



## FIRST APPOINTMENT ORIENTATION

Thank you for choosing the Brief Therapy Institute of Denver, Inc for your behavioral healthcare services. We recognize you have many choices and we appreciate your trust in us.

We appreciate your downloading and completing the paperwork prior to your first session. Completing the paperwork allows your therapist the opportunity to spend a greater amount of time on clinical rather than administrative issues.

Some things to keep in mind:

- ✓ Remember, you can download and print, review, or ask for a complete set of Brief Therapy Institute of Denver, Inc. Privacy Policies.
- ✓ Your therapist will review and answer any questions about this paperwork or other matters.
- ✓ Please bring your authorization number, if given to you by your insurance company.
- ✓ Please bring your insurance card.
- ✓ We will need information about your copayment and/or deductible. If you do not know this information, please contact your insurance company and ask for an explanation of benefit coverage for mental/behavioral health issues.
- ✓ We will need your primary care physician's telephone number.
- ✓ If you have seen a counselor or psychiatrist within the last two years, we will need a telephone number to contact them.
- ✓ It is very helpful for the therapy process if you bring a list of goals for therapy. This will help you and your therapist make better use of the first session.

### **GOALS FOR THERAPY, PLEASE LIST:**

Office Use Only:

Name: \_\_\_\_\_

Chart #: \_\_\_\_\_

**CLIENT INFORMATION**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

street city state zip

BIRTH DATE: \_\_\_\_\_ AGE: \_\_\_\_\_ GENDER: \_\_\_ MALE \_\_\_ FEMALE

SOCIAL SECURITY #: \_\_\_\_\_

RELATIONSHIP STATUS: \_\_\_ MARRIED \_\_\_ SEPARATED \_\_\_ SINGLE  
\_\_\_ DIVORCED \_\_\_ COHAB. \_\_\_ CHILD

I AGREE TO PAY MY CO-PAY OF \_\_\_\_\_ AT THE END OF EACH SESSION

IF I AM SELF PAYING, I WILL PAY \_\_\_\_\_ AT THE END OF EACH SESSION

WHOM SHOULD WE THANK FOR THE REFERRAL? \_\_\_\_\_

**CONTACT INFORMATION**

HOME PHONE: \_\_\_\_\_ BEST TIME TO CALL: \_\_\_\_\_

Can we leave a message? \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ MAY WE CALL YOU IN CONFIDENCE AT WORK: \_\_\_\_\_

Can we leave a message? \_\_\_\_\_

PARENT TO CONTACT IF PATIENT IS CHILD: \_\_\_\_\_

**INSURANCE INFORMATION**

NAME OF INSURED (if different than patient) : \_\_\_\_\_

ADDRESS OF INSURED (if different than patient): \_\_\_\_\_

GENDER: \_\_\_ MALE \_\_\_ FEMALE BIRTHDATE: \_\_\_\_\_ SS#: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

MEMBER ID# \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

INSURED'S EMPLOYER: \_\_\_\_\_ STATUS: EMPLOYED TERMINATED LOA

AUTHORIZATION # \_\_\_\_\_ INSURANCE TYPE: HMO PPO OTHER DEDUCTIBLE: \_\_\_\_\_

**WHO WOULD YOU LIKE NOTIFIED IN CASE OF EMERGENCY?**

NAME: \_\_\_\_\_ RELATIONSHIP TO YOU: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

Office Use Only:

Name: \_\_\_\_\_

Chart #: \_\_\_\_\_

**AGREEMENTS AND DISCLOSURES**  
**(for all participants over 18 years of age)**

**AGREEMENTS**

1. I authorize the Brief Therapy Institute of Denver, Inc. to contact the referral source for treatment, payment, or health care operations, **understanding that personal information will need to be released to my insurance company or the company that manages my benefits.**  
 yes  no
2. I authorize the Brief Therapy Institute of Denver, Inc. to bill my insurance/managed care company for the psychotherapy. The Brief Therapy Institute of Denver may need to disclose clinical information necessary to process all claims.  
 yes  no
3. I authorize \_\_\_\_\_ to make payment directly to  
(insurance/managed care company)  
the Brief Therapy Institute of Denver, Inc. for the benefit specified and otherwise payable to me, but not to exceed the usual and customary charges for the services.  
 yes  no
4. I authorize the Brief Therapy Institute to mail any correspondence regarding my treatment, satisfaction with treatment, updates about my treatment and educational programs during and after the completion of my treatment to my home mailing address.  
 yes  no
5. I want my primary care physician to be notified of my treatment at the Brief Therapy Institute of Denver?  
 yes  no

**DISCLOSURES**

1. I realize that the Brief Therapy Institute of Denver, Inc conducts research and I understand that all research is calculated, reported, and described in a manner that maintains my confidentiality and total anonymity.  
 yes  no
2. I understand the Brief Therapy Institute of Denver, Inc cannot be held responsible for being unable to access me due to telephone devices that may block their calls, my use of a pager system in which I cannot be directly reached, any form of caller identification, **or any type of device that does not allow my therapist to make direct telephone contact with me.**  
 yes  no

**FINANCIALS**

1. My usual and customary rate for providing direct face-to-face psychotherapy services is \$120.00 per hour, \$75 per 45 minutes.
2. You will be billed **\$75 for not giving a minimum of 24 hours notification** of cancellation. This outstanding balance must be paid prior to additional psychotherapy services being delivered.
3. You will be billed for non covered and non routine services such as extended telephone consultation, crisis intervention, report writing, extended care coordination with other providers at a rate of \$2.50 per minute. You will be informed of events involving additional billing prior to the event.
4. Any legal reporting, consultation, or coordination will be billed at a rate of \$3.50 per minute.

Additional comments/special conditions:

**\*\* Appointments scheduled 4:00 pm or later and all Saturday appointments will be billed \$100.00 for "no show" or not giving a minimum of 24 hour notice of cancellation. A deposit of \$100.00 will be needed to schedule additional appointments at these times following a "no show" or late cancellation \*\***

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

Office Use Only:

Name: \_\_\_\_\_

Chart #: \_\_\_\_\_

## AUTHORIZATION TO RELEASE INFORMATION

Client Name (please print)		Date of Birth		SS#	
I authorize Brief Therapy Institute of Denver to exchange information with:					Phone
Name of Person or Organization			Street Address/ City/ State/ Zip Code		
<input type="checkbox"/>	Therapist	<input type="checkbox"/>	Attorney	<input type="checkbox"/>	
<input type="checkbox"/>	School	<input type="checkbox"/>	Physician	<input type="checkbox"/>	

The information to be disclosed includes:

<input type="checkbox"/>	Assessments	<input type="checkbox"/>	Medication History	<input type="checkbox"/>	Psychiatric/Psychological Evaluations
<input type="checkbox"/>	Service Plans	<input type="checkbox"/>	Lab Studies	<input type="checkbox"/>	Complete Health Record
<input type="checkbox"/>	Progress Notes	<input type="checkbox"/>	Discharge Summaries	<input type="checkbox"/>	Other

Dates Include: \_\_\_\_\_ All dates of treatment OR From \_\_\_\_\_ to \_\_\_\_\_

The purpose for the release is: \_\_\_\_ Continuity of care \_\_\_\_ Other

I UNDERSTAND that the information to be released may include information related to drug abuse and alcoholism or alcohol abuse; and that this information is protected by federal law [42 CFR Part 2] the released information may also include psychiatric and HIV/AIDS conditions.

I UNDERSTAND that the information disclosed pursuant to this Authorization might be redisclosed by the recipient and might be no longer protected by Federal Privacy Regulation [45 CFR Part 164].

I UNDERSTAND that I may revoke the Authorization at any time by giving written notice to Brief Therapy of Institute of Denver, except to the extent that Brief Therapy Institute of Denver has already taken action on this request. This Authorization will expire on \_\_\_\_\_ date), or, if left blank, one year from date of my signature. I release Brief Therapy Institute of Denver from all liability or disclosing the requested information.

I UNDERSTAND that treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization.

### NOTICE TO THE RECIPIENT OF THE INFORMATION

*This information has been disclosed to you from records protected by federal confidentiality rules [42 CFR Part 2 and 45 CFR Part 164]. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by [42CFR Part 2 or 45 CFR Part 164]. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict and use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.*

\_\_\_\_\_  
Signature of Client or Legal Representative

\_\_\_\_\_  
Please print name of Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Aimee Gee LMFT # 625, LAC, #125

\_\_\_\_\_  
Date

If you are a Legal Representative, please circle one: Parent of minor / Guardian / Custodian / GAL / MDPOA / Personal Representative (Executor of Estate)

This consent may be revoked by me at any time except to the extent action has been taken.

Signed: \_\_\_\_\_ Date \_\_\_\_\_

A copy or facsimile of this Authorization is as the original.

Office Use Only:

Name: \_\_\_\_\_

Chart #: \_\_\_\_\_

# Privacy Notice

To comply with federal health insurance portability and accountability act guidelines the Brief Therapy Institute of Denver, Inc. has implemented the following policy regarding patient privacy and confidentiality. You may request a copy of our complete set of guidelines, you can review the guidelines posted in the waiting room, or you may review and download the policies from our web site. Our office holds patient record information confidential and we will only use your information for the following reasons: **treatment, payment and health care operations**. The following is a partial list of whom your information can be disclosed, if needed, to:

- Primary care physicians
- Psychiatrists
- Medical specialists
- Diagnostic facilities
- Hospitals, including psychiatric
- Labs
- Insurance companies
- Billing and collection services
- School officials: administrators, counselors, teachers

## Disclosing Record Information

Release of information to any other entity not listed above will require a signed authorization from you or your guardian. This request must be dated, show who the information is to be released to or requested from, the specific information to be released or acquired. These authorizations will have an end date. Additional requests beyond the end date will require a new authorization. We will keep a record of all disclosures in your file. This information will be available for you to review.

## You Have a Right to Access Your Records

You can review and obtain copies of your records. Our office requires a written request, and we will make the records available within 10 days of your request.

## Record Storage

The Brief Therapy Institute of Denver, Inc stores paper copies of **administrative** records for the appropriate length of time per clinician regulations. **Clinical records** are stored **electronically** for the appropriate length of time per clinician regulations.

## Miscellaneous

If we need to contact you by telephone and leave a message we will only leave our name and our phone number. We will not leave any information on an answering machine or with anyone other than the patient or guardian unless we have your consent. It will be your responsibility to return the call.

## Acknowledgment

I acknowledge that I have reviewed this privacy notice and that I may request or download the Brief Therapy Institute of Denver's full privacy policy.

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Signature

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Date

Office Use Only:

Name: \_\_\_\_\_

Chart #: \_\_\_\_\_

Office Use Only:  
Name: \_\_\_\_\_

Chart #: \_\_\_\_\_

**Medical Information – Please complete for all participants in therapy**

Name	Last 2 years Major medical events	Current medications Prescribed and over the counter	Dosage	Allergies? To what?

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Psychiatrist: \_\_\_\_\_ Phone: \_\_\_\_\_

Pediatrician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Tobacco Use: Cigarettes \_\_\_\_ Chewing \_\_\_\_ Other \_\_\_\_ How much \_\_\_\_\_

Who \_\_\_\_\_

Alcohol and Drug Use:

Who?	Type?	Amount?	Frequency?
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Family history of alcohol/drug use, mental health, physical conditions:

Member: \_\_\_\_\_ History: \_\_\_\_\_

Office Use Only:

Name: \_\_\_\_\_

Chart #: \_\_\_\_\_

If you use herbal supplements or vitamins, please list:

## **Client E-Mail Usage Consent**

Your therapist will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks identified below, your therapist cannot guarantee the security of email communication, and is not liable for improper disclosure of confidential information that is not caused by the therapist's intentional misuse.

### **RISKS OF USING E-MAIL TO COMMUNICATE WITH YOUR THERAPIST**

Transmitting client information by e-mail has a number of risks that clients should consider before using e-mail to communicate with your therapist. These include, but are not limited to, the following risks:

- E-mail can be circulated, forwarded and stored in numerous paper and electronic files.
- E-mail can be immediately broadcast worldwide and be received by unintended recipients.
- E-mail senders can easily type in the wrong email address.
- E-mail is easier to falsify than handwritten or signed documents.
- Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
- Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.
- E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- E-Mail can be used to introduce viruses into computer systems.
- E-mail can be used as evidence in court.

### **CLIENT OBLIGATIONS WHEN CONSENTING TO E-MAIL**

- Use e-mail for general client information only. Do not use e-mail for medical emergencies, other time sensitive matters, or for non-general medical information. Include your name in the body of the message and identify the category of question in the subject line. Include a phone number where you can be reached. Please review your e-mail to make sure your question is as clear as possible.
- Follow-up with your therapist if you have not received a response to your email within 5 business days.
- Take precautions to preserve the confidentiality of e-mail. Use screen savers and safeguard your computer password.
- Inform your therapist of any changes to your e-mail address.
- Withdraw consent to email client information through hardcopy written communication to your therapist.

### **ALTERNATE FORMS OF COMMUNICATION**

I understand that I may also communicate with the therapist via telephone or during a scheduled appointment and that the e-mail is not a substitute for the care that may be provided during an office visit. Appointments should be made to discuss any new issues as well as any sensitive information.

### **TYPES OF E-MAIL TRANSMISSIONS THAT CLIENT AGREES TO SEND AND/OR RECEIVE**

Office Use Only:

Name: \_\_\_\_\_

Chart #: \_\_\_\_\_

The types of information that can be communicated via e-mail with your therapist includes: appointment scheduling requests, billing and insurance questions and patient education. Your therapist will not engage in email communication that is unlawful, such as unlawfully practicing therapy across state lines. If you are not sure if the issue you wish to discuss should be included in an e-mail, you should call your therapist's office to schedule an appointment.

**HOLD HARMLESS**

I agree to indemnify and hold harmless the therapist, his/her therapy practice, the Brief Therapy Institute of Denver and its officers, website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the therapist or the use of the therapist's web-site, any arrangements you make based on information obtained by the Site, any products or services obtained through the Site, and any breach by me of these restrictions and conditions. The therapist does not warrant that the functions contained in any materials provided will be interrupted or error-free, that defects will be corrected, or that the therapist's website or server that makes such site available is free of viruses or other harmful components.

**TERMINATION OF THE E-MAIL RELATIONSHIP**

The therapist shall have the right to immediately terminate the e-mail relationship with you if he/she determines, in his/her sole discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engage in conduct which the therapist determines, in his/her sole discretion to be unacceptable. The e-mail relationship between the therapist and the client will terminate in the event the therapist, in his/her sole discretion, no longer wishes to utilize the e-mail to communicate with all of his/her patients.

**FORWARDING E-MAIL**

I understand that there may be times in which the therapist must forward the information I have provided via e-mail to a third party for treatment, billing and payment purposes. I expressly provide my consent to allow the therapist to forward these e-mails to a third party under these conditions and evidence my consent by placing my initials below:

\_\_\_\_\_ (please initial if you agree)

**CLIENT ACKNOWLEDGEMENT AND AGREEMENT**

I have discussed with the therapist and acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the therapist and me, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that the therapist may impose to communicate with patients by e-mail. Any questions I may have had were answered.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date

Client E-Mail Address: \_\_\_\_\_

Office Use Only:  
Name: \_\_\_\_\_

Chart #: \_\_\_\_\_

Office Use Only:

Name: \_\_\_\_\_

Chart #: \_\_\_\_\_