Compassion Connection Therapy

Consent for Counseling Services to Minors

In order for minor children/adolescents to receive psychological services, it is necessary for the parent or legal guardian to grant permission for such services to occur.

Names and date of birth of child(ren) to receive psychological services:

Name _____

Date of Birth _____

Name _____

Date of Birth _____

Name _____

Date of Birth _____

Name of person requesting services:

_____

Your relationship to child(ren): Parent Step-parent Guardian Grandparent Other

Are you the legal parent or custodian to above-named children? Yes No

I_____ hereby swear that I have legal right to obtain treatment for the above-named children: Yes No

In instances of divorce, it is essential that the legal custodian of the child(ren) grant permission for the services. If you are a divorced parent, a stepparent, a grandparent, a guardian, or other, you may be asked to provide a copy of the court order which names you the legal custodian of the above children**. Are you willing to do so?** Yes No

If the answer to any of the above questions is "No," counseling services cannot be provided to the above-named child(ren) until a copy of the court order which names you the legal custodian is provided to this office.

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I acknowledge that both natural parents, even though divorced, may have a right to obtain, from the provider named below, information regarding the nature and course of treatment of the child(ren).

Colorado State law mandates the reporting of certain types of child abuse, including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional and psychological abuse. All actual or suspected acts of child abuse will need to be reported to the appropriate agency.

This treatment may also include referral to other appropriate State and County agencies for further counseling.

I, _____, consent to Jessie Harris, LCSW of Compassion Connection Therapy, LLC in providing psychological services to the child(ren) named above.

Signature of person authorizing consent Date

_____ _____

Signature of therapist Date

_____ _____

**In State of Colorado clients age 12 and older can consent to their own outpatient mental health treatment*

Compassion Connection Therapy
Authorization for Disclosure of Protected Health Information & Request for Confidential Communication

I, _____, hereby authorize Jessie Harris, LCSW of Compassion Connection Therapy, LLC: 5335 W. 48th Ave Denver, CO 80212 720-213-8580, to obtain from and share information regarding:

_____ _____
Client Name Client DOB

Person/entity authorized to receive information:

Name:_____
Please indicate relationship with this individual:
❑ Physician ❑ Attorney ❑ Mental Health Professional ❑ Family Member ❑ School
❑Other:_____

Address: _____

Phone # and/or email: _____

Information may include: (Check ALL that apply):
o Summary of Progress
o Evaluation/Assessment
o Attendance/Participation Progress
o Billing Information
o Termination Summary
o Other

For the Purpose of:
o Treatment (Internal & External)
o Operations (Administrative)
o Payment (Reimbursement)
o Legal
o Other

I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, and drug or alcohol abuse and/or alcoholism.

AUTHORIZATION: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by sending a letter to Jessie Harris, LCSW of Compassion Connection Therapy, 5335 W. 48th Ave Suite 500 Denver C0 80212 or by signing the revocation request below. I understand that my revocation will not be effective to the extent that action has already been taken in reliance on it. This

authorization expires three months from the date of the client's signature below, unless otherwise specified here: _____. If I have authorized disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be valid as the original.

I understand that authorizing the disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee will be charged for any copy of my health record. I understand Jessie Harris, LCSW will provide me a copy of the signed authorization form. If I have questions about disclosure of my health information, I can contact Jessie Harris, LCSW.

I also herewith release Jessie Harris, LCSW and Compassion Connection Therapy, LLC from all liability for releasing such information.

NOTICE TO WHOM THIS INFORMATION IS GIVEN: This information has been disclosed to you from records in which confidentiality is protected by Federal Law. Federal regulations prohibit you from making further disclosure of this information without the specific written consent of the person to whom it pertains.

X _____ _____
Client(s) Signature Date

X_____ _____ _____
Legal Guardian or Authorized Representative Relationship Date
**If client is under the age of 18, Guardian consent is required*

I hereby revoke this Authorization to Release/Request for Information:

_____ _____
Client Date

_____ _____
Witness Date

A copy of this Authorization is as valid as the original.

Compassion Connection Therapy
Disclosure Statement and Notice of Privacy Practices

CREDENTIALS

I am a Licensed Clinical Social Worker. My degree is Masters of Social Work, from the University of Denver. This degree was conferred in 2015. I will adhere to the Code of Ethics of the National Association of Social Workers. The practice of both licensed and registered persons in the field of psychotherapy is regulated by the Colorado State Department of Regulatory Agencies. My license was issued in 2017 by the state of Colorado and is active. My CO license number is 09925002. Any concerns may be addressed to the appropriate licensing board: **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 must hold a masters degree in their profession and have two years of post-masters supervision. This disclosure statement is required by the Mental Health Professions Licensing Act.

CLIENTS RIGHTS

- ♥ You have the right to be treated with respect and dignity.
- ♥ You have the right to receive information about the methods of therapy and the techniques used.
- ♥ You have the right to have information about the fees associated with your treatment.
- ♥ You have the right to seek a second opinion from another therapist.
- ♥ You have the right to terminate therapy at any time.
- ♥ You have the right to be informed about confidentiality and limitations associated with it.
- ♥ In a professional therapy relationship, **sexual intimacy is never appropriate**

and is illegal. If sexual intimacy occurs, it should be reported to the Department of Regulatory Agencies.

CONFIDENTIALITY

Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes, and the HIPAA Notice of Privacy Rights you were provided, as well as other exceptions in Colorado, Wyoming and Federal law. For example, mental health professionals are required to report suspected child abuse and when the patient is a danger to self/others or gravely disabled to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly.

APPOINTMENTS

Therapy sessions are generally 50-60 minutes, unless scheduled otherwise with your therapist. This time is reserved for you. In the case that you need to cancel or reschedule an appointment, 24-hour advance notice is required. With less than 24 hours notice, you may be charged the full amount for the scheduled session. This will be your responsibility. To cancel- please call, email, text, or cancel through the client portal. If you no call no show for 4 consecutive appointments you will be administratively discharged.

FEES

Our full fee for a 50-60 minute session is $175.00. Your fee is due in full at each session. Payment for your session will be collected at the end of each session. We can accept cash, check and credit cards. We are not currently accepting insurance, please discuss options for out of network benefits reimbursement with your insurance company and your therapist would be happy to help you with the process and provide you documentation (Superbill) for reimbursement of services if applicable. If your balance is

unpaid for 30 days you may be administratively discharged until paid in full. While telephone conversations that are strictly for scheduling purposes are not charged, telephone conversations of a clinical nature that exceed 30 minutes, may be charged at a case management rate. The fee for case management includes external meetings to collaborate with providers and clinical consultation via phone. The fee for 30 minutes is $65.00. Your fee is due at the time of your next session. Reports and court appearances require professional time for which we charge the same rate as case management. The use of a third party collection agency may be used to collect past due fees for services.

CONSULTATION AND SCOPE OF SERVICES

There may be times when I, as your psychotherapist, may need to consult with a colleague or another professional, such as an attorney or physician, concerning issues raised by you in therapy. Confidentiality is not waived during these consultations. By signing this disclosure statement, you give me permission, as your psychotherapist, to consult with other professionals as needed to provide professional services to you. This permission may be revoked at any time.

If I, as your psychotherapist, believe the psychotherapeutic issues are above my level of competence or outside of my scope of practice, I am legally required to refer, terminate or consult with other professionals in order to provide you with appropriate treatment. I will notify you of such concerns

TREATMENT PLANNING AND EVALUATION

Since Compassion Connection Therapy, LLC is not a 24-hour crisis-intervention agency, in case of an emergency, 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/family basis, guarantees cannot be made as to treatment outcome. If we cannot provide the services you need, your therapist will offer you referral information.

The client (and guardian when appropriate) will play a critical role in establishing treatment goals. Treatment goals are established with the best interest of the client as the number one priority. The therapist will work to establish measurable, attainable goals in a language that the client understands and with awareness for any cultural considerations. Periodically, client and therapist will assess progress toward treatment goals.

SOCIAL MEDIA AND ELECTRONIC COMMUNICATION

Careful consideration should be taken when considering whether or not to connect with Compassion Connection Therapy, LLC through social media. Compassion Connection Therapy, LLC will not initiate or reciprocate any communication through these platforms. Any attempts to connect with your therapist's personal accounts will be denied, and is strongly discouraged. Email is an acceptable form of communication for non-clinical conversations such as scheduling. However, there is no assumption of confidentiality when using email although HIPAA compliant and secure email is used. It is possible for messages sent via email to be intercepted by a user other than the intended recipient.

RECORD KEEPING

All paper records are secured in a locked file box which is stored in a locked office. All notes and billing are processed and secured by a HIPAA compliant EHR (Electronic Health Record) system.

Compassion Connection Therapy
Disclosure Statement and Notice of Privacy Practices

I have read the preceding information and I have received a copy of this document. I understand my rights and responsibilities as a client and my therapist's responsibilities to me. By signing below, I acknowledge my understanding and agree to all terms discussed in this disclosure statement. I may end therapy at any time for any reason and I may refuse any requests or suggestions made by my therapist. By signing this form, I affirm that I am either over the age of eighteen or that I am the legal guardian and/or custodial parent with legal right to consent to treatment for any minor child or children; and, that I am requesting psychotherapy services

This disclosure statement will expire one year from the date indicated below or when such form is updated, whichever comes first. This disclosure statement may be revoked at will by the client at any time for any reason. Such revocation is not retroactive. I consent to treatment at Compassion Connection Therapy, LLC.

I attest that I am authorized to give permission for my child(ren) to have counseling at Compassion Connection Therapy, LLC.

_____
Print Client Name

_____ _____
Adult/Parent/Guardian Signature Date

_____ _____
Teen Signature (ages 12-18) Date

_____ _____
Therapist Signature Date

NOTICE OF PRIVACY PRACTICES
Compassion Connection Therapy, LLC
Jessie Harris, LCSW
720-213-8580

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), this notice describes how health information about you is protected, and also how it may be used and disclosed. During the process of providing services, Compassion Connection Therapy, LLC. will obtain, record, and use mental health information about you that is described below. Colorado and Wyoming law provide strict protection for patient confidentiality, which together with ethical restrictions and standards often will be more private than HIPPA guidelines.

USES, DISCLOSURES, AND COMMUNICATION OF PROTECTED INFORMATION

A. General Uses and Disclosures Not Requiring the Patient's Consent.

1. Treatment: Treatment refers to the provision, coordination, or management of health care (including mental health care) and related services. During treatment, the provider may consult with other providers, without identifying you by name, and also not disclosing any other identifying information about you, in order to ensure the best care possible for you concerns.

2. Payment: Payment refers to the activities undertaken by the provider to obtain or provide reimbursement for the provision of health care. For example, the provider will use your information to develop accounts receivable information, to bill you, and with your consent, third parties. If you elect to have a third party pay for your treatment, the information provided to the third party may include information that identifies you as well as your diagnosis, type of service, date of service, and other information about your condition and treatment.

3. Contacting the Patient: The provider may contact you to remind you of appointments, or to change or cancel appointments. The provider may leave messages on voicemail or with other parties, identifying the name and phone number of the provider. The provider will use best judgment in the details left on a voicemail. If you do not want provider leaving messages, or if you wish to restrict the messages in any way, please notify the provider in writing.

4. Required by Law: The provider will disclose protected health information when required by law or necessary for healthcare oversight. This includes, but may not be limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when there is a legal duty to warn or take action regarding imminent danger to others; (d) when the patient is a danger to self or others or gravely disabled; (e) when a coroner is investigating the patient's death.

5. Family members: Except for certain minors, protected health information cannot be provided to family members without the patient's consent. In situations where family members are present during a discussion with the patient, and it can be reasonably inferred from the circumstances that the patient does not object, information may be disclosed in the course of

that discussion. However, if the patient objects, protected health information will not be disclosed.

6. Emergencies: In life-threatening emergencies, the provider will disclose information necessary to avoid serious harm or death.

B. Patient Authorization or Release of Information: The provider 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 a release of information, it may later be revoked, provided that the revocation is in writing. The revocation will apply, except to the extent that the provider has already taken action in reliance thereon.

C. Alternative Means of Receiving Confidential Information: You have the right to request that you receive communications of protected health information from the provider by alternative means or at alternative locations. For example, if you do not want the provider to mail statements or other materials to your home, you can request that this information be sent to another address. There are limitations to granting of such requests. You will also have to pay any additional costs that may be associated with such a request.

D. Protection of Confidential Information: The provider has taken steps to protect the confidentiality of your information, including the use of name codes, password protected electronic medical record, locked filing cabinets, paper shredding, and other security measures. Your files will be destroyed (shredded or incinerated) when past the time required for the maintenance of such records. If you have further questions, please contact, Jessie Harris, LCSW 720-213-8580

I hereby acknowledge that I have received a copy of the provider's Notice of Privacy Rights.

_____ _____

Client/Guardian Signature Date

_____ _____

Therapist Signature Date