Front Range Psychological Associates

526 Briggs Street
Suite A
Erie, Colorado 80516
303-828-3080

PERSONAL INFORMATION

Name_____ Date_____
first initial last

Address_____
street apt. city state zip

Home Phone _____>> OK to call? Y N OK to leave message? Y N
Pager/Cell Phone _____>> OK to call? Y N OK to leave message? Y N
Work Phone _____ >> OK to call? Y N OK to leave message? Y N

***We provide a free, monthly e-newsletter. If you would like to receive this newsletter, please provide your email address**:_____

Gender __F __M Date of Birth _____ Age _____

Relationship Status: __ single __married __ separated __ divorced __ committed relationship

Living With: __ spouse/partner __ parent[s] __ roommate[s] __ children __ other _____

Please list each person living with you, their relationship, and age:

1._____

2. _____

3. _____

4._____

Education: Highest grade completed or highest degree _____

Occupation: _____ Employer: _____

EMERGENCY CONTACT

Name :_____ Relation to You _____

Home Phone _____ Cell Phone _____ Work Phone _____

PRIMARY INSURANCE

Card Holder _____ Relationship to you _____

Insurance Company_____ Phone _____

Policy # _____ Group # _____

Policy Holder's Social Security #_____-____-_____ **Policy Holder's Date of Birth** _____

Policy Holder's Employer_____

Who Referred You? (check all that apply)

___	Insurance Provider List	___	Internet	___	Court Ordered
___	Support Group	___	Telephone Book	___	Mental Health
___	Psychiatrist	___	Partner/significant other		Professional
___	Family Doctor	___	Employer	___	A former client of
___	OB/Gyn	___	Parents/family		FRPA
___	Friend	___	Attorney	___	Other _____

PREVIOUS COUNSELING ___ No ___ Yes

If yes, please give therapist's name, dates, and reason:

_____

_____

_____

_____

Ever been hospitalized for a mental health concern? ___ No ___ Yes

SYMPTOM CHECKLIST (check all that apply)

___ Work/Career problems	___ Sexual problems	___ Physical or sexual
___ Sleep pattern disturbances	___ Guilt/shame	abuse or assault
___ Nervous or anxious feelings	___ Shyness	___ Other trauma
___ Sadness	___ Anger management	___ Cultural/ethnic/racial issues
___ Repetitive/ intrusive thoughts	___ Dealing with conflict	___ Pregnancy-related problems
___ Motivation problems	___ Legal problems	___ Sexual orientation issues
___ Concentration problems	___ Alcohol use or abuse	___ Grief or loss
___ Loneliness or isolation	___ Health/physical illness	___ Impulsiveness
___ Panic attacks	___ Aging	___ Trouble saying no/setting
___ Drug use or abuse	___ Identity	limits
___ Eating or body image issues	___ Concerns about family	___ Relationship problems

___ Child Custody Issues

___ I have used illegal drugs (marijuana, cocaine, pills, etc.) within the past year.

___ I have on average _____alcoholic drinks on days I chose to drink.

___ I have been arrested in the past year.

___ I often go on eating binges.

___ I vomit, take laxatives, or exercise a great deal to control my calorie intake.

___ In the past I have made a suicide attempt.

___ I have been thinking about harming or killing myself:

_____today _____this week _____ in the last month _____ in the last 6 months

___ I have periods where I need very little sleep, think fast, work fast, and feel much happier than usual.

___ I have thoughts about harming others.

MEDICAL HISTORY

Past health problems or illnesses: _____

Current health problems or illnesses: _____

Dr.'s name who is treating you for above problems: _____

I am currently taking medication prescribed by a doctor. (Please list)

Medication	Reason	Medication	Reason
_____	_____	_____	_____
Medication	Reason	Medication	Reason
_____	_____	_____	_____

I take the following herbal supplements, teas, or over the counter medications on a regular basis: _____

_____

For Office Use Only:

DSM-IV Diagnosis:

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

GAF _____

Additional Notes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I, _____, understand that as part of my health care, Front Range Psychological Associates originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health care professionals who contribute to my care,
- A source of information for applying my diagnosis and service information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Privacy Practi*ces that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the *Notice of Privacy Practices* prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Front Range Psychological Associates is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that action has already been taken based on my initial signing of this consent. I also understand that by refusing to sign this consent or revoking this consent, Front Range Psychological Associates may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand Front Range Psychological Associates reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Front Range Psychological Associates change their *Notice of Privacy Practices* they will send a copy of any revised notice to the address I've provided.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures by fax.

By my signature below, I attest that I fully understand and accept the terms of this consent.

_____ _____

Client's Signature Date

Front Range Psychological Associates

526 Briggs Street
Suite A
Erie, CO 80516.

303-828-3080

CONFIDENTIALITY

The communication between you—the client or patient—and your therapist is confidential. This means that you have the privilege to refuse to disclose and to prevent your therapist from disclosing confidential communications made for the purpose of diagnosis or treatment without your written consent.

No disclosure can be made, with the following exceptions:

- If you have abused or are abusing a child or an adult.
- If you are a danger to yourself or others.
- If you assert that you mental condition is an issue in a claim or defense as part of civil or criminal law proceedings.
- If your assessment and/or treatment is court ordered.
- If you seek reimbursement for the cost of your therapy from an HMO, managed care, or insurance company. Your direction that such information be provided does not constitute a waiver of your privilege and your therapist will continue to protect that privilege after providing information to an HMO, managed care or insurance company. Your therapist cannot, however, control how such information may be treated by an HMO, managed care or insurance company. The waiver you sign with your insurance company may make your records available to case management, utilization review and other entities which request your records, such as life insurance companies.
- In proceeding to assist you with entering a hospital for emotional and/or chemical dependency treatment when you and/or your therapist in the course of diagnosis or treatment determine that you are in need of hospitalization.

I have read and understand the limits to confidentiality and have discussed this information with my therapist.

_____ _____
Client Signature Date

_____ _____
Therapist's Signature Date

Front Range Psychological Associates

526 Briggs Street
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303-828-3080

CLIENT RESPONSIBILITIES

1. You are responsible for rendering payment at the time of service unless other arrangements are made in advance. We accept cash, check, Visa, or Mastercard.
2. Returned checks and balances older than 30 days will be subject to additional collection fees and interest charges of 1.5% per month.
3. You are responsible for requesting payment from your insurance company for services rendered by this office. We will verify benefits and submit claims to your insurance company if applicable. **You are responsible for any fees not paid by your insurance company.**
4. **If you need to reschedule an appointment, it is your responsibility to contact our office at least 24 hours in advance. Late cancellations and/or failure to keep your appointment will be billed at $115/session. If you need to make changes to a Monday appointment, changes need to be made by the previous Friday. These fees are not paid by your insurance company.**
5. It is your responsibility to respect the confidentiality of others. We must request that you NEVER discuss the presence of any other client you may meet or see at our office.
6. Although you have the right to terminate counseling at any time, we strongly recommend that a termination appointment be scheduled before you conclude therapy. It is advantageous to both you and your therapist to have a sense of closure regarding your treatment.

I have read and understand my responsibilities as a client of Front Range Psychological Associates. I will do my best to adhere to the policies presented above.

_____ _____
Client Signature Date

_____ _____
Therapist's Signature Date

NOTICE OF MENTAL HEALTH PRACTITIONERS' POLICIES AND PRACTICES TO PROTECT THE PROVACY OF YOUR HEALTH INFORMATION

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

FRONT RANGE PSYCHOLOGICAL ASSOCIATES
Stephanie S. Smith, Psy.D.
526 Briggs Street
Suite A
Erie, Colorado 80516
303-828-3080

I. Uses and Disclosures for Treatment, Payment, and Healthcare Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes. To help clarify these terms, here are some definitions:

"PHI" refers to information in your health record that could identify you.
"Treatment, Payment, and Health Care Operations"

- Treatment is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
- Payment is when I obtain reimbursement for your health care. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.

"Use" applies only to activities with my practice group, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

"Disclosure" applies to activities outside of my practice group, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when you appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization from you before releasing your psychotherapy notes. "Psychotherapy notes" are notes that I have made about our conversation during private, group, joint, or family counseling sessions, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection that PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided that each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

CHILD ABUSE: If I have reasonable cause to believe that a child is dependent, neglected, or abused, I must report this belief to the appropriate authorities, which may include the Colorado Department for Families and Children or its designated representative, the state's attorney or the county attorney, or local law enforcement agency or the Colorado State Police.

"Dependent child" mean any child, other than an abused or neglected child, who is under improper care, custody, control, or guardianship that is not due to an intentional act of the parent, guardian, or person exercising custodial control or supervision of the child.

ADULT AND DOMESTIC ABUSE: If I have reasonable cause to believe that an adult has suffered abuse, neglect, or exploitation, I must report this belief to the Colorado Department for Families and Children.

HEALTH OVERSIGHT ACTIVITIES: The Colorado Board of Examiners of Psychology may subpoena records from me relevant to its disciplinary proceedings and investigations.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.

SERIOUS THREAT TO HEALTH OR SAFETY: if you communicate to me an actual threat of physical violence against a clearly identified or reasonably identifiable victim or an actual threat of some specific violent act, I have a duty to notify the victim and law enforcement authorities.

WORKERS' COMPENSATION: if you file a claim for workers' compensation, you waive the psychologist-patient privilege and consent to disclosure of your health information reasonably related to your injury or disease to your employer, workers' compensation insurer, special fund, uninsured employers' fund, or the administrative law judge.

IV. Patient's Rights and Psychologist's Duties:

Patient's Rights:

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of PHI. However, I am not required to agree to a restriction you request.

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.

Right to Inspect and Copy: You have the right to inspect or obtain a copy of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to an Accounting: You generally have the right to receive an accounting of disclosures on the PHI. On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy: You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI

I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

If I revise my policies and procedures, I will notify you by submitting the revised copy to you by mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Stephanie Smith, PsyD at 303-828-3080.

If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to: Stephanie Smith, PsyD P.O. Box 1154
Erie, Colorado 80516.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed about can provide you with the appropriate address upon request.

You have specific rights under the privacy rule. I will not retaliate against you for exercising your right to file a complaint.