Laura Gomez-Weakley, LPC, NCC, MEd, MHEd
7800 S. Elati, Suite 301, Littleton, CO 80122
303-916-8847
lgweakley.com

Client Information Sheet

PATIENT INFORMATION (please print) **TODAYS DATE**_____

Name: Last Name, First, M.I.) Sex: M ❍F ❍ Marital Status: Md.❍ Single◉ Div.❍ Sep.❍ Child❍

_____**Birth Date**_____/_____/_____

Address:_____**Apt. No.**_____

City_____ **State**_____ **Zip Code** _____ **Employer/School**_____

Phone (hm)_____(wk)_____(cell/pager)_____

Email_____

INSURANCE INFORMATION (If you would like therapist to bill your insurance company, complete this section.)

Name of Insured: (Last Name, First, M.I.) Sex: M❍ F❍ **Insured Birth Date**_____/_____/_____

_____

Insured Address:_____

Phone: (hm)_____(wk)_____(Cell/pager_____

Social Security #_____**Employer**_____

Insurance Plan Name:_____ **Mental Health Phone#:**_____

Insurance Plan Address:_____

Insured I.D.#:_____**Group #:**_____**Plan #:**_____

Second Insurance:_____ **Group #:**_____**Plan#:**_____

Name of Insured:_____ **ID#:**_____**Mental Health Phone #:**_____

RESPONSIBLE PARTY INFORMATION (Please print)
(Check all that apply) Patient❍ Spouse❍ Father❍ Mother❍ Guardian❍ Insurance❍ Church❍ Other

Responsible Party Name:_____

Billing Address:_____Apt. No._____

City:_____**State:**_____**Zip Code:**_____

Phone: (hm)_____(wk)_____(cell/pager)_____

Laura Gomez-Weakley, LPC
Licensed Professional Counselor
7800 S Elati, Suite, 301
Littleton, CO 80120
303-916-8847

Mandatory Disclosure of Information to Clients
(12-43-214, C.R.S.)

1. Degrees: M.Ed. (Master's of General Counseling), M.H.ED. (Master's of Health Education).
   Professional Licensed Therapist LPC #1883
   National Certified Counselor (NCC) #43370
   Certification: Biofeedback Certification (CBT-2005)

2. The Colorado State Department of Regulatory Agencies (DORA) regulate the practice of both licensed and unlicensed persons in the field of psychotherapy. Any questions, concerns, or complaints regarding the practice of psychology may be directed to the State Grievance Board, 1560 Broadway, Suite 1340, Denver, Colorado, 80202, 303-894-7766.

3. Client Rights and Important Information:
   a. You are entitled to receive information from me about my method of therapy, the techniques I use, the duration of your therapy (if I can determine it), and my fee structure. Please ask if you would like to receive this information.

   b. You can seek a second opinion from another therapist or terminate therapy at anytime.

   c. In a professional relationship, such as ours, sexual intimacy between a therapist and client is NEVER appropriate. If sexual intimacy occurs, it should be reported to the State Grievance Board.

   d. Information disclosed to a licensed professional counselor, licensed clinical social worker, licensed marriage and family therapist or a licensed psychologist is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates. However, there are exceptions to the rule of legal confidentiality. These exceptions are listed in the Colorado statutes (12-43-218, C.R.S.). Some examples of exceptions to confidentiality are: mandatory reporting of child abuse/ neglect, abuse/neglect of mentally incompetent, and threat of harm to self or others. You should be aware that, except in the case of information given to a licensed professional counselor, legal confidentiality does not apply in a criminal or delinquency proceeding. Also, if your bill is not paid or arrangements are not made to pay off the outstanding balance, then the fact that you have received professional services, the dates of those services, and the amount owed may be revealed, either to a collection agency or to the courts.

4. Fees for evaluation, psychotherapy and biofeedback are charged by time intervals in accordance with insurance industry standards. My rates range from $130.00 - $150.00 per session. Various fees are also charged for phone sessions.

5. The use of biofeedback in evaluations and treatment involves attaching electrodes to various locations such as at fingertips, on muscles, or locations on the scalp typically those related to pain, stress, or dysfunction. The electrodes do nothing to you; they simply monitor your body's physiology. Electrode sites usually need to be cleansed, such as with an alcohol swab, before attaching the electrodes, many of which have a conductive gel surrounded by an adhesive tape to hold them in place. If you have questions or concerns about the electrodes, the gel or tape, the cleansing, the sites or how and where the electrodes are placed, please state this before any are attached. The sites should be explained and your permission obtained before any are attached. When relaxation training is part of your treatment, you sit or lie back as comfortably as possible while being guided with techniques. Lights are often dimmed if acceptable to you.

OFFICE HOURS:

1. My regular office hours are Tuesday, Wednesday and Thursday from 8:00 am - 2:30 pm

2. **FEES:** The first session (60-70 minute diagnostic interview) is $150.00. Fees for individual psychotherapy are $130.00 per 45-50 minutes session, and $150.00 per 60 minute session. Family therapy and couples counseling sessions are $130.00 for 45-50 minutes. If a session goes beyond the allotted time, additional charges will be pro-rated.

FEES: (please initial_____)

3. **CONFIDENTIALITY:** All sessions are legally confidential, with noted exceptions, unless the patient or guardian provides written consent to release information. Confidentiality is waived in certain cases of implied or suspected danger to self or others, grave disability and suspected child abuse. Other exceptions to the general rule of legal confidentiality are listed in Colorado statues (see section 12-43-218, C.R.S., 1988) and will be discussed with you if the situations arise in treatment.

Confidentiality is also waived in cases where you or the responsible party is unwilling to pay your bill and a satisfactory financial arrangement cannot be reached. These accounts are forwarded to a collection agency or attorney. In these cases, your name, address, pertinent telephone numbers, place of business, and amount owed will be forwarded to the collection agency.

CONFIDENTIALITY: (please initial_____)

4. **BILLING:** Clients are required to pay at the time of service or provide proof of insurance billing information. **There are no exceptions.**

All clients who do not pay at the time of service are assessed an **automatic $10.00 billing fee.** All returned checks are assessed a $25.00 bank charge.

Laura Gomez-Weakley, LLC will attempt to do all in its power to help me receive reimbursement from my insurance plan or other sources; however, I am ultimately responsible for payment of these services. Alternative payment arrangements may be made in advance of services provided under extenuating circumstances.

As with all medical services, when dealing with insurance, please be advised that Laura Gomez-Weakley, LLC is required to make a medical diagnosis for insurance billing purposes. Therefore, your medical information can be shared by your insurance company with other medical databases. Sharing of medical information can potentially affect your rates of insurability. Please be advised that your insurance company may require treatment planning information other than your diagnosis. If you choose to have Laura Gomez-Weakley, LLC bill your insurance, permission to discuss treatment information is assumed to be granted by the nature of the insurance requirements. If you wish to avoid disclosure of personal treatment information to your insurance company, you have the right to privately pay for your services to Laura Gomez-Weakley, LLC.

BILLING PROCEDURES: (please initial_____)

5. **CANCELLATIONS:** Appointments must be canceled 24 hours in advance. Appointments not canceled 24 hours in advance will be charged the full fee.

If you are a client with a standing weekly appointment and you cancel two sessions in a row, your appointment slot will no longer be guaranteed and it will open up to other clients.

CANCELLATIONS: (please initial_____)

6. **EMERGENCY: If you have an urgent matter that cannot wait until your scheduled appointment, please call my office number at 303-916-8847.** You may also leave me messages on my email at laura@lgweakley.com

I make every possible effort to return phone messages as soon as possible, usually within 24 hours Mondays-Thursdays. However, I cannot guarantee a 24 hours response on Friday, Saturday and Sundays.

If I am out of town, please call me for urgent matters ONLY. You may leave a voice message and I will return your call as soon as I can.

Always call 911 or go to your nearest hospital emergency room if there is a life threatening emergency.

EMERGENCY COVERAGE: (please initial _____)

I HAVE READ THE DISCLOSURE STATEMENT AND IT HAS BEEN PROVIDED VERBALLY AS WELL. I HAVE BEEN MADE FULLY AWARE OF MY THERAPIST'S CREDENTIALS AND OFFICE POLICIES. I HAVE READ THE "EMERGENCY COVERAGE" AND AGREE TO CALL 911 AS MY PRIMARY SOURCE OF MEDICAL HELP INCLUDING SUICIDAL THOUGHTS AND INTENTIONS. I MAY REQUEST A COPY OF THE DISCLOSURE STATEMENT. I FULLY UNDERSTAND MY RIGHTS AS A CLIENT OR AS THE CLIENT'S RESPONSIBLE PARTY.

_____

Please print Client Name

_____

Client or Guardian Signature Date

_____

Therapist Signature

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

_____

Laura Gomez-Weakley, LLC, LPC

NOTICE OF PRIVACY RIGHTS

THIS NOTICE DESCRIBES HOW MEDICAL (INCLUDING MENTAL HEALTH) INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. During the process of providing services to you, the provider will obtain, record, and use mental health and medical information about you that is protected health information. Ordinarily, that information is confidential and will not be used or disclosed, except as described below.

1) USES AND DISCLOSURES OF PROTECTED INFORMATION

A. ***General Uses and Disclosures Not Requiring the Client's Consent***. The provider will use and disclose protected health information in following ways.

a. *Treatment*. Treatment refers to the provision, coordination, or management of health care (including mental health care) and related services by one or more health care providers. For example, the provider will use your information to plan your course of treatment. As to other examples, the provider may consult with professional colleagues or ask professional colleagues to cover calls for the practice for the provider and will provide the information necessary to complete those tasks.

b. *Payment*. Payment refers to the activities undertaken by a health care provider (including a mental health provider) to obtain or provide reimbursement for the provision of health care. The provider will use your information to develop accounts receivable information, bill you, and with your consent, provide information to your insurance company or other third party payer for services provided. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnosis, type of service, date of service, provider name/identifier, and other information about your condition and treatment.

c. *Health Care Operations*. Health Care Operations refers to activities undertaken by the provider that are regular functions of management and administrative activities of the practice. For example, the provider may use or disclose your health information in the monitoring of service quality, staff evaluation, and obtaining legal services.

d. *Contacting the Client*. The provider may contact you to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.

e. Required by Law. The provider will disclose protected health information when required by law or necessary for health care oversight. This includes, but is not limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when there is a legal duty to warn or take action regarding imminent danger to others; (d) when the client is a danger to self or others or gravely disabled; (e) when a coroner is investigating the client's death; or (f) to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, or regulatory compliance.

f. *Crimes on the premises or observed by the provider*. Crimes that are observed by the provider or the provider's staff, crimes that are directed toward the provider or the provider's staff, or crimes that occur on the premises will be reported to law enforcement.

g. *Business Associates*. Some of the functions of the provider may be provided by contracts with business associates. For example, some of the billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services. In those situations, protected health information will be provided to those contractors as is needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.

h. *Research*. The provider may use or disclose protected health information for research purposes if the relevant limitations of the Federal HIPAA Privacy Regulation are followed 45 CFR 164.512(i).

i. *Involuntary Clients*. Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.

j. *Family Members*. Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of that discussion. However, if the client objects, protected health information will not be disclosed.

k. *Emergencie*s. In life threatening emergencies the provider will disclose information necessary to avoid serious harm or death.

B. ***Client Authorization or Release of Information***. The provider may not use or disclose protected health information in any other way without a signed authorization or release of information. When you sign an authorization, or a release of information, it may later be revoked, provided that the revocation is in writing. The revocation will apply, except to the extent the provider has already taken action in reliance thereon.

2. YOUR RIGHTS AS A CLIENT

A. ***Access to Protected Health Information***. You have the right to inspect and obtain a copy of the protected health information the provider has regarding you, in the designated record set. However, you do not have the right to inspect or obtain a copy of psychotherapy notes. There are other limitations to this right, which will be provided to you at the time of your request, if any such limitation applies. To make a request, ask you therapist.

B. ***Amendment of Your Record***. You have the right to request that the provider amend your protected health information. The provider is not required to amend the record if it is determined that the record is accurate and complete. There are other exceptions, which will be provided to you at the time of your request, if relevant, along with the appeal process available to you. To make a request, ask your therapist.

C. ***Accounting of Disclosures***. You have the right to receive an accounting of certain disclosures the provider has made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment, or health care operations. In addition, the accounting does not include disclosures made to you, disclosures made pursuant to a signed Authorization, or disclosures made prior to April 14, 2003. There are other exceptions that will be provided to you, should you request an accounting. To make a request, ask your therapist.

D. ***Additional Restrictions***. You have the right to request additional restrictions on the use or disclosure of your health information. The provider does not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. To make a request, ask your therapist.

E. ***Alternative Means of Receiving Confidential Communications***. You have the right to request that you receive communications of protected health information from the provider by alternative means or at alternative locations. For example, if you do not want the provider to mail bills or other materials to your home, you can request that this information be sent to another address. There are limitations to the granting of such requests, which will be provided to you at the time of the request process. To make a request, ask your therapist.

F. ***Copy of this Notice***. You have a right to obtain another copy of this Notice upon request.

3. ADDITIONAL INFORMATION

A. ***Privacy Laws***. The provider is required by State and Federal law to maintain the privacy of protected health information. In addition, the provider is required by law to provide clients with notice of the provider's legal duties and privacy practices with respect to protected health information. That is the purpose of this Notice.

B. ***Terms of the Notice and Changes to the Notice***. The provider is required to abide by the terms of the notice, or any amended Notice that may follow. The provider reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all protected health information that it maintains. When the Notice is revised, the revised Notice will be posted at the provider's service delivery sites and will be available upon request.

C. ***Complaints Regarding Privacy Rights***. If you believe the provider has violated your privacy rights, you have the right to complain to the provider. Your therapist is the person designated within the practice to receive your complaints. You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave., S.W., Room 515F, HHH Bldg., Washington, D.C. 20201. It is the policy of the provider that there will be no retaliation for your filing of such complaints.

D. ***Effective Date***. This Notice is effective April 14, 2003

Laura Gomez-Weakley, LLC, LPC

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY RIGHTS

Name of client:_____

I hereby acknowledge that I have received a copy of the provider's Notice or Privacy Rights.

Signature_____ Date_____

_____

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

_____*For Provider Use Only*_____

If an acknowledgment signature could not be obtained, document our good faith effort to obtain the acknowledgment signature and the reason why it was not obtained:

_____

_____

_____

_____

_____

By (facility representative):_____

Date:_____

Release of Information
Laura Gomez-Weakley, LLC

I (we) do hereby give permission to Laura Gomez-Weakley, LLC and the following listed below to mutually exchange any and all information regarding my (our) social, emotional, psychological, and medical histories including assessments, backgrounds, opinions, and any other relevant data necessary to assist Laura Gomez-Weakley, LLC and those listed below to continue to provide service to me (us). I (we) understand that this notice will remain in effect until canceled by written notice to Laura Gomez-Weakley, LLC.

This Authorization is intended to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

I (we)_____

_____

release information to (name & address)_____

_____

release information to (name & address)_____

_____

release information to (name & address)_____

_____

I (we) agree to indemnify and hold harmless all persons and groups named above from any and all liability for claims, actions, damages or suits arising from or relating to the release or exchange of information made pursuant to this authorization for release of confidential information.

Except as authorized herein, confidential information will not be disclosed without my (our) consent, except where the law may compel disclosure.

I (we) have read the foregoing, understand its content, and agree to these conditions.

Signed_____Date_____

Signed_____Date_____

Signed_____Date_____

Laura Gomez-Weakley, LLC

CREDIT CARD AUTHORIZATION FORM

Laura Gomez-Weakley, LLC requests that you provide your credit card information below. If you choose to pay by credit card your credit card will be charged after each session the day the session occurs.

I authorize Laura Gomez-Weakley, to charge my credit card after each session. _____

By signing this authorization form, you agree to notify Laura Gomez-Weakley of any changes to your credit card information such as a new expiration date or when your credit card has been cancelled, lost, stolen or revoked. A new form must be submitted if information such as the list of authorized users and the credit card account's expiration date is amended.

_____VISA _____MASTERCARD _____American Express

Full Name on the Credit Card:_____

Credit Card Number: _____

Expiration Date: _____CCV Code:_____Zip Code:_____

_____This credit card authorization form will remain in effect and on file unless revoked in writing or until the therapeutic relationship is terminated, at which time, authorization to charge your credit card will be revoked, unless an outstanding balance remains on your account after termination. Laura Gomez-Weakley will not share your credit card information with any third-party without your consent. Your credit card information will be kept confidential.

_____Card Holder is the client (or parent/legal guardian) receiving services from Laura Gomez-Weakley.
I hereby authorize Laura Gomez-Weakley to charge the above credit card number for payment of the counseling fees I or my minor child/ren incurs, which shall include late or past due fees or fees related to cancellations or no-shows. I understand that my credit card will be billed in accordance with the authorizations listed above.

Client/Parent/Legal Guardian Signature Date