ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices for Sharon DeGuevara, effective October 2019.

Name (please print): _____
Signature: _____ Date: _____

I am a parent or legal guardian of _____ (client name). I have received a copy of the Sharon DeGuevara Counseling's Notice of Privacy Practices effective October 2019.

Name (please print): _____
Relationship to Patient: ☐ Parent ☐ Legal Guardian
Signature: _____ Date: _____

For Office Use Only:

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective October 2019 given to individual on _____ (date)

☐ In Person ☐ Mailing ☐ Email ☐ Other _____

Reason individual or parent/legal guardian did not sign this form:

☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other _____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature.

☐ In person conversation _____
☐ Telephone contact _____
☐ Mailing _____
☐ Email _____
☐ Other _____

Staff Name (please print): _____ Title: _____

Signature: _____ Date: _____

SHARON DEGUEVARA COUNSELING, LLC **Disclosure Statement and Informed Consent**
Colorado Licensed Clinical Social Worker #115 www.SharonDeGuevara.com
8 W Dry Creek Circle, Suite 207 info@SharonDeGuevara.com
Littleton, Colorado 80120 (303) 345-1157

Client Contact & Confidential Communication

Email Communication: This means of contact is primarily used for scheduling and brief response. IF a client chooses to send personal information by way of internet, it is the client's responsibility for the security of that information. Sharon DeGuevara uses a secure server, and if necessary, will use an encrypted form of transfer for confidential records. Once the communication is transferred to the client's server, the security of that information becomes the client's responsibility. Additionally, it is the client's responsibility to discern what information is sent in an email.

(Initial)_____As client, I will not hold Sharon DeGuevara liable for information put at risk electronically and/or for mishandling once information is on the client's server.

Texting: Occasionally, texting may be appropriate for scheduling or brief messages. This is at the client's discretion. Sharon will not text personal information pertaining to the client, and the client understands that texting is not a secure manner of communication. (Initial)_____I understand that texting is not a secure way to communicate with Sharon DeGuevara.

Online Counseling: In some cases, this may be permitted. Please note that e-mail correspondence for this purpose is used only for appropriate situations and must meet ethical codes. Although every precaution will be taken, online communication may not be completely confidential. E-mail response time is typically 12-48 hours. At any point, if the counseling conflicts with ethical standards, Sharon DeGuevara reserves the right to discontinue services. Payment for this type of service is limited to credit cards. Online counseling is not intended for individuals under the age of 18 or for those in crisis. If you are in crisis, feel unsafe, or are actively suicidal, please call your local emergency room, hotline, or 911.
_____If applicable, please initial that you understand the above information regarding Online Counseling.

(Initial)_____ As client, I realize that although every precaution will be taken, the above means of communication may not be completely confidential and I authorize the following request(s).

Client's name: _____DOB:_____Relationship to Client (if applicable)_____

Check those that apply:

_____ I give consent to be contacted at the phone numbers provided.
_____ I give consent to be texted on my mobile device.
Home #_____ Cell #_____ Work #_____
_____ I give consent to be left a voice mail if needed.
_____ I give consent to be contacted by - and/or to receive Email. Email address:_____
_____ I give consent to receive FAX information/forms if necessary. FAX#_____

Financial Policy

In order to determine if my services will be of benefit to you, I am happy to offer you a 15-minute consultation by phone or in person at no charge. Thereafter, my fee per counseling session is $130 per 50-minute appointment and $190 per 75-minute appointment. Payment is due at time of service and I accept cash, checks, credit card or HSA card.

You may contact me with questions about the fee structure and/or recommended duration of therapy sessions. Regarding health insurance, I do not file for reimbursement. However, upon request, I will provide you with a monthly receipt for services for you to file with your insurance company.

I will not agree to court appearances or other legal involvements unless we have discussed the matter thoroughly and both agree that such involvement is within my range of competence and will not interfere with the treatment relationship. Professional fees for court appearances, dispositions and attorney consultations are $300 per hour including travel and waiting time, payable in advance only. In addition, if I need to cancel existing client appointments, I will charge my session fee for missed work appointments.

Cancellation Policy & Payment Information

Services are by appointment only and are scheduled weeks in advance. As this time is reserved exclusively for you, it is my policy to charge for missed appointments and appointments not cancelled at least 24 hours in advance. If you are unable to keep a scheduled appointment, please notify me at **(303) 345-1157.** If I do not receive such advanced notice, you will be responsible for paying for the missed session fee. Session fee: $130 per 50 min. For appointments scheduled on Mondays, cancellation is necessary by Friday at the scheduled hour. **In the case of an emergency, special consideration may be given regarding the cancellation policy.*

Please initial _____ and complete required information below.

The above-mentioned fee will be charged to the following credit card: □ Visa □ MasterCard □ Amex

Credit Card #: _____ Security Number on back of card _____

Name on Card: _____ Expiration: _____

I, _____, understand and agree that if I do not show up for my scheduled appointment or if I cancel my scheduled appointment with less than 24-hour notice, the above named credit card will be charged in the amount of $130.00.

For your protection, once above payment records are no longer needed, they will be destroyed in a way that renders them "unreadable or indecipherable". For paper records, this would mean secure shredding of the documents. For electronic records, other secure erasure methods will be used.

(Initial)_____I would like to use this billing information for sessions. (Initial)_____I would like to use an alternate form of payment.

Signature _____Phone #_____ Date _____

www.SharonDeGuevara.com info@SharonDeGuevara.com