CLIENT INFORMATION FORM

Sharon DeGuevara Counseling, LLC
(303) 345-1157 www.SharonDeGuevara.com
8 W. Dry Creek Circle, Suite 100
Littleton, Colorado 80120

Name: _____

Parent(s) name (if client is under the age of 18):_____

Address: _____

Phone: H ( ) _____ W ( ) _____ C ( ) _____

Email Address: _____

Date of Birth: _____ Age: ____ Relationship Status (if applicable): _____

Referred by: _____

Please state in your own words what difficulty brings you to counseling.

_____
_____
_____
_____

Any prior counseling experience? If so, was it helpful?

_____
_____
_____
_____

In case of an emergency, contact:

Name _____ Relationship _____

Address _____

Phone _____

I have received copies of the Professional Disclosure/Informed Consent and Privacy Forms of Sharon DeGuevara, MSW, LCSW.

_____ _____
Client Signature (18 or over) Date

_____ _____
If a Minor (under 18) - Parent/Guardian 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 100 info@SharonDeGuevara.com
Littleton, Colorado 80120 (303)345-1157

Degrees, Licensing & Credentials

I hold a Bachelor of Arts in Social Work from the University of Iowa (1997), along with a Master's Degree in Social Work from the University of Denver (1999). I am a Licensed Clinical Social Worker (LCSW) In the State of Colorado (#115). My license, Practice and professional behavior are regulated by the Mental Health Licensing Section of the Division of Regulations. As a Licensed Clinical Social Worker, I meet all of the educational, experience and training requirements for licensure. In addition to being governed by the Colorado Mental Health Statutes, I also adhere to NASW Codes of Ethics and standards. You can expect me to practice in a manner that is consistent with these codes. The Board of Social Work Examiners can be reached at 1560 Broadway, Suite 1350, Denver, 80202, (303) 894-7800. NASW Codes of Ethics.

Levels of regulation of mental health professionals in Colorado include licensing (requires minimum education, experience, and examination qualifications), certification (requires minimum training, experience, and for certain levels, examination qualifications), and registration (does not require minimum education, experience, or training.) All levels of regulation require passing a jurisprudence take-home examination.

Regulatory Requirements for Mental Health Professionals in compliance with § 12-245-216 (1)(b)(I), C.R.S includes the following:

- An Unlicensed Psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.
- A Certified Addiction Technician must be a high school graduate, complete required training hours, pass the National Addiction Exam, Level I or an equivalent exam, and complete 1,000 hours of supervised experience.
- A Certified Addiction Specialist must have a bachelor's degree in behavioral health, complete additional required training hours, pass the National Addiction Exam, Level II or an equivalent exam and complete 2,000 hours of supervised experience.
- A Licensed Addiction Counselor must have a clinical master's or doctorate degree, pass the Master Addiction Counselor Exam or an equivalent exam, and complete 3,000 of supervised experience.
- A Licensed Social Worker must hold a master's degree from a graduate school of social work and pass an examination in social work.
- A Licensed Clinical Social Worker must hold a master's or doctorate degree from a graduate school of social work, practiced as a social worker for at least two years, and pass an examination in social work.
- A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.
- A Licensed Marriage and Family Therapist must hold a master's or doctoral degree in marriage and family counseling, have at least two years post-master's or one-year post-doctoral practice, and pass an exam in marriage and family therapy.
- A Licensed Professional Counselor must hold a master's or doctoral degree in professional counseling, have at least two years post-master's or one-year postdoctoral practice, and pass an exam in in professional counseling.
- A Licensed Psychologist must hold a doctorate degree in psychology, have one year of post-doctoral supervision, and pass an examination in psychology.

Client Rights & Responsibilities

You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure. Some clients need only a few counseling sessions to achieve their goals, while others require months or even years of counseling. As a client, you maintain control of yourself, and you may end our counseling relationship at any time, although I recommend that you participate in a termination session. You have the right to refuse or discuss with me any of the counseling techniques and suggestions that I use. If you are dissatisfied with my work for any reason, please let me know. In some situations, I may help you find another counselor with whom you may be able to work more effectively. It is your right to seek a second opinion from another therapist. If counseling is successful, you should feel you are able to face life's challenges without the support or involvement of a counselor, and you should feel a sense of success in satisfactorily resolving your problems. Should you or I feel that a referral is needed, I will provide you with some alternatives including professionals, specialists, and/or programs to assist you. It will be your responsibility to contact and evaluate these referrals.

Counseling Relationship & Effects of Counseling

While our sessions may be psychologically intimate, it is important for you to understand that our relationship is strictly professional and not social. Our contacts, other than chance meetings, will be limited to appointments you arrange with me. During the time that we work together, we will meet at mutually agreed upon times. If we should run into each other outside of counseling, I will let you acknowledge me or initiate a conversation if you choose to. You will be best served if our relationship remains professional and our sessions concentrate exclusively on your concerns. While you will learn much about me as we work together, it is imperative that you remember that you are experiencing my professional role. Within the professional relationship, sexual intimacy is never appropriate and should be immediately reported to the Department of Regulatory Agencies, Division of Registrations, Mental Health Section.

It is my intention to render services in a professional manner consistent with accepted standards of practice. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. It is possible that these changes can affect your relationships, job, and/or understanding of self. At any time, you have the right to initiate a conversation regarding any possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling.

Confidentiality

The information provided by the client(s) during therapy is legally confidential. All of our communication becomes part of clinical records. All written records of our counseling sessions will be maintained by me and kept in a confidential and secure place. I will keep confidential the things you tell me, and they will not be disclosed to others unless you give me written consent. However, Colorado law does specify some exceptions to the general rule of confidentiality, some of which are listed in the Colorado Statutes (C.R.S. 12-245-220), the HIPAA Notice of Privacy Rights you were provided, as well as other exceptions in Colorado and Federal law.

I am required to disclose information under the following circumstances:

-Situations of suspected or confirmed child abuse or neglect;
-Abuse or exploitation of an at-risk adult or elder, including imminent risk of such abuse;
-Threats of harm to others, including people identifiable by their association with a specific location or entity;
-Threats of harm to yourself.

Please be advised that there is no time limit on the mandatory reporting of child abuse. This means that even adult clients who experienced childhood abuse (no matter how long ago) might disclose in therapy past abuse incidents that still fall under the mandatory reporting requirements. The law requires that if there is reasonable cause to know or suspect that the perpetrator has subjected any other child currently under eighteen years of age to abuse or neglect or to circumstances or conditions that would likely result in abuse or neglect and/or is in any "position of trust" with children today then past abuse disclosed by an adult client is required to be reported. If you have questions or concerns about these requirements, please discuss further with your therapist.

In the situations outlined above, I may be required to take protective actions which may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If such a situation arises during our work together, I will make every attempt to discuss it fully with you before taking necessary action.

You should also be aware that provisions concerning disclosure of confidential communications will not apply to any delinquency or criminal proceedings, except as provided in section 13-90-107 C.R.S. If a legal exception arises during therapy, if feasible, you will be informed accordingly.

Record-Keeping

I maintain a paper record of the services provided to you and take reasonable precautions to ensure the privacy and security of any physical paper records including keeping the records in a locked file cabinet. Records are maintained and will be destroyed in accordance with state and federal laws and regulations. Currently, Colorado law requires that I maintain your records for a period of seven (7) years commencing on the date of termination of services or the date of last contact with the client, whichever is later. When the client is a child, the records must be maintained for a period of seven years commencing either upon the last day of treatment or when the child reaches 18 years of age, whichever comes later, but in no event shall records be kept for more than 12 years. After this time, your records will be destroyed. If you would like further information about the maintenance of your records, please ask.

Any person who alleges that a mental health professional has violated the licensing laws related to the maintenance of records of a client eighteen years of age or older, must file a complaint or other notice with the licensing board within seven years after the person discovered or reasonably should have discovered this.

Supervision & Consultation

I participate in professional, confidential consultation to provide the best possible services for the clients I counsel. Therefore, occasionally it may be necessary for me to discuss your case with a student, licensure candidate, another therapist, pediatrician, family physician, psychiatrist, supervisor, supervisee, or other helping professional. All of those I supervise are under the same legal and ethical requirements, and your confidentiality will be protected according to the laws and statutes of the Mental Health Code of Colorado. If you have any questions regarding this practice, you have the right to inquire at any time.

Social Media Policy

In order to maintain professional boundaries, I do not accept personal Facebook, LinkedIn, Twitter, Instagram, Snapchat and/or other friend/connection/follow requests via any form of social media.

Litigation Limitation

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be confidential and sensitive in nature, it is agreed that should there be any legal proceedings (such as, but not limited to divorce/custody disputes, injuries, lawsuits, etc.), neither you nor your attorney(s), nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of therapy records be requested/released unless otherwise agreed upon. Should I be court ordered as an expert witness to either appear, submit documentation/reports/therapy summaries, and/or

consult with other professionals regarding a client's case – fees are $300 per hour, including travel time. You will be responsible for paying for any professional time I spend on your legal matter, even if the request comes from another party. Please initial _____

Fees & Payment Policies

My fee per counseling session is $165 per 50-minute appointment. When necessary, I offer extended sessions with a fee adjustment.

I also charge this same $165 per 50-minute rate for other professional services, such as report writing, telephone calls, preparation of reports or treatment summaries, meeting with other professionals with your authorization, and time spent performing other services you request of me. *Please note that I do not provide Emotional Support Animal (ESA) letters or disability paperwork for therapy clients as this is beyond my scope of practice.* Fees are subject to change periodically, and I will notify you in advance of any such fee increase. Regarding payment for any of the above services, cash and checks are accepted prior to our session, or for your convenience, you can pay by credit card or HSA card. Payment is due on the day of your counseling session and credit cards are billed post session. It is the client's responsibility to keep payment information up to date. There will be a $25.00 charge for returned checks. If your account has not been paid for more than thirty (30) days and payment arrangements have not been agreed upon, your account will be considered past due and I have the option of using legal means to secure the payment. This may involve using a collection agency or filing a claim in small claims court. In collection situations, I will make all efforts to release the minimum information necessary to proceed with collections or a claim, which will include the client name, dates, times, and the nature of services, and the amount due. Before I engage a collection agency, I will provide you with written notice of my intent to do so, sent to your last address I have on record, and give you an opportunity to make payment arrangements.You may contact me with questions about the fee structure and/or recommended duration of therapy sessions.

Regarding Health Insurance

I am an out-of-network provider; therefore, it is your responsibility to file with your insurance company for reimbursement. Should you wish to file for reimbursement, I will provide you with a monthly receipt upon request. All sessions must be paid in full. If insurance does not reimburse as anticipated, it is your responsibility to address the issue with your insurance provider.

I am not a Medicaid provider. If you have Medicaid coverage that includes mental health services, I am not able to offer mental health services to you.

Please select one: I do_____ (or) I do not_____ currently have Medicaid coverage.

Emergency Situations

I can be reached at (303) 495-0317 during the weekdays (Mondays–Thursdays) between the hours of 9:00 a.m.-3:00 p.m. If you do not reach me, please leave a voice mail message, and I will return your call as soon as possible. If your call is after hours or I cannot get in touch with you, please call the closest hospital/crisis center, dial 988 or 911, or go straight to a hospital emergency room. You can also call the Colorado's Crisis Hotline at (844) 493-8255. If you have left an emergency message on my voicemail and then reach someone else, or have taken other actions, please call me and let me know the status of your emergency situation. Although I hope no unexpected interruptions in our counseling sessions occur, it is possible that an emergency situation could prevent me from attending a session. If this should occur, you will be contacted, informed of the situation, and given instructions as to what to do while I am away from the office. I typically take vacations during the year, but will notify you of my plans in advance, and you will be given the name and phone number of a contact person if you experience difficulty while I am away.

"No Secrets"

When treating a couple or a family, the couple or family is considered to be the client. If one member of the couple or family discloses information that is directly relevant to the treatment of the couple or family, it may be necessary to share that information with the other members of the couple or family for the sake of facilitating treatment. I will use my best judgement in deciding when or if such disclosures will be made and, whenever possible, I will first give you the opportunity to share the information yourself. In addition, if a request is made for the records of couple or family therapy, records will only be released with the consent of all parties, and any information that is released will be released to both members of the couple or to all adults engaging in family therapy. This "no secrets" policy is intended to allow me to continue to provide therapy to the family or couple by preventing, as much as possible, conflicts of interest that may arise. If you feel it necessary to talk about matters that you do not wish to have disclosed, you should consult with a separate therapist for individual treatment.

Treatment of Minors

If you are consenting to the treatment of a minor child, you will be required to provide a copy of the most recent Court Order Custody Agreement and/or Parenting Plan, if applicable, that gives you the authority to consent to the treatment of the child. By signing this form, you agree to keep me informed of any supplemental court orders or other proceedings that impact your parental rights, custody arrangements, or decision-making authority. Failure to produce the Court Order will prohibit me from seeing the minor child. If there is joint medical decision-making authority for your child, I will require both parents to consent to treatment and will not proceed until such consent is obtained.

It is beyond the scope of my practice to provide custody recommendations, and any such request will be denied. The Court can appoint professionals who have the expertise to make such recommendations. By signing below, you agree not to subpoena my records or ask me to testify in court or to provide letters or documentation expressing my opinion about custody or visitation. Despite this, a Court may still require me to testify or to provide treatment information to an evaluator. I will comply with these requests as

legally required and you will be required to compensate me for time spent providing these services as indicated in the "Litigation Limitation" section above.

In the course of treatment with your child, I may involve other family members in your child's treatment. However, please remember that my client is your child, not the other family members of the child. Any meetings with you or other family members will be documented in your child's record. These notes will be available to anyone who has legal access to your child's treatment record.

Therapy is most effective when there is a trusting relationship between the therapist and client. Privacy is important in establishing trust, and as a result, it is often important for child or adolescent clients to have a level of privacy around the therapy. It is my policy to provide parents with general information about their child's treatment, but not to share specific information disclosed during therapy. This includes behaviors that you may not approve of but which do not place your child at imminent risk or danger. If I ever feel that your child is in danger, I will communicate this information to you. By way of example, if your child tells me that s/he has tried alcohol a few times at parties, I will not generally share this with you. If your child shares that s/he has been drinking and driving or riding with a drunk driver, I would share this information with you. If you have questions about the types of information I will share, you can feel free to ask me hypothetical questions about situations that I would or would not disclose to you.

Although you may have the legal right to access any written record I keep, by signing this agreement you are agreeing that your child or adolescent should have privacy around their therapy, and you agree not to request access to your child's full record.

Good Faith Estimate

You are entitled to receive this "Good Faith Estimate" of what the charges could be for psychotherapy services provided to you. This section provides an estimate of the cost of services provided, and your total cost of services will depend on the number of psychotherapy sessions you attend and the type/amount of services that are provided to you. Please note that it is not possible for a psychotherapist to know how many psychotherapy sessions may be necessary in advance.
There may be additional items or services I may recommend separate from your care with me. These are not reflected in this good faith estimate. *This estimate is not a contract and does not obligate you to obtain any psychological services.*
The fee for a 50-minute psychotherapy visit (in-person or via telehealth) is $165. The frequency of psychotherapy visits that are appropriate in your case may be more or less than once per week, depending on your needs. Based upon a fee of $165 per 50-minute session, if you attend one psychotherapy session per week, your estimated charge would be $660 for four visits provided over the course of a 4-week month. If you attend one psychotherapy session every 2 weeks, your estimated charge would be $330 for two visits provided over the course of a 4-week month. Your total estimated charges will increase according to the number of sessions and length of treatment.

Interruption of Services – Professional Designee

In the event that I am disabled, die, or become incapacitated, the following provider will act as my Professional Designee and will have access to my client files: Jana Briggs with Jana Briggs Counseling & Associates. The Professional Designee will contact you to notify you of the event and will assist in continuing your care and treatment with the least amount of disruption possible by providing you with referrals and transferring your client record, if requested, to your new provider. If you are not comfortable with the above listed Professional Designee for any reason, please let me know and we will discuss alternatives.

Acknowledgement & Consent

By signing below, you are indicating: 1) I have read this statement; 2) We verbally reviewed the information contained in this statement; 3) Any questions I have about this statement have been answered to my satisfaction; 4) I have voluntarily sought counseling on my own initiative and am under no obligation to apply the counsel that I may receive; 5) I voluntarily accept the help offered by Sharon DeGuevara; 6) I will not hold Sharon DeGuevara liable for my health, behavior, or well-being in any way; 7) I acknowledge my commitment to conform to the specifications of this disclosure statement; 8) I consent to treatment - and/or- give my permission as parent/guardian for a minor in my care to be treated.

Client Signature (Parent/Guardian if client is under age of 18): _____ Date:_____

*If parents are separated or divorced and have joint decision-making authority related to counseling a minor, please add additional signature here:
*(Parent/Guardian if client is under age of 18): _____ Date:_____

Sharon DeGuevara, MSW, LCSW CO-115 _____ **Date verbally reviewed**_____

SHARON DEGUEVARA COUNSELING, LLC HIPAA - Privacy of Information Policies

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

In the course of providing services to you, I will obtain, record, and use mental health and medical information about you that is considered Protected Health Information, or "PHI." PHI is defined as "individually identifiable health information" that is created or received by a healthcare provider and which relates to past, present, or future health, provision of healthcare, or payment for provision of healthcare and that either identifies the individual or could be used to identify the individual. HIPAA and other laws regulate the use and disclosure of PHI when it is transmitted electronically. This Notice describes Jana Briggs' policies related to the use and disclosure of your PHI.

Uses and Disclosures Not Requiring Consent.

Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow me to use and disclose your health information for these purposes. In most cases, I am limited to disclosing the minimum information necessary to accomplish these purposes. To help clarify these terms, here are some examples:

• *Treatment* is when I use and disclose health information to provide, coordinate or manage your health care and other services related to your health care. If I decide to consult with another licensed health care provider about your condition, I would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist me in the diagnosis or treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard, because physicians and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care among health care providers or by a health care provider with a third party, consultations between health care providers, and referrals of a patient for health care from one health care provider to another.

• *Payment* is when I use and disclose health information to obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

• *Health Care Operations* refers to the use and disclosure of health information for activities that relate to the performance and operation of my practice. Examples of health care operations are review of treatment procedures or business operations, quality assessment and improvement activities, and staff training.

PLEASE NOTE: I, or someone acting with my authority, may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your prior written authorization is not required for such contact.

Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. I will also obtain an authorization from you before using or disclosing PHI in a way that is not described in this Notice. You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in certain circumstances, including, but not limited to:

• *Child or At-Risk Adult Abuse:* If I have reasonable cause to know or suspect that a child has been subjected to abuse or neglect or an at-risk adult has been mistreated, self-neglected, or financially exploited or is at imminent risk of mistreatment, self-neglect, or financial exploitation, then I must report this to the appropriate authorities.

• *Health Oversight Activities:* If the Colorado state licensing board or an authorized professional review committee is reviewing my services, I may disclose PHI to that board or committee.

• *Judicial and Administrative Proceedings:* If you are involved in a court proceeding where you are being evaluated for a third party or where the evaluation is court ordered, I may disclose PHI to the court. You will be informed in advance if this is the case.

• *Serious Threat to Health or Safety:* If you communicate to me a serious threat of imminent physical violence against a specific person or persons, including those identifiable by association with a specific place, I have a duty to notify any person or persons specifically threatened, as well as a duty to protect by taking other appropriate action. If I believe that you are at imminent risk of inflicting serious harm on yourself, I may disclose information necessary to protect you. In either case, I may disclose information in order to initiate hospitalization.

• *Business Associates*: I may enter into contracts with business associates to provide billing, legal, auditing, and practice management services that are outside entities. 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.

• *In Compliance with Other State/Federal Laws and Regulations:* PHI may be disclosed when the use and disclosure is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS), to a medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions (fitness for military duties, eligibility for VA benefits, etc.)

Client Rights

When it comes to your PHI, you have certain rights. This section explains your rights and some of Coname's responsibilities to help you.

• *Right to Request Restrictions*: You have the right to request restrictions on certain uses and disclosures of protected health information regarding you. The request must be in writing, and I am not required to agree to a restriction you request.

• *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)

• *Right to Inspect and Copy*: You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

• *Right to Amend*: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

• *Right to an Accounting*: You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

• *Right to a Paper Copy*: You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

• *Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket*: You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

Provider's Duties

As a mental health provider, I have certain duties to you related to your PHI. These are described below.

• I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

• I am required to notify you if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

• I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

• If I revise my policies and procedures, I will send a revised Notice of Privacy Practices by mail or email to the address I have in your record.

Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact the Privacy Officer at:

Sharon DeGuevara Counseling, LLC - Attn: Records;
8 W. Dry Creek Circle, Suite 100
Littleton, CO 80120
Email: info@SharonDeGuevara.com

If you believe that your privacy rights have been violated and wish to file a complaint with my office, you may send your written complaint to:

Sharon DeGuevara Counseling, LLC - Attn: Records;
8 W. Dry Creek Circle, Suite 100
Littleton, CO 80120
Email: info@SharonDeGuevara.com

You may also send a written complaint to:

The Secretary of the U.S. Department of Health and Human Services
Centralized Case Management Operations, U.S. Department of Health and Human Services
200 Independence Avenue, S.W., Room 509F HHH Bldg.
Washington, D.C. 20201,
Email: OCRComplaint@hhs.gov.

Sharon DeGuevara Counseling will not retaliate against you for exercising your right to file a complaint.

This Notice is effective October 2019.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

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 **Communication, Cancellation & Payment Policies**
Colorado Licensed Clinical Social Worker #115 www.SharonDeGuevara.com
8 W Dry Creek Circle, Suite 100 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 DeGeuvara 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 DeGeuvara 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 DeGeuvara.

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 DeGeuvara 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:
Home #_____ Cell #_____ Work #_____
_____ I give consent to be texted on my mobile device.
_____ 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:_____

Cancellation Policy

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: $165 per 50 min. For appointments scheduled on Mondays, cancellation is necessary by Friday at the scheduled hour. **In the case of a true 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: _____ Billing Zip Code: _____

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 $165.00.

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 _____