Grace Edstrom, LCSW
Therapy for Couples, Individuals, Teens & Families

MANDATORY DISCLOSURE FORM & CLIENT AGREEMENT 2015

Thank you for choosing to receive therapeutic services with me. I look forward to working with you and getting to know you better. Please read the information below thoroughly, initial where appropriate, and sign at the bottom. Thanks!

PAYMENT & CANCELLATIONS

Sessions are typically 50 minutes in length. **Payment of $110 is required in full at the end of each session**. Cash, checks and credit cards are accepted. All checks should be made payable to Grace Edstrom.

Unless 24- hours or more notice is given, it is very difficult for me to schedule another person in your appointment slot. As a result, 24- hours notice of a cancellation is required or I will charge you the full amount of your session fee. I understand that emergency situations arise such as a sudden illness, car accident or family death; in such situations, an exception to the 24- hour cancelation policy may be considered.

COURT RELATED MATTERS

I understand that my counselor will not willingly testify in any court proceeding as this role, more often than not, jeopardizes the therapeutic relationship. However, if required by law to appear and/or testify, I understand that I will be charged $300.00 per hour for court testimony, depositions, and court preparation, including all travel time. (Initial Here) _____

DISCLOSURE REGARDING DIVORCE AND CUSTODY LITIGATION

If you are involved in divorce or custody litigation, my role as therapist is not to make recommendations to the court concerning custody or parenting issues. By signing this Disclosure Statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that I write any reports to the court or to your attorney, making recommendations concerning custody. The court can appoint professionals who have no prior relationship with the family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interests of the family's children.

CLIENT RIGHTS AND IMPORTANT INFORMATION

A) You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy (if I can determine it), and my fee structure. Please ask if you would like to receive this information.

B) You can seek a second opinion from another therapist or terminate therapy at any time.

C) In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Department of Regulatory Agencies, Mental Health Section.

D) Generally speaking, information provided by and to a client in a professional relationship with a psychotherapist is legally confidential and the therapist cannot disclose the information without the client's consent. There are several exceptions to confidentiality which include: (1) I am required to report any suspected incident of child abuse or neglect to

law enforcement; (2) I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (3) I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled as a result of a mental disorder; (4) I am required to report any suspected threat to national security to federal officials; and (5) I may be required by Court Order to disclose treatment information.

E) Under Colorado law, C.R.S.§14-10-123.8, parents have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information. If you request treatment information from me, I may provide you with a treatment summary, in compliance with Colorado law and HIPPA Standards.

LIMIT OF SERVICES AVAILABLE

I do not provide emergency and after-hours services. If you find yourself in a life-threatening situation, you agree to take the necessary steps to keep yourself safe, up to and including calling 911 or going to the emergency room (at your cost) if necessary. **I do not provide medications, psychiatric services, or psychological testing.**

*I have read the preceding information and it has been presented to me verbally. I understand and agree to all of the disclosures and financial obligations that have been made to me.

Client Name: _____ Client Name: _____

Signature: _____ Signature: _____

Date: _____ Date: _____

Therapist Signature: _____ Date: _____

Referral Source
How did you hear about Grace Edstrom? _____

Grace Edstrom, LCSW
Therapy for Couples, Individuals, Teens & Families

CLIENT INFORMATION SHEET

Today's Date: _____/_____/_____

Name: _____

Address: _____

Street City State Zip Code

Email: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Date of Birth: _____ Age: _____

Relationship Status (Please circle) : Married Engaged Separated Single Divorced Partnered

Name of parent to contact if client is a child: _____

Cell Phone: _____ Email: _____

Other members involved in therapy:

Name **Phone Number:**	**Age**	**Relationship**
Name **Phone Number:**	**Age**	**Relationship**

Name **Phone Number:**	**Age**	**Relationship**

Have you participated in therapy or counseling in the past (Please circle)? Yes No

If yes, tell me about your experience of therapy (positive, negative, mixed, etc.):

_____

_____

3600 S Yosemite St. Suite 1050, Denver, CO) 80237 Phone: 303.667.4557
gjetherapy@gmail.com

Please list any current prescribed psychiatric medication:

_____

Has anyone in your family (immediate or extended) experienced difficulties with mental health (ex: depression, anxiety, bipolar, schizophrenia, substance abuse, etc.)? Please explain:

_____

Have you or members of your family been or are currently victims of abuse (physical, sexual, emotional, domestic)?

_____

_____

Are you or someone in your family currently suicidal or homicidal?

_____

What is going well for you or in your family/relationship at this time?

_____

_____

Is faith/spirituality in important part of your life? If so, please explain:

_____

In your own words, what is the concern or problem that brings you into therapy today?

_____

_____

On a scale of 1 – 10 (1 = minimal challenge, 10 = extreme challenge), circle how would you rate this problem today?

1 2 3 4 5 6 7 8 9 10

What would you like to gain from our work together? (therapy goals):

_____

_____

On a scale of 1 – 10 (1 = no motivation and 10 = ready to do or try anything), how motivated are you to make changes that will improve your concern or problem? Circle: **1 2 3 4 5 6 7 8 9 10**

Who might you want to involve in therapy that is not here today?

_____

_____

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NOTICE OF PRIVACY PRACTICES
OF
Grace J. Edstrom, LCSW

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective April 14, 2003

If you have any questions or requests about this Notice, please contact Grace Edstrom at (303) 667-4557

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 client's 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 clients, or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of 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, the clinician does not 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 for Protected Health Information.

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 it is thought that access to your mental health records would harm you, your access may be restricted. Ask your clinician for the Request Form for PHI and the appeal process.

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. An appeal process is available if the clinician determines the record is accurate and complete as is. Ask your clinician for the Request Form PHI and the appeal process available to you.

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. 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.

Grace J. Edstrom, LCSW

Acknowledgement of Receipt of Notice of Privacy Rights

I, _____, and _____, acknowledge that I/we have
Client Name (print) Client Name (print)

received a copy of the Notice of Privacy for Grace J. Edstrom, LCSW. I/We understand that it is our responsibility to read this document.

_____
Client Signature

_____
Client Signature

_____ _____
Signature of Client or Personal Representative Date

If not the client, please print name and state legal authority to sign for client.

***

Electronic and Text Messaging Communication Disclosure

- Please be aware that e-mail and or/text messaging is not a secure method of communicating confidential information. If you wish to contact me confidentially, please wait until an in-person session, or call me directly at 303-667-4557.

- Both my phone and computer are password protected. However, it is impossible to assure privacy of any communication by electronic means as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete, or contain viruses. If you are uncomfortable with this possible limitation to your privacy, please communicate by other means.

- Please sign below to acknowledge that you have read the above limits to your confidentiality and accept that Grace Edstrom, LCSW does not accept liability for any error or loss of information that is transmitted electronically.

Signature _____ Date_____

Signature _____

Date ___/___/___

3600 S Yosemite St. Suite 1050, Denver, CO) 80237 Phone: 303.667.4557
gjetherapy@gmail.com

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Credit Card Authorization Form

I, _____ , hereby authorize Grace Edstrom, LCSW to charge my credit card account for
Client's name
for therapeutic services accrued in the treatment of _____. I authorize Grace Edstrom,
Client's name
LCSW to charge my credit card for outstanding balances and for late cancelations/missed appointments (when I do not provide a 24-hour notice).

Credit Card Information: ( ) VISA ( ) MasterCard ( ) American Express

Credit Card Number:_____

Expiration Date: _____ /_____ VID Code: _____

Credit Card Billing Zip Code: _____

Email Address to Send Receipts, if desired:_____

Authorization Valid Until: End of treatment, or otherwise requested by Client. Initials Here: _____

Signature of Responsible Party:

_____

*Note - Your completion of this authorization form helps us to protect you from credit card fraud. Grace Edstrom, LCSW will keep all information entered on this form strictly confidential

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