SUSAN BOLEY, PH.D.
26W Dry Creek Circle, Suite 180
Littleton, CO 80120
Phone 303-794-7761

Adult Intake

Name______________________________________ Date of Birth_______________ Age______

Address____

Phone (Home)____________________ (Cell)___________________ (Work)__________________

Email Address_________________________________

Marital Status________________________ Name of Spouse ______________________________

Names and Ages of Children____

Occupation and Employer____________________________ Highest Level of Education __________

Primary Care Physician __________________________

Previous Mental Health Treatment or Hospitalization ____
____
____
____

Please note any way that previous therapy was helpful for you _________________________________
____
____

Family History of Mental Health Treatment ____
____
____

Current Medication and Dosages ____
____
____

Current Illnesses, Injuries or Disabilities ____
____
____

Past Significant Illnesses, Injuries or Disabilities ____
____
____
____

Average number of hours you sleep at night __________ Describe your sleep pattern_____________
____

Describe your exercise habits ____

Describe your appetite ____

How many drinks do you have in a typical day ____ week ____ month _____

Do you smoke? _____ How many cigarettes in a typical day? _____

Do you use marijuana? _____ How often? ______ Other drugs? _____ What do you use? __________
____
____

Describe past drug/alcohol use ____
____
____

Briefly describe your reasons for seeking therapy at this time ______________________________________
____
____
____
____

What goals do you wish to accomplish during the therapy process? ________________________________
____
____
____
____

Please check all of the items below that describe your situation:

□ Abuse/trauma – physical, sexual, emotional, neglect

□ Aggression, violence

□ Alcohol use

□ Anger, hostility, arguing, irritability

□ Anxiety, nervousness

□ Attention, concentration, distractibility

□ Career concerns, goals, and choices

□ Childhood issues

□ Codependence

□ Confusion

□ Compulsions and/or obsessions (thoughts or actions that repeat themselves)

□ Decision-making, indecision, mixed feelings, putting off decisions

□ Delusions (false ideas)

□ Dependence

□ Depression, low mood, sadness, crying

□ Divorce, separation, marital conflict, infidelity/affairs

□ Drug use – prescription medications, over-the-counter medications, street drugs

□ Eating problems – overeating, under eating, appetite, vomiting

□ Emptiness

□ Failure

□ Fatigue, tiredness, low energy

□ Fears, phobias

□ Financial or money troubles, debt, impulsive spending, low income

□ Gambling

□ Grieving, mourning, deaths, losses, divorce

□ Guilt

□ Headaches, other kinds of pains

□ Health, illness, medical concerns, physical problems

□ Inferiority feelings

□ Impulsiveness, loss of control, outbursts

□ Irresponsibility

□ Judgment problems, risk taking

□ Legal matters, charges, suits

□ Loneliness

□ Memory problems

□ Mood swings

□ Oversensitivity to rejection

□ Panic or anxiety attacks

□ Perfectionism

□ Pessimism

□ Procrastination, lack of motivation

□ Relationships problems (with friends, with relatives, or at work)

□ School problems

□ Self-centeredness

□ Self-esteem

□ Self-neglect, poor self-care

□ Sexual issues, dysfunctions, conflicts, identity issues

□ Sleep problems (too much, too little, insomnia, nightmares)

□ Spiritual, religious, moral, ethical issues

□ Stress and tension

□ Suspiciousness

□ Suicidal thoughts

□ Temper problems, self-control, low frustration tolerance

□ Thought disorganization and confusion

□ Threats, violence

□ Weight and diet issues

□ Withdrawal, isolation

□ Work problems, employment issues

The Patient Health Questionnaire (PHQ-9)

Patient Name ____ Date _______________

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at All	Several Days	More than Half of the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

10. If you checked off any problems on this page as a 1, 2 or 3, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

SUSAN BOLEY, PH.D., P.C.
26 W DRY CREEK CIRCLE, SUITE 180
LITTLETON, CO 80120
303-794-7761

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Appointments

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45 to 60-minute session (one appointment hour of 45 to 60 minutes duration) per week at a time we agree on, although some sessions may be more or less frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions or missed appointments. If it is possible, I will try to find another time to reschedule the appointment.

PROFESSIONAL FEES

My fee is $185 for the initial intake session, for subsequent therapy sessions the fee is $140 for a 45 minute session and $160 for a 55-60 minute session. In addition to therapy appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than ten minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. Special services, such as Shared Parenting Support Program, Reintegration Therapy, court related psychological testing, or attorney consultation is billed at $220 per hour. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $250 per hour for preparation and $300 per hour for attendance at any legal proceeding.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office between 9 AM and 5 PM, Monday through Thursday, and 9 AM to noon on Friday, I will not answer the phone when I am with a patient. When I am unavailable, my telephone will go to voicemail. Please always leave a phone number when you leave a message, which will help me return your call more quickly. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the mental health professional on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- You should be aware that I employ administrative staff. In most cases, I need to share protected information with these individuals for administrative purposes, such as billing and quality assurance. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without my permission.

- As required by HIPAA, I have a formal business associate contract with any businesses I associate with, in which they promise to maintain the confidentiality of data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations and/or a blank copy of this contract.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I am required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, I am required to submit a report to the Workers' Compensation Division.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reasonable cause to know or suspect that a child has been subjected to abuse or neglect or if I have observed a child being subjected to circumstances or conditions which would reasonably result in abuse or neglect, the law requires that I file a report with the appropriate governmental agency. Once such a report is filed, I may be required to provide additional information.
- If I have reasonable cause to believe that an at-risk adult has been or is at imminent risk of being mistreated, self-neglected, or financially exploited, the law requires that I file a report with the appropriate governmental agency. Once such a report is filed, I may be required to provide additional information.
- If a patient communicates a serious threat of imminent physical violence against a specific person or persons, I must make an effort to notify such person; and/or notify an appropriate law enforcement agency; and/or take other appropriate action including seeking hospitalization of the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

I will not create recordings of any of our work without written consent from you. Further, I would request that you ask my permission to record any sessions or telephone calls with me. Without written consent, neither photographing nor recording is allowed.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others, or where information has been supplied to me by others confidentially, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. In most situations, I am allowed to charge a copying fee. The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your Clinical Record, you have a right of review, which I will discuss with you upon request.

In addition, I also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record, and information that has been supplied to me confidentially by others. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed Authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

PATIENT RIGHTS

HIPAA provides you with several rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS & PARENTS

Patients under 15 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records, unless I decide that such access is likely to injure the child. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is generally my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also, upon request, provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. If payment in full is not made within 10 days after the scheduled due date for any billing, a late charge in the amount of 1.5% will be added to the unpaid balance. There will be a $10.00 processing charge for any check returned to us uncollected by the bank.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT/PAYMENT AGREEMENT

If I am a contracted provider with your insurance company, please present your insurance card and authorization number, if applicable, when you check in for your first appointment. Understanding your health insurance policy is very important. Your policy is a contract between you and your insurance company. It is your responsibility to know your benefits and obligations under your insurance plan. When a referral is made on your behalf to another mental health care provider, it is your responsibility to check your insurance guidelines and see if this provider is covered under your specific plan. Should your employer change insurance coverage, it is your responsibility to let me know. Please be an informed patient and read all information your company sends you. If you have any questions, you may call the phone number on your insurance card.

CLIENT INFORMATION:
Last Name: ______________________________ First Name: ____________________________ MI: _____
Address: ____
City: ____ State: __________ Zip: ___________________
Home Phone: ____________________________________ Work Phone: _____________________________
Email: ____ Cell Phone: _____________________________
Date of Birth: ____________________
Employer: ______________________________________ Phone: _____________________________________
Employer's Address: ____

INSURED/GUARANTOR (Holder of insurance if <u>different</u> from client):
Last Name: ______________________________ First Name: ____________________________ MI: _____
Address: ____
City: ____ State: __________ Zip: ___________________
Home Phone: ____________________________________ Work Phone: _____________________________
Email: ____ Cell Phone: _____________________________
Date of Birth: ____________________
Sex: F___ M___
Employer: ______________________________________ Phone: _____________________________________
Employer's Address: ____

PRIMARY INSURANCE:
Name of Insurance Company: ____
Billing Address of Insurance Company: ____
Phone: ___________________________ ID#: _______________________ Group #: _________________
Authorization Number (if applicable): ____
Relationship to Insured (if client not the primary insured): ______________________________________

SECONDARY INSURANCE:
Name of Insurance Company: ____
Billing Address of Insurance Company: ____
Phone: ___________________________ ID#: _______________________ Group #: _________________
Authorization Number (if applicable): ____
Relationship to Insured (if client not the primary insured): ______________________________________

ASSIGNMENT OF BENEFITS	**RELEASE OF INFORMATION**
I authorize Susan Boley, Ph.D., PC. to accept assignment of benefits. _____ YES ____ NO	I authorize Susan Boley, Ph.D., P.C. to release any information necessary to process my insurance claim. ____YES ____NO

It is your responsibility to keep track of your scheduled appointment times. Please be mindful that appointment times are reserved for you, and a 24 hour notice is necessary for change or cancellation in order for us to make the time available for others. Should you have a late cancellation or missed appointment, a charge will be incurred. **A missed appointment (failure to keep an appointment without notice) will result in a full session charge. A late cancellation (notice of less than 24 hours) will result in a charge of one-half the session fee. Please note that these charges are not payable by insurance.**

Would you like an appointment reminder by ____ email or _____ text?

Email address ____

Cell phone number ____________________________________

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

____

Client Name

__________________________________ ______________________

Client (Parent/Guardian) Signature Date

COLORADO NOTICE FORM – HIPAA NOTICE FORM

Susan Boley, Ph.D., P.C.
26 W Dry Creek Circle, Suite 180
Littleton, CO 80120

Notice of Psychologists' Policies and Practices to Protect the Privacy 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.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. 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 healthcare. 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 within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], 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 your 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 before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, 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 know or suspect that a child has been subjected to abuse or neglect, I must immediately report this to the appropriate authorities.

- *Adult and Domestic Abuse* – If I have reasonable cause to believe that an at-risk adult has been mistreated, self-neglected, or financially exploited and is at imminent risk of mistreatment, self-neglect, or financial exploitation, then I must report this belief to the appropriate authorities.

- *Health Oversight Activities* – If the Colorado State Board of Psychologist Examiners or an authorized professional review committee is reviewing my services, I may disclose PHI to that board or committee.

- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privileged does not apply when you are being evaluated or 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 a serious threat of imminent physical violence against a specific person or persons, I have a duty to notify any person or persons specifically threatened, as well as a duty to notify an appropriate law enforcement agency or by taking other appropriate action. If I believe that you are at imminent risk of inflicting serious harm on yourself, I may disclose information necessary to protect you. In either case, I may disclose information in order to initiate hospitalization.

- *Worker's Compensation* – I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provided benefits for work-related injuries or illness without regard to fault.

There may be additional disclosures of PHI that I am required or permitted by law to make without your consent or authorization, however the disclosures listed above are the most common.

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 protected health information regarding you. 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. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) 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 of 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 in writing.

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 me to discuss your questions.

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 my office at 11 W Dry Creek Circle, Suite 140, Littleton, CO 80122.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above 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.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on January 1, 2018.

I will limit the uses or disclosures that I will make as follows:

In most cases I do not release my records. Because mental health records may contain sensitive information, Colorado law states that a summary of records pertaining to a patient's mental health problems may, upon written request and signed and dated authorization, be made available to the patient or the patient's designated representative following termination of the treatment program. That is, I may choose to write a summary of treatment rather than releasing my records.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice in writing.

DISCLOSURE STATEMENT

1. Susan Boley, Ph.D.
26 W. Dry Creek Circle, Suite 180
Littleton, CO 80120
303-794-7761

2. I have a Doctorate Degree in Clinical Psychology from the California School of Professional Psychology. I was required to complete four years of course work and practicum clinical work, a doctoral dissertation, as well as a one year internship in clinical psychology to receive this degree. I completed my internship at the University of Minnesota Medical School. After receiving my degree I then completed a one-year postdoctoral fellowship at the University of Minnesota Medical School, which included clinical supervision. Upon completing this work I was able to sit for licensure which included taking a national exam, a jurisprudence exam, as well as an oral exam. I am a licensed psychologist in Colorado. My license number is 2224.

3. The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The Board of Psychologist Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 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 a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.

4. You are entitled, to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy, if known, and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time.

5. In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

6. 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, as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly.

7. Mental health professionals are required to maintain client records for a period of seven years from the date of termination of services. Mental health professionals may dispose of records seven years after the last date of service.

I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the client's responsible party.

____
Print Client's name

____ __________
Client's or Responsible Party's Signature Date

If signed by Responsible Party, please state relationship to client and authority to consent:______________________________

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Surprise/Balance Billing Disclosure Form

Surprise Billing – Know Your Rights

Beginning January 1, 2020, Colorado state law protects you* from "surprise billing," also known as "balance billing." These protections apply when:

- You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or

- You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado

What is surprise/balance billing, and when does it happen?

If you are seen by a health care provider or use services in a facility or agency that is not in your health insurance plan's provider network, sometimes referred to as "out-of-network," you may receive a bill for additional costs associated with that care. Out-of-network health care providers often bill you for the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:

Emergency Services

If you are receiving emergency services, the most you can be billed for is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility where you receive emergency services and any providers that see you for emergency care.

Nonemergency Services at an In-Network or Out-of-Network Health Care Provider

The health care provider must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. They must also tell you what types of services that you will be using may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for **covered** services is your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance. These providers cannot balance bill you for additional costs.

Additional Protections

- Your insurer will pay out-of-network providers and facilities directly.

· Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.

· Your provider, facility, hospital, or agency must refund any amount you overpay within sixty days of being notified.

· No one, including a provider, hospital, or insurer can ask you to limit or give up these rights.

If you receive services from an out-of-network provider or facility or agency in OTHER situations, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be balance billed.

If you want to file a complaint against your health care provider, you can submit an online complaint by visiting this website: https://www.colorado.gov/pacific/dora/DPO_File_Complaint.

If you think you have received a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact the billing department, or the Colorado Division of Insurance at 303-894-7490 or 1-800-930-3745.

*This law does NOT apply to ALL Colorado health plans. It only applies if you have a “CO-DOI” on your health insurance ID card.

Please contact your health insurance plan at the number on your health insurance ID card or the Colorado Division of Insurance with questions.

Susan Boley, Ph.D. P.C. is an in-network provider for Cigna, Anthem Blue Cross/Blue Shield, and Medicare. All other insurance plans are considered out of network and Dr. Boley will not bill the insurance company directly. Dr. Boley will provide, upon request, a form for you to submit to your out of network insurance company.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS DISCLOSURE FORM.

____

Signature   Date