CLIENT - THERAPIST AGREEMENT

Look Inside Counseling, LLC

The practice of both licensed and registered persons in the field of psychotherapy is regulated by the Colorado State Department of Regulatory Agencies. Any concerns may be addressed to the appropriate licensing board or:

- Colorado State Grievance Board;1560 Broadway Street; Suite 1350; Denver, CO 80202; 303-894-7800
- 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 masters degree in their profession and have two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a masters degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1,000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelors degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical masters degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required.

CLIENTS RIGHTS:
You are entitled to receive information about methods of therapy, the techniques used, the duration of therapy if known, and the fee. You may seek a second opinion from another therapist and may terminate therapy at any time. In a professional therapy relationship, sexual intimacy is never appropriate and is illegal in Colorado. It should be reported to the Grievance Board.

CONFIDENTIALITY:
The information provided by you during therapy is legally confidential except as required by law. There are exceptions to the rule of confidentiality. In general, these exceptions include:

1. The law requires reporting cases in which:
   - the client may present a danger to self or others,
   - there is indication of child abuse or neglect or elderly abuse or neglect.

2. Therapist(s) and/or records may be subpoenaed in Court proceedings including but not limited to child custody, criminal, and delinquency cases.

If exceptions arise regarding confidentiality, they will be discussed with you.

APPOINTMENTS:
Therapy sessions are 50, 75, or 100 minutes, as predetermined by client and therapist. This time is reserved for you. In the case that you need to cancel or reschedule an appointment, 48-hour advance notice is required. With less than 48 hours notice, you will be charged the full amount for the session. Regarding cancellation for weather, Look Inside Counseling's policy is as follows: If Denver Public Schools is closed, you will not be charged for a missed session if you are unable to make it. If DPS is open, we are open, too! It is likely Look Inside Counseling is open even if DPS is closed, so please check with your therapist directly either way should you wish to come in on a snowy day.

BETWEEN-SESSION CONTACT
Boundaries are very important in the therapeutic relationship. Part of our jobs as therapists is to help our clients recognize the importance of boundaries and help them learn to adhere to and/or maintain good, healthy boundaries. Our role is to help you *in session*, so that you can go out into the world and practice the things

you've learned. It is for this reason that Look Inside Counseling has a strict between-session contact policy. Phone calls and emails can be used between sessions, when absolutely necessary, but any contact over 5 minutes will be charged at our full rate of $190.00/hr (or the hourly rate predetermined by you and your therapist). Texting is to be used for scheduling purposes ONLY. Texting is not to be used to update your therapist throughout the week. If you are a parent and your child is in therapy with me, you are asked to please attend the first 5-10 minutes of each session to update the therapist on your child's progress and/or to address any concerns. Phone calls or emails will not be answered between the hours of 6pm and 8am, and any phone calls or emails received after 6pm will be returned the next business day.

FEE:
Our full fee for a 50-minute session is $190.00. Your fee due in full each session. Look Inside Counseling, LLC reserves a few sessions per week at a reduced rate; the necessity for this is to be determined by the client and therapist, and will be reevaluated every 6 months or as your income changes.

Please have your cash or pre-written check ready prior to the beginning of each session. Please note that while we do accept checks, it is impossible to maintain 100% confidentiality with checks, as the tellers at the bank (and those ultimately processing the check) will see your name, as well as the name of my business which says that I own and operate a counseling business. **If you give Look Inside Counseling, LLC a check and it is returned or bounces, you are responsible for paying any fees associated with this transaction.** Additionally, at this point, we will no longer accept checks from you. If you end therapy with an unpaid balance and do not make arrangements to settle the bill, your account may be turned over to a collection agency. Any costs incurred in the collection are your responsibility.

Telephone conversations of a clinical nature may be charged as regular sessions. Reports and court appearances require professional time for which we charge a rate of $500 per hour. Court appearances require 4-hour minimum, and the time starts from the moment your therapist enters the building until the moment your therapist leaves. A court appearance is seldom beneficial to the therapeutic relationship, and for this reason, Look Inside Counseling, LLC likes to discuss every other option first before committing to a court appearance. Clerical or administrative work requested by you (such as faxing, phone calls, and/or writing reports for insurance purposes, attorneys, or other agencies) will be charged at a rate of $50/hour. You have the choice to pay this at the next session or we can run your card for the fee once we've submitted an invoice to you.

TREATMENT PLANNING AND EVALUATION:
Since Look Inside Counseling is not a 24-hour crisis-intervention agency, in case of an emergency, you may call the numbers on the accompanying EMERGENCY NUMBERS sheet, or you may call 911 or go to the nearest hospital emergency room.

Your therapist can approximate length of treatment and probable results; however, as response differs on an individual basis, guarantees cannot be made as to treatment outcome. If one of our therapists cannot provide the services you need, s/he can offer you referral information.

Periodically, client and therapist will assess progress toward treatment goals. It can be mutually beneficial if termination is discussed in advance.

TERMINATION:
It is always best to have a closing session when finishing therapy. If for some reason you chose to forgo this session, and do not inform your therapist that you are through with therapy, s/he will reach out to you two times, over the course of 30 days, to try to contact you about rescheduling/terminating. If we do not hear from you, we will call you at or after the end of the 30 day period, to inform you that Look Inside Counselign, LLC will be closing your file, and you will no longer be considered a client of Look Inside Counseling LLC. You are always welcome to reach back out in the future after this phone call, should you wish to begin therapy again with your therapist.

****

I have received a copy of the NOTICE OF PRIVACY PRACTICES (HIPPA). _____Client initials.

I have been given a copy of this CLIENT-THERAPIST AGREEMENT. I have read the preceding information, it has also been provided verbally, and understand my/my child's rights as a client or as the client's responsible party. I consent to treatment at Look Inside Counseling, LLC.

Adult Signature	Date	Teen Signature (ages 15-18)	Date
Therapist Signature	Date	Therapist Signature	Date

FOR FAMILIES:

Name(s) of Client(s) if minors

I attest that I am authorized to give permission for my child(ren) to have counseling at Look Inside Counseling, LLC.

Parent/Guardian Signature (of children age 14 and under)	Date	Parent/Guardian Signature (of children age 14 and under)	Date
Therapist Signature	Date		

CREDIT CARD AUTHORIZATION FORM

Look Inside Counseling, LLC requests that you provide your credit card information below. If you choose to pay by credit card your credit card will be charged $190 after each session on the day the session occurs (or the cost of your pre-determined session rate if different from $190). If you choose to pay by cash or check, your credit card will only be charged if your account is past due and/or for any additional fees you and/or your minor child/ren incur such as late cancellation or no-shows fees.

□ I do not authorize Look Inside Counseling, LLC to charge my credit card after each session but only for additional fees I and/or my minor child/ren incur as set forth in the businesses disclosure statement and policies. I will be notified of the type of additional fees I and/or my minor child/ren incur.

□ I authorize Look Inside Counseling, LLC to charge my credit card after each session and for any and all additional fees I and/or my minor child/ren incur.

If your credit card does not go through, you do not have a credit card, or you do not wish to provide your credit card information, in the event your account remains past due for thirty (30) days, your account may be sent to collections. Look Inside Counseing, LLC reserves the right to send your account to collections, in accordance with Look Inside Counseling, LLC's policies and procedures; at any time after you account is considered past due.

By signing this authorization form, you agree to notify your therapist at Look Inside Counseling, LLC of any changes to your credit card information such as a new expiration date or when your credit card has been cancelled, lost, stolen, or revoked. A new form must be submitted if information such as the list of authorized users and the credit card account's expiration date is amended.

Please check one:

□ Card Holder is the client (or parent/legal guardian) receiving services from Look Inside Counseling, LLC

□ Card Holder is a third-party payer for the client receiving services from Look Inside Counseling, LLC

Look Inside Counseling, LLC ACCEPTS THE FOLLOWING CREDIT CARDS:

☐ **VISA**

☐**DISCOVER**

☐**AMERICAN EXPRESS**

☐ **MASTERCARD**

Name on Credit Card:_____

Type of Credit Card: Visa _____ Mastercard _____
Discover _____ American Express _____

Credit Card Number_____

CCV Code: _____

Expiration Date: _____

Card Holder's Full Address, including zip code (the mailing address for your Credit Card statements):

_____

_____

_____

This credit card authorization form will remain in effect and on file with Look Inside Counseling, LLC unless revoked in writing or until the therapeutic relationship is terminated, at which time, authorization to charge your credit card will be revoked, unless an outstanding balance remains on your account after termination. Look Inside Counseling, LLC will not share your credit card information with any third-party without your consent. Your credit card information will be kept confidential.

If Card Holder is a Third-Party Payor:

I_____, hereby authorize Look Inside Counseling, LLC to charge the above bank credit card number for payment of the counseling fees Client_____ incurs; which shall include late or past due fees or fees related to cancellations or no-shows. I understand that my credit card will be billed in accordance with the authorizations listed above. I agree to notify Look Inside Counseling, LLC of any changes to my credit card information including a new expiration date or when my credit card has been cancelled, lost, stolen, or revoked. I understand as a third-party payor that I am only entitled to receive information concerning payment and that this Credit Card Authorization Form does not authorize me to receive any confidential and protected information about Client beyond payment.

_____ _____
Third-Party Payor's Signature DATE

_____
Print Name

I, Client, authorize my therapist at Look Inside Counseling, LLC to communicate with the above Third-Party Payor solely is it may relate to payment for services I receive from Look Inside Counseling, LLC.

_____ _____
Client's Signature DATE

_____
Print Name

If Card Holder is Client:

I_____, hereby authorize Look Inside Counseling, LLC to charge the above bank credit card number for payment of the counseling fees I or my minor child/ren incur; which shall include late or past due fees or fees related to cancellations or no-shows. I understand that my credit card will be billed in accordance with the authorizations listed above. I agree to notify Look Inside Counseling, LLC of any changes to my credit card information including a new expiration date or when my credit card has been cancelled or revoked.

Client Name:_____

_____ _____
Client/Parent/Legal Guardian Signature DATE

_____
Print Name

Look Inside Counseling, LLC
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL (INCLUDING MENTAL HEALTH) INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. During the process of providing services to you, I will obtain, record, and use mental health and medical information about you that is protected health information. Ordinarily that information is confidential and will not be used or disclosed, except as described below.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

A. General Uses and Disclosures Not Requiring the Client's Consent. We may use and disclose protected health information about you without your authorization in the following circumstances.

1. *Treatment.* Treatment refers to the provision, coordination, or management of health care and related services by one or more health care providers. For example, we may use your information to plan your course of treatment and to consult with another health care provider to ensure the most appropriate methods are being used to assist you.

2. *Payment.* Payment refers to the activities undertaken by a health care provider to obtain or provide reimbursement for the provision of health care. We may use and give your information to others to bill and collect payment for the treatment and services provided to you. For example, we may share portions of your information with billing services and billing personnel, collection services, insurance companies, health plans, and third party payers which provide you coverage. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnosis, type of service, date of service, provider name/identifier, and other information about your condition and treatment.

3. *Health Care Operations.* Health Care Operations refers to activities that are regular functions of management and administrative activities. For example, we may use your health information in monitoring of service quality, staff training and evaluation, medical reviews, legal services, auditing functions, compliance programs, business management and general administrative activities, and planning for future operations.

4. *Contacting the Client.* We may contact you to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.

5. *Required by Law.* We will disclose protected health information when required by law. This includes, but is not limited to the following situations:

   i. Reporting child abuse or neglect;

   ii. When the disclosure is for judicial and administrative proceedings, for example in response to an order of a court or administrative tribunal;

   iii. When there is a legal duty to warn or take action regarding imminent danger to others;

   iv. When the client is a danger to self or others or is gravely disabled;

   v. When required to report certain communicable diseases and certain injuries;

   vi. When a Coroner is investigating the client's death; and

   vii. To government regulatory and oversight agencies which are authorized by law to oversee our operations.

6. *Crimes on the premises or observed by therapist.* Crimes that are observed by the therapist, which are directed toward the therapist or occur on the property of the therapist's place of business, will be reported to law enforcement.

7. *Business Associates.* Some of the functions of the health care providers may be provided by contracts with business associates. For example, some administrative, clinical, quality assurance, billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform these services. In those situations, protected health information will be provided to those contractors as is needed to perform their contracted tasks. In those situations, the business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.

8. *Research.* We may use or disclose protected health information for research purposes if the relevant limitations of the Federal HIPAA Privacy Regulation are followed. 45 CFR §164.512(i).

9. *Involuntary Clients.* Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, and others, as necessary to provide the care and management coordination needed.

10. *Family Members.* Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of that discussion. However, if the client objects, protected health information will not be disclosed.

11. *Emergencies.* In the life threatening emergencies, we will disclose information necessary to avoid serious harm or death.

B. Client Authorization or Consent. We may not use or disclose protected health information in any other way without a signed Authorization or Release of Information. When you sign an Authorization or Release of Information, it may later be revoked, provided that the revocation is in writing. The revocation will apply except to the extent that we have already relied on it.

C. Psychotherapy Notes. We maintain psychotherapy notes separately from the remainder of our records. Use or disclosure of these notes will occur only under these circumstances: (a) you specifically authorize their use or disclosure in a separate written authorization; (b) the therapist who wrote the notes uses them for your treatment; (c) we may use them for our own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; (d) if you bring a legal action and we have to defend ourselves; and (e) certain limited circumstances defined by law.

II. YOUR RIGHTS AS A CLIENT:

A. Additional Restrictions. You have the right to request additional restrictions on the use or disclosure of your health information. We are not required to agree to your request, and there are certain limits to any restriction, which will be provided to you at the time of your request. To exercise this right, ask your therapist for the appropriate request form.

B. Alternative Means of Receiving Confidential Communications. You have the right to request that you receive communications of protected health information by alternative means or at alternative locations. For example, if you do not want to receive bills or other materials at your home, you can request that this information be sent to another address. To exercise this right, ask your therapist for the appropriate request form.

C. Access to Protected Health Information. You have the right to inspect and obtain a copy of the protected health information contained in clinical, billing and other records used to make decisions about you. Your request must be in writing. We may charge you related fees. There are some limitations to this right,

which will be provided to you at the time of your request, if relevant, along with the appeal process available to you. To exercise this right, ask your therapist for the appropriate request form.

D. Amendment of Your Record. You have the right to request amendment of your protected health information. Your request must be in writing and it must explain why the information should be amended. We are not required to amend the record if it is determined that the record is accurate and complete. There are other exceptions, which will be provided to you at the time of your request, if relevant, along with the appeal process available to you. To exercise this right, ask your therapist for the appropriate request form.

E. Accounting of Disclosures. You have the right to receive an accounting of certain disclosures we have made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment, or health care operations. In addition, the accounting does not include disclosures made to you or disclosures authorized by you. There are other exceptions that will be provided to you, should you request an accounting. To exercise this right, ask your therapist for the appropriate *request form.*

F. *Copy of the Notice.* You have a right to request a paper copy of this Notice at any time.

G.

III. ADDITIONAL INFORMATION:

A. Privacy Law. We are required to abide by the terms of this Notice, or any amended Notice that may follow.

B. Terms of the Notice. We are required to abide by the terms of this Notice, or any amended Notice that may follow.

C. Changes to the Notice. We reserve the right to change our privacy practices and the terms of this Notice at any time, and to make the new Notice provisions effective for all protected health information that we maintain. Copies of the revised Notice will be available upon request.

D. Complaints Regarding Privacy Rights. If you are concerned that we may have violated your privacy rights, you may file a complaint to your therapist. You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to the Office of Civil Rights. U.S. Department of Health and Human Services, 200 Independence Avenue, S.W. Room 515F, HHH Bldg. Washington, D.C. 20201. It is our policy that there will be no retaliation for your filing of such a complaint.

E. Effective Date. This Notice is effective July 1, 2009.

F. Additional Information. If you want more information about our privacy practices or have questions or concerns, please contact your therapist.

Signed: _____ Date: _____

Therapist Signature: _____ Date: _____

CONSENT FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION BY UNSECURE TRANSMISSIONS

This consent form is for the communication of Protect Health Information ("PHI") that Kelsey Shane may transmit without the written authorization of the client as described in the Uses and Disclosure section of Kelsey Shane's Notice of Privacy Policies.

I, _____, hereby consent and authorize my therapist at Look Inside Counseling, LLC to communicate my PHI through the following non-secure transmissions (please initial all your choices):

_____ Cellular/Mobile Phone this includes text messaging
(Please Insert Cell Phone Number: _____)
_____ Unsecured Email
(Client's Email: _____ □ Send □ Receive
Therapist's Email: Kelsey@lookinsidecounseling.com □ Send □ Receive)
Please Circle One: Work Personal
_____ Other Media:
(Please describe: _____)
_____ I do not wish to have my protected health information transmitted electronically

Should you and your therapist agree to communicate by the approved communications listed above, i.e. text, email, telephone, or any other electronic method of communication, confidentiality extends to those communications. However, Look Inside Counseling, LLC cannot guarantee that those communications will remain confidential. Even though we may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by an unintended third-party. There is never a 100% guarantee information will remain confidential when transmitted electronically.

I, _____, understand that Look Inside Counseling, LLC may have to use and disclose PHI without my written authorization, under certain circumstances already pre-disclosed to you (such as if you are a risk to self/others). However, I consent to my therapist transmitting the following PHI by the above selected electronic communications (please initial all your choices):

_____ Information related to scheduling/appointments
_____ Information related to billing and payments
_____ Information related to your mental health treatment (this may contain personal materials, forms, suggested articles, homework, etc.)
_____ Information related to the therapist's operations
_____ Other Information; Please Describe: _____

I further understand that if I initiate communication via electronic means that I have not specifically consented to in this form, I will need to amend this consent form so that my therapist may communicate with me via that method.

_____ _____
Signature of Client/Parent/Legal Guardian DATE