Archway

Counseling and Consulting

Hello,

Welcome to Archway Counseling and Consulting, I look forward to working with you. In order to better serve you it is important that I get some background information. This document begins that process.

Please print single pages 2-23 (single-sided) of this document and complete the forms in their entirety. Please review the HIPPA information on pages 24-28. There will be places that will need to be completed in our first session (e.g., there are places where I will need to sign). If you are seeking couples counseling, in addition to the above, print out pages 4-9 and page 23 for your partner and have them fill out these pages and bring to the first session.

Bring the completed paperwork to your first session, this paperwork covers a wide range of history, and **will take about 40-45 minutes** to complete. Please allow enough time **before** our first session to complete. During the first session we will
1) review and sign the legal documents,
2) review the information you provide from the paperwork,
3) spend time getting to know you, and
4) discuss your counseling goals, and outline a plan to best attain those goals.

In addition to the completed paperwork, please **bring your insurance card, or a copy of your insurance card both front and back.**

I accept check and cash only, please write checks to Archway Counseling. Our address is 899 Logan Street, Suite 209. The waiting room is contained within the suite. At the time of our appointment, I will look for you in the suite 209 waiting room

There are a few visitor parking spots on the south side of the building. They are clearly marked visitor parking, and are available for 2 hours. If the parking lot is full there is street parking on Logan, Pennsylvania and on 9th avenue. Parking on Pennsylvania has two-hour free parking.

If you have any questions please contact me at 303.642.6636. I look forward to meeting you.

Sincerely,

DJohns PhD, LPC, LAC, NCC

David Johns
PhD, LPC, LAC, NCC

Archway Counseling and Consulting

R. David Johns

Information Sheet

The information you provide in this intake form may be confidential; however, certain otherwise confidential information may be shared as required by law. You are not required to supply the information contained in this Intake Form. Please provide as much information as possible.

Client Information

Last Name :	First Name :	Middle Name :	DOB :	Age :	Sex :

Patient Contact		**Guarantor Information**	
Street		Name	
City, State, Zip		Address	
Cell Phone			
Home Phone		Cell Phone	
Email**		Home Phone	

****Please be aware there is a risk that an unintended third-party may access information shared by electronic transmissions such as email and cell phone. By allowing David Johns to contact you by email you are consenting to receive electronic communications and understand the risks involved. David Johns cannot guarantee that confidential information shared using electronic communications will remain confidential.**

Payer Type (circle one)				
Self –pay	Medicaid	Commercial	Workers Comp	Auto Insurance

Primary Insurance Information				
Insurance Name: *		Insured Name*		
Address:		Subscriber ID*		
		Group Number*		
E-Payer ID		Relation	[ ] Self [ ] Spouse [ ] Child [ ] Other	
Provider Phone Number*		Authorization #		
Fax Number		Deductible	$	Co-Pay $

Secondary Insurance Information				
Insurance Name:*		Insured Name*		
Address:		Subscriber ID*		
		Group Number*		
E-Payer ID		Relation	[ ] Self [ ] Spouse [ ] Child [ ] Other	
Provider Phone Number*		Authorization #		
Fax Number		Deductible	$	Co-Pay $

Cell 303.642.6636
DrDavid@ArchwayCounseling.net

CLIENT INFORMATION

Name: _____

Employer: _____

Occupation: _____

Work Address Street:_____

Work Phone _____

Marital Status: □ Single □ Married or Civil Union □ Separated □ Divorced □ Partnered

Height: _____ Weight: _____ Hair Color:_____ Eye Color: _____
Gender: _____ Race:_____ Ethnicity: _____
Car Year/ Make/Model:_____ Car Color: _____
License Plate Number: _____ State Issued: _____

IN CASE OF AN EMERGENCY

In case of an emergency, David Johns may be required to contact someone on your behalf. Please list your emergency contact below, which David Johns may contact on your behalf. David Johns will only share the minimum amount of information necessary with your emergency contact should he or she need to be contacted.
I authorize David Johns/ Archway Counseling and Consulting to contact the following person(s):
Name_____ Relationship_____ Phone(____)_____
Address: Street: _____ City/State:_____ Zip Code: _____
Name_____ Relationship_____ Phone(____)_____
Address: Street: _____ City/State:_____ Zip Code: _____

_____

Client Signature Date

PERSONAL INFORMATION

Name:_____
Referred by: _____

Previous Counseling/Treatment: In order to provide you with continuous and congruent care, David Johns may need to contact your previous or current Mental Health Provider. Any contact that he may have with your previous or current Mental Health Provider will require you to sign an Authorization for Release of Protected Health Information and Confidential Information.

Have you ever sought counseling before: □ YES □ NO

If yes, please list your reason(s) for seeking mental health services (if you are currently seeing another mental health provider, please list the reason(s) here as well):

_____
_____
_____
(Who) _____ (Where) _____ (When) _____ (Results) _____
(Date of Last Session) _____
(Who) _____ (Where) _____ (When) _____ (Results)_____
(Date of Last Session) _____
May David Johns contact your previous or current Mental Health Provider: □ YES □ NO

Are you currently in counseling with the above listed mental health provider: □ YES □ NO
Nature of Current Problems/ Reason for seeking counseling:

_____
_____
_____
_____
Others Living in the Home:
Name _____ DOB ___/___/___ School/Employer: _____
Relationship: _____
Name _____ DOB ___/___/___ School/Employer: _____
Relationship: _____
Name _____ DOB ___/___/___ School/Employer: _____
Relationship: _____
Name _____ DOB ___/___/___ School/Employer: _____
Relationship: _____

MEDICAL/HEALTH INFORMATION

In order to provide you with continuous and congruent care, David Johns may need to contact your primary care physician. Any contact that David Johns may have with your Primary Care Physician will require you to sign an Authorization for Release of Protected Health Information and Confidential Information.
Primary Care Physician: _____ Physician's Phone: (____) _____
Physician's Address: _____
Date of Last Visit and/or Physical: _____
Medical Conditions: _____

(Name: _____)

Allergies: _____

Adverse Reaction to Medications _____

Medication	Dosage	Frequency	Start Date	Reason	Prescriber

Chronic medical conditions: _____

Infectious diseases :_____ _____

Learning Disability: _____

Recent weight changes: Lost _____lbs. in _____ weeks/months? Intentional? Y N

Gained _____lbs. in _____ weeks/months? Intentional? Y N

Past illnesses / injuries / traumas:

_____

Surgeries: _____

Hospitalizations (medical and psychiatric):

_____

_____

Please describe your reason for seeking counseling at this time and what would you like to achieve in counseling? What do you hope to accomplish?

_____

_____

_____

_____

_____

Spiritual/Faith Information: How does your spirituality or religious faith play a role in your life?

_____

_____

_____

How would you describe your strengths? (Name:_____)

_____

_____

_____

Who are the people and organizations that you can use for support?

_____

_____

Please circle your response below for the following questions. *	
1. Do you often find yourself preoccupied with sexual thoughts?	Yes No
2. Do you hide some of your sexual behavior from others	Yes No
3. Have you ever sought help for sexual behavior you did not like?	Yes No
4. Has anyone been hurt emotionally because of your sexual behavior?	Yes No
5. Do you feel controlled by your sexual desire?	Yes No
6. When you have sex, do you feel depressed afterwards?	Yes No

**Assessment questions from http://www.scsexaddiction.com/PATHOS_Assessment.html*

Please circle your response below for the following questions. While you were growing up, during your first 18 years of life: *	
Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?	Yes No
Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?	Yes No
Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?	Yes No
Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?	Yes No
Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	Yes No
Were your parents ever separated or divorced?	Yes No
Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?	Yes No
Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?	Yes No
Was a household member depressed or mentally ill, or did a household member attempt suicide?	Yes No
Did a household member go to prison?	Yes No
**Assessment questions from http://acestoohigh.com/got-your-ace-score/*	

(Name: _____)

Rate your current distress level for each symptom / concern that applies to you**, using the scale below**:

0 ---------- 5 ----------10

No Distress **Moderate Distress** **Extreme Distress**

_____Mood Swings	_____Weight loss
_____ Depression	_____Weight gain
_____ Inability to feel pleasure	_____ Homicidal thoughts / actions
_____Insomnia (inability to sleep)	_____ Obsessive thoughts
_____Day time sleepiness /Excessive Sleep	_____ Perfectionism
_____Worthlessness:	_____ Health concerns
_____Guilt	_____ Hormonal / endocrine imbalances
_____Difficulty concentrating	_____ Self esteem concerns
_____Indecisiveness	_____ Grief / losses
_____Thoughts of death	_____ Loss of meaning in life
_____Suicidal thoughts	_____Spiritual/Religious Concerns
_____Suicidal plans	_____Alcohol/drug abuse (self)
_____ Memory problems (short term)	_____ Alcohol/drug abuse (others)
_____ Memory problems (long term)	_____ Nicotine addiction
_____Social difficulties	_____ Caffeine addiction
_____Occupational/Job difficulties	_____ Eating disorders
_____Decreased need for sleep	_____ Compulsive gambling
_____Exaggerated Feelings of egocentrism/self-importance	_____ Pornography
	_____ Sexual addiction
_____ Paranoid thoughts / behaviors	_____ Computer / phone/internet addiction
_____Hallucinations (audio / visual)	_____ Other addictions (identify)
_____Anxiety/Fear	_____ Communication problems
_____ Stress	_____ Sexual problems
_____Disturbing dreams	_____ Marital / relationship conflicts
_____Estrangement from others	_____ Blended family problems
_____Hopelessness	_____ Conflict with parents
_____Irritability	_____ Conflict with siblings
_____Outbursts of Anger/Rage	_____ Conflict with children
_____Easily Startled	_____ School / work conflicts
_____ Panic attacks	_____ Legal problems
_____ Loss of appetite	_____ Financial problems
_____Increased appetite	_____ Job / employment problems
_____Re-experiencing traumatic events	_____ Emotional abuse (past)
_____Avoiding people, places	_____ Emotional abuse (current)
_____Avoiding thoughts, feelings, conversations	_____ Physical abuse (past)
	_____ Physical abuse (current)
_____Inability to recall traumatic event(s)	_____Sexual Abuse (past)
_____Inability to have loving feelings towards others	_____Sexual Abuse (current)
	_____Other concerns_____

David Johns- Archway Counseling and Consulting Disclosure (revision 11/2019)
Cell 303.642.6636
DrDavid@ArchwayCounseling.net

Drug and Alcohol Information (Name: _____)

Directions: The questions that follow are about your use of alcohol and other drugs. Your answers will be kept private. Mark the response that best fits for you. Answer the questions in terms of your experiences in the past 6 months. Do not include time incarcerated. *

1. During the last 6 months…. 1. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin, or other opioids, uppers, downers, hallucinogens, or inhalants	Yes No
2. Have you felt that you use too much alcohol or other drugs?	Yes No
3. Have you tried to cut down or quit drinking or using alcohol or other drugs?	Yes No
4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors or a treatment program.)	Yes No
5. Have you had any health problems? For example, have you: ___Had blackouts or other periods of memory loss **Yes No** ___Injured your head after drinking or using drugs **Yes No** ___Had convulsions, delirium tremens (DTs) **Yes No** ___Had hepatitis or other liver problems **Yes No** ___Felt sick, shaky, or depressed when you stopped **Yes No** ___Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs **Yes No** ___Been injured after drinking or using **Yes No** ___Used needles to shoot drugs **Yes No**	Yes No
6. Has drinking or other drug use caused problems between you and your family or friends	Yes No
7. Has your drinking or other drug use caused problems at school or work?	Yes No
8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.)	Yes No
9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?	Yes No
10. Are you needing to drink or use drugs more and more to get the effect you want?	Yes No
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?	Yes No
12. When drinking or using drugs are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone?	Yes No
13. Do you feel bad or guilty about your drinking or drug use?	Yes No
14. Have you ever had a drinking or other drug problem?	Yes No
15. Have any of your family members ever had a drinking or drug problem?	Yes No
16. Do you feel that you have a drinking or drug problem now?	Yes No

*Assessment questions from http://www.ncbi.nlm.nih.gov/books/NBK64187/

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(Name:_____)

Please provide the following information of drug and alcohol use.	**AGE of first use**	**CURRENT USE**		**Date of last use**
		Number of times in past two weeks	**Quantity in past two weeks**	
Beer (12 oz per drink: 5% alcohol)				
Malt Liquor (9 oz per drink; 7% alcohol				
80 Proof distilled spirits (1.5 oz per drink; 40% alcohol)				
Wine (5 oz per drink; 12% alcohol)				
Tobacco: cigarettes, cigars, vaporizers, chew				
Marijuana Recreational				
Marijuana Medical				
Cocaine/crack				
Methamphetamine				
Heroin				
Prescription Pain killers				
PCP, LSD				
Ecstasy				
Other				

To be completed by adults (18 yrs and older)	**Circle**	
Have you ever felt like you should cut down on your drug or alcohol use?	yes	no
Has a friend or relative expressed concerns about your use?	yes	no
Have you ever felt guilty about your drinking or drug use?	yes	no
Have you ever had to take a drink or use a drug the next day to steady your nerves?	yes	no
Are you a recovering alcoholic or a recovering drug addict?	yes	no
Is there a history of problems with drug or alcohol use in your family?	yes	no

_____ _____

Client Signature Date

_____ _____

Parent/Legal Guardian Signature Date

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DrDavid@ArchwayCounseling.net

DISCLOSURE STATEMENT

Welcome to Archway Counseling and Consulting. We want your experience here to be positive and growth promoting. Following is some information about Archway Counseling's policies and procedures. Please take your time, read this carefully, and ask if you have any questions.

Everyone twelve (12) years and older must sign this disclosure statement. A parent or legal guardian with the authority to consent to mental health services for a minor child/ren in their custody must sign this disclosure statement on behalf of their minor child under the age of twelve (12) years old. A parent or legal guardian with the authority to consent to mental health services for a minor child/ren in their custody must also sign this disclosure statement on behalf of their minor child over the age of twelve (12) but under the age of fifteen (15) years old, unless said minor is voluntarily seeking psychotherapeutic services for themselves without their parent's or legal guardian's knowledge or consent. In this case, the minor who is between the age of twelve (12) and fourteen (14) years old, in addition to this disclosure statement, shall also sign a Voluntary Consent for Psychotherapeutic Services form.

The mental health professional providing services to a minor between the age of twelve (12) and fourteen (14) may advise the minor's parent or legal guardian of services provided with the consent of the minor or a court in specific circumstances, unless notifying the parent or legal guardian would be inappropriate or detrimental to the minor's care and treatment. The mental health professional may notify the parent or legal guardian, without the minor's consent, if in their professional opinion the minor is unable to manage their own care or treatment, or if the minor expresses any suicidal ideation.

In divorce or custody situations and because of the Colorado Department of Regulatory Agencies view on parental consent, it is Archway Counseling and Consulting's policy to seek the consent of both parents/legal guardians, however this consent does not supersede any court order outlining parental decision-making and custodial rights. This policy is irrespective of any court determination and this is the governing policy unless the child's health, safety, and welfare could be at risk. If this is the case, you must inform the Archway Counseling and Consulting so that appropriate action for the protection and welfare of the child may be taken. This disclosure statement contains the policies and procedures of Archway Counseling and Consulting and is HIPAA compliant. No medical or psychotherapeutic information, or any other information related to your privacy, will be revealed without your permission unless mandated by Colorado law and Federal regulations (42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164).

General Information about Your Therapist

David Johns, PhD, LPC, LAC, NCC
899 Logan Street
Denver, CO 80203

Phone 303-642-6636
Website: ArchwayCounseling.net
Email: DrDavid@ArchwayCounseling.net

Education

Doctorate-Counseling Education and Supervision	University of Northern Colorado (2014)
Master of Counseling	Idaho State University (2006)
Bachelor of Arts (French)	Boise State University (1994)
Completed Level 1 Training-Gottman Couples Method Certificate (2-day training, no continuing education requirements)	Gottman Institute (2011)
Compassion Fatigue Educator Certificate (2-day training, no continuing education requirements)	Figley Institute (2006)
EMDR Basic Training	EMDR of the Rockies (2018)

Experience

Owner/ Psychotherapist	Archway Counseling & Consulting (2017-present)
Contract Counselor/Psychotherapist	Insight Counseling Center (2010-2017)
Adjunct Professor	Regis University (2014-present)
Contract Counselor/Psychotherapist	Episcopal Service Corps (2015- 2018)
Contract Counselor/Psychotherapist	Jefferson Center for Mental Health (2010)
Counselor/Psychotherapist	The Council on Substance Abuse (2007-2009)
Counselor/Psychotherapist	Centus Counseling (2007-2008)
Counselor/Psychotherapist/Intern	Community Partnerships (2005-2006)
Counseling Intern	College of Idaho (2005-2006)
ISU Clinic Coordinator	Idaho State University (2005-2006)

Licensure/Certification

State of Colorado, Licensed Professional Counselor (License number 5317)
State of Colorado, Licensed Addiction Counselor (License number 751)
National Certified Counselor (Certification Number 222769)

2. The Colorado Department of Regulatory Agencies ("DORA"), Division of Professions and Occupations ("DOPO") has the general responsibility of regulating the practice of Licensed Psychologists, Licensed Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified and Licensed Addiction Counselors, and registered individuals who practice psychotherapy. The agency within DORA that specifically has responsibility is the Mental Health Section, 1560 Broadway, Suite #1350, Denver, CO 80202, (303) 894-2291 or (303) 894-7800; DORA_MentalHealthBoard@state.co.us. The State Board of Licensed Professional Counselor Examiners regulates Licensed Professional Counselors and the State Board of Addiction Counselor Examiners regulates Certified Addiction Counselors II; both can be reached at the address listed above. Clients are encouraged, but not required, to resolve any grievances through Archway Counseling and Consulting's internal process.

3. You, as a client, may revoke your consent to treatment or the release or disclosure of confidential information at any time in writing and given to your therapist.

4. Mental Health Regulation and Types of Licenses and Registration. Levels of Psychotherapy Regulation in Colorado include licensing (requires minimum education, experience, and examination qualifications), Certification (requires minimum training, experience, and for certain levels, examination qualifications), and Registered Psychotherapist (does not require minimum education, experience, or examination qualifications.) All levels of regulation require passing a jurisprudence take-home examination. The practice of licensed, certified, or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Professions and Occupations, Department of Regulatory Agencies. The Colorado Board of Licensed Professional Counselor Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800; DORA_MentalHealthBoard@state.co.us and the State Board of Addiction Counselors can also be reached the same way. 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 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. A Licensed Social Worker must hold a master's 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 bachelor's 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 master's 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. **I am a Colorado Licensed Professional Counselor (LPC), and a Licensed Addiction Counselor (LAC).**

5. Information about Therapy and Fees. 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. You may also revoke your consent to treatment, release of confidential information or disclosure in writing and given to your therapist at any time. You are entitled to request restrictions on certain uses and disclosures of protected health information as provided by 45 CFR 164.522(a), however I am not required to agree to a restriction request. Please review the Notice of Privacy Policies for more information.

I approach counseling therapy from a wellness and integrated model in order to build on each client's unique skills and strengths. This integrated approach draws from Cognitive/Behavioral, Couples and Family, Humanistic, and Experiential models of counseling. This approach facilitates positive growth and congruency for the individual in the **emotional, intellectual, physical, spiritual, and relationship realms**. I use these skills with people to understand and resolve issues such as depression, anxiety, bi-polar, grief, trauma, sexuality, relationships, spirituality, substance abuse and dual diagnoses. I have completed Level One Training in Gottman Method Couples Therapy and use the Gottman method with couples. Generally speaking, my therapeutic approach involves looking at underlying issues with the aim of personal transformation and freer, more positive living. **Length of therapy varies**, depending on the nature of the problem and the desired level of change of the client. While some issues may be resolved within a few sessions, deep level change often takes time. **No one can guarantee the outcome of therapy**. Therapy depends on the fit between client, therapist, and therapeutic method and is **dependent on the client's motivation and willingness to experience the anxiety of the change process**. Please feel free to discuss with me at any time your goals for therapy and any thoughts or questions you have about the work we are doing together. If at any point you would like to try another approach, please feel free to talk with me about this and I will be happy to provide appropriate referrals. There is no guarantee that psychotherapy will yield positive or intended results. Although every effort will be made to provide a positive and healing experience, every therapeutic experience is unique and varies from person to person. Results achieved in a therapeutic relationship with one person are not a guarantee of similar results with all clients.

Archway Counseling and Consulting **provides therapeutic services by scheduled appointment only and does not provide emergency/crisis counseling**. In the event you are unable to reach me at the number I provided to you, and you are having a true medical or psychiatric emergency, notify 911 immediately, go to the nearest emergency room, or call Colorado's Crisis Hotline (844) 493-8255, and then notify me. If you seek after hours and/or emergency treatment from any counseling agency center, hospital, or emergency room, you will be solely responsible for any fees due. If you leave me a voicemail, I will return your call by the end of the next business day, excluding holidays and weekends.

The fee for individual psychotherapy is $180 per clinical hour. The fee for group therapy is $50 for one hour. You will be charged for missed individual sessions ($100) unless you give me 24 hours' notice/one business day notice, excluding emergencies. You will be charged the no-show fee if you are more than ten minutes late. Please see the Fee Agreement for more details.

If your therapeutic issues are above my level of competence or outside the scope of my practice, I am <u>legally required</u> to refer, terminate or consult.

6. Prohibited Relationships. In a professional relationship, sexual intimacy is never appropriate, is unethical, is illegal, and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder listed above.

7. Confidentiality. Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent or in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates if the psychotherapist is a Licensed Psychologists, Licensed Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified and Licensed Addiction Counselors, or a Registered Psychotherapist. There are exceptions to this confidentiality, some of which are listed in C.R.S.§ 12-43-218 and the Notice of Privacy Rights you were provided, as well as other exceptions in Colorado and Federal law. If a legal exception arises during therapy, if feasible, you will be informed accordingly. You should be aware that provisions concerning disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in C.R.S § 13-90-107. Some of the exceptions to confidentiality are as followed:

- I am required by law to report suspected child abuse and/or neglect, without an investigation, to the proper authorities.
- I am required to report any suspected incident or imminent risk of elder abuse and/or exploitation of an at-risk elder, age 70 years or older, to law enforcement which may include contacting law enforcement to perform a wellness check for the person of concern.
- If I determine, in my sole discretion, that you are a serious harm/danger to yourself or others, I may be required to take action, such as seek hospitalization without your consent or contact law enforcement.
- I am required to report any suspected threat to national security to federal officials
- I am required to report any threats against specific locations and/or entities, including those identifiable by their association with a specific location or entity such as mosques, synagogues, churches, schools, theaters, workplaces, etc. to appropriate authorities or to warn the party, location, or entity you threatened.
- I may be required by Court Order to disclose confidential information
- If I am unable to collect my agreed upon fee, I may send your name and address to a collection agency or seek the assistance of the Court. Only the minimum amount of information will be disclosed to collect my fee and I will notify you prior to sending the information to the collections agency by contacting you at your last known address.
- If you file an official complaint or a lawsuit against me, according to Colorado law, I may disclose confidential information.
- As a standard of practice, I may seek consultation from another professional, such as another mental health professional or an attorney, about issues raised by you in therapy. However, your confidentiality is still protected and only the minimum amount of information necessary to consult will be disclosed. Signing this disclosure statement gives me permission to consult as needed to provide professional services to you. You will need to sign a separate Release of Information for any discussion or disclosure of your protected health information to another professional besides an attorney that I retain.
- **Clerical and billing** persons hired by me may have access to limited confidential information. This information is protected from further disclosure and is used solely for administrative and billing purposes.
- In couples counseling or where the consent of both parents/legal guardians are required to treat a minor child, both spouses and/or parents/legal guardians will be required to sign a release of information prior to any disclosure.
- There may be other exceptions to confidentiality as provided by HIPAA regulations and other Federal and/or Colorado laws and regulations
- Due to the public nature of social media, and my primary role of confidentiality as a mental health

provider, I will not accept personal Facebook, LinkedIn, Twitter, Instagram and/or other friend/connection/follows requests via any form of social media. As such, any request will be denied in order to maintain professional boundaries. By signing this disclosure statement, **you agree not to discuss, comment, as questions, contact, and/or otherwise communicate with me regarding therapeutic issues via any social media platform**. If you have a therapeutic question/issue, by signing this disclosure statement you agree to contact me through the mode you consented to and not through social media.

- In couples and/or family counseling, I have a **firm no secrets policy**. This means there may be times when individual sessions are beneficial to the therapeutic process in the course of couples and/or family counseling. If I meet with one or both of you in individual sessions, we will likely share contents of that meeting with the partner at the next couple's session. The information shared in individual sessions is **not** confidential from the other partner. Should you reveal information that may be harmful to your partner and you refuse to disclose the information, therapy services, among other things may be terminated. I may choose to disclose information revealed in the individual sessions if I, in my sole discretion, determine that the information must be disclosed for therapy to be effective. If appropriate, I will give you the opportunity to disclose the information first. However, I will not lie or refuse to answer any question posed by the other person. Should you feel it is necessary to disclose something to me and wish for it to be kept confidential; I can refer you to another therapist who can treat you individually. Please be aware that information you choose to share with me that is particularly pertinent to both of you may come out in counseling. This pertains to all face-to-face, written, and phone conversations and messages. **I cannot be subpoenaed to testify or produce records without consent and authorization from all parties.**
- When treating a Client who is a Minor under the age of fifteen (15) and where there exists a custody arrangement between the parents or legal guardians (such as a divorce or separation), it is my policy to communicate with both parents/guardians via email (i.e. all communication will "cc" both parties). This policy is necessary to maintain transparency and professionalism, and to ensure the well-being of the therapeutic relationship with the Minor Client. This policy does not supersede any court order outlining decision-making or custodial rights but is or may be required by DORA. Further, I reserve the right, in my sole discretion, to engage in any individual email communication or face-to-face interaction in the lobby/waiting area. In the event that such an interaction occurs, I will notify the other party of said interaction and summarize the contents of the conversation, unless prohibited by professional rules or regulations regarding the protection of the health, safety, and welfare of the child/ren. This policy will also be extended to clients who are over the age of twelve (12) but under the age of fifteen (15) when and if their parents or legal guardians are notified of their receiving psychotherapeutic services.

8. Maintenance of Client Records. As a client, you may request a copy of your Client Record at any time. In accordance with the Rules and Regulations of Colorado's Department of Regulatory Agencies, LPC, and LAC rules and regulations, I will maintain your client record (consisting of disclosure statement, contact information, reasons for therapy, notes, etc.) for a period of seven (7) years after the termination of therapy or the date of our last contact, whichever is later. I cannot guarantee a copy of your Client Record will exist after this seven-year period. Should you wish to obtain a copy of your record, you will be charged a reasonable fee for the cost of duplication

9. Teletherapy. In general, I do not provide teletherapy, which is therapy conducted over telephone or video chat. Should you want teletherapy, please discuss the request with me. It is within my sole discretion whether to accommodate your request for teletherapy. In addition, due to the risks of third-parties gaining access to confidential information, all communications via email and text should be limited to administrative purposes and not used as an avenue for therapy. Confidentiality extends to communications by text, email, telephone, and/or other electronic means. However, I cannot guarantee that those communications will be kept confidential and/or that a third-party may not access our communications. Even though I may utilize state of

the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by a third-party.

10. Electronic Communications. By signing this disclosure statement, you consent to receiving appointment reminders, information about treatment alternatives, and/or other health-related benefits and services that may be of interest to you. Appointment reminders and other information will be provided in accordance with the Consent for Communication of Protected Health Information by Unsecure Transmissions. If you choose to initiate communication by an electronic mode that you have not specifically consented to in the Consent Form, you will need to amend the Consent Form so that I may communicate with you by that electronic mode.

11. Electronic Records. I may keep and store records for each client electronically on my laptop, desktop computer, or mobile devices. In order to maintain security and protect the record, I employ the use of firewalls, antivirus software, passwords that are changed regularly, and encryption methods to protect the electronic devices from unauthorized access. I can also remotely wipe out data on mobile devices if the mobile device is lost, stolen, or damages. Archway Counseling and Consulting also has entered into a Business Associates Agreement with email.1and1.com, the email service provider Archway Counseling and Consulting uses. Because of this Agreement, email.1and1.com is obligated by federal law to protect these backups from unauthorized use or disclosure. Email.1and1.com may store the records on a cloud-based backup which means the backups are stored on computers that are connected to the internet. These computers are kept in secure data centers, where various security measures are used to maintain the protection of the computer from physical access by unauthorized persons.

12. Availability and Response Policy. My normal business hours are from Monday to Friday, 9:00am - 6:30pm. However, as a therapist, the majority of my business hours are devoted to seeing my clients in therapy, which means I am not always available for immediate contact via phone, text, or email. This is especially true for emergencies, as I am not equipped to respond immediately.

The best way to contact me is via (phone/email). Every effort will be made to respond to you in a clear and timely manner. Voicemails and texts sent to 303-642-6636 will be returned within 24 hours, excluding Saturdays, Sundays, and holidays. Emails sent to DrDavid@ArchwayCounseling.net will be returned within 24 hours, excluding Saturdays, Sundays, and holidays. It is my policy to return all phone calls, texts, and emails during my normal business hours (referenced above). I also reserve the right, in my sole discretion, to return communication outside of these hours; but any communication which I initiate outside of these normal business hours is in no way a guarantee or a promise of availability outside of my normal business hours.

13. Discontinuation of Therapy. Should you choose to discontinue therapy for more than sixty (60) days by not communicating with me, your treatment will be considered "terminated." You may be able to resume therapy after the sixty (60) day period by discussing your decision to resume therapy services with me. Ability to resume therapy after sixty (60) days will depend upon my availability and will be within my sole discretion. This disclosure statement will remain in effect should you resume therapy if one (1) year has not elapsed since your last session. You may be asked to provide additional information to update your client record. By signing this disclosure statement, you understand "discontinuing therapy" means that you have not had a session with me for at least sixty (60) days, unless otherwise agreed to in writing.

14. Extraordinary Events. In the case that I become disabled, die, or am away on an extended leave of absence (hereinafter "extraordinary event,") the following Mental Health Professional Designee will have access to my client files. If I am unable to contact you prior to the extraordinary event occurring, the Mental Health Professional Designee will contact you. Please let me know if you are not comfortable with the below listed Mental Health Professional Designee and we will discuss possible alternatives at this time.

NAME: Kelly Crim
ADDRESS: 3900 S Wadsworth Blvd Suite 360
Lakewood, Colorado 80235
TEL: (720) 388-1760
CREDENTIALS: Licensed Professional Counselor #4240

The purpose of the Mental Health Professional Designee is to continue your care and treatment with the least amount of disruption as possible. You are not required to use Mental Health Professional Designee for therapy services, but Mental Health Professional Designee can offer you referrals and transfer your client record, if requested.

15. Additional Considerations: Archway Counseling and Consulting does not provide letters for Emotional Support Animals. Archway Counseling and Consulting is not qualified to evaluate your animal for the appropriateness of serving as either a service animal or an emotional support animal. All requests for ESA letters will be declined.

Additionally, Archway Counseling and Consulting is only qualified to speak to your engagement in the counseling process. All requests for letters of recommendation pertaining to anything outside of the therapeutic relationship (i.e job, college, etc.) will be declined.

AS A CLIENT:

You as a Client agree and understand the following:

1. I understand that Archway Counseling and Consulting may contact me to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to me in accordance with Archway Counseling and Consulting's Consent for Communication of Protected Health Information by Unsecure Transmissions.

2. I understand that if I initiate communication via electronic means that I have not specifically consented to in Archway Counseling and Consulting's Consent for Communication of Protected Health Information by Unsecure Transmissions, I will need to amend the consent form so that my therapist may communicate with me via this method.

3. I understand that there may be times when my therapist may need to consult with a colleague or another professional, such as an attorney or supervisor, about issues raised by me in therapy. My confidentiality is still protected during consultation by my therapist and the professional consulted. Only the minimum amount of information necessary to consult will be disclosed. Signing this disclosure statement gives my therapist permission to consult as needed to provide professional services to me as a client. I understand that I will need to sign a separate Authorization for Release of Information for any discussion or disclosure of my protected health information to another professional besides a colleague, supervisor or attorney retained by my therapist.

4. I understand that, in general, Archway Counseling and Consulting does not provide Teletherapy, such as therapy over telephone or video chat. I understand that communications via email and text should be limited to administrative purposes and not used as an avenue for therapy. I understand that should I want Teletherapy, I will discuss my request with my therapist. I understand that it is in my therapist's sole discretion whether to accommodate my request for Teletherapy.

5. I understand that my therapist, does not accept personal Facebook, LinkedIn, Twitter, Instagram, and/or other friend/connection/follow requests via any Social Media. Any such request will be denied in order to maintain professional boundaries. I understand that Archway Counseling and Consulting has, or may have, a

business social media account page. I understand that there is no requirement that I "like" or "follow" this page. I understand that should I "like" or choose to "follow" Archway Counseling and Consulting's business social media page that others will see my name associated with "liking" or "following" that page. I understand that this applies to any comments that I post on Archway Counseling and Consulting's page/wall as well. I understand that any comments I post regarding therapeutic work between my therapist and I will be deleted as soon as possible. I agree that I will refrain from discussing, commenting, and/or asking therapeutic questions via any social media platform. I agree that if I have a therapeutic comment and/or question that I will contact my therapist through the mode I consented to and not through social media.

6. I understand that if I have any questions regarding social media, review websites, or search engines in connection to my therapeutic relationship, I will immediately contact my therapist and address those questions.

7. I understand my therapist provides non-emergency therapeutic services by scheduled appointment only. If, for any reason, I am unable to contact my therapist by the telephone number provided to me, 303-642-6636 and I am having a true emergency, I will call 911, check myself into the nearest hospital emergency room, or call Colorado's Crisis Hotline (844) 493-8255. Archway Counseling and Consulting does not provide after-hours service without an appointment. If I must seek after-hours treatment from any counseling agency or center, I understand that I will be solely responsible for any fees due. I understand that if I leave a voicemail for my therapist on the phone number provided, my therapist will return my call by the end of the next business day, excluding holidays and weekends.

8. If my therapist believes my therapeutic issues are above his level of competence or outside of his scope of practice, my therapist is legally required to refer, terminate, or consult.

9. **I understand that I am legally responsible for payment for my therapy services. If for any reason, my insurance company, HMO, third-party payer, etc. does not compensate my therapist, I understand that I remain solely responsible for payment. I also understand that signing this form gives permission to my therapist to communicate with my insurance company, HMO, third-party payer, collections agency or anyone connected to my therapy funding source regarding payment. I understand that my insurance company may request information from my therapist about the therapy services I received which may include but is not limited to: a diagnosis or service code, description of services or symptoms, treatment plans/summary, and in some cases my therapist's entire client file. I understand that once my insurance company receives the information I or my therapist has no control of the security measures the insurance company takes or whether the insurance company shares the required information. I understand that I may request from my therapist a copy of any report Archway Counseling and Consulting submits to my insurance company on my behalf. Failure to pay will be a cause for termination of therapy services.**

10. I understand that this form is compliant with HIPAA regulations and no medical or therapeutic information or other information related to my privacy, will be released without permission unless mandated by Colorado law as described in this form and the Notice of Privacy Policies and Practices. By signing this form, I agree and acknowledge I have received a copy of the Notice or declined a copy at this time. I understand that I may request a copy of the Notice at any time.

11. I understand that if I have any questions about my therapist's methods, techniques, or duration of therapy, fee structure, or would like additional information, I may ask at any time during the therapy process. By signing this disclosure statement, I also give permission for the inclusion of my partners, spouses, significant others, parents, legal guardians, or other family members in therapy when deemed necessary by myself or my therapist. I agree that these parties will have to sign a separate Consent for Third-Party Participation Agreement or may have to sign a separate disclosure statement in order to participate in therapy.

12. I understand that should I choose to discontinue therapy for more than sixty (60) days by not

communicating with Archway Counseling and Consulting or my therapist, my treatment will be considered "terminated." I may be able to resume therapy after the sixty (60) day period by discussing my decision to resume therapy services with Archway Counseling and Consulting. Ability to resume therapy after sixty (60) days will depend upon my therapist's availability and will be within his sole discretion. This disclosure statement will remain in effect should I resume therapy if one (1) year has not elapsed since my last session. However, I may be asked to provide additional information to update my client record. I understand "discontinuing therapy" means that I have not had a session with my therapist for at least sixty (60) days, unless otherwise agreed to in writing.

13. There is no guarantee that psychotherapy will yield positive or intended results. Although every effort will be made to provide a positive and healing experience, every therapeutic experience is unique and varies from person to person. Results achieved in a therapeutic relationship with one person are not a guarantee of similar results with all clients.

14. Because of the nature of therapy, I understand that my therapeutic relationship has to be different from most other relationships. In order to protect the integrity of the counseling process the therapeutic relationship must remain solely that of therapist and client. This means that my therapist cannot be my friend, cannot have any type of business relationship with me other than the counseling relationship (i.e. cannot hire me, lend to or borrow from me; or trade or barter for services in exchange for counseling); cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client, and cannot hold the role of counselor to his relatives, friends, the relatives of friends, people known socially, or business contacts. I further understand that my therapist will not write letters of recommendation for me or serve as a reference for a job application.

15. I understand that should I cancel within 24 hours of my appointment or fail to show up for my scheduled appointment without notice ("no-show") or am more than 10 minutes late to my scheduled appointment, excluding emergency situations, my therapist has a right to charge my credit card on file, or my account, for the amount specified below under "Fee Agreement."

16. I also affirm, by signing this form, I am at least fifteen (15) years old and consent to treatment and therapy services here at Archway Counseling and Consulting. In the event that I am the legal guardian and/or custodial parent with the legal right to consent to treatment for any minor child/ren who is under the age of fifteen (15) and for whom I am requesting therapy services here at Archway Counseling and Consulting, I understand it is Archway Counseling and Consulting's policy to seek the consent of both parents/legal guardians. Further, in the event of a custody or divorce dispute, I and the therapist must obtain the consent from the other parent/legal guardian for my minor child/ren's treatment in accordance with DORA policy.
If I am the non-custodial parent signing this consent form for my minor child/ren's treatment in accordance with DORA's policy, I understand that my access to my child/ren's treatment and client record may be limited by court order.

In the event that I am over the age of twelve (12) but under the age of fifteen (15) years old, I affirm that I am consenting to treatment and psychotherapeutic services here at Archway Counseling and Consulting, and that I have been advised by David Johns of the importance of involving my parents and/or legal guardians, and that I have willingly signed the Voluntary Consent for Psychotherapeutic Services form.

17. I understand that if I am consenting to treatment and therapy services for my minor child/ren that my therapist will request that I produce, in advance of commencing services with Archway Counseling and Consulting, the Court Order Custody Agreement and/or Parenting Plan that grants me the authority to consent to mental health services for my minor child and make therapeutic decisions on behalf of my minor child/ren. I also understand that it is Archway Counseling and Consulting's policy to request and seek consent from both my minor child/ren's parents, but that such consent does not supersede the Court Order Custody Agreement

and/or Parenting Plan. By signing this form, I understand and consent to Archway Counseling and Consulting's "No Secrets" in Custody Circumstances Policy as outlined above. Further, I understand and agree to keep my therapist informed of any proceedings or supplemental court orders that affect my parenting rights, custody arrangements, and decision-making authority. I understand that failing to provide the Court Order Custody Agreement and/or Parenting Plan will prohibit my therapist from providing therapy to my minor child/ren. I understand that it is beyond the scope of my therapist's practice to provide custody recommendations. Any request for custody recommendations will be denied. A Court is able to appoint professionals with the expertise to make such recommendations.

18. By signing this form, I affirm that I am fully informed of the therapy services I am requesting and that Archway Counseling and Consulting is providing, and grant my consent to receive such therapy services.

My signature below affirms that the preceding information has been provided to me in writing by my primary therapist, or if I am unable to read or have no written language, an oral explanation accompanied the written copy. I understand my rights as a client/patient and should I have any questions, I will ask my therapist.

_____ _____

Print Client Name Client Date of Birth

_____

Client or Responsible Party's Signature Date

_____ _____

Print Client Name Client Date of Birth

_____

Client or Responsible Party's Signature Date

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

_____

_____

David Johns, PhD, LPC, LAC, NCC Date

Cell 303.642.6636
DrDavid@ArchwayCounseling.net

FEE AGREEMENT

STANDARD FEE FOR SERVICES
I understand that the standard fee for services for individual, couple, and family psychotherapy is $180.00 per 50-minute session. The fee for group counseling is $50.00 per session hour session. Any additional non-standard services will be charged a different fee. You will be notified in writing of these additional non-standard services and the fee, should the need for such services arise.

A fee will be charged for all other auxiliary services including mental health evaluations, progress reports, collateral contacts, or any other report or services made at the request of the client. Fees for auxiliary services will be agreed upon in writing prior to commencement of such services. Also, a fee will be charged at the session rate on a pro-rated basis for phone calls longer than ten (10) minutes. Any court testimony, appearances, or other requests for legal services such as: testimony related matters like case research, report writing, travel, depositions, actual testimony, cross examination time, and courtroom waiting time will be charged at a rate of $600 per hour with a deposit of $600.00. The higher rate also includes attorney fees I may incur in preparing for the requested legal services.

Your fee/co-payment is due in full at each session unless you and I agree to alternative arrangement for payment in writing. Have your cash or pre-written check ready prior to the beginning of each session. Archway Counseling and Consulting does not take credit cards. I also understand that if my situation changes – at any point – that I am invited to re-negotiate this fee with my therapist. In other words, at no time should my decision to participate in therapy be contingent on my ability to pay. I understand that unless another payment schedule is specifically arranged and agree to in writing; the standard fee for services applies. Any revisions to these standard fees for services are indicated on the reverse.

All accounts that are not paid within thirty (30) days from the date of service shall be considered past due. If your account is past due, please be advised that I may be obligated to turn past due accounts over to a collection agency or seek collection with a civil court action. By signing below, you agree that I may seek payment for your unpaid bill(s) with the assistance of a collection's agency. Should this occur, I will provide the collection agency or Court with your Name, Address, Phone Number, and any other directory information, including dates of service or any other information requested by the collection agency or Court deemed necessary to collect the past due account. I will not disclose more information than necessary to collect the past due account. I will notify you of my intention to turn your account over to a collection agency or the Court by sending such notice to your last known address.

I am a Medicaid provider. If you have Medicaid coverage that includes mental health services, I am able to offer mental health services to you. Medicaid rates/fees will apply. For non-covered Medicaid services, I must obtain prior written approval before providing the service. This approval requires your signature, acknowledgment the service is not a Medicaid covered service, and your agreement to pay for the service.

PAYMENT AGREEMENT
I understand that if I am paying privately I will pay for all services provided either for myself or for my designee, (name) _____, (relationship) _____, at the conclusion of each session on the day the services are provided.
I understand that if I am not able to honor my financial commitment that this may be grounds for conversing therapeutically about financial issues, renegotiating my therapeutic contract, exploring alternative options, and/or terminating from treatment. I understand that if I am not able to make a payment after a particular session that I may ask my therapist for an extension for one week. I agree to make every effort to remit payment within that time frame. I also understand that I may not have more than two unpaid sessions accumulated at any one time. If this should happen, I understand that I will need to speak with my therapist in order to negotiate the next steps.

I understand that I may pay with cash, personal checks, or money orders, however, should my personal check be returned due to insufficient funds, I will be assessed a $40.00 service charge and I will be requested to pay with cash, or money order thereafter. I realize that while my signature does not bind me to therapy, it does make me responsible for all charges incurred prior to my termination.

MISSED SESSION POLICY

I understand that I will be charged $100 for any missed appointments ("no-shows") or appointments cancelled with less than 24 hours' notice, or if I am late by more than ten minutes, excluding emergency situations including but not limited to: death of a family member, car accidents, and unanticipated child illness. I further understand that most third-party payment sources, such as victim compensation funds and insurance companies, do not pay for missed sessions and thus I am solely responsible for these fees.

LIMITATIONS OF CONFIDENTIALITY

I understand that if I am providing payment for a non-minor designee, I may not have legal access to any kind of privileged and confidential information about that individual including assessment information, diagnostic information, or therapeutic progress. By contrast, I do understand that if another party, such as an insurance company, is providing payment for my therapeutic services, I authorize that individual or institution to be informed of my presence in treatment, details of my diagnoses and care, and/or my discharge from treatment. I also understand that there are further limitations to confidentiality discussed in the *Disclosure Statement or* other agreements and am aware of these constraints. **I also understand that signing this form gives permission to my therapist to communicate with my insurance company, medical biller, HMO, third-party payor, collections agency or anyone connected to my therapy funding source. I understand that my insurance company may request information from my therapist about the therapy services I received which may include but is not limited to: a diagnosis or service code, description of services or symptoms, treatment plans/summary, and in some cases my entire client file. I understand that once my insurance company receives the information I or my therapist have no control of the security measures the insurance company takes or whether the insurance company shares the required information. I understand that I may request from my therapist a copy of any report he submits to my insurance company on my behalf.**

USING INSURANCE OR THIRD-PARTY PAYMENT SOURCES

I understand and recognize that I am actively participating and investing in the therapeutic process. By taking responsibility for payment of my therapy services I am able to maintain a direct relationship with this investment. **I understand that I am legally responsible for payment for my therapy services. <u>If for any reason</u>, my insurance company, HMO, third-party payor, etc. does not compensate my therapist; I understand that I remain solely responsible for payment.** I understand that *Archway Counseling and Consulting* recognizes that I may wish to use an in or out-of-network insurance plan, EAP program, Health Savings Account, cafeteria plan, victim compensation program, or other such third-party payer. If I should choose to use a third-party payment source, I understand that I am still responsible for direct payment to *Archway Counseling and Consulting* and that no guarantees can be made in terms of my reimbursement by the third-party payment source. *Archway Counseling and Consulting* will work with me as much as possible to facilitate this process. I understand that if I use insurance or another type of third-party payment source that I authorize *Archway Counseling and Consulting* to release and/or exchange any pertinent information with such entities in order to utilize these benefits. I understand that most third-party payment sources, such as insurance companies, do not pay for missed sessions and thus I am solely responsible for these fees.

REVISIONS TO FEE SCHEDULE
I understand that if I am committed to starting counseling at *Archway Counseling and Consulting* and am not able to pay the full standard fee; my therapist will work with me on finding an adjusted fee within his/her sole discretion. I understand that should my insurance benefits lapse, expire, or otherwise end, that I will continue pay the same contracted fee as if my insurance coverage were still in place.

FEE SCHEDULE ADJUSTMENTS
The following reflects the adjusted fee schedule my therapist and I have agreed to:

$ 180 Full Fee for Individual Psychotherapy, Couple, or Family Therapy
$ 50 Fee for Group Psychotherapy
$ 100 No-Show, Late Cancellation or when client arrives later than 10 minutes past scheduled appointment
$ 40 Insufficient funds Bank Fee
$ 600/hour Court Testimony, preparation etc.
$_____Other: _____
$_____Insurance Copay/ Co-insurance Rate: _____

[ ] I have contacted my insurance company, and inquired as to insurance benefits including copay, co-insurance, deductible, out of pocket etc.

[ ] I have NOT contacted my insurance company, and inquired as to insurance benefits including copay, co-insurance, deductible, out of pocket etc.

MEDICAL BILLING
Archway Counseling and Consulting has contracted with Infinite Billing Solutions to bill insurance claims. They can be reached at:
Infinite Billing Solutions
500 SW S Avenue #813, Blue Springs, Missouri 64013
phone: 816.598.6000

I have read the preceding information and I agree to the aforementioned terms:

Client Name: _____

Client Signature: _____ Date: _____

Parent/Legal Guardian: _____ Relationship: _____

Therapist Signature: _____ Date: _____
Therapist Name: David Johns, PhD, LPC, LAC, NCC

CONSENT FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION BY UNSECURE TRANSMISSIONS

This consent form is for the communication of Protect Health Information ("PHI") that Archway Counseling and Consulting may transmit without the written authorization of the client as described in the Uses and Disclosure section of its Notice of Privacy Policies.

I, _____, hereby consent and authorize Archway Counseling and Consulting to communicate my PHI through the following unsecure transmissions (please initial all your choices):

_____ Cellular/Mobile Phone this includes text messaging
(Please Insert Cell Phone Number: _____
_____ Unsecured Email
(Client's Email: _____ _____ □ Send □ Receive
Counselor's Email: DrDavid@ArchwayCounseling.net □ Send □ Receive)
Please Circle One: Work Personal
_____ Appointment/Scheduling Reminder via email and/or telephone
_____ Other Media:
(Please describe: _____
_____ I do not wish to have my PHI transmitted electronically

Should we agree to communicate by the approved communications listed above, i.e. text, email, telephone, or any other electronic method of communication, confidentiality extends to those communications. However, Archway Counseling and Consulting cannot guarantee that those communications will remain confidential. Even though Archway Counseling and Consulting may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by an unintended third-party. There is never a 100% guarantee information will remain confidential when transmitted electronically.

I, _____, understand that Archway Counseling and Consulting may use and disclose the following PHI without my written authorization. However, I consent to Archway Counseling and Consulting transmitting the following PHI by the above selected electronic communications (please initial all your choices):

_____ Information related to scheduling/appointments
_____ Information related to billing and payments
_____ Information related to your mental health treatment (this may contain personal materials, forms, suggested articles, homework, etc.)
_____ Information related to Archway Counseling and Consulting's operations
_____ In accordance with an Authorization for Release of Information signed by me
_____ I wish to receive the Archway Counseling and Consulting blog via my email address
_____ Other Information; Please Describe: _____

I further understand that if I initiate communication via electronic means that I have not specifically consented to in this form, I will need to amend this consent form so that my counselor/therapist may communicate with me via that method.

_____ _____
Signature of Client/Parent/Legal Guardian DATE

899 N. Logan Street Suite 209
Denver, CO 80203
303.642-6636
Mailing Address: P.O. Box 100084
Denver, Colorado 80210

NOTICE OF PRIVACY POLICIES AND PRACTICES

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

Given the nature of Archway Counseling and Consulting's work, it is imperative that it maintains the confidence of client information that it receives in the course of its work. Archway Counseling and Consulting is a mental health counseling practice that provides mental health services. The practice works solely to provide the best counseling treatment options to its clients. Archway Counseling and Consulting prohibits the release of any client information to anyone outside immediate staff, employees, interns, and/or volunteers except in limited circumstances in accordance with this Notice of Privacy Policies and Practices. Discussions or disclosures of protected health information ("PHI") within the organization are limited to the minimum necessary that is needed for the recipient of the information to perform his/her job. Please review this Notice of Privacy Policies and Practices ("Notice of Privacy Policies"). It is the policy of Archway Counseling and Consulting to:

1. fully comply with the requirements of the HIPAA General Administrative Requirements, the Privacy and Security Rules;
2. provide every client who receives services at Archway Counseling and Consulting with a copy of this Notice of Privacy Policies;
3. ask the client to acknowledge receipt when given a copy of this Notice of Privacy Policies;
4. ensure the confidentiality of all client records transmitted by facsimile;
5. obtain from each client an informed Authorization for Release of Protected Health Information form when required.

Archway Counseling and Consulting is required to follow all state and federal statutes and regulations including Federal Regulation 42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164, governing testing for and reporting of TB, HIV AIDS, Hepatitis, and other infectious diseases, and maintaining the confidentiality of PHI.

PHI refers to any information that is created or received by Archway Counseling and Consulting, and relates to an individual's past, present, or future physical or mental health or conditions and related care services or the past, present, or future payment for the provision of health care to an individual; and identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual.

PHI includes any such information described above that Archway Counseling and Consulting transmits or maintains in any form, this includes Psychotherapy Notes. HIPAA and federal law regulate the use and disclosure of PHI when transmitted electronically.

YOUR RIGHTS AS A CLIENT:

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your mental health record

- You can ask to see or get an electronic or paper copy of your mental health record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee to fulfill your request.
- If we deny your request, in whole or in part, we will let you know why in writing and whether you have the option of having the decision reviewed by an independent third-party.

Ask us to correct your mental health record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.
- Please review the Consent For Communication Of Protected Health Information By Unsecure Transmissions
- You are required to "opt-in" to receive communications electronically as set-forth in the Consent for Communication of Protected Health Information by Unsecure Transmissions. If you choose not to "opt-in" to receive electronic communications, we will not communicate with you via electronic means.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.
- You may also file a complaint with the Colorado Department of Regulatory Agencies, Division of Professions and Occupations, Mental Health Section; 1560 Broadway, Suite 1350, Denver, Colorado, 80202, 303-894-2291; DORA_Mentalhealthboard@state.co.us. Please note that the Department of Regulatory Agencies may direct you to file your complaint with the U.S. Department of Health and Human Services Office for Civil Rights listed above and may not be able to take any action on your behalf.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A use of PHI occurs *within* a covered entity (i.e., discussions among staff regarding treatment). A disclosure of PHI occurs when Archway Counseling and Consulting reveals PHI to an outside party (i.e., Archway Counseling and Consulting provides another treatment provider with PHI, or shares PHI with a third party pursuant to a client's valid written authorization).

Archway Counseling and Consulting may use and disclose PHI, without an individual's written authorization, for the following purposes:

1. Treatment: disclosing and using your PHI by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members and for coverage arrangements during your primary therapist's absence, and for sending appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
2. Payment: disclosing and using your PHI so that Archway Counseling and Consulting can receive payment for the treatment services provided to you, such as: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization of review activities.
3. Health Care Operations: disclosing and using your PHI to support Archway Counseling and Consulting's business operations which may include but not be limited to: quality assessment activities, licensing, audits, and other business activities.

Uses and disclosures for payment and health care operations purposes are subject to the minimum necessary requirement. This means that Archway Counseling and Consulting may only use or disclose the minimum amount of PHI necessary for the purpose of the use or disclosure (i.e., for billing purposes, a therapist would not need to disclose a client's entire medical record in order to receive reimbursement. A therapist would likely only need to include a service code and/or diagnosis etc.). Uses and disclosures for treatment purposes are not subject to the minimum necessary requirement.

Archway Counseling and Consulting is required to promptly notify you of any breach that may have occurred and/or that may have compromised the privacy or security of your PHI.

Confidentiality of client records and substance abuse client records maintained are protected by federal law and regulations. It is Archway Counseling and Consulting's policy that a client must complete an Authorization for Release of Protected Health Information provided by Archway Counseling and Consulting, prior to disclosing health information to another individual and/or entity for any purpose, except for treatment, payment, or health care operations in accordance with this Notice of Privacy Policies.

Absent the above referenced form, other than for treatment, payment, or health care operations purposes, Archway Counseling and Consulting staff is prohibited from disclosing or using any PHI outside of or within the organization, including disclosing that the client is in treatment without written authorization. However, Archway Counseling and Consulting is permitted and/or required to report or disclose PHI if and when any of the following occur with any Archway Counseling and Consulting client:

1. Responding to lawsuit and legal actions (Disclosure by a court order, in response to a complaint filed against a counselor of Archway Counseling and Consulting, etc. This does not include a request by you or another party for your records).
2. Disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation.
3. Help with public health and safety issues (Client commits or threatens to commit a crime either at Archway Counseling and Consulting or against any person who works for Archway Counseling and Consulting; A minor or elderly client reports having been abused or there is a suspicion of abuse; Client is planning to harm another person, including but not limited to the harm of a child or at-risk elder; Client reports suicidal ideations or self harm).
4. Address workers' compensation, law enforcement, and other government requests.
5. Respond to organ and tissue donation requests.
6. In compliance with other state and/or federal laws and regulations.

The above exceptions are subject to several requirements under the Privacy Rule, including the minimum necessary requirement and applicable federal and state laws and regulations. See 45 C.F.R. § 164.512. Before using or disclosing PHI for one of the above exceptions, Archway Counseling and Consulting staff must consult Archway Counseling and Consulting's Privacy Officer, David Johns (303-642-6645, DrDavid@ArchwayCounseling.net) to ensure compliance with the Privacy Rule. Violation of these federal and state guidelines is a crime carrying both criminal and monetary penalties. Suspected violations may be reported to appropriate authorities, as listed above in the "Client Rights" section, in accordance with federal and state regulations. Know that Archway Counseling and Consulting will never market or sell your personal information without your permission.

SPECIAL AUTHORIZATIONS

Certain categories of information have extra protections by law, and thus require special written authorizations for disclosures.

Psychotherapy Notes*:* Archway Counseling and Consulting may keep and maintain "Psychotherapy Notes." Psychotherapy Notes may include but are not limited to 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 record. These notes are given a greater degree of protection than PHI. These are not considered part of your "client record." I will obtain a special authorization before releasing your Psychotherapy Notes and test results.

HIV Information*:* Special legal protections apply to HIV/AIDS related information. I will obtain a special written authorization from you before releasing information related to HIV/AIDS.

Alcohol and Drug Use Information: Special legal protections apply to information related to alcohol and drug use and treatment. I will obtain a special written authorization from you before releasing information related to alcohol and/or drug use/treatment.

You may revoke all such authorizations to release information (PHI, Psychotherapy Notes, HIV information, and/or Alcohol and Drug Use Information) at any time, provided each revocation is in writing, signed by you, and signed by a witness. 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, the law provides the insurer the right to contest the claim under the policy.

As a covered entity under the Privacy and Security Rules, Archway Counseling and Consulting is required to reasonably safeguard PHI from impermissible uses and disclosures. Safeguards may include, but are not limited to the following:

1. Not leaving lab results unattended where third parties without a need to know can view them.
2. Any PHI received as an Archway Counseling and Consulting employee, intern, or volunteer about a client or potential Archway Counseling and Consulting client, may not be used or disclosed for non-work purposes or with unauthorized individuals. Archway Counseling and Consulting may only use and disclose such PHI as described above.
3. When speaking with a client about his or her PHI where third parties could possibly overhear, the conversation will be moved to a private area.
4. Seeking legal counsel in uncertain situations and/or incidences.
5. Obtaining a Business Associates Agreement with those third-parties that have access to and/or store client information.
6. Implementing FAX security measures
7. Obtaining your consent prior to sending any PHI by non-secure electronic transmissions
8. Provide information on Archway Counseling and Consulting's electronic record-keeping.

YOUR CHOICES:

For certain health information, you can tell us (verbal authorization) your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. We may request you sign a separate document if you authorize us to share certain PHI. You may revoke that authorization at anytime for future disclosure.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest and for your care/treatment. We may also share your information when needed to lessen a serious and imminent threat to public health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This notice is effective March, 2017.

D Johns PhD, LPC, LAC, NCC

R. David Johns PhD, LPC, LAC, NCC

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html