bliss
Psychotherapy & Consulting

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Informed Consent and General Information

Welcome to my practice. This document contains important information about my professional services and business practices: my Disclosure Statement, Notice of Privacy Practices, Financial Policy and Fee Agreement, and Communication Policy and Email/Text Informed Consent. Please read it carefully and jot down any questions you might have so that we can discuss them.

Degrees and Credentials:
B.S. in Sociology, Texas A&M University, 2003
M.S. in Social Work, The University of Texas at Austin, 2005
LMSW, State of Texas, License 40952 – July 2005 to July 2009
LCSW, State of Texas, License 40952, July 2009 to April 2013
LCSW, State of Colorado, License 09923050, October 2012 to current

Client Rights and Responsibilities: The practice of licensed or registered persons in the field of psychotherapy is regulated by the Division of Professions and Occupations. The Board of Social Work Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado, 80202, (303) 894-2291.

As to the regulatory requirements applicable to mental health professionals:

- 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.
- Certified Addiction Counselor I (CAC I) must be a high school graduate, complete required training hours and 1,000 hours of supervised experience.
- Certified Addiction Counselor II (CAC II) must complete additional required training hours and 2,000 hours of supervised experience.
- Certified Addiction Counselor III (CAC III) must have a bachelor's degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience.
- Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III

requirements.

- Licensed Social Worker must hold a master's degree in social work.
- 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 require supervision for licensure.
- Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's 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.

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

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

Generally speaking, the information provided by and to a 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 and Federal law. For examples, mental health professionals are required to report suspected child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly.

As part of my professional will, I have a person and an alternate who will handle my records should anything happen to me. By signing this document, you are agreeing to release your health records to the executor of my professional will in the event that my professional will go into effect.

HIPAA Notice of Privacy Practices

A signature at the end of the informed consent form is a release for me to share information as provided in the HIPPA statement.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY. If you have any questions or requests about this Notice, please contact me at (720) 583-5335.

My Practice is required by State and Federal law to maintain the privacy of protected health information. In addition, the Practice is required by law to provide clients with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to your mental health information, and to request that you sign the attached written acknowledgement that you received a copy of this Notice. This Notice describes how the Practice may use and disclose your protected health information. This Notice also describes your rights regarding your protected health information and how you may exercise your rights.

Protected Health Information, PHI, is information the Practice has created or received about your physical or mental health condition, the health care we provide to you, or the payment for your health care; and identifies you or could be reasonably used to identify you. It includes your identity, diagnosis, dates of service, treatment plan, and progress in treatment.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

Permissible Uses and Disclosures Not Requiring Your Written Authorization: Your mental health information may be used and disclosed in the following ways.

- **Treatment:** Your mental health information may be used and disclosed in the provision and coordination of your healthcare. For example, this may include coordinating and managing your health care with other health care professionals. Your mental health information may be used and disclosed when I consult with another professional colleague, or if you are referred for medication, or for coverage arrangements during my absence. In any of these instances only information necessary to complete the task will be provided.
- **Payment:** Your mental health care information will be used to develop accounts receivable information, to bill you, and with your consent to provide information to your insurance company or other third party payer for services provided. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnosis, dates and type of service, and other information about your condition and treatment, but will be limited to the least amount necessary for the purposes of the disclosure.
- **Health Care Operations:** Your mental health information may be used and disclosed in connection with our health care operations, including quality improvement activities, training programs and obtaining legal services. Only necessary information will be used or disclosed.

- **Required or Permitted by Law:** Your mental health care information may be used or disclosed when I am required or permitted to do so by law or for health care oversight. This includes, but is not 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 to take action regarding imminent danger to others; (d) when the client is a danger to self or others or gravely disabled; (e) when a coroner is investigating the clients death; or (f) to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, or regulatory compliance.
- **Contacting the Client:** You may be contacted to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.
- **Crimes on the premises or observed by the provider:** Crimes that are observed by the therapist or the therapist s staff, crimes that are directed toward the therapist or the therapist's staff, or crimes that occur on the premises will be reported to law enforcement.
- **Business Associates:** 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. In those situations, protected health information will be provided to those contractors as is 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.
- **Involuntary Clients:** Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.
- **Family Members:** Except for certain minors, incompetent client, 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 the discussion. However, if the client objects, protected health information will not be disclosed.
- **Emergencies:** In life threatening emergencies the practice will disclose information necessary to avoid serious harm or death.
- **Uses and Disclosures Requiring Your Written Authorization or Release of Information:** Except as described above, or as permitted by law, other uses and disclosures of your mental health information will be made only with your written authorization to release the information. When you sign a written authorization, you may later revoke the authorization in writing as provided by law. However, that revocation may not be effective for actions already taken under the original authorization.
- **Psychotherapy Notes:** Psychotherapy notes are maintained separate from your mental health record. These notes will be used only by your therapist and disclosure will occur only under these circumstances: (a) you specifically authorize their use or disclosure in a separate written authorization; or (b) the therapist who wrote the notes uses them for your treatment; or (c) they may be used for training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills; or (d)

if you bring a legal action and we have to defend ourselves; and (e) certain limited circumstances defined by the law.

YOUR RIGHTS AS A CLIENT:

Additional Restrictions: You have the right to request additional restrictions on the use or disclosure of your mental health information. However, I do not always have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. Ask your clinician for the Request Form.

Alternative Means of Receiving Confidential Communications: You have the right to request that you receive communications from the practice by alternative means or at alternative locations. For example, you may request that bills and other correspondence be sent to an address other than your home address. Ask your clinician for the Request Form.

Access to Protected Health Information: You have the right to inspect and obtain a copy of your protected health information in the mental health and billing record. However, any psychotherapy notes are for the use of your therapist, and are treated differently. If seek this, it is within your clinician's discretion whether or not you are given the full record of notes or a summary. Ask your clinician for the Request Form.

Amendment of Your Record: You have the right to request an amendment or correction to your protected health information. If the clinician agrees that the amendment or correction is appropriate, the Practice will ensure the amendment or correction is attached to the record.

Accounting of Disclosures: You have the right to receive an accounting of certain disclosures the practice has 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, disclosures authorized by you, or disclosures made prior to April 14, 2003. Other exceptions will be provided to you, should you request an accounting. Ask your clinician for the Request Form.

Right to Revoke Consent or Authorization: You have the right to revoke your consent or authorization to use or disclose your mental health information, except for action that has already taken place under your consent or authorization.

Copy of this Notice: You have a right to obtain a copy of this Notice upon request.

The Practice is required to abide by the terms of this Notice, or any amended Notice that may follow. The Practice reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that it maintains. When changes are made, the revised Notice will be posted at the Practice's office and copies will be available upon request.

If you believe the Practice has violated your privacy rights, you may file a complaint with the person designated within the Practice to receive your complaints, Elena Davis. 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 the policy of the Practice that there will be no retaliation for your filing of such a complaint.

Financial Policy and Fee Agreement

I will verify your insurance benefits as a courtesy to you. I will do my best to make sure that your insurance is billed in a timely manner, and that the benefits your insurance company affords you, are the same benefits quoted to us when we verified your benefits.

In this regard, you are liable for all amounts your insurance deems are your responsibility. These are normally:

- Deductible amounts
- Co-Insurance (percentage) and/or Co-Pay amounts (flat amount)
- Non-covered services
- Services rendered before insurance policy began or after it was terminated
- Fees for sessions canceled less than 24 hours in advance.

If you cancel a session without significant cause*, it must be 24 hours in advance (and one business day) or you will be charged the full fee for that session using the credit card on file ending in _____. **

A cancelled appointment delays our work. Additionally, I am rarely able to fill a canceled session unless I know at least 24 hours in advance. **Significant cause includes major, unforeseen events occurring within 1 business day of the scheduled appointment, such as hospitalizations, house fires, car crashes, deaths in the immediate family etc. ** 24 hours means that cancellations must be received at least 24 hours in advance for appointments scheduled Tuesday through Friday. Cancellations for Monday appointments MUST be received before noon on the preceding Friday.*

It is preferred that you pay your expected responsibility amounts at the time of service. However, as a courtesy to you, I may instead put amounts deemed to be your responsibility on your Debit or Credit card, once your insurance has processed your claim correctly, or earlier if deemed appropriate by the billing manager.

My full fee is $80 for a 45-minute session and $100 for a 60-minute session. We agree that you will either: pay the total fee in full at each session without using insurance, file your own insurance claims and pay in full at time of service, or ask me to file your insurance claim at each session and pay your cost share at the time of service.

Payments can be made with cash (no change), check, money order, FSA card, or credit card. There will be a $20.00 processing charge for any check returned to us uncollected by the bank. Any unpaid balance that is not received by Bliss Psychotherapy & Consulting LLC/J.Delaine Taylor, LCSW within 90 days after the date of billing will accrue a monthly late charge of 6% of the unpaid balance.

Communication Policy and Email/Text Informed Consent

It is important for me to have balance, as well as autonomy, in my professional and personal life. With this in mind, I attempt to operate my practice in a way that is responsible to your needs, encouraging of your independence and in line with necessary boundaries in our therapist-client relationship.

Phone Calls: Mental health concerns must be called in via the office telephone number and not via email or text. If I do not answer, please leave a message. I will return your call as soon as possible. If you are having an emergency, call 911 or go to the nearest emergency room.

Phone conversations longer than 5 minutes regarding mental health concerns will be charged at $25.00 for each 15 minutes. Health insurance cannot be billed for this service.

I do not return non-emergent phone calls during evenings or weekends.

If I am to be unavailable for an extended time, my voicemail greeting will include the contact information of a colleague who will cover client emergencies.

Emails and Text Messages: I do not regularly answer emails or texts during evenings or weekends. Please limit the use of emails and text messages to administrative concerns, brief questions or information, or follow-up messages.

Email and text communication are not to be used for mental health concerns or therapeutic exchanges. Mental health concerns must be called in via the office telephone number.

Email and Text Consent: In order to communicate with me via text or email, you must provide your consent, recognizing that email is not a secure form of communication. There is some risk that any protected health information that may be contained in such email may be disclosed to, or intercepted by, unauthorized third parties. I will use the minimum necessary amount of protected health information to respond to your query.

Legal Proceedings Policy

Custody, divorce, and separation: When working with individuals and families when there are matters related to any sort of legal proceedings, for example, divorce and separation, I will not be available to engage in legal or related aspects of the process. However, I request that parents provide me with each written decree, so that I am fully informed as to what is legally expected of you and your family.

Court Fees: If I am subpoenaed by the court, court testimony on a client 's behalf is charged at a higher rate of **$225 per hour** including: testimony related matters like case research, report writing, travel, depositions, actual testimony, cross examination time, and courtroom waiting time.

ACKNOWLEDGMENT OF RECEIPT OF DISCLOSURE STATEMENT

I have been informed of my therapist's degrees, credentials, and licenses. I have read the preceding information and understand my rights and responsibilities as a client. I have read and understand the Health Information Portability and Accountability Act (HIPAA) Information that was provided and I hereby authorize Delaine Taylor to release information provided in the HIPAA information.

Client Signature _____ Date _____

Guardian Signature (if applicable) _____ Date _____

CONSENT FOR TREATMENT OF A MINOR OR A DEPENDENT
(if applicable)

I am the legal guardian or legal representative of the patient and on the patient s behalf legally authorize the practitioner to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

Patient Name _____

Signature of Client or Personal Representative _____ Date _____

Relationship to Patient _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY RIGHTS

I, _____, acknowledge that I received a copy of the Notice of Privacy Practices for J. Delaine Taylor, LCSW.

Signature of Client or Personal Representative _____ Date _____

J. Delaine Taylor, LCSW _____ Date _____

ACKNOWLEDGMENT OF RECEIPT OF FINANCIAL POLICY AND FEE AGREEMENT

I, _____, acknowledge that I received a copy of the Financial Policy and Fee Agreement for J. Delaine Taylor, LCSW.

I AGREE TO THE FOLLOWING PAYMENT PLAN TO COVER MY PORTION OF THE CHARGES (check one):

_____ I DO NOT HAVE INSURANCE AND WILL PAY IN FULL AT THE TIME OF SERVICE.

_____ I WILL FILE MY OWN INSURANCE AND WILL PAY IN FULL AT THE TIME OF SERVICE.

_____ PLEASE FILE MY INSURANCE. I WILL PAY MY COST SHARE AT THE TIME OF SERVICE.

I understand that if problems arise in getting payments from my insurance company, it will be my responsibility to pay the bill and settle with the carrier unless the provider has otherwise contracted with my carrier. I agree to pay off any balance on my account within 90 days unless I have made other arrangements. Balances over 90 days will accrue a 6% interest charge. I understand that a $20 charge will be added to my account for checks returned for insufficient funds.

I authorize Bliss Psychotherapy to send information to a collection agency if I do not pay my bill according to this document. If a collection agency is necessary I understand I will be charged a 6% interest fee on the balance the time it is sent, in addition to a $15 collections fee.

We agree that I will be charged $_____/45 minute session and/or $_____/60 minute session.

I authorize a charge of $80.00 to my credit card if I do not make my scheduled appointment and fail to notify the office at least 24 hours in advance or come to an appointment more than 15 minutes late.

_____ _____

Signature of Client or Personal Representative Date

_____ _____

J. Delaine Taylor, LCSW Date

ACKNOWLEDGEMENT OF RECEIPT OF COMMUNICATION POLICY AND EMAIL/TEXT INFORMED CONSENT

I, _____, acknowledge that I received a copy of the Communication Policy and Email/Text Informed Consent for J. Delaine Taylor, LCSW.

_____ Yes, I have read the Email/Text Informed Consent and consent to unencrypted, but confidential email/text correspondence.
_____ No, I am not interested in email/text correspondence.

_____ _____
Client Signature (or Guardian for Minor) Date

ACKNOWLEDGEMENT OF RECEIPT OF LEGAL PROCEEDINGS POLICY

I, _____, acknowledge that I received a copy of the Legal Proceedings Policy for J. Delaine Taylor, LCSW.

_____ _____
Client Signature (or Guardian for Minor) Date