TAYLOR WHITE, LCSW
3445 PENROSE PLACE, #240
BOULDER, CO 80301
303/384-8677

NOTE:

PLEASE SIGN & RETURN **LAST PAGE** OF THIS DOCUMENT FOR YOUR INTAKE.

The following is an explanation of my services, including the parameters of our relationship, fees and billing information, your responsibilities and rights as my client and required legal disclosures. Please read over the following information carefully, sign and date the document, and take a copy for your records. If you have any questions, please let me know.

My degrees include a Master of Social Work (1995) from the University of Denver and a Bachelor of Arts in Psychology (1992) from the University of South Carolina. I am a licensed clinical social worker (license #992190) in the State of Colorado. I use a combination of treatment modalities including psychodynamic, cognitive and solution-focused techniques. We can discuss these techniques at any time during your treatment. Your involvement and actions are essential to our work together and I encourage your participation and feedback throughout treatment.

CONFIDENTIALITY

Generally speaking, information provided by and to a client during therapy sessions is legally confidential if the therapist is a certified school psychologist, licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, licensed psychologist or unlicensed therapist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's written consent.

There are exceptions to the general rule of legal confidentiality. These exceptions are listed in the Colorado statutes (Section 12-43-218). They include any information provided by a client regarding child abuse or neglect, suicidal intent or homicidal intent. By law I am required to report this information to the authorities and other necessary parties in an attempt to keep all parties safe from harm.

You have a right to seek a second opinion from another therapist or terminate therapy at any time. In a professional relationship such as ours, sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the State Grievance Board, 1560 Broadway, Suite #1340, Denver, CO 80202 (303) 894-7766.

I seek consultation and supervision from colleagues when I believe it would be beneficial to our work together. Information is shared on a limited basis and in a manner that protects your identity.

FEES AND BILLING INFORMATION

My fee is $200.00 per 50-minute session. All fees are to be paid upon services rendered. A copy of the previous month's sessions, fees and diagnosis (if applicable) can be obtained for insurance reimbursement. Please request this service no later than the 3rd week of the month.

You will be charged for time beyond our 50-minute appointment at a percentage rate equivalent to your regular fee. You will be charged for appointments that are missed or cancelled with less than 24 hours notice, and for phone calls longer than 10 minutes. Please inquire about my fees for legal evaluations, workshops, or public speaking, should you wish to access these additional services.

TERMINATION

Following our initial session, feel free to ask for my best estimate of the length of treatment required to address the issues that you have presented. However, it may not be possible to determine the length of your therapy at the outset, or we may find that our initial prediction proves to be an over or underestimate. My professional judgement will require termination of your therapy at some point; usually this will be at a time that seems appropriate to you as well. However, I may unilaterally terminate my services to you for certain reasons, such as 1) my judgement that the therapy is not helpful, or that you have obtained the maximum benefit; 2) your failure or refusal to cooperate in your therapy; or 3) your refusal to pay me promptly for services. You also have the right to terminate with me at any time. I urge you to discuss any decision to terminate with me prior to doing so, so that we may both have a sense of closure. You may also seek a second opinion at any time.

AVAILABILITY

I make every effort to return all phone calls within 24 hours or sooner if possible, Monday through Friday. I am available to you by phone between appointments, but as noted above, you will be charged for longer, non-routine calls. If I will be unavailable for a day or more, I will leave instructions on my voice mail regarding how you may access a back-up therapist. If for any reason you are unable to reach me in an emergency, please contact the nearest hospital emergency room. Although I can respond to the occasional emergency, I do not provide such services on a routine basis. If, during the course of our work together, it becomes clear to me that emergency services are required on a regular basis, I may recommend a transfer to a therapist who can provide such services.

T A Y L O R W H I T E , L C S W
3 4 4 5 P E N R O S E P L A C E , # 2 4 0
B O U L D E R , C O 8 0 3 0 1
3 0 3 / 3 8 4 - 8 6 7 7

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 I may 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.

Uses and Disclosures Not Requiring Clients Consent.

1. *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.

2. *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 information provided to insurers and other third party payors 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.

3. *Health Care Operations*. Health Care Operations refers to activities undertaken by the Provider that are regular functions of management and administrative activities.

4. *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.

5. *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 required to report certain communicable diseases and certain injuries; and (f) when a Coroner is investigating the clients death.

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

8. *Family Members*. Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the clients 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.

9. *Emergencies.* In life threatening emergencies, Provider will disclose information necessary to avoid serious harm or death.

Release of Information requiring your consent or authorization

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.

II. YOUR PRIVACY RIGHTS AS A CLIENT:

1. You have the right to request restrictions on the use and disclosure of your protected health information.

2. You have the right to receive confidential communications concerning your medical condition and treatment

3. You have the right to inspect and copy your protected health information

4. You have the right to amend or submit corrections to your protected health information

5. You have the right to receive and accounting of how and to whom your protected health information has been disclosed.

6. You have the right to receive additional printed copies of this notice

III. ADDITIONAL INFORMATION

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 its legal duties and privacy practices with respect to protected health information. That is the purpose of this Notice. The Provider is required to abide by the terms of this 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 in the Providers service delivery sites and will be available upon request**.**

Complaints Regarding Privacy Rights. If you believe the Provider has violated your privacy rights, you have the right to complain to Provider management. To file your complaint, call the Office of Consumer and Family Affairs at 303-443-8500. It is the policy of the Provider that there will be no retaliation for your filing of such 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, 1961 Stout Street - Room 1426, Denver, CO 80294 303-844-2024; 303-844-3439 (TDD); 303-844-2025 (FAX)

E. Effective Date. This Notice is effective April 14, 2003.

T A Y L O R W H I T E , L C S W
3 4 4 5 P E N R O S E P L A C E , # 2 4 0
B O U L D E R , C O 8 0 3 0 1
3 0 3 / 3 8 4 - 8 6 7 7

I have read the preceding information, understand my rights and responsibilities as a client and accept all the conditions of the disclosure and HIPAA privacy rights.

_____ _____

Name Client Signature Date

_____ _____

Date of Birth Email

_____ _____ _____

Street Address Home Phone Work Phone

_____ _____

City, State, Zip Cell Phone

Emergency Contact: Name and Telephone Number_____

_____

Who can I thank for referring you to me? _____

PLEASE CHECK ONE OF THE FOLLOWING FOR BILLING:

_____ Please bill me monthly with a HCFA insurance form for me to submit to my insurance. I understand I will pay the total of the bill to you directly and submit the form for reimbursement.

_____ Please bill me monthly for my own personal records. I understand I will pay the total of the bill to you directly.

_____ I prefer to pay cash or check per session.