19 East Abarr Drive~Pueblo West, CO 81007
435-817-0155

Professional Disclosure Statement, Member Rights, Fee Schedule, Consent to Services and Coordination of Care

Clive R. Hallam-LMFT, MBA
Licensed Marriage and Family Therapist, CO-0001268, UT-8971102-3902 and WY-134

As your therapist I will treat you with respect as a unique individual. Although I am trained in a number of theoretical and practice modalities, I generally use a mindful awareness and a skills based therapeutic approach to assist clients in resolving problems in their lives.

In the event that a more intensive level of care or treatment outside my scope of competence is warranted, I may provide you with a referral to another professional for those services. If referred for additional services, you will be responsible for payment for those services.

As a Licensed Marriage and Family Therapist I follow the ethical rules and laws of my profession, the rules and regulations of the Colorado Department of Regulatory Agencies (DORA) and the Code of Ethics of the American Association of Marriage and Family Therapists (AAMFT). These include but are not limited to rules governing standards of confidentiality, dual relationships, and the prohibition against sexual intimacy between counselors and clients.

I will respect the inherent rights and responsibilities of your parents (for clients under 15 years of age) and may share information with them about you as therapeutically indicated. I am sensitive to the cultural and social diversity among families. I recognize that all parents (custodial and non-custodial) are vested with certain rights and responsibilities for the welfare of their children by virtue of their position and according to the law.

Regarding standards of confidentiality, it is important to note that I may break confidentiality, according to legal and ethical rules, for any of the following matters:

- Abuse or harmful neglect of children, the elderly or disabled or incompetent individuals is known or reasonably suspected.
- The validity of a will of a former client is contested.
- Information related to counseling is necessary to defend against a malpractice action brought by a client.

- An immediate threat of physical violence against a readily identifiable victim is disclosed to the counselor.
- In the context of civil commitment proceedings, where an immediate threat of self-inflicted harm is disclosed to the counselor.
- The client alleges mental or emotional damages in civil litigation or his/her mental or emotional state becomes an issue in any court proceeding concerning child custody or visitation.
- The patient or client is examined pursuant to a court order.
- In the context of investigations and hearings brought by the client and conducted by the Board, where violations of this act are at issue.

The following is information regarding mandatory disclosure and informed consent.

(I) A client is entitled to receive information about the methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure;

(II) The client may seek a second opinion from another therapist or may terminate therapy at any time;

(III) In a professional relationship, sexual intimacy is never appropriate and should be reported to the director or the board that regulates, registers, certifies, or licenses such unlicensed psychotherapist, registrant, certificate holder, or licensee;

(IV) The information provided by the client during therapy sessions is legally confidential in the case of licensed marriage and family therapists, social workers, professional counselors, psychologists, licensed or certified addiction counselors, and unlicensed psychotherapists, except as provided in section 12-43-218 and except for certain legal exceptions that will be identified by the licensee, registrant, certificate holder, or unlicensed psychotherapist should any such situation arise during therapy.

(2) If the client is a child who is consenting to mental health services pursuant to section 27-10-103, C.R.S., disclosure shall be made to the child. If the client is a child whose parent or legal guardian is consenting to mental health services, disclosure shall be made to the parent or legal guardian.

(3) In residential, institutional, or other settings where psychotherapy may be provided by multiple providers, disclosure shall be made by the primary therapist. The institution shall also provide a statement to the patient containing the information in paragraphs (c) and (d) of subsection (1) of this section and a statement that the patient is entitled to the information listed in paragraphs (a) and (b) of subsection (1) of this section concerning any psychotherapist in the employ of the institution who is providing psychotherapy services to the patient.

(4) The disclosure of information required by subsection (1) of this section is not required when psychotherapy is being administered in any of the following circumstances: (a) In an emergency; (b) Pursuant to a court order or involuntary procedures pursuant to sections 27-10-105 to 27-10-109, C.R.S.; (c) The sole purpose of the professional relationship is for forensic evaluation; (d) The client is in the physical custody of either the department of corrections or the department of human services and such department has developed an alternative program to provide similar information to such client and such program has been established through rule or regulation pursuant to the "State Administrative Procedure Act", article 4 of title 24, C.R.S.; (e) The client is incapable of understanding such disclosure and has no guardian to whom

disclosure can be made; Effective July 1, 2009 Page 13 of 65 COLORADO MENTAL HEALTH PRACTICE ACT (f) By a social worker practicing in a hospital that is licensed or certified under section 25-1.5-103 (1) (a) (I) or (1) (a) (II), C.R.S.; (g) By a person licensed or certified pursuant to this article, or by an unlicensed psychotherapist practicing in a hospital that is licensed or certified under section 25-1.5- 103 (1) (a) (I) or (1) (a) (II), C.R.S.

(5) If the client has no written language or is unable to read, an oral explanation shall accompany the written copy.

(6) Unless the client, parent, or guardian is unable to write, or refuses or objects, the client, parent, or guardian shall sign the disclosure form required by this section not later than the second visit with the psychotherapist.

IMPORTANT INFORMATION FOR HEALTH FIRST COLORADO MEMBERS

<u>As a Health First Colorado Member, you have the right to:</u>

- Be treated with respect, dignity and regard for your privacy;
- Be free from discrimination on the basis of race, religion, gender, age, disability, health status, or sexual orientation;
- Get information on treatment options in a way that is easy to understand;
- Take part in decisions made about your health care. This includes the right to refuse treatment, except as required by law;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
- Ask for and get a copy of your medical record. You may ask for it to be changed or corrected;
- Have an independent advocate;
- Ask that we include a specific provider in our network;
- Get a second opinion;
- Receive culturally competent services;
- Get interpreter services if you have disabilities or if you do not speak English;
- Be told if your provider stops seeing members or has changes in services;
- Tell others your opinion about our services. You can tell regulatory agencies, the government, or the media without it affecting how we provide covered services;
- Get medically necessary mental health care services according to federal law;
- Be free to use all of your rights without it affecting how you are treated; and
- Be free from sexual intimacy with a provider.

If this happens, report it to the: Colorado Department of Regulatory Agencies (DORA). Phone: 303-894-7788 or write to: DORA, 1560 Broadway, Suite 1350, Denver, CO 80202

<u>As a Health First Colorado Member, you have the Responsibility to:</u>

- Learn about your mental health benefits and how to use them
- Be a partner in your care. This means:
  - Following the service plan you and your therapist have agreed on
  - Participating in treatment and working toward the goals of your service plan
  - Taking medications as agreed upon between you and your prescriber.
- Tell your therapist or if you do not understand the service plan, if you do not agree with the plan, or if you want to change it.

- Give your therapist or doctor the information s/he needs to provide good care. This includes signing releases of information so that your providers can coordinate your care.
- Come to your appointments on time. Call the office if you will be late or if you can't keep the appointment.
- Cooperate with Beacon Health Options, the Health First Colorado contractor that works with your provider. You may call Beacon Health Options at 1-800-804-5008 for questions about choosing a provider or making your first appointment.
- Let us know when you change your address or phone number, and when you have lost or renewed your eligibility for Health First Colorado.
- Treat others with courtesy and respect as you want to be treated.

Advance Directives:

Even though Beacon Health Options and your therapist provide mental health services, federal law requires that we tell adult patients about Colorado laws relating to your right to make health care decisions and Advance Directives. You can receive mental health care whether or not you have an advance directive.

What is a Medical Advance Directive? Advance Directives are written instructions that express your wishes about the kinds of medical care you want to receive in an emergency. In Colorado, Medical Advance Directives include:

- **Medical Durable Power of Attorney:** This names a person you trust to make medical decisions for you if you cannot speak for yourself.
- **Living Will:** This tells your doctor what type of life supporting procedures you want and do not want.
- **Cardiopulmonary Resuscitation (CPR) Directive of "Do Not Resuscitate Order":** This tells medical personnel not to revive you if your heart or lungs stop working.

Your provider will ask you if you have an Advance Directive. If you wish, your provider will put a copy of your Advance Directive in your medical file. If a medical provider does not follow your Advance Directive, you may call the Colorado Department of Public Health and Environment at 303-692-2980.

For more information about Advance Directives, talk with your **P**rimary **C**are **P**hysician (PCP). To get a copy of Beacon Health Options' policy on Advance Directives, call the Office of Member and Family Affairs at 303-432-5956 or 1-866-245-1959.

Well-Child Exams (EPSDT)

For clients under the age of 21, we are required to ask if any mental health issues were found in your child's last medical visit or well-child exam. We want to address the issues that were found and coordinate care with your primary care physician (PCP). Your provider will ask you to sign a release of information.

If your child has not had a well-child exam within the last year, your therapist will suggest that you schedule an appointment. If you do not have a PCP or you want a new PCP, you may call Health Colorado. For help in Denver, call 303-839-2120; outside of Denver, call 1-888-367-6557 (The call is free.); TTY**:** 1-888-876-8864.

Clive Hallam's education:

Bachelor of Science, Human Development and Family Studies,
University of Utah

Masters of Science, Marriage and Family Therapy,
University of New Hampshire

Masters of Business Administration
University of Phoenix

Fees: 120.00 dollars for initial session, 90.00 for subsequent sessions or the agreed upon fees are as stated on the summary of benefits connected to your insurance policy. Payment is expected at the time of service. 24-hour advanced notice to rescheduled or to cancel your appointment is required to avoid paying the full amount of your appointment fee.
Call 435-817-0155 or your clinician directly to reschedule or to cancel.

I, _____, have had this document explained to me and I understand, and agree to, the contents therein. I also agree to the terms and conditions regarding treatment services, confidentiality, professional relationships, and payment for services. My signature also provides my consent to treatment services and my agreement to participate fully or to the best of my ability. I also understand that I am not required to sign this document and that I am not waiving any of my rights. I understand that I may discuss any concerns relating to treatment services prior to beginning therapy.

Thank you for choosing My Therapy Matters and I appreciate the opportunity to work with you. If you have additional questions or concerns please contact me directly. If you have questions or concerns regarding HIPAA, you may visit www.hhs/gov/ocr/hipaa or call 1-800-627-7748 or email questions to: ocrprivacy@os.dhhs.gov

_____ _____
Client/Parent (or Guardian)/Member Signature Date

_____ _____
Clinician Signature Date

Credit Card Payment Authorization

If you are choosing to use Medicaid, do not complete this section.

Cash, personal checks, credit or debit cards are accepted forms of payment at My Therapy Matters and you are welcome to choose your preferred form of payment. Regardless of your preferred form of payment, it is the policy of My Therapy Matters to have an active credit card on file for each client. The active credit card will only be used with your knowledge and verbal permission. The selected credit card can be used for your session fees or in the event that you are unable to bring cash or check to your scheduled appointment.

The credit card on file may be used in the event that you do not provide 24-hour advanced notice to reschedule or cancel your scheduled appointment. By signing this document you are authorizing My Therapy Matters to charge your credit card up to 120.00 dollars if you cancel or reschedule your appointment with less than 24-hours advanced notice. Medical or family emergencies or other unforeseen circumstances beyond your control will not be considered grounds for a no-show fee and do not require 24-hour advanced notice.

By signing this document, you are authorizing My Therapy Matters to charge your provided credit card up to 120.00 dollars per session. Credit card payments also have a usage fee of approximately 3% per transaction. My Therapy Matters and/or Clive Hallam's name may appear on your credit card receipt which may create a record of services received that could be visible to your credit institution.

It is expected that you provide updated credit card information as quickly as possible to My Therapy Matters. My Therapy Matters will make every reasonable effort to protect your sensitive credit card information and transactions including encryption programs, dual locking systems for all documents and shredding all documents within industry standards.

Credit Card number:_____

Card expiration date:_____

Three digit authorization code (back of card)_____ Billing Zip code:_____

Client Signature:_____Date:_____

Parents Signature (if client is under 18)_____Date:_____

Therapist
Signature:_____Date:_____

PHYSICAL AND BEHAVIORAL HEALTH COORDINATION OF CARE INFORMATION

19 East Abarr Drive~Pueblo West, CO 81007
435-817-0155
Clive R. Hallam-LMFT, MBA
Licensed Marriage and Family Therapist, CO-0001268, UT-8971102-3902 **and WY-134**

Date: _____ RE:_____
To: _____ Client's Date of Birth:_____

Dear Dr.
I am currently providing mental health treatment to this client. This client was enrolled for treatment on _____ and has designated you as his/her primary care physician. A release of information was signed. We have encouraged him/her to maintain ongoing medical care with you. We wish to keep you informed of pertinent information related to his/her mental health treatment.

Primary DSM-V/ICD-10 Diagnosis: _____
Secondary: _____

Current medications (as reported by client):_____
_____

Treatment considerations:_____
_____

PLEASE BE AWARE THAT THE ABOVE INFORMATION WAS ACCURATE AS OF THE TIME THIS LETTER WAS SENT. IN THE COURSE OF TREATMENT, CHANGES MAY OCCUR.

Behavioral Health Provider Name:_____with My Therapy Matters
Fax# 719-299-4638
Office Location: 19 East Abarr Drive. Pueblo West, CO 81007
Phone# 435-817-0155

TO FACILITATE COORDINATION OF CARE, PLEASE SEND US RELEVANT INFORMATION REGARDING THIS CLIENT'S MEDICAL TREATMENT, INCLUDING ANY ICD-10 MEDICAL DIAGNOSES, MEDICATIONS PRESCRIBED AND ANY ABNORMAL LAB RESULTS, AS APPROPRIATE.

Also, please indicate additional correspondence you would like to receive (optional):
( ) Notice of a Psychiatric Hospitalization ( ) Behavioral Health Treatment Plan Information
( ) Notice of an Emergency Room Visit

Sincerely,

Primary Clinician:_____

Client/Guardian:_____Date:_____

☐ By checking this box I _____ am declining any coordination of care information to be shared. I understand that I can choose to have coordination of care information shared in the future.

Original to: PCP, Copy to: Chart