



Welcome!

Thank you for choosing Elliant Counseling Services, PC (**ECS**). We are dedicated to providing quality counseling services. Below, you will find information regarding our office policies, non-discrimination, confidentiality, consent and competent service.

This packet provides you and your counselor the information necessary to move forward with counseling services.

Please complete and sign the following forms for your initial meeting with your counselor and retain a copy for your personal records.

Thank You!

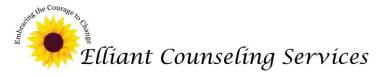
Elliant Counseling Services, PC

7500 E Arapahoe Road, Suite 295 Centennial, Colorado 80112

720-883-1480 | www.elliantcounseling.com







Practice, Payment and Confidentiality Policies

SESSIONS & FEES

ECS therapists are divided into 3 different levels of experience and so we have 3 different rates. We charge the following fee/per minute schedule:

Lead Therapist

\$155/50 minute session (typical therapy hour) \$230/75 minute session \$335/100 min 2-hour Intensive Session \$490/150 Min 3-hour Intensive Session

Specialist

\$130/50 minute session (typical therapy hour) \$195/75 minute session \$275/100 Min 2-hour Intensive Session

Associate

\$100/50 minute session (typical therapy hour) \$150/75 minute session \$225/100 Min 2-hour Intensive Session

Initial therapy sessions are 75 minutes long and bills at the 50 min rate. This allows adequate time to go over your welcome packet information, reasons for seeking therapy, and discussing therapeutic goals.

Phone consultations and support calls lasting more than 10 minutes are billed in 15-minute increments. Various groups are available to attend and sessions are \$75 per 90-minute group.

PAYMENT POLICY

ECS therapists see clients on a fee-for-service basis only and the client (parent or responsibly party) is responsible for payment in full at the time of each session. Any other arrangements must be made in advance. We accept cash, check, and all major credit/debit/FSA/HSA cards. Any check returned for non-sufficient funds will be charged a \$34.00 administrative fee, plus any additional banking fees associated with the check.

INSURANCE

ECS does not directly bill <u>any</u> insurance or medical plan providers. Many insurance plans reimburse for some portion of psychotherapy. Please direct questions about reimbursement amounts and timelines to your insurance company. ECS will provide an insurance-ready Receipt of Services Rendered form for you to initiate the reimbursement process privately through your insurance company if you so choose. Please know that it is your responsibility to pursue these claims. ECS will not complete any insurance paperwork and we are not an in-network provider.



CANCELLATIONS / LATE / NO SHOW

We understand that it may, at times, be necessary to cancel an appointment. To help us be the most efficient and responsible in the use of our time, we require that any changes or cancellations be made a minimum of 24 hours in advance. The best way to communicate with us regarding changes or cancellations is by phone. Without this 24-hour notice, you will be charged a \$75.00 fee for that appointment. If you are late for an appointment, we must still end on time and you will be charged for the full session. If you do not call and do not show for a scheduled appointment, you may be charged the full session fee. Emergency situations are exceptions to this policy and will be evaluated and discussed on a case-by-case basis.

COMMUNICATION

Often, we are not immediately available by telephone. When we are unavailable, you can leave a message on our confidential voice mail. It may be 24-48 hours before we can return your call. We check our phone for text messages regularly and can respond more quickly by Text. We will make every effort to return your call on the same day, with the exception of weekends and holidays.

EMAIL

ECS requests that E-mail communication be kept to a minimum, limiting communication to administrative concerns or general information only. To protect your confidentiality, please do not discuss confidential information by email as it is not a secure method of communication and we cannot guarantee confidentiality. Any email correspondence may become a part of your clinical record.

Email should never be used to contact us in the event of an emergency.

Informed Consent to Communicate Via Email:

ECS will only communicate with you by email with your informed consent. I have read and understand the above information and wish to exchange communications via email.

□ Yes □ No	(Initials)	۱
□ res □ No	(Imuais))

TEXT MESSAGING

To protect your confidentiality, ECS requests that text communication be kept to a minimum. This would include communication via administrative concerns, such as cancellations and scheduling changes. Please do not discuss confidential information via text message as it is not a secure method of communication and we cannot guarantee confidentiality.

Informed Consent to Communicate Via Text Messaging:

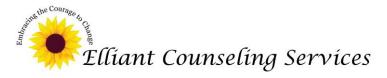
ECS will only communicate with you by text with your informed consent. I have read and understand the above information and wish to exchange communications via text messaging.

☐ Yes ☐ No	(Initials)

Other forms of Electronic Communication

Please do not use any personal messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact ECS. These sites are not secure or confidential, instead use any of the Elliant email addresses.





Social Media

We do not accept friend or contact requests from current or former clients on any social or networking site (Facebook, LinkedIn, etc.). We believe adding clients as friends or contacts on these sites may compromise your confidentiality, our respective privacy, and the boundaries of our therapeutic relationship.

FINANCIAL AGREEMENT AND AUTHORIZTION FOR TREATMENT

I have read the preceding information and I understand my rights as a client. I authorize treatment of the person named below and agree to pay all fees as stated above.

Print Client Name or Responsible Party	Signature Client or Responsible Party	Date
		//
Print Joint Client Name	Signature Joint Client Name	Date





Today's Date: ___/___

Confidential Client Information

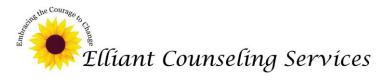
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Medical History
Are you currently under medical care? \square Yes \square No If yes, please describe:
Physician's Name Phone:
Do you take any prescription medications? $\ \square$ Yes $\ \square$ No
If yes, list name, dosage and frequency:
Other significant medical history:
Counseling History
Have you ever seen a counselor/therapist/psychologist/psychiatrist? ☐ Yes ☐ No
Please provide, Name: Date:/ Location:
When was your last appointment with any of the above?
Reason for Counseling
Why are you seeking counseling now?
How long have these concerns been causing you distress?
How do you hope counseling will help?

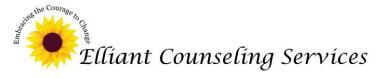




FUNCTIONAL ASSESSMENT QUESTIONNAIRE

1. Have you ever been hospitalized for psychological problems? Yes \square No \square If yes, give date(s), places, and problem(s):
2. Rate your average daily mood level (10 = high, 1 = low): Are there major highs or lows? Yes □ No □
3. Have you ever attempted suicide? Yes No If yes, share when and how:
4. Has any close relative attempted or committed suicide? Yes ☐ No ☐ If yes, share who, when and how.
5. Do you experience significant problems with any of the following behaviors (circle all that apply)? Drug Use Anger Management Conflicts at Home Difficulties Concentrating Sleep Disturbance Drinking Problem Eating Problems Conflicts at Work/School Suicidal Thoughts Tends to Isolat If yes, describe when these behavior(s) began and how they are impacting you now?
If yes to drinking or using drugs, how much of a problem is it today and have you ever been in treatment for this problem? If so, where and when did treatment occur?
6. Do you experience significant problem with any of the following emotions/ feelings (circle all that apply)? Angry (mad) Depressed (sad) Anxious or Panicky (scared) Hopeless Helpless Overwhelmed Worthless Directionless Exhausted Alone If yes, describe how long you have been feeling these particular emotions and feelings?
7. Do you experience significant problem with any of the following physical sensations (circle all that apply)? Headaches Dry Mouth Reduced/Increased Appetite Tremors Floating Sensation Palpitations Tingling Twitching Blackouts Numbness If yes, describe how long you have been experiencing these sensations?





NOTICE OF PRIVACY POLICIES AND PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL AND MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Elliant Counseling Services, PC ("ECS") believes it may be a covered entity under the Health Insurance Portability and Accountability Act (HIPAA) and thus provides its clients with this Notice of Privacy Policies & Practices and complies with the procedures and protocols listed herein. If ECS is determined not to be a covered entity under HIPAA, it will still follow this Notice of Privacy Policies & Practices regarding use and disclosure of PHI; however, the client may not be entitled to the rights set forth in the "Your Rights as a Client" section.

Given the nature of ECS's work, it is imperative that it maintains the confidence of client information that it receives in the course of its work. ECS is a mental health practice that provides mental health services. ECS's practice works solely to provide the best counseling treatment options to its clients. ECS is prohibited from releasing any client information to anyone outside immediate staff, employees, interns, and/or volunteers except in limited circumstances in accordance with this Notice of Privacy Policies and Practices. Discussions or disclosures of protected health information ("PHI") within the practice are limited to the minimum necessary that is needed for the recipient of the information to perform his/her job. Please review this Notice of Privacy Policies and Practices ("Notice of Privacy Policies"). It is my policy to:

- 1. fully comply with the requirements of the HIPAA General Administrative Requirements, the Privacy and Security Rules:
- 2. provide every client who receives services with a copy of this Notice of Privacy Policies;
- 3. ask the client to acknowledge receipt when given a copy of this Notice of Privacy Policies;
- 4. ensure the confidentiality of all client records transmitted by facsimile;
- 5. obtain from each client an informed Authorization for Release of Protected Health Information form when required.

ECS is required to follow all state and federal statutes and regulations including Federal Regulation 42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164, governing testing for and reporting of TB, HIV AIDS, Hepatitis, and other infectious diseases, and maintaining the confidentiality of PHI.

PHI refers to any information that I create or receive, and relates to an individual's past, present, or future physical or mental health or conditions and related care services or the past, present, or future payment for the provision of health care to an individual; and identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. PHI includes any such information described above that I transmit or maintain in any form, this includes Psychotherapy Notes. HIPAA and federal law regulate the use and disclosure of PHI when transmitted electronically.



YOUR RIGHTS AS A CLIENT

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your mental health record

- You can ask to see or get an electronic or paper copy of your mental health record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee to fulfill your request.
- If we deny your request, in whole or in part, we will let you know why in writing and whether you have the option of having the decision reviewed by an independent third-party.

Ask us to correct your mental health record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.
- Please review the Consent for Communication of Protected Health Information by Non-Secure Transmissions.
- You are required to "opt-in" to receive communications electronically as set-forth in the Consent for Communication of Protected Health Information by Non-Secure Transmissions. If you choose not to "opt-in" to receive electronic communications, we will not communicate with you via electronic means.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Additional Restrictions

• You have the right to request additional restrictions on the use or disclosure of your mental health information. However, we do not have to agree to that request, and there are certain limits to any restriction. Ask us if you would like to make a request for any restriction(s).





Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate against you for filing a complaint.
- You may also file a complaint with the Colorado Department of Regulatory Agencies, Division of Professions and Occupations, Mental Health Section; 1560 Broadway, Suite 1350, Denver, Colorado, 80202, 303-894-2291; DORA_Mentalhealthboard@state.co.us. Please note that the Department of Regulatory Agencies may direct you to file your complaint with the U.S. Department of Health and Human Services Office for Civil Rights listed above and may not be able to take any action on your behalf.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A use of PHI occurs within a covered entity (i.e., discussions among staff regarding treatment). A disclosure of PHI occurs when ECS reveal PHI to an outside party (i.e., ECS provides another treatment provider with PHI, or shares PHI with a third party pursuant to a client's valid written authorization).

ECS may use and disclose PHI, without an individual's written authorization, for the following purposes:

1. Treatment: disclosing and using your PHI by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members and for coverage arrangements during your therapist's absence, and for sending appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.





- 2. Payment: disclosing and using your PHI so that ECS can receive payment for the treatment services provided to you, such as: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization of review activities.
- 3. Health Care Operations: disclosing and using your PHI to support ECS's business operations which may include but not be limited to: quality assessment activities, licensing, audits, and other business activities.

Uses and disclosures for payment and health care operations purposes are subject to the minimum necessary requirement. This means that ECS may only use or disclose the minimum amount of PHI necessary for the purpose of the use or disclosure (i.e., for billing purposes ECS would not need to disclose a client's entire medical record in order to receive reimbursement. ECS would likely only need to include a service code and/or diagnosis etc.). Uses and disclosures for treatment purposes are not subject to the minimum necessary requirement.

ECS is required to promptly notify you of any breach that may have occurred and/or that may have compromised the privacy or security of your PHI.

Confidentiality of client records and substance abuse client records maintained are protected by federal law and regulations. It is ECS's policy that a client must complete an Authorization for Release of Protected Health Information it provides prior to disclosing health information to another individual and/or entity for any purpose, except for treatment, payment, or health care operations in accordance with this Notice of Privacy Policies.

Absent the above referenced form, other than for treatment, payment, or health care operations purposes, ECS is prohibited from disclosing or using any PHI outside of or within the organization, including disclosing that the client is in treatment without written authorization, unless one of the following exceptions arises:

- 1. Responding to lawsuit and legal actions (Disclosure by a court order, in response to a complaint filed against ECS, etc. This does not include a request by you or another party for your records).
- 2. Disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation.
- 3. Help with public health and safety issues (Client commits or threatens to commit a crime either at ECS's office or against any person who works for ECS; A minor or elderly client reports having been abused or there is reasonable suspicion that abuse has or will take place; Client is planning to harm another person, including but not limited to the harm of a child or at-risk elder; Client is imminently dangerous to self or others).
- 4. Address workers' compensation, law enforcement, and other government requests.
- 5. Respond to organ and tissue donation requests.
- 6. Business Associates: ECS may enter into contracts with business associates to provide billing, legal, auditing, and practice management services that are outside entities. In those situations, protected health information will be provided to those contractors as needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.
- 7. In compliance with other state and/or federal laws and regulations.



The above exceptions are subject to several requirements under the Privacy Rule, including the minimum necessary requirement and applicable federal and state laws and regulations. See 45 C.F.R. § 164.512. Before using or disclosing PHI for one of the above exceptions, ECS's staff must consult its Privacy Officer (Linnaya Widhalm, LPC, CAC III, MAC, CSAT, 303-241-1080, Linnaya@ElliantCounseling.com) to ensure compliance with the Privacy Rule. Violation of these federal and state guidelines is a crime carrying both criminal and monetary penalties. Suspected violations may be reported to appropriate authorities, as listed above in the "Client Rights" section, in accordance with federal and state regulations. Know that ECS will never market or sell your personal information without your permission.

SPECIAL AUTHORIZATIONS

Certain categories of information have extra protections by law, and thus require special written authorizations for disclosures.

Psychotherapy Notes: ECS may keep and maintain "Psychotherapy Notes", which may include but are not limited to notes ECS makes about your conversation during a private, group, joint, or family counseling session, which is kept separately from the rest of your record. These notes are given a greater degree of protection than PHI. These are not considered part of your "client record." ECS will obtain a special authorization before releasing your Psychotherapy Notes.

HIV Information: Special legal protections apply to HIV/AIDS related information. ECS will obtain a special written authorization from you before releasing information related to HIV/AIDS.

Alcohol and Drug Use Information: Special legal protections apply to information related to alcohol and drug use and treatment. ECS will obtain a special written authorization from you before releasing information related to alcohol and/or drug use/treatment.

You may revoke all such authorizations to release information (PHI, Psychotherapy Notes, HIV information, and/or Alcohol and Drug Use Information) at any time, provided each revocation is in writing, signed by you, and signed by a witness. You may not revoke an authorization to the extent that (1) ECS has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, the law provides the insurer the right to contest the claim under the policy.

As a covered entity under the Privacy and Security Rules, ECS is required to reasonably safeguard PHI from impermissible uses and disclosures. Safeguards may include, but are not limited to the following:

- 1. Not leaving test results unattended where third parties without a need to know can view them.
- 2. Any PHI received as an employee, intern, or volunteer about a client or potential client, may not be used or disclosed for non-work purposes or with unauthorized individuals. ECS may only use and disclose such PHI as described above.
- 3. When speaking with a client about his or her PHI where third parties could possibly overhear, the conversation will be moved to a private area.
- 4. Seeking legal counsel in uncertain situations and/or incidences.





- 5. Obtaining a Business Associates Agreement with those third-parties that have access to and/or store client information. Some of the functions of the practice may be provided by contracts with business associates. For example, some of the billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services.
- 6. Implementing FAX security measures.
- 7. Obtaining your consent prior to sending any PHI by unsecure electronic transmissions.
- 8. Providing information on my electronic record-keeping.

YOUR CHOICES

For certain health information, you can tell ECS (verbal authorization) your choices about what it shares. If you have a clear preference for how ECS shares your information in the situations described below, talk to ECS. Tell ECS what you want it to do, and it will follow your instructions. ECS may request you sign a separate document if you authorize it to share certain PHI. You may revoke authorization at any time for future disclosure.

In these cases, you have both the right and choice to tell ECS to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell ECS your preference, for example if you are unconscious, ECS may go ahead and share your information if ECS believes it is in your best interest and for your care/treatment. ECS may also share your information when needed to lessen a serious and imminent threat to public health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Changes to the Terms of this Notice

ECS can change the terms of this notice, and the changes will apply to all information ECS has about you. The new notice will be available upon request, in ECS's office, and on the website.

This notice is effective 11-2018.

Client Signature Date

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html



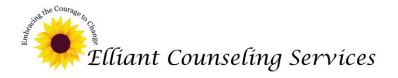
Acknowledgement of Purpose of Support Sessions

As part of a successful treatment plan and to assist in relationship mending and development, support sessions can be conducted. It is to be understood that support sessions are not considered to be either couples or family services. A support session is to help you understand the primary client that is receiving services. Support sessions can occur after every third session with primary client.

If you contact me by phone, email, fax, etc., I will not hold secrets and this information will be shared in the next session with primary client.

Primary Client Name (printed)	Primary Client (Signature)	Date
		//
Client Name (printed)	Client Signature	Date
Client Name (printed)	Client Signature	Date
Psychological Test Reports	nation in your file, including but not lim Counseling Record Status of Treatmen	ls
Social History Summary Medical Records (+ medications received Billing and Financial Information		
derstand client files may be maintained up to fi	ve years after discontinued/terminatio	on of treatment with:
	_ (name of Therapist), and I may withd	
derstand client files may be maintained up to fi	_ (name of Therapist), and I may withd	





RELEASE / To / From / Between the following

Name	Name
Center/ Agency	Center / Agency
Phone / Fax	Phone / Fax
The information listed below contained in the record of:	I and the second
individual on this request. I understand that the informa the following condition(s):	elease/request information specified below to the organization, agency, or tion to be released includes verbal and/or written information regarding
Psychological or Psychiatric Conditions	Substance Abuse
INFORMATION REQUESTED:	
I authorize the following information to be released:Discharge Summary	Educational Information
Psychiatric History & Assessment	Status of Attendance & Involvement in Treatment
Psychological Testing	Medications, Prescriptions, & Diagnostic Info.
Social History Summary	Medical History & Physical Exam
Treatment Plan, Goals, and Objectives	Final Diagnosis
Other (List)	
PURPOSES:	
I understand that this information will be used for:	
Purposes of further evaluation	Other
AUTHORIZATION:	
knowledge. I understand that I may revoke this authorize	that the information given above is accurate to the best of my ation at any time, except to the extent that action has already been taken HOSE RECEIVING THIS AUTHORIZATION IS PROHIBITED. I hereby release
	result from furnishing the information released or requested. Without
OTHER CONDITIONS:	
A copy of this authorization or my signature thereon ma	y be utilized with the same effectiveness as an original.
X	
Signature of Client	Date
X	
Signature of Witness / Parent (if applicable)	Date

(Parental signature required for clients under the age of 15. For clients age 16-17, both client and parent signatures are required.)