Sarah Lynn Brill MSW.
Individual, Couples, and Family Psychotherapist

CLIENT AGREEMENT 2014

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

CANCELLATIONS

Unless 24- hours or more notice is given, it is very difficult for me to schedule another person in your appointment slot. As a result, 24- hours notice of a cancellation is required or I will charge you the full fee of $100. I understand that emergency situations arise such as a sudden illness, car accident or family death; and, in such situations, an exception to the 24- hour cancellation policy will be made.

EMERGENCIES

I do not carry a pager. I also do not have the same access as clinicians in an agency setting. Therefore, in the case of an emergency situation in which there is an imminent concern regarding life and death, please call 911. In the case of any other clinical emergency, please call (720) 466-3571 and leave a message on my voice mail. I generally check voice mail several times per day and will try to return your call regarding a clinical emergency the day the message is received. If at any time we decide your needs have intensified, and you require someone who is available 24- hours per day, I will refer you to an appropriate clinician.

PAYMENT

Sessions are typically 50 minutes in length. **Payment of $100.00 is required in full at the beginning of the session**. If needed, please ask for a payment plan or other arrangement. I will send an invoice to you each month that includes the information you will need to submit to your insurance. Please check with your insurance company ahead of time to see if they need any special information on the invoice.

COURT RELATED MATTERS

I understand that my counselor will not willingly testify in any court proceeding as this role, more often than not, jeopardizes the therapeutic relationship. However, if required by law to appear and/or testify, I understand that I will be charged $250.00 per hour for time spent in activities preparing for a courtroom appearance. I also understand that I will be charged $800 per courtroom appearance – regardless of the time spent in the courtroom and regardless of whether my counselor is able to testify that day or not. Payment for courtroom appearance will be required prior to my counselor's appearance in court. ___________

Initial here

I understand and agree to all of the policies listed above, and to meet all financial obligations.

Signature of Client or Legal Guardian: ______________________________ Date: _______

Print Name: ______________________________________

Address: ____

3600 S Yosemite St. Suite 1050, Denver, Co 80327 Phone: 720.466.3571
Sarah.explorer@gmail.com

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CLIENT INFORMATION SHEET-- Children

Child's Name: (*First, Middle, Last*): ______________________________

Address: ______________________________

____

Home Telephone: ____________________ Cell Phone: ____________________

Date of Birth: ______________ Age: ________

Name of School/ Grade: ______________________________

Mother/Guardian: ____________________ Father/Guardian: ____________________

Address: (if different than above) Address: (if different than above)

____________________ ____________________

____________________ ____________________

H Telephone: ____________________ H Telephone: ____________________

W Telephone: ____________________ W Telephone: ____________________

Cell Phone: ____________________ Cell Phone: ____________________

Profession: ____________________ Profession: ____________________

Email: ______________ Email: ______________

Step-Mother:____________________ Step-Father:____________________

Primary Care Physician

Name: ______________________________

Address: ______________________________

____

Phone Number: ______________________________

Is there information that would be helpful for me to obtain from your PCP? Yes No

Please list the members of your household: (name, age, relationship) ____________________

____

____

Referral Source

How did you hear about Sarah Brill? ______________________________

Please include the address for your referral source if you have it: ______________________________

Medical/Psychological Information

Birth History: Please check one.

___ *Natural Delivery* ___ *C Section*

___ *Natural Delivery with Complications* ___ *Adoption*

___ Other ________________________

If complications, please explain: ____

Has your child been reaching her/his developmental milestones "on time"? *Yes* *No*

If no, please describe: ____

____

Is your child taking any medications? *Yes* *No*

If yes, please list the medication and dosage. ____

____

Has your child ever received psychotherapy services in the past? *Yes* *No*

If so, with whom? ____

____

Please list any therapists and their phone numbers who are currently involved with your child:________________________

____

____

Has the above-listed client received medical or psychological diagnoses in the past? *Yes* *No*

If yes, please list diagnoses. ____

____

Please state the nature of your concerns regarding your child and family ______________________________

____

____

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Family History ***(Please check items that apply.)   UK = Unknown, M=Maternal, P=Paternal, C=Child, S= Sibling***

Diagnosis	*Yes*	*No*	*UK*	*M,P,C,S*	*Diagnosis*	*Yes*	*No*	*UK*	*M,P,C,S*
Depression					Metabolic Disorder				
Anxiety					Heart Disease				
Bipolar Disorder					Allergies				
ADD/ADHD					Asthma				
Sleep Disorder					Sinus Infections				
Autism/Asperger's/ PDD					Obsessive - Compulsive Disorder				
Tourette's					Sensory Integration				
Genetic Disorder					Substance Abuse				
Fragile X					Other:				

NOTICE OF PRIVACY PRACTICES OF Sarah L. Brill MSW

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

Effective April 14, 2003

If you have any questions or requests about this Notice, please Sarah Brill at (720) 466-3571.

My Practice is required by State and Federal law to maintain the privacy of protected health information. In addition, the Practice is required by law to provide clients with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to your mental health information, and to request that you sign the attached written acknowledgement that you received a copy of this Notice. This Notice describes how the Practice may use and disclose your protected health information. This Notice also describes your rights regarding your protected health information and how you may exercise your rights.

"Protected Health Information, PHI", is information the Practice has created or received about your physical or mental health condition, the health care we provide to you, or the payment for your health care; and identifies you or could be reasonably used to identify you. It includes your identity, diagnosis, dates of service, treatment plan, and progress in treatment.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Permissible Uses and Disclosures Not Requiring Your Written Authorization Your mental health information may be used and disclosed in the following ways.

- **Treatment:** Your mental health information may be used and disclosed in the provision and coordination of your healthcare. For example, this may include coordinating and managing your health care with other health care professionals. Your mental health information may be used and disclosed when I consult with another professional colleague, or if you are referred for medication, or for coverage arrangements during my absence. In any of these instances only information necessary to complete the task will be provided.
- **Payment:** Your mental health care information will be used to develop accounts receivable information, to bill you, and with your consent to provide information to your insurance company or other third party payer for services provided. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnosis, dates and type of service, and other information about your condition and treatment, but will be limited to the least amount necessary for the purposes of the disclosure.
- **Health Care Operations:** Your mental health information may be used and disclosed in connection with our health care operations, including quality improvement activities, training programs and obtaining legal services. Only necessary information will be used or disclosed.
- **Required or Permitted by Law:** Your mental health care information may be used or disclosed when I am required or permitted to do so by law or for health care oversight. This includes, but is not limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when there is a legal duty

to warn or to take action regarding imminent danger to others; (d) when the client is a danger to self or others or gravely disabled; (e) when a coroner is investigating the client's death; or (f) to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, or regulatory compliance.

- **Contacting the Client:** You may be contacted to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.
- **Crimes on the premises or observed by the provider:** Crimes that are observed by the therapist or the therapist's staff, crimes that are directed toward the therapist or the therapist's staff, or crimes that occur on the premises will be reported to law enforcement.
- **Business Associates:** Some of the functions of the practice may be provided by contracts with business associates. For example, some of the billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services. In those situations, protected health information will be provided to those contractors as is needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.
- **Involuntary Clients:** Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.
- **Family Members:** Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of the discussion. However, if the client objects, protected health information will not be disclosed.
- **Emergencies:** In life threatening emergencies the practice will disclose information necessary to avoid serious harm or death.

Uses and Disclosures Requiring Your Written Authorization or Release of Information

Except as described above, or as permitted by law, other uses and disclosures of your mental health information will be made only with your written authorization to release the information. When you sign a written authorization, you may later revoke the authorization in writing as provided by law. However, that revocation may not be effective for actions already taken under the original authorization.

- **Psychotherapy Notes:** Psychotherapy notes are maintained separate from your mental health record. These notes will be used only by your therapist and disclosure will occur only under these circumstances: (a) you specifically authorize their use or disclosure in a separate written authorization; or (b) the therapist who wrote the notes uses them for your treatment; or (c) they may be used for training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills; or (d) if you bring a legal action and we have to defend ourselves; and (e) certain limited circumstances defined by the law.

YOUR RIGHTS AS A CLIENT

Additional Restrictions: You have the right to request additional restrictions on the use or disclosure of your mental health information. However, the clinician does not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. Ask your clinician for the Request Form for Protected Health Information.

Alternative Means of Receiving Confidential Communications: You have the right to request that you receive communications from the practice by alternative means or at alternative locations. For example, you may request that bills and other correspondence be sent to an address other than your home address. Ask your clinician for the Request Form.

Access to Protected Health Information: You have the right to inspect and obtain a copy of your protected health information in the mental health and billing record. However, any psychotherapy notes are for the use of your therapist, and are treated differently. If it is thought that access to your mental health records would harm you, your access may be restricted. Ask your clinician for the Request Form for PHI and the appeal process.

Amendment of Your Record: You have the right to request an amendment or correction to your protected health information. If the clinician agrees that the amendment or correction is appropriate, the Practice will ensure the amendment or correction is attached to the record. An appeal process is available if the clinician determines the record is accurate and complete as is. Ask your clinician for the Request Form PHI and the appeal process available to you.

Accounting of Disclosures: You have the right to receive an accounting of certain disclosures the practice has made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment, or health care operations. In addition, the accounting does not include disclosures made to you, disclosures authorized by you, or disclosures made prior to April 14, 2003. Other exceptions will be provided to you, should you request an accounting. Ask your clinician for the Request Form.

Right to Revoke Consent or Authorization: You have the right to revoke your consent or authorization to use or disclose your mental health information, except for action that has already taken place under your consent or authorization.

Copy of this Notice: You have a right to obtain a copy of this Notice upon request.

The Practice is required to abide by the terms of this Notice, or any amended Notice that may follow. The Practice reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that it maintains. When changes are made, the revised Notice will be posted at the Practice's office and copies will be available upon request.

If you believe the Practice has violated your privacy rights, you may file a complaint with the person designated within the Practice to receive your complaints, Lauren H. Kerstein, LCSW. You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 515F, HHH Bldg., Washington, D.C. 20201. It is the policy of the Practice that there will be no retaliation for your filing of such a complaint.

Sarah L. Brill MSW

Acknowledgement of Receipt of Notice of Privacy Rights

I, ________________________________, acknowledge that I received a copy of the Notice
Client Name

of Privacy Practices for Sarah L. Brill MSW.

____ ____________________
Signature of Client or Personal Representative Date

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

---*For Practitioner Use Only*--

I attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

- q Individual refused to sign
- q Communications barriers prohibited obtaining acknowledgement
- q Client was incapable of signing
- q Other (Specify)____

____

_______________________________________ _____________________
Signature of Practitioner Date

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Authorization For Release of Information

I, ________________________________, hereby authorize Sarah L. Brill and
Client

______________________________________, at ________________________ to exchange information.
Name Telephone

The type of information to be disclosed:
Evaluations _____ Medical/Hospital Records_____ Diagnosis _____ Psychological/Medical Test Results_____ Treatment Plan_____ Mental Health Record Summary_____ Course of Treatment_____ Psychotherapy Notes ____ Other ____________________

The purpose of such disclosure:
Ongoing Treatment_____ Medical Care_____ Consultation_____ Evaluation_____ Transfer_____ Legal issues_____ Coordination of Care_____ Health Benefit Utilization_____ Other __________

Exceptions:____

The designated information about me ( ) may ( ) may not be transmitted by fax, electronic mail or other electronic file transfer mechanisms. Lauren Kerstein and the above designated person ( ) may ( ) may not discuss by telephone the content of the information released.

This consent is in effect until__________________________. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already take place.

I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential in the case of licensed clinical social workers, except as provided in section 12.43.218 CRS and except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children.

I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

____

Date **Signature of Client or Personal Representative**

FEDERAL REGULATIONS PROHIBIT THE RECIPIENT OF THIS INFORMATION FROM MAKING ANY FURTHER DISCLOSURES OF THIS INFORMATION.

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