY

1. If you threaten to harm yourself or someone else.
2. If you know of an ongoing and current child or elder abuse.
3. If the therapist or her files are subpoenaed by the court.

I understand and agree with the preceding relevant paragraphs.

_____ _____

Client Signature Date

_____ _____

Signature of Parent / Legal Guardian Date

_____ _____

Witness Date

Amanda M. Coover, MA, LMFT
Licensed Marriage and Family Therapist License # LMFT .0001278

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HIPAA NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act ("HIPAA") requires that we maintain the privacy of your medical information and provide you with this notice in writing of our privacy practices. We value the confidentiality of your personal health information ("PHI"). Your health information includes records that we create and obtain when we provide care to you, including records of your symptoms, examination and test results, diagnosis, treatments, and referral for further care, in addition to bills and payment information, and insurance claims that we maintain related to your care. This notice describes how physical and mental health information about you may be used and disclosed, your rights regarding this information, and how you may access this information. Please review it carefully. Any questions should be directed to our office.

Consistent with HIPAA and Colorado law, we are required to:

- Maintain the privacy of protected health information as required by law.
- Give you this notice of our legal duties and privacy practices regarding your health information.
- Follow the terms of the Notice currently in effect.

It is the policy of our office that a notice of privacy practices be provided to all subject individuals at the first patient encounter if possible and that all uses and disclosures of protected health information be done in accordance with this office's notice of privacy practices. In order to better serve our patients, office staff may receive and read email messages, and may also hear and transcribe voicemail messages from patients. Our office staff abides by HIPAA guidelines. The following describes the way we may use and disclose your health information. Except for the following purposes, we will use and disclose your health information only with your written permission. You may revoke this permission at any time by writing to our office.

It is our policy that all routine and recurring uses and disclosures of PHI (except for uses or disclosures made 1) for treatment purposes, 2) to or as authorized by the patient, or 3) as required by law for HIPAA compliance, such uses, and disclosures of protected health information must be limited to the minimum amount of information needed to accomplish the purpose of the use of disclosure. It is our policy that non-routine uses and disclosures will be handled pursuant to established criteria. It is also our policy that all requests for protected health information (except as specified above) must be limited to the minimum amount of information needed to accomplish the purpose of the request. We may use and disclose your physical and mental health information for your treatment and to provide you with treatment-related health care services. We may use and disclose your physical and mental health information to contact you and remind you of your appointment times, to advise you of treatment alternatives, health-related benefits, or other services you could use. We will disclose your physical and mental health information when required to do so by international, federal, state, or local law.

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HIPAA NOTICE OF PRIVACY PRACTICES

It is our policy to require authorization for any use or disclosure of psychotherapy notes, as defined in the HIPAA regulations, except for treatment, payment, or healthcare operations as follows:
A. Use by originator for treatment;
B. Use of disclosure in defense of a legal action brought by the individual whose records are in issue;
C. Use of disclosures as required by law, or as authorized by law to enable health oversight agencies to oversee the originator of the psychotherapy notes, it is our policy to provide copies of psychotherapy notes to the patient, along with the information of the entity requesting the notes, allowing the patient to provide the notes to the requesting entity.

You have the right to inspect and/or receive a copy of your physical and mental health information and billing records, except in very limited circumstances. You have the right to request an amendment to your records. You have the right to an accounting of disclosures of your PHI. All requests should be made in writing to this office. We may change this notice and make it effective for medical information we already have in addition to new information we may obtain from you. You have a right to request a paper copy of the current notice at any visit or by written request to this office, If you have any questions or complaints regarding your privacy rights, please contact this office at the address above.

If you believe your privacy rights have been violated, you may file a complaint with Amanda Coover, LMFT. To file a complaint with the Colorado Department of Regulatory Affairs; Division of Professions and Occupations; 1560 Broadway Suite 1350 Denver, CO 80202. Phone: 303.894.7800; Fax: 303.894.7693; Email: dora_dpo_licensing@state.co.us. You will not be penalized for filing a complaint.

Patient Acknowledgment of Receipt of HIPAA Notices of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices of Amanda M. Coover, LMFT

_____ _____
Client Signature Date

_____ _____
Signature of Parent / Legal Guardian Date

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Coover Counseling Services, PLLC

DISCLOSURE STATEMENT

This statement is being provided to you so that you are aware of your rights as a psychotherapy client. Please read this and discuss any questions or concerns you have before signing it.

Clinician:
Amanda Coover, LMFT; Colorado License # MFT.0001278
Phillips Graduate Institute; 2004

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 family therapists, licensed school psychologists practicing outside the school setting, and unlicensed individuals whom practice psychotherapy. All questions and/or complaints should be addressed to: the Department of Regulatory Agencies, Mental Health Section, Board of Psychologist Examiners, 1560 Broadway, Suite 1350, Denver, Colorado, 80202, (303) 894-7800.

Client Rights and Important Information:

- Generally speaking, the information provided by and to you as the client during the therapy sessions is legally confidential. Since the information if legally confidential, I cannot be forced to disclose any of your information without your consent. Information disclosed to me 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.
- There are exceptions to the general rule of legal confidentiality. These exceptions are listed in the Colorado statutes (C.R.S. 12-43-218). You should 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. Confidentiality may also be waived in the event of physical abuse and/or neglect of a child, including any past or present sexual contact with a minor. All therapists are required by law to report instances to the appropriate Department of Social Services. Additionally, in the event of imminent danger to yourself or another person, I am required by law to protect you, which may result in you being hospitalized. I have a duty to warn anyone who may be in imminent danger as a result of your threats or frame of mind.
- Additionally, although confidentiality extends to communications by text, email, telephone, and/or other electronic means, I cannot guarantee that those communications will be kept confidential, and/or a third party may not access our communications. Even though I may utilize state-of-the-art encryption methods, firewalls, and backup systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by a third party.

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DISCLOSURE STATEMENT

- 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 Master's Degree in their profession and have two years of post-master supervision. A Licensed Psychologist must hold a Doctorate Degree in Psychology and have one-year post-doctoral supervision. A Licensed Social Worker must hold a Master's Degree in Social Work.
- You, as a client, may revoke your consent to treatment or the release or disclosure of confidential information at any time in writing and given to your therapist.
- You are entitled to seek a second opinion from another therapist or terminate therapy at any time.
- You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of therapy (if I am able to determine it), and my fee structure. Please ask if you would like to receive the information.
- In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant, or certificate holder.
- You can seek a second opinion from another therapist or terminate therapy at any time.
- "No Secrets" Policy: When treating a couple or a family, the couple or family is considered to be the client. At times, it may be necessary to have a private session with an individual member of that couple or family. There may also be times when an individual member of the couple or family chooses to share information in a different manner that does not include other members of the couple or family (IE: on a telephone call, via email, or via private conversation). In general, what is said in these individual conversations is considered confidential and will not be disclosed to any third party unless your therapist is required to do so by law. However, in the event that you disclose information that is directly related to the treatment of the couple or family, it may be necessary to share that information with the other members of the couple or family in order to facilitate the therapeutic process. Your therapist will use his/her best judgment as to whether, when, and to what extent such disclosures will be made. If appropriate, your therapist will first give the individual the opportunity to make the disclosure themselves. This "no secrets" policy is intended to allow your therapist to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise when an individual's interests may not be consistent with the interests of the couple or family being treated. If you feel it necessary to talk about a matter that you do not wish to have disclosed, you should consult with a separate therapist whom can treat you individually.

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DISCLOSURE STATEMENT

Fee Information

My fee structure, services and fee policy are outlined as follows:
S175 per therapy session for Private Pay. For insurances, I am in-network with, I will charge the co-pay amount and further reimbursement will be through your insurance provider. If insurance denies your claim, you are responsible for the remainder of the fees up to the S175 per hour session rate. Telephone conversation in excess of 10 minutes, reading and responding to lengthy email communication, consulting with other professionals, time involved in discussing your case, letters or summaries related to your therapy and filing our reports may all be charged on a pro-rated basis at the regular session price of S175 per hours and will be billing in increments of 15 minutes.
It is the policy of my practice to collect all fees at the time of service, unless you make arrangement for payment and we both agreed to such arrangement. In addition, I request you fill out a "Credit Card Authorization" form to keep in your file. All accounts that are not paid within thirty (30) days from the date of service shall be considered past due. If your account is past due, please be advised that I may be obligated to turn any past due accounts over to a collection agency or seek collection with a civil court action. By signing below, you agree that I may see payment for your unpaid bill(s) with the assistance of a collection agency or Court with your Name, Address, Phone Number and any other directory information, including dates of services or any other information request by the collection agency or Court deemed necessary to collect the past due account. I will notify you of my intention turn your account over to a collection agency or the Court by sending such notice to your last known address.
Therapy fees and treatment are based on a 45-50 minute clinical hours, instead of a 60 minutes clock hour so that I may review my notes and assessments on your behalf.

Missed Appointments and Cancellations

If you are unable to keep an appointment, please notify me within 24 hours of our appointment time. If you do not notify me of the cancellation prior to 24 hours of our scheduled session, you will be charged the full amount of the private pay therapy rate (S175).

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DISCLOSURE STATEMENT

As A Client:

- I understand that there may be times when my therapist may need to consult with a colleague or another professional, such as an attorney or supervisor, about issues raised by me in therapy. My confidentiality is still protected during consultation by my therapist and the professional consulted. Only the minimum amount of information necessary to consult will be disclosed. Signing this disclosure statement gives me therapist permission to consult as needed to provide professional services to me as a client. I understand that I will need to sign a separate Authorization for Release of Information for any discussion or disclosure of my protected health information to another professional besides a colleague, supervisor or attorney retained by my therapist.
- I understand that my therapist does not accept personal Facebook, LinkedIn, Twitter, Instagram, and/or other friend/connection/follow requests via any social media. Any such request will be denied in order to maintain professional boundaries. I understand that Amanda Coover, LMFT has, or may have a business social media account page. I understand there is no requirement that I "like" or "follow" this page. I understand that should I "like" or choose to "follow" Amanda Coover, LMFT's business social media page others will see my name associated with "liking" or "following" that page. I understand that this applies to any comments that I post on Amanda Coover LMFT's page/wall as well. I understand that any comment I post regarding therapeutic work between my therapist and I will be deleted as soon as possible. I agree that I will refrain from discussing, commenting, and/or asking therapeutic questions via any social media platform I agree that if I have a therapeutic comment and/or question, I will contact my therapist through the mode I consented to, not through social media.
- I understand my therapist provides non-emergency therapeutic services by scheduled appointment only. If, for any reason, I am unable to contact my therapist by the telephone number provided to me, 720-310-8462, and I am having a true emergency, I will call 911, check myself into the nearest emergency room or call Colorado Crisis Hotline at 844-493-8255. Amanda Coover, LMFT does not provide after-hours service without an appointment. If I must seek after-hours treatment from any counseling agency or center, I understand that I am solely responsible for any fees due. I understand that if I leave a voicemail for my therapist on the phone number provided, my therapist will return my call by the end of the next business day, excluding weekends and holidays.

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DISCLOSURE STATEMENT

- If my therapist believes my therapeutic issues are above his or her level or outside of his or her scope of practice, my therapist is legally required to refer, terminate or consult.
- I understand that should I choose to discontinue therapy for more than sixty (60) days by not communicating with Amanda Coover, LMFT, my treatment will be considered "terminated". I may be able to resume therapy after the sixty (60) day period by discussing my decision to resume therapy services with Amanda Coover, LMFT's. Ability to resume therapy services will depend on my therapist's availability and will be within her sole discretion.
- There is no guarantee that psychotherapy will yield positive or intended results. Although every effort will be made to positive and healing experience, every therapeutic experience is unique and varies from person to person. Results achieved in a therapeutic relationship with one person are not a guarantee of similar results with all clients.
- In order to protect the integrity of the counseling process, the therapeutic relationship must remain that of the therapist and client. This means that my therapist cannot be my friend, cannot have any type of business relationship with me, cannot have any kind of romantic or sexual relationship with a former or current client, or any people close to a client, and cannot hold the role of a counselor to his or her relatives, friends, the relatives of friends, people known socially or business contacts.
- I also affirm, by signing this form, that I am at least 12 (twelve) years old and consent to treatment and therapy services at Amanda Coover, LMFT, or that I am a legal guardian and/or custodial parents with the legal right to consent to treatment for any minor children under the age of 12 (twelve) years.
- I understand that if I am consenting to treatment and therapy services for my minor child(ren) that my therapist will request that I produce a Court Order Custody Agreement and/or Parenting Plan that grants me the authority to consent to mental health services for my minor child(ren). I understand that it is beyond the scope of my therapist to provide custody recommendations. Any request for custody recommendations will be denied. A court is able to appoint professionals with the expertise to make sure recommendations.

Health Insurance Privacy Notice (HIPAA)
I understand that this form is compliant with HIPAA regulations and no medical or therapeutic information or other information related to my privacy will be released without permission unless mandated by Colorado law as described in this form and the Notice of Privacy Policies and Practices. By signing this form, I agree and acknowledge I have received a copy of this Notice of declined a copy at this time. I understand that I may request a copy of this Notice at any time.

By signing this form, I affirm that I am fully informed of the therapy services I am requesting and that Amanda Coover, LMFT is providing, and granting my consent to receive such therapy services.

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DISCLOSURE STATEMENT

My signature below affirms that the preceding information has been provided to me in writing by my primary therapist or if I am unable to read and have no written language, an oral explanation accompanied by the written copy. I understand my rights as a client and should I have any questions, I will as my therapist.

Client Signature _____ Date _____

Signature of Parent / Legal Guardian _____ Date _____

Clinician Signature: _____ Date _____

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INTAKE FORM

CLIENT NAME _____

PARENT/GUARDIAN _____

ADDRESS _____

HOME PHONE _____ CELL PHONE_____

EMAIL ADDRESS _____

MAY I LEAVE A MESSAGE ON EITHER HOME OR CELL PHONE #?

HOME **CELL** (*CIRCLE ONE*)

MAY I EMAIL THE EMAIL ADDRESS LISTED ABOVE? **YES** **NO** *(CIRCLE ONE)*

EMERGENCY CONTACT _____ PHONE NUMBER _____

Please complete ROI for Emergency Contact

REFERRED BY _____

REASON FOR SEEKING TREATMENT_____

_____

_____

_____

GOAL(S) FOR THERAPY _____

_____

_____

_____

CURRENT PRESCRIPTIONS/MEDICAL CONDITIONS/ALLERGIES _____

_____

_____

_____

CURRENT PSYCHIATRIST _____

INTAKE FORM

SUBSTANCE ABUSE HISTORY

TOBACCO USE: CURRENT SUSPECTED PAST NEVER

ALCOHOL USE: CURRENT SUSPECTED PAST NEVER

OTHER DRUGS: CURRENT SUSPECTED PAST NEVER

DETAILS:_____

_____

_____

History of Abuse? Yes No

DETAILS:_____

_____

_____

History of Trauma? Yes No

DETAILS:_____

_____

_____

DEVELOPMENTAL HISTORY OF CLIENT

PROBLEMS WITH PREGNANCY OR DELIVERY: YES NO

PROBLEMS WITH EATING, SLEEPING, OR CRYING SPELLS: YES NO

DELAYS IN WALKING, TALKING, TOILET TRAINING, ETC.: YES NO

ACADEMIC PROGRESS WITHIN NORMAL LIMITS: YES NO

SOCIALIZATION SKILL AGE APPROPRIATE: YES NO

CONFLICT IN FAMILY OF ORIGIN SETTING: YES NO

SUBSTANCE ABUSE OR ABUSE ISSUES IN THE FAMILY: YES NO

MENTAL ILLNESS IN THE FAMILY HISTORY: YES NO

DETAILS:_____

_____

_____

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INTAKE FORM

CURRENT SI/SELF HARM: YES NO

HISTORY OF SI/SELF HARM: YES NO

CURRENT HI YES NO

HISTORY HI YES NO

CURRENT AUDITORY/VISUAL HALLUCINATIONS: YES NO

HISTORY AUDITORY/VISUAL HALLUCINATIONS: YES NO

DETAILS:_____

_____

_____

CONCERN WITH SLEEP? YES NO

DETAILS:_____

_____

_____

CONCERN WITH APPETITE? YES NO

DETAILS:_____

_____

_____

LEGAL CONCERNS (ON PROBATION/PAROLE? YES NO

DETAILS:_____

_____

_____

MILITARY SERVICE? YES NO

IF YES, WHAT BRANCH? _____

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INTAKE FORM

TRAUMA RELATED TO MILITARY SERVICE? YES NO

DETAILS:_____

_____

_____

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AUTHORIZATION TO EXCHANGE CONFIDENTIAL INFORMATION

I, (Name of Client)_____ hereby authorize AMANDA COOVER, LMFT to exchange confidential information regarding my treatment with _____

_____

_____

_(Name/Address/Phone Number)

This authorization permits the exchange of the following information:

__ Any and All Information Necessary _____ Diagnosis

_____Treatment Plan ____ Progress to Date

____ Dates of Treatment ___Client Records ____ Summary of Treatment

____ Other _____

I authorize the exchange of information described above for the following purpose(s):

_____

_____

_____

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.
This authorization is effective from_____to_____ (not to exceed 1 year).

_____ _____

Client Signature Date

_____ _____

Signature of Parent / Legal Guardian Date

_____ _____

Witness Date

Amanda M. Coover, MA, LMFT
Licensed Marriage and Family Therapist License # LMFT .0001278