## Confidentiality and Privacy

**Confidentiality/Client Privacy Practices:** All communication between the therapist and client is considered privileged, kept confidential and is not revealed to anyone without the client's written permission. There are several exceptions to this, of which you should be aware:

When individuals intend to harm others or themselves, state law requires that the therapist take action to inform and protect others from possible harm. The law also mandates reporting of child and elder abuse.

If a complaint is filed against the therapist with the Colorado Department of Regulatory Affairs (DORA), DORA has the authority to subpoena confidential records relevant to that complaint.

If you file a worker's compensation claim, I must furnish a report to your employer within five days and at subsequent intervals. Although in most legal proceedings client records are confidential, there are some exceptions, such as a request by court order or subpoena.

In order to provide the best care for my clients, I sometimes consult other licensed mental health professionals about a case. No identifying information is used in the consultation process, and my consultant would also be legally bound to keep the consultation confidential.

For clients who are under 18 years of age and not emancipated, parents and children should be aware that the law may allow parents to examine their child's treatment records unless I determine that access would have a detrimental effect on my professional relationship with the client, or to his/her physical safety or psychological well-being.

The law and standards of my profession require that I keep Protected Health Information (PHI) about you in your Clinical Record. Except for unusual circumstances, you may examine and/or receive a copy of your Clinical Record, if requested in writing. Federal law (HIPPA) grants you certain rights regarding your records, including the right to amend your record, the right to restrict what information is disclosed to others, an accounting of disclosures, determining the location to which protected information is sent, to record complaints about my policies and procedures, and to obtain a paper copy of this Agreement.

**Disclosure Statement**

Lisa received her Bachelor of Arts Degree in Psychology from University of California, San Diego. She received her Master's Degree in Marriage, Family and Child Counseling from University of San Diego. Lisa is a Colorado Licensed Marriage and Family Therapist (#856).

**Receipt and Acknowledgment of Confidentiality and Privacy Practices**

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Confidentiality and Privacy Practices of Lisa McSeveney, LMFT. I understand that if I have any questions regarding the policies or my privacy rights, I can contact Lisa at 760-608-3746 or discuss it with her at my next session.

_____ _____

**Client Signature** **Date**

## Policies, Consent to Treatment & Therapist Disclosure

**Appointments**: An appointment is scheduled specifically for you. I ask that you notify me at least 24 hours in advance if you are unable to keep your appointment and wish to cancel or reschedule. **Missed appointments and late cancellations, other than those due to emergencies, will be charged the full hourly fee.** This cannot be billed to insurance and must be paid by the time of the next visit.

**Authorizations, Fees and Payments**: Required managed care authorizations need to be obtained prior to scheduled appointments. I authorize Lisa McSeveney, LMFT to file all claims for Professional Services rendered, and authorize all insurance payments for those services to be paid directly to TurningPoint Counseling, PLLC. I also authorize Lisa McSeveney, LMFT to release any medical or other information necessary to process claims to my insurance company or its agent. I understand that it is my responsibility to pay for any deductible amount, co-pay, any non-covered service (i.e. missed appointment fees, completion of claim forms, court appearance fees), or services in which I am ineligible. I understand that it is my responsibility to obtain prior authorization for treatment from my insurance carrier and that failure to obtain authorization may result in increased financial expenses for services.

The standard fee for counseling is **$125 per session**. In cases of documented special need, a fee adjustment may be made, at therapist's discretion. Other services, such as letters, reports, consultations, etc., will be charged at the session rate for the amount of time required. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time, including preparation and transportation costs, even if I am called to testify by another party. Fees/co-payments are payable at the time of service.

**Agreed upon fee/Insurance co-payment**:_____

**Returned Check Policy:** There is an additional $35 fee for any check returned for non-sufficient funds.

**Urgent calls**: For life threatening emergencies, you need to call 911. Other urgent messages can be left on voice mail (MF 8 a.m. to 5 p.m.). Calls after office hours will be returned the following business day.

**Contacting Client:** There may be times I may need to contact you. To ensure your confidentiality, **please initial** the mode of communication and contact numbers that you prefer:

_____(initial) Home phone _____

_____(initial) Cell phone _____

_____(initial) Work phone _____

_____(initial) e-mail _____

_____(initial) home address _____

_____

**Consent to Treatment & Policy Agreement:**
I consent to assessment, treatment, and/or diagnostic procedures for myself or for my minor child. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I agree to the policies outlined above.

_____ _____

Client or Representative Date Lisa McSeveney, LMFT Date

## Release of Information

I authorize Lisa McSeveney, LMFT , to make contact, by phone, in writing, or in person with

_____ and to release any and all information concerning me as may be
(name of other professional)

necessary and/or helpful in my clinical evaluation, treatment planning, and treatment activity. I authorize

_____ to release any and all information requested by Lisa
(name of other professional)

McSeveney ,LMFT. It is my intention that the professionals with whom I have been in treatment and with whom I am currently in treatment be able to freely exchange information in order to best serve me. I understand that this authorization for sharing of treatment information terminates 90 days from signature date below.

| _____ | _____ | _____ |
|---|---|---|
| Client's Name (Print) | Client's Name (Sign) | Date |

| _____ | _____ |
|---|---|
| Lisa McSeveney, LMFT | Date |