Patient Information

Dx Code:_____
(For Office Use Only)

Sex: (please circle) M F

Patient Name _____ Date of Birth _____

Email Address _____ Work Phone # (Ext.) _____ Home/Cell Phone # _____

Marital Status _____ Spouse's Name _____ Social Security # _____

Street Address _____

City _____ State _____ Zip _____

Patient Employer _____ Street Address _____

City _____ State _____ Zip _____

Who may we contact in case of an emergency? (List name, address, phone) _____

Name, address, phone of nearest relative not living with you. _____

Responsible Party Information

Responsible Party's Name _____

Responsible Party's Relationship to Patient _____

Responsible Party's Home Address _____

City _____ State _____ Zip _____

Home/Cell Phone # _____ Work Phone # _____ Employer _____

Georgia Hitchcock
Counselor, LPC, CACIII 1115 S Josephine St. Denver, Colorado 80210 (303) 722-6640

Referral Information

Were you referred by a doctor/therapist/acquaintance? If so, please give name and phone #.

If neither of the above applies how did you find out about me?

Insurance Information

Will we be billing insurance on your behalf? Yes [ ] No [ ]

Policy Holder's Name | DOB | Relationship to Patient

Policy Holder's Employer

Insurance Company Name | Address

City | State | Zip

Insurance company Phone | Policy # | Policy Holder's Social Security #

For office-based psychotherapy, medication consultations, psychiatric, medication consultations, psychiatric evaluations and other professional services, payment in full is required at the time services are rendered unless prior arrangements have been made with the business office.

You are responsible for all charges for professional services rendered on behalf of the identified patient, including any charges not reimbursed by your insurance carrier, unless a special arrangement has been agreed upon in writing. You will be charged a rebilling fee of $3.00 per month from the date of initial billing for any self-pay balance over 30 days on your account.

It is my policy that you will be charged for missed appointments unless I receive notice to cancel at least twenty-four hours before your scheduled appointment. Should your appointment be scheduled on a Monday, notice would need to be given the Friday before the appointment. Please initial _____

The signature(s) below indicate that you understand our financial policies and certify that you are financially responsible for services provided. You are responsible for any collection or attorney fees or court costs associated with use of outside agencies required collection of your account.

Patient Signature (If over 15) | Date

Responsible Party | Date

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Authorization to Release Information

Authorize the release of the information provided above and any medical information necessary to 1) provide for adequate professional coverage in the absence of the primary doctor, 2) to verify insurance coverage and 3) to file a claim for insurance benefits related to professional services rendered.

Also authorize the above named doctor to speak with and/or write a report to my referring doctor/therapist and grant my permission and request any medical records including psychiatric records regarding my medical history.

_____ _____
Patient Signature Date

_____ _____
Responsible Party Date

Authorization of Assignment of Benefits

Authorize direct payment of insurance benefits from _____
(Insurance Company)
_____for professional services rendered.
(Doctor)

_____ _____
Parent Signature Date

_____ _____
Responsible Party Date

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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Fees and Billing

Insurance Clients

All costs not paid for by your insurance company are your responsibility.

Please bring your insurance card or your ID number, group number, phone number and address of your insurance company, with your authorization number and information on co-pays and benefit coverage. Please make sure you have contacted your insurance company to let them know you are seeing me for counseling before your first session. They can give you authorization quickly.

Full payment or co-payment is due at each session. Co-payments are acceptable with pre-approval from your insurance company. Please give 24 hours notice if you need to cancel your appointment, otherwise you will be billed a $40 fee for the appointment, if you do not cancel your appointment you will be billed the full amount of $120, as insurance companies require patients to assume responsibility for such charges. In order to receive payment from your insurance company, a Health Insurance Claim Form must be fully filled out and signed. Should a bill be unpaid for more than sixty days, it will be turned over to a collection agency.

Employee Assistance Clients

For employee assistance (EAP) clients, there is usually no charge for sessions as your employer has an arrangement with the EAP company I am a provider for. However, if you do not cancel an appointment at least 24 hours in advance, I will need to bill you for the appointment for that time, The EAP companies do not generally pay for missed appointments, so it is your responsibility. Please note that is not my preference, so if you'll kindly call in advance we can avoid this.

I understand this policy (Signature)_____

Date:_____

Georgia Hitchcock
Counselor, LPC, CACIII 1115 S Josephine St. Denver, Colorado 80210 (303) 722-6640

Psychotherapist-Patient Services Agreement

Welcome to my practice. This document contains important information about my professional services and business policies. 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 procedures. When you initial where requested by “x” and sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy or if you have not satisfied any financial obligations you have incurred.

Except in emergency situations, or where psychotherapy is being administered as the result of court order, every licensed or unlicensed psychotherapist shall provide the following information in writing to each client during the initial contact.

Georgia Hitchcock
Master of Arts Degree, Counseling and Guidance
University of Northern Colorado, 1985
License Colorado LPC 338

The Colorado department of Regulatory Agencies has the general responsibility of regulation the practice of licensed psychologists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, certified school psychotherapists, and unlicensed individuals who practice psychotherapy. The agency with the department that has the responsibility specifically for licensed and unlicensed psychotherapists is:

State Grievance Board
1560 Broadway Suite 1340, Denver, CO 80202
(303) 894-7766

Client rights and information:

x____ You're entitled to receive information from this agency about our methods of therapy, the techniques used, the duration of therapy, if it can be determined. You can seek I second opinion from another therapist or terminate therapy at any time. In a professional relationship, sexual intimacy between therapist and client is never appropriate. If sexual intimacy occurs, it should be reported to the State Grievance Board

Privileged Communication:

x____ The information provided by a client during therapy sessions is legally confidential, except as provided in section 12.43 218 CRS and except for certain legal exceptions which will be identified by the license, should any such situations arise during the course of treatment. Any threats to self or others, and in the case of suspected or reported child abuse, confidentiality regulations do not apply

Psychological Services:

x____ The practice of psychotherapy is not an exact science and no guarantees will be made to you, as a patient, as to the results of treatment or examinations during the course of treatment. There are benefits and risks involved since therapy often involves discussing unpleasant aspects of your life. At times, you may feel discomfort. However, psychotherapy has many benefits which include developing better relationships, finding solutions to problematic areas, and significant reduction in feelings of distress.

Appointments:

x____ I schedule appointments as 60 minute sessions (one appointment hour of 60 minute duration). Once an appointment hour is scheduled, you will be expected to pay for it unless your provide 24 hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. When possible, I will try to find another time to reschedule that appointment.

Professional Fees:

x____ My hourly fee is $120.00. All payment will be made in full before each session begins. 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 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other services you may request of me. 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'm called to testify by

another party. Because of the difficulty of legal involvement, I charge $150.00 per hour for preparation and attendance at any legal proceeding. There will be a retainer fee of $500.00 due prior to any of my services. This will be required in the form of cash, check, or cashier's check.

Contacting me:

x____ It is likely you may receive my confidential voice mail if trying to reach me. I check my messages several times a day and will try to get back with you within 24 hours, excluding weekends and holidays. Should I be unavailable for an extended period of time, I will provide the name of another therapist covering for me. If your situation is life threatening, call 911 or your family physician, or go to the nearest emergency room. Telephone calls in excess of 10 minutes will be prorated at my fee of $120 per hour.

x____ In the event you choose to e-mail or text me, you acknowledge that all electronic communication is unsecure. You acknowledge that this may be a form of communication during the therapeutic relationship unless you specifically request otherwise. When therapeutic communication occurs by electronic means, there are potential risks and benefits, including but not limited to, issues of confidentiality, clinical limitations, transmission difficulties, and ability to respond to emergencies. This therapist is aware of the limitations regarding confidential transmission by internet or electronic media and will take extra care when transmitting or receiving such information.

MINORS and their PARENTS or GUARDIANS (**please read this section in its entirety)**

x____ Minors **under** 15 years of age: Generally, a parent of a minor child under the age of 15 has the right to access the minor child's patient information. An exception to this may occur because the privacy in psychotherapy is often crucial to successful progress, particularly with adolescents. In this case, it may be determined that access would have a detrimental effect on the therapist/patient relationship with the minor child, or that the minor child's physical safety or psychological well0being may be jeopardized. If a parent or guardian is not actively participating in treatment with the minor child, it is my intent to provide general information about the progress of the minor child's treatment if requested.

x____ Minors **over** 15 years of age: In accordance with HIPAA regulation; once the minor child reaches the age of 15 years, any access to his/her patient information rests solely with the minor child- not the parent or guardian. Please note: If in my professional opinion, I feel that the minor child may be in danger or self-harm or may be a danger to someone else, it is understood by the minor child signing this document that his/her right of confidentiality will not apply in these circumstances and I will notify the minor child's parents of my concerns. Before giving the parents any information, I will discuss the matter with the minor child, if possible, and do my best to handle any objections he/she may have.

Billing and Payments:

x____ You will be expected to pay for each session at the time it is held. If your account has not been paid for more than 60 days and arrangements for the 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:

x____ Health insurance policies usually provide some coverage for mental health treatment. It is your responsibility to obtain pre-authorization, when required, from the insurance company PRIOR to the first session. Preauthorization of insurance coverage is not a guarantee of coverage; I can only assist with the benefits and submission of claims, as quotes and payments are at the discretion of your insurance company. Any discrepancy regarding payment for treatment will be the responsibility of you, the Patient. This would occur only if the insurance company does not authorize benefits. Please note: Insurance deductibles and co-pays are payable at the time of service. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled, however, you (NOT your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

x____ You should also be aware that your contact with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record, In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company's file, though required to keep your information confidential, I have no control over what they do with it once it is in their hands. By signing the Agreement, you agree that I can provide requested information to your carrier.

By signing the Agreement, you agree that you have received a copy of the service agreement and were made aware of my professional services and business policies of my practice.

_____ _____

Signature of Client Date

_____

Printed name

Georgia Hitchcock
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Disclosure Statement

1. Georgia Hitchcock, 7900 East Union Ave, 11th floor, Denver, CO. 80237, 1115 So. Josephine St, Denver, CO., 80210

2. Child Development/Elementary Education, B.S, counseling psychology, M.A., Certified Addictions Counselor, CACIII, Marriage and Family-Therapy Certificate, Licensed Professional Counselor, LPC, internship Porter Hospital, Eating Disorder Unit for four years, Dept. of Psychiatry, Univ. of CO., Infant/early childhood mental health training.

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 Licensed Professional Counselor Examiners can be reached at- 1560 Broadway, Suit. 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 registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required.

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 [If you are HIPAA covered add: "and the Notice of Privacy Rights you were provided"] 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.

I have read the preceding information, 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:

_____