A New Outlook
Counseling Services

Niki Worthan, MA, LAC
8181 Arista Place, Suite #261
Broomfield, CO 80021
(720) 669-7292 (Office)
(720) 344-4804 (Fax)

PSYCHOTHERAPY INFORMATION DISCLOSURE STATEMENT

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a client in psychotherapy, you have certain rights that are important for you to know about because this is your therapy, whose goal is your well-being. There are also certain limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you.

My Responsibilities to You as Your Therapist

I. Confidentiality

With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act so as to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you. You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically (for example, sending bills or faxing information), it will be done with special safeguards to insure confidentiality. If you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential. All emails are retained in the logs of your or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. Any email I receive from you, and any responses that I send to you, will be printed out and kept in your treatment record.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.

2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 48 hours and Adult Protective Services immediately.

3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. I am not obligated to do this, and would explore all other options with you before I took this step. If at that point you were unwilling to take steps to guarantee your safety, I would call the crisis team.

The next is not a legal exception to your confidentiality. However, it is a policy you should be aware of if you are in *couple's therapy* with me.

If you and your partner decide to have some individual sessions as part of the couple's therapy, what you say in those individual sessions will be considered to be a part of the couples therapy, and can and probably will be discussed in our joint sessions. *Do not tell me anything you wish kept secret from your partner.* I will remind you of this policy before beginning such individual sessions.

II. Record-keeping.

I keep very brief records, noting only that you have been here, what interventions happened in session, and the topics we discussed. If you prefer that I keep no records, you must give me a written request to this effect for your file and I will only note that you attended therapy in the record. Under the provisions of the Health Care Information Act of 1992, you have the right to a copy of your file at any time, giving me the chance to print it out from my computer. You have the right to request that I correct any errors in your file. You have the right to request that I make a copy of your file available to any other health care provider at your written request. I maintain your records in a secure location that cannot be accessed by anyone else.

III. Diagnosis

If a third party such as an insurance company is paying for part of your bill, I am normally required to give a diagnosis to that third party in order to be paid. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. If I do use a diagnosis, I will discuss it with you. All of the diagnoses come from a book titled the ***DSM-V or ICD-10;*** I have a copy in my office and will be glad to let you borrow it and learn more about what it says about your diagnosis.

IV. Other Rights

You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time.

V. Managed Mental Health Care

If your therapy is being paid for in full or in part by a managed care firm, there are usually further limitations to your rights as a client imposed by the contract of the managed care firm. These may include their decision to limit the number of sessions available to you, to decide the time period within which you must complete your therapy with me, or to require you to use medication if their reviewing professional deems it appropriate. They may also decide that you must see another therapist in their network rather than me, if I am not on their list. Such firms also usually require some sort of detailed reports of your progress in therapy, and on occasion, copies of your case file, on a regular basis. I do not have control over any aspect of their rules. However, I will do all that I can to maximize the benefits you receive by filing necessary forms and gaining required authorizations for treatment, and assist you in advocating with the MC company as needed.

My Training and Approach to Therapy

My approach to therapy is Cognitive Behavioral Therapy. Cognitive behavioral therapy (or cognitive behavioral therapies or CBT) is a psychotherapeutic approach that aims to solve problems concerning dysfunctional emotions, behaviors and cognitions through a goal-oriented, systematic procedure. The title is used in diverse ways to designate behavior therapy, cognitive therapy, and to refer to therapy based upon a combination of basic behavioral and cognitive research.

There is empirical evidence that CBT is effective for the treatment of a variety of problems, including mood, anxiety, personality, eating, substance abuse, and psychotic disorders. Treatment is often manualized, with specific technique-driven brief, direct,

and time-limited treatments for specific psychological disorders. CBT is used in individual therapy as well as group settings, and the techniques are often adapted for self-help applications. Some clinicians and researchers are more cognitive oriented (e.g. cognitive restructuring), while others are more behaviorally oriented (in vivo exposure therapy). Other interventions combine both (e.g. imaginal exposure therapy).

CBT was primarily developed through a merging of behavior therapy with cognitive therapy. While rooted in rather different theories, these two traditions found common ground in focusing on the "here and now", and on alleviating symptoms. Many CBT treatment programs for specific disorders have been evaluated for efficacy and effectiveness; the health-care trend of evidence-based treatment, where specific treatments for symptom-based diagnoses are recommended, has favored CBT over other approaches such as psychodynamic treatments. In the United Kingdom, the National Institute for Health and Clinical Excellence recommends CBT as the treatment of choice for a number of mental health difficulties, including post-traumatic stress disorder, OCD, bulimia nervosa and clinical depression, and for the neurological condition encephalomyelitis.

Therapy also has potential emotional risks. Approaching feelings or thoughts that you have tried not to think about for a long time may be painful. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to the relationships you already have. You may find your relationship with me to be a source of strong feelings. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful. You normally will be the one who decides therapy will end, with three exceptions. If we have contracted for a specific short-term piece of work, we will finish therapy at the end of that contract. If I am not in my judgment able to help you, because of the kind of problem you have or because my training and skills are in my judgment not appropriate, I will inform you of this fact and refer you to another therapist who may meet your needs.

If you do violence to, threaten, verbally or physically, or harass myself, the office, or my family, I reserve the right to terminate you unilaterally and immediately from treatment. If I terminate you from therapy, I will offer you referrals to other sources of care, but cannot guarantee that they will accept you for therapy. I am away from the office several times in the year for extended vacations. I will tell you well in advance of any lengthy absences, and give you the name and phone number of the therapist who will be covering my practice during my absence. I am available for brief between-session phone calls during normal business hours. If you believe that you cannot keep yourself safe, please call 911, or go to the nearest hospital emergency room for assistance.

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Your Responsibilities as a Therapy Client

I. You are responsible for coming to your session on time and at the time we have scheduled. Sessions last for 50 minutes. If you are late, we will end on time and not run over into the next person's session. If you miss a session without canceling, or cancel with less than twenty-four hours' notice, you will be charged for the cancellation. The answering machine has a time and date stamp which will keep track of time to cancellation. I cannot bill these sessions to your insurance. The only exception to this rule is if you would endanger yourself by attempting to come (for instance, driving on icy roads without proper tires).

II. You are responsible for paying for your session weekly unless we have made other firm arrangements in advance. My fee for a session is $130.00. If we decide to meet for a longer session, I will bill you prorated on the hourly fee. Emergency phone calls of less than ten minutes are normally free. However, if we spend more than 10 minutes in a week on the phone, if you leave more than ten minutes worth of phone messages in a week, or if I spend more than 10 minutes reading and responding to emails from you during a given week I will bill you on a prorated basis for that time. My fees go up $10.00 every two years, on the even year. If a fee raise is approaching I will remind you of this well in advance. For people who decide to work with me on an ongoing basis I also offer discounted packages of 5 or 10 sessions, prepaid and non-refundable. The 5 session package is to be used within 2 months, the 10 session package within 4 months. As fees are occasionally adjusted, please contact me to discuss my current fees.

III. If you have insurance, you are responsible for providing me with the information I need to send in your bill. You must pay me your deductible at the beginning of each calendar year if it applies and any co-payment. You must arrange for any pre-authorizations necessary. I will bill directly to your insurance company via electronic means for you once a month. You must provide me with any forms, completely filled out as needed, your complete insurance identification information, and the complete address of the insurance company. If a check is mailed to you, you are responsible for paying me that amount at the time of our next appointment. If the insurance over-pays me, I will credit it to your account or refund it to you if you would prefer that.

IV. I am not willing to have clients run a bill with me. I cannot accept barter for therapy, nor can I take DSHS medical coupons. I am a Medicare participating provider and accept assignment from them.

Complaints

If you're unhappy with what's happening in therapy, I hope you'll talk about it with me so that I can respond to your concerns. I will take such criticism seriously, and with care and respect. If you believe that I've been unwilling to listen and respond, or that I

have behaved unethically, you can complain about my behavior to the Department of Regulatory Agencies, 1560 Broadway, Suite 1550, Denver, CO 80202. Please feel free to discuss your complaints about me with anyone you wish, and do not have any responsibility to maintain confidentiality about what I do that you don't like, since you are the person who has the right to decide what you want kept confidential.

Client Consent to Psychotherapy

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I consent to the use of a diagnosis in billing, and to release of that information and other information necessary to complete the billing process. I agree to pay the fee of $130.00 per session. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake therapy with Niki Worthan, MA, LAC. I know I can end therapy at any time I wish and that I can refuse any requests or suggestions made by Ms. Worthan. I am over the age of eighteen.

Client signature:_____ Date:_____

Client signature:_____ Date:_____

Therapist signature:_____ Date:_____

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ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF DISCLOSURE STATEMENT

"You May Refuse to Sign This Acknowledgement' '

I, (Please Print Name)_____, have received a copy of this office's Notice of Disclosure Statement.

(Please Print Name) _____

(Signature)_____

(Date)_____

For Office Use Only

A New Outlook Counseling Services, LLC attempted to obtain written acknowledgement of receipt of our Notice of Disclosure Statement, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____Communications barriers prohibited obtaining the acknowledgement

_____An emergency situation prevented us from obtaining acknowledgement

_____Other (Please Specify)

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INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name:_____

(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____

(Last) (First) (Middle Initial)

Birth Date:____/____/____ Age:_____Gender: □ Male □ Female

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Marital Status:

□ Never Married □ Domestic Partnership □ Married □ Separated

□ Divorced □ Widowed

Please list any children/age: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: (_____) _____ May we leave a message? □Yes □No

Cell/Other Phone: (_____) _____ May we leave a message? □Yes □No

E-mail:_____May we email you? □Yes□No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: _____

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Are you currently taking any prescription medication?
- ☐ Yes
- ☐ No

_____

Please list: _____

Have you ever been prescribed psychiatric medication?
- ☐ Yes
- ☐ No

Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

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Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in: _____

4. Please list any difficulties you experience with your appetite or eating patterns.

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? _____

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7. Are you currently experiencing any chronic pain?
□ No
□ Yes

If yes, please describe? _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

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11. What significant life changes or stressful events have you experienced recently:

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FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

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1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation:

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

_____

_____

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4. What do you consider to be some of your weakness?

5. What would you like to accomplish out of your time in therapy?

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I hereby authorize **A New Outlook Counseling Services, LLC** Office#(720)669-7292 Fax#(720) 344-4804
To use and release information pertaining to:

_____ _____
Full Name of Client **Date of Birth**

To:_____
Recipient Agency or Individual **Address** **Phone or Fox #**

To release the following health information about me: (Please check appropriate boxes. NOTE if a category is marked "Yes" and a line follows the category, you *MUST* describe the number and/or procedures done).

No	Yes	
		Name and/or phone number
		Demographic information (age, sex, ethnicity, address, etc.)
		Diagnosis(es)
		History and/or Physical
		Laboratory results:
		Psychological/Psychiatric evaluation summary:
		Billing/Financial information
		Progress Report/Treatment Summary/Family Therapy Summary
		Urinalysis/Breathalyzer results record
		Other (Specify):

**Information contained psychotherapy notes may not be released by this authorization. A special authorization must be obtained.

The information is required for: (Please check boxes that apply, if "Other" is checked, you *MUST* describe the purpose for information being provided.

	Treatment (to obtain additional)		Court for:
	Consideration/Maintenance of Employment		School, eligibility, credits
	Probation/Parole, ongoing eligibility		Voc Rehab, initial and ongoing eligibility
	Social Services, to obtain eligibility for treatment		Family members, to inform them of my care and treatment
	Other: (Specify):		

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Part 160 &164, and cannot be disclosed without my written permission unless otherwise provided for by the regulations I also understand that I may revoke this permission in writing at any time (refer to your copy of the HIPAA Notice of Privacy Practices for information on how to revoke this permission) except to the extent that action has been taken in reliance on it, and that in any event this permission expires automatically on the date written below:

_____
Date (2 Years)

I understand that generally, A New Outlook Counseling Services, LLC., may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances, I may be denied treatment if I do not sign an authorization form. For e ample, if funding for my treatment is contingent on the agency providing the funding receiving reports on my progress in treatment, I may be refused treatment funded by that source if I am unwilling to consent to release progress reports. I also understand that the people who get this information may give out my information, and it may no longer be protected. However, A New Outlook Counseling Services, LLC., will try to prevent redisclosure of my information by providing notification of prohibition of redisclosure to those receiving my information. I understand that I will be given a copy of this permission once I have signed and dated it.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Authorized Representative (Describe relationship) Date

_____ _____
Witness Date

(Send original if requesting information from another party. Send copy if releasing information to another party. Send copy if information requested from A New Outlook Counseling Services, LLC., by another party.)

01/2011

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_____
Date (2 Years)

I understand that generally, A New Outlook Counseling Services, LLC., may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances, I may be denied treatment if I do not sign an authorization form. For e ample, if funding for my treatment is contingent on the agency providing the funding receiving reports on my progress in treatment, I may be refused treatment funded by that source if I am unwilling to consent to release progress reports. I also understand that the people who get this information may give out my information, and it may no longer be protected. However, A New Outlook Counseling Services, LLC., will try to prevent redisclosure of my information by providing notification of prohibition of redisclosure to those receiving my information. I understand that I will be given a copy of this permission once I have signed and dated it.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Authorized Representative (Describe relationship) Date

_____ _____
Witness Date

(Send original if requesting information from another party. Send copy if releasing information to another party. Send copy if information requested from A New Outlook Counseling Services, LLC., by another party.)

01/2011

A New Outlook Counseling Services
1510 W. Canal Ct. Ste 2500
Littleton, CO 80120
Main Office – 303-798-2196
Fax – 303-730-2418

CREDIT CARD AUTHORIZATION

Name on authorized credit card: _____

Credit card #: _____

Expiration date:_____ CCV _____

Billing address: _____

City:_____State:_____Zip: _____

I, the undersigned, authorize A New Outlook Counseling Services to charge my credit card $150 for a failed appointment which includes missing a scheduled appointment without notice or with less than 24-hour notice. Unpaid balances upon discharge from the practice will be charged to my credit card. I understand that declined charges may result in loss of scheduling privileges or discharge as a patient from the practice.

Signature:_____ Date: _____

Printed name: _____