



## LEGACY CENTER

19751 E. MAINSTREET SUITE 218 - PARKER CO 80138  
PHONE: 303-841-4005 - FAX: 720-851-4890  
INFO@LEGACYPARKER.COM - WWW.LEGACYPARKER.COM

### INFORMED CONSENT AGREEMENT

I acknowledge that I have discussed and understand information regarding the therapy I am considering. The risks and benefits of treatment have been discussed with me. I have had all my questions answered fully. I wish to be seen as a client for psychological services provided by Legacy Comprehensive Counseling & Consulting. These psychological services may include individual and family therapy, ABA therapy, group, and/or psychological testing.

I give my permission to my therapist at Legacy Comprehensive Counseling & Consulting to observe and to keep records of treatment contacts and sessions with me. I understand that developing a treatment plan with my Legacy therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedure provided by Legacy. I understand that I cannot make audio or video recordings at any time during my treatment at Legacy. This includes, but is not limited to recording devices from cameras, cellular phones, iPhones, etc.

I understand that Legacy is a multi-disciplinary team including child psychologists, master level therapists, pre-doctoral interns/externs, registered psychotherapists, post-doctoral level therapists, certified behaviorists and behavior technicians. I understand that my therapist may discuss my treatment plan, diagnosis, and progress with the other Legacy providers and supervised interns/technicians (if applicable) for the purpose of consulting, teaching, and/or treatment planning. I understand that all Legacy therapists, providers, interns, and employees are held to the same limits of confidentiality as my primary therapist.

I am aware that I may stop my treatment with my Legacy therapist at any time. The only thing I will still be responsible for is paying my outstanding balance on services I have already received or the addition of late fees on an outstanding balance from services received. If I decide to stop treatment, I understand that I will need to cancel any future appointments that I have scheduled at Legacy with the Legacy receptionist in order to avoid late cancel or no-show charges accruing on my account after I decide to stop treatment.

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show, I may be charged a fee for that missed appointment (if a third party payer is involved, their direction will be followed). I also understand that if I am 15 minutes late for any scheduled appointment the appointment will need to be rescheduled. In this occurrence I understand that I will also be charged for a \$50 late cancel fee.

I am aware that an agent of my insurance company or other third-party payer may be given extensive information about the diagnosis, progress, discharge, cost(s), dates(s), and providers of any services or treatments that I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment. Additionally, I understand that the therapist's billing agent and administrative assistant will have access to my contact information, as well as certain clinical data necessary for billing purposes.

I understand that I may not be able to reach my therapist at all times. In the event of an emergency, my alternative contacts are my family physician and emergency services at a hospital.

The confidentiality of all materials related to my treatment will be protected by Legacy except in the following situations:

1. if I give my written permission for information to be shared with another agency or person,
2. information required by my insurance company for billing purposes (this may include procedures and diagnoses)
3. if there is a suspicion of neglect or abuse of a child or an elderly person,
4. if I (or my child) threaten(s) to seriously hurt myself (him/herself) or someone else.
5. if my records are subpoenaed by court of law.
6. if my account is overdue by 90 days or more, Legacy may be obligated to turn past due accounts to a contracted collection agency or seek collection with a civil court action.

My signature below shows that I understand and agree with all of these statements.

Signature \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_  
Client's Signature (15 years or older)

Signature \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Parent, Guardian or Personal Representative (if patient under 15)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Therapist's Signature, Legacy Comprehensive Counseling & Consulting



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## DISCLOSURE FORM

It is Legacy's practice to provide our clients the following information verbally and in writing during our initial session.

<p><u>Molly M. White, Ph.D., BCBA-D</u>          B.S. in Psychology, Kansas State University, 2000          M.S. in Psychology, Oklahoma State University, 2002          Ph.D. in Clinical Psychology, Oklahoma State University, 2005          Internship: University of Tennessee Professional Psychology Internship Consortium (APA Accredited)          Postdoctoral Fellowship: University of Tennessee Health Science, Center Boling Center for Developmental Disabilities (APPIC Listed)          ABA Certification Program, UC Denver, 2012          Board Certified Behavior Analyst, BACB, 2012, #1-13-12783          Licensure: State of Colorado, Psychologist, 2007, #3115          Orientation &amp; Method of Treatment: Applied Behavior Analysis, Cognitive Behavioral Therapy, Family Systems Therapy, and Developmental Theory</p>	<p><u>Keri A. Israelski, Psy.D., LLC</u>          B.S. with majors in Psychology and Interpersonal Communication, Western Michigan University, 2004          M.A. in Clinical Psychology, The Chicago School of Professional Psychology, 2006          Psy.D. in Clinical Psychology, The Chicago School of Professional Psychology, 2009          Predoctoral and Postdoctoral Internship: Children's Behavioral Health Services, Edwardsville, PA          Licensure: State of Colorado, Psychologist, 2011, #3575          Keri Israelski, Psy.D. is an independent contractor with Legacy Center          Orientation and Method of Treatment: Cognitive Behavioral Therapy, Family Systems Therapy, Strength Based and Client-Centered approach</p>
<p><u>Kara Knox, LPC, BCBA</u>          B.A. in Psychology, Westmont College, 2005          M.A. in Counseling, Colorado Christian University, 2011          ABA Certification Program, UC Denver, 2012          Licensed Professional Counselor, State of Colorado, 2012, #11358          Board Certified Behavior Analyst, BACB, 2012, #1-13-13197          Kara also works on the testing team at Legacy Center under the supervision of Molly White, Ph.D., BCBA-D.          Orientation &amp; Method of Treatment: Applied Behavior Analysis and Cognitive Behavioral Therapy</p>	<p><u>Marikay White, LCSW</u>          B.S. in Medical Technology, Kansas State University, 1969          Master of Social Work, University of Kansas, 1993          Licensure: State of Colorado, Licensed Clinical Social Worker, 1999, #992316          State of Kansas, Licensed Specialist Clinical Social Worker, 1995, #1693          Orientation &amp; Method of Treatment: Cognitive Behavioral Therapy, Interpersonal Therapy, Family Systems, and Client-Centered Therapy</p>
<p><u>Karalynn Royster, Psy.D.</u>          B.S. in Family Social Science, University of Minnesota, 2008          M.A. in Forensic Psychology, University of Denver, 2012          Psy.D. in Clinical Psychology, University of Denver, 2016          Postgraduate Certificate in Infant, Early Childhood, &amp; Family Mental Health, 2017          Licensure: State of Colorado, Psychologist, 2018, #4834          Orientation and Method of Treatment: Integrative, Cognitive Behavioral Therapy, Psychodynamic, Attachment, Family Systems, PCIT</p>	<p><u>Kate Brant, MS</u>          B.S. in Psychology, University of Miami, 2005          M.S. in School Psychology, Nova Southeastern University, 2009          M.S. in Clinical Psychology, Nova Southeastern University, 2011          Registration: State of Colorado, Registered Psychotherapist, NLC.0106581          Kate works on the testing team at Legacy Center under the supervision of Molly White, Ph.D., BCBA-D</p>
<p><u>Caren Rhodes, Ph.D., Ed.S.</u>          B.A. in Psychology and Spanish University of North Carolina, Chapel Hill, 2008.          Ed.S. Child, Family, and school Psychology (with an Early Childhood Certificate), University of Denver, 2012.          Ph.D. in Child Family and School Psychology, University of Denver, 2019.          Certificate of Completion, Pediatric Traumatic Brain Injury, University of Colorado, Denver, 2011.          Certificate of Completion, Neurodevelopmental Disabilities, University of Colorado Anschutz Medical School, 2013          Registration: State of Colorado, Registered Psychotherapist, NLC. 0110019.          Registration: State of Colorado, Psychologist Candidate, PSYC.00014222          Licensure: State of Colorado, School Psychologist (0-21), 2015, 141875          Caren is employed at Legacy Center as a Post-Doctoral Fellow, and is under the supervision of Molly White, Ph.D., BCBA-D          Orientation and Method of Treatment: Eclectic, Integrative, Client-Centered, and Rational-Emotive.</p>	

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed social workers, licensed professional counselors, licensed marriage and family therapists, licensed school psychologists practicing outside the school setting, and registered psychotherapists who practice psychotherapy.

<b>Mental Health Professional Division</b>	<b>Address</b>	<b>Phone Number</b>
Addiction Counselor Program	1560 Broadway Denver, CO 80202, Suite 1350	303-894-7800
Marriage & Family Therapists Examiners Board	1560 Broadway Denver, CO 80202, Suite 1350	303-894-7800
Professional Counselors Examiners Board	1560 Broadway Denver, CO 80202, Suite 1350	303-894-7800
Psychologist Examiners Board	1560 Broadway Denver, CO 80202, Suite 1350	303-894-7800
Social Work Examiners Board	1560 Broadway Denver, CO 80202, Suite 1350	303-894-7800
State Board of Registered Psychotherapists	1560 Broadway Denver, CO 80202, Suite 1350	303-894-7800

<b>Mental Health Providers</b>	<b>The Regulatory Requirements Applicable to Mental Health Professionals</b>
Licensed Clinical Social Worker	Must hold a masters degree in their profession and have 2 years of post-masters supervision
Licensed Marriage and Family Therapist	Must hold a masters degree in their profession and have 2 years of post-masters supervision
Licensed Professional Counselor	Must hold a masters degree in their profession and have 2 years of post-masters supervision
Licensed Social Worker	Must hold a masters degree in social work
Licensed Psychologist	Must hold a doctorate degree in psychology and have 1 year of post-doctoral supervision
Psychologist Candidate	Must hold the necessary licensing degree and be in the process of completing the required supervision for licensure
Marriage and Family Therapist Candidate	Must hold the necessary licensing degree and be in the process of completing the required supervision for licensure
Licensed Professional Counselor Candidate	Must hold the necessary licensing degree and be in the process of completing the required supervision for licensure
Certified Addition Counselor I (CAC I)	Must be a high school graduate and complete required training hours and 1,000 hours of supervised experience
Certified Additional Counselor II (CAC II)	Must complete additional required training hours of a CAC I and 2,000 hours of supervised experience
Certified Additional Counselor III (CAC III)	Must hold a bachelors degree in behavioral health and complete additional required training hours and 2,000 hours of supervised experience
Licensed Addition Counselor	Must hold a clinical masters degree and meet the CAC III requirements
Registered Psychotherapist	Registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required

#### Client's Rights and Important Information:

1. You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy (if I can determine it), and my fee structure.  
Legacy's fees for services are outlined as follows:  
The expectation is that payment is due when services are rendered, unless you make arrangements for payment and we both agree to such an arrangement. All accounts that are not paid within 30 days from the date of services shall be considered past due. In the rare event that there is a balance in 30 days, any unpaid balance will be charged a \$20 late fee charge a month. In the event that an account is overdue by 90 days or more, Legacy may be obligated to turn past due accounts to a collection agency or seek collection with a civil court action. Should this occur, Legacy will provide the collection agency or Court with your Name, Address, Phone Number, and any other directory information, including dates of services or any other information requested by the collection agency or Court deems necessary to collect the past due account. Should conditions of non-payment persist, I understand that Legacy may discontinue treatment.
2. Please let me know if you have any questions about my methods, techniques, or duration of therapy or my fee structure.
3. You can seek a second opinion from another therapist or terminate therapy at any time.
4. In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. It is a crime as well as a regulatory wrong in Colorado. If sexual intimacy occurs, it should be reported to the Department of Regulatory Agencies, Mental Health Section at 1560 Broadway, Suite 1560, Denver, Colorado 80202, (303) 894-7800 and/or your local law enforcement agency.
5. Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the therapist is a of licensed psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, licensed school psychologist, or registered psychotherapist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent. Information disclosed to a licensed psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, licensed school psychologist, or registered psychotherapist is privileged communication and cannot be disclosed without the consent of the person to whom the testimony sought relates. There are exceptions to the general rule of legal confidentiality. These exceptions are listed in the Colorado Statutes (C.R.S. 12-43-218) and in the Notice of Privacy Rights you were provided. You should be aware that provisions concerning disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in section 13-90-107 C.R.S.

There are other exceptions that I will identify to you as the situations arise during therapy.

- a. An important consideration is my obligation, by law and ethical standards, to report any suspicion of the occurrence of child abuse or neglect immediately to the proper authorities. Similar obligations exist in the area of suspected elder abuse.

- b. You should also be aware that if you should communicate any information involving a threat to yourself or to others, I may be required to take immediate action to protect you or others from these threats. Additionally, I am obligated to inform both the person who is threatened and the authorities, should I be informed of intended harm to someone. Should I believe that there is a danger of harm to self or others, it is my obligation to make that information known.
  - c. Additionally, it is my obligation to comply with any court directions, including subpoenas, whereby I am ordered by the court to disclose information. In most situations, we will have had the opportunity to process this eventuality together prior to any court appearance.
  - d. Legacy may be obligated to turn past due accounts to a contracted collection agency or seek collection with a civil court action. Should this occur, Legacy will provide the collection agency or Court with your Name, Address, Phone Number, and any other directory information, including dates of services or any other information requested by the collection agency or Court deems necessary to collect the past due account.
  - e. When providing services to children and adolescents, it is important that parents/caregivers understand that some information will be held confidential. It is equally important that the child or adolescent understand that knowledge by this therapist of potentially dangerous behaviors be shared with the parent(s)/caregiver(s). Whenever possible, such disclosure will be processed first with the child or adolescent.
6. Should you discontinue therapy for more than 60 days, your treatment will be considered “terminated.” You may resume therapy anytime after the 60 day period. This disclosure statement will remain in effect should you resume therapy and you may be asked to provide additional information to update your client records.

If you have any questions or would like additional information, please feel free to ask.

By signing below, you are indicating that you have been provided this information verbally and have read the preceding information and that you understand your rights as a client or as the client’s responsible party.

Signature_____	Printed Name_____	Date _____
Client’s Signature (15 years or older)		
Signature_____	Printed Name_____	Date _____
Signature of Parent, Guardian or Personal Representative (if patient under 15)		
Signature_____	Date _____	
Therapist’s Signature, Legacy Comprehensive Counseling & Consulting		



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### FINANCIAL POLICY AND PATIENT AGREEMENT

As a courtesy Legacy Comprehensive Counseling & Consulting will bill your insurance company for the services provided if the therapist you are seeing is in your insurance company's network. Payment of your deductible, co-pay and/or co-insurance is your responsibility and may be collected from you at the time the service is rendered. Some services (including some psychological testing services) may be processed through your insurance company before you are charged for your portion. In these situations, your credit card on file will be charged for your portion (copays, deductible, co-insurance) immediately after Legacy Center receives notice of your amount due from your insurance company. Legacy Center is unable to give an estimation of when your credit card on file will be charged due to the unknown length of time that your insurance company will take to process your claim. If your insurance company denies payment for any reason, the entire fee is your responsibility and will be charged to your credit card on file upon notice of denial from your insurance company.

In the event that your credit card on file is declined for any reason, a fee will be applied to your account each month that your balance is not paid in full. In the event that an account is overdue by 90 days or more, Legacy will turn over past due accounts to a contracted collection agency or seek collection with a civil court action. Should this occur, Legacy will provide the collection agency or Court with your Name, Address, Phone Number, and any other directory information, including dates of services or any other information requested by the collection agency or Court deems necessary to collect the past due account. Should conditions of non-payment persist, I understand that Legacy will discontinue treatment. In case of default you will be liable for all costs of collections including, but not limited to, late fees, interest, collection fees, court costs and attorney fees.

Your healthcare insurance coverage is a contract between you and your healthcare insurance company. It is your responsibility to know and understand your coverage benefits, eligibility and limitations. We strongly encourage you to check with your insurance company PRIOR to having services performed so that there are no financial concerns after the services have been rendered that you will not be prepared for. Insurance companies sometimes inform Legacy Center of their payment intentions and policies; Legacy Center staff sometimes relays this information to clients, however, this transfer of information is a courtesy only and Legacy Center is not responsible for any financial decision that your insurance company ultimately makes. The client is ultimately responsible for payment in full regardless of decisions made by your insurance company. The patient is responsible to make available to Legacy complete insurance information for accurate filing of claims. Insurance information includes 1) Any necessary authorizations or pre-certifications for primary and secondary insurance coverage, and 2) All identification and benefits cards and documents. The patient agrees that if the insurance company denies benefits for any reason, or if full payment is not received from the insurance carrier within 45 days as designated by Colorado law, then the patient is responsible for the full amount of the bill immediately, which will be billed to your credit card on file. Further, please understand that we are legally obligated to assign procedure codes and diagnostic codes based on services provided to you. We **CANNOT** change the coding later if the insurance company does not cover a particular code or service.

If you need to cancel or reschedule an appointment, you are required to provide **24 hours** advance notice by phone, otherwise you will be charged \$50 for each missed appointment. (For group sessions this fee will be \$45). Late cancel and no-show fees will be assessed for any reason, including illness, weather, or traffic. Missed appointments are the client's responsibility. Legacy Center requires that clients maintain documents on file authorizing Legacy Center to charge your credit card for payment of no-show fees and late cancels. Your credit card will be charged at the time we are informed of the late cancel or fifteen minutes after your appointed time for no-shows. Additionally, should multiple late cancels and/or missed appointments occur (i.e., 3 or more), I understand that Legacy may discontinue treatment. Legacy sincerely appreciates your cooperation. At any time you have any questions regarding insurance, fees, balances or payments please feel free to ask.

If you have a child or adolescent who will be attending Legacy Center without the financially responsible person(s) present at the appointment, please provide the client with the means to make the payment. Alternately, you can coordinate payment ahead of time. You can do this by contacting Legacy Center and making the payment over the phone with your credit card, providing your credit card information to Legacy Center to keep on file and charge at the time of service, or pre-paying the fee.

Client/Guardian Initials \_\_\_\_\_

By this agreement, the patient also authorizes the exchange of considerable amounts of medical information relating to care and claims with Legacy's contracted billing agent, billing staff, and the patient's insurance company(s), including the diagnosis and authorizes insurance payment to be made directly to Legacy for services provided under the patient's insurance agreement and otherwise payable to the patient.

If you are not using your insurance, total payment of fees is due at the time of service. A complete fee schedule is listed below. Acceptable forms of payment are cash, personal check or Visa/MasterCard/Discover credit card. Please note, Legacy is not responsible for holding checks. All checks will be deposited once they are received by the billing department. Should a check be returned for insufficient fund, or a credit card declined, a service fee of \$20 will be assessed.

If the client's account has an individual credit on file that is larger than \$25, Legacy Center will issue a refund check to the person who is listed as financially responsible to the client in the client's new patient packet. Individual credits on file that are \$25 or less will not be refunded unless specifically requested for in writing to 19751 East Mainstreet, Suite 215 Parker, CO 80138 attn: Billing Department.

Service	Time	Fee			
		Licensed Psychologist	Licensed M.A. Level Therapist (on insurance panels)	Licensed M.A. Level Therapist (not on insurance panels)	Registered Unlicensed Therapist
Intake for Counseling	50 minutes	\$150	\$131.77	\$100	\$80
Therapy Session	45 minutes	\$130	\$127.79	\$100	\$80
Couples or Family Session	50 minutes	\$130	\$127.79	\$100	\$80
Group Counseling	60 minutes	\$45	\$45	\$45	\$45
Comprehensive Evaluations, including Autism, Developmental, Learning Disability, Dyslexia, ADHD, Mood, Behavioral, OCD, and/or Gifted & Talented	Testing, Interpretation and Report Write-up	Cost is determined by the type of evaluation requested. This will be discussed at the intake session and before scheduling the testing appointments			
Becoming a Love and Logic Parent (group or individual sessions offered)	6 x 2 hour sessions fee includes workbook	\$150 Individual		\$250 Couple	
Court Appearance	2 hour minimum ( <u>includes travel time</u> )	\$200 per hour			
Court Preparation	2 hour minimum	\$200 per hour			
Case Management (phone calls to clients or other professionals, client requested completion of paperwork, documents, forms etc.)	Less than 5 Minutes	No Charge			
	5 – 15 Minutes	\$30			
	16 – 30 Minutes	\$60			
	31 – 45 Minutes	\$90			
	46 – 60 Minutes	\$120			

We thank you for taking the time to read and complete this form. We are making every effort to comply with the government rules and the rules of all insurance plans for claims submission.

PATIENT AGREEMENT: I have read and understand the Financial Policy above and agree to the terms stated. Additionally, my signature indicated that I authorize Legacy to bill my insurance company and to directly reimburse this office.

Signature \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_  
 Client's Signature (15 years or older)

Signature \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of Parent, Guardian or Personal Representative (if patient under 15)

Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Therapist's Signature, Legacy Comprehensive Counseling & Consulting



# Legacy Center Credit Card on File

Date: \_\_\_\_\_

Client's Name: \_\_\_\_\_

Client's DOB: \_\_\_\_\_

As a courtesy Legacy Comprehensive Counseling & Consulting will bill your insurance company for their portion of the fee if the therapist you are seeing is in your insurance company's network. Payment of your deductible, co-pay and/or co-insurance is your responsibility and may be collected from you at the time the service is rendered. Some services (including some psychological testing services) may be processed through your insurance company before you are charged for your portion. In these situations, your credit card on file will be charged for your portion (copays, deductible, co-insurance) immediately after Legacy Center receives notice of your amount due from your insurance company. Legacy Center is unable to give an estimation of when your credit card on file will be charged due to the unknown length of time that your insurance company will take to process your claim. If your insurance company denies payment for any reason, the entire fee is your responsibility and will be charged to your credit card on file upon notice of denial from your insurance company.

I, \_\_\_\_\_, authorize the use of my credit card for the following charges: Appointment fees including, but not limited to, co-pays, co-insurances, deductibles, private pay fees, and charges denied by your insurance company, as well as charges related to No-Shows, Late Cancellations and Late Fees.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Authorized Credit Card Information **(Please note that a credit card is required)**

Card Number : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Expiration Date : \_\_\_\_\_ / \_\_\_\_\_

Billing Zip Code: \_\_\_\_\_

Card Holders Name: \_\_\_\_\_

Card Holders Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If you would like us to first try to run appointment fees through your HSA or FSA card prior to charging the remaining balance left over to your credit card, please fill out your HSA/FSA card information below (Please note: We will not bill charges related to no-shows, late-cancellations or late fees to your HSA/FSA card; these charges will go directly to your credit card on file.)

## Authorized HSA/FSA Card Information

Card Number : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Expiration Date : \_\_\_\_\_ / \_\_\_\_\_

Billing Zip Code: \_\_\_\_\_

Card Holders Name: \_\_\_\_\_

Card Holders Signature: \_\_\_\_\_ Date: \_\_\_\_\_





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### **Notice of Privacy Practices and Protected Health Information**

**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.**

Whenever you see the word “you” in this document, it means “you or your child” (if applicable).

#### **Understanding Your Health Information**

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services is referred to as Protected Health Information (“PHI”). Each time you visit Legacy Comprehensive Counseling & Consulting a record of your visit is made. This record contains information about your symptoms, examinations, test results, medications you take, and the plan for your care. This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and mental health Code of Ethics. It also describes your rights regarding how you may gain access to and control your Protected Health Information.

#### **Uses and Disclosures of Health Information**

##### **Legacy Comprehensive Counseling & Consulting will use your Protected Health Information for treatment**

Legacy Comprehensive Counseling & Consulting will document information in your record about your examination and the care planned for you. Your health information may be used and disclosed by those who are involved in your care for the purpose providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. If another provider referred you to Legacy Comprehensive Counseling & Consulting, with your consent Legacy may send copies of your medical record to that person so he or she will have updated information to help in your care. Legacy may also use health information about you to call you or send you a letter to remind you about an appointment, to follow up with tests results, or to provide you with information about other care that could benefit your health. I understand that Legacy is a multi-disciplinary team including child psychologists, master level therapists, interns, occupational therapists, and speech therapists. I understand that my therapist may discuss my treatment plan, diagnosis, and progress with the other Legacy providers and supervised interns (if applicable) for the purpose of consulting, teaching, and/or treatment planning. I understand that all Legacy therapists, providers, interns, and employees are held to the same limits of confidentiality as my primary therapist.

##### **Legacy Comprehensive Counseling & Consulting will use your Protected Health Information for payment.**

Legacy Comprehensive Counseling & Consulting will send a bill to you or your insurance company. Legacy may include information that identifies you, as well as your diagnoses, procedures, healthcare providers and supplies used. Legacy also may contact your insurance company to determine if they will pay for your medical care as part of their certification process. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

### **Other Disclosures: Business Associates**

There are some services provided through contacts with business associates (e.g., billing agency). To protect your health information, however, Legacy Comprehensive Counseling & Consulting requires the business associates to protect your information. Further, Legacy is required to notify you directly of any privacy breaches committed by a business associate.

### **Required by Law**

Legacy Comprehensive Counseling & Consulting may also disclose protected health information required by law without your authorization to the following entities or types of entities that includes, but is not limited to:

- Abuse and Neglect
- Judicial and Administrative Proceedings
- Emergencies
- Family Involvement in Care
- Health Oversight
- Public Safety (Duty to Warn)
- Research
- Food and Drug Administration
- Public Health or legal authorities charged with disease prevention
- Correctional institutions
- Workers Compensation Agents
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Examiners
- National Security and Intelligence Agencies
- Law enforcement as required by law or in accordance with a valid subpoena

Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types and uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the mental health licensing boards or the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

### **Verbal Permission**

Legacy may use or disclose your PHI to family members that are directly involved in your treatment with your verbal permission.

### **Written Permission**

Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which you may revoke.

### **Marketing**

Legacy will **not** use information in your records for marketing purposes.

**Patient Rights: You have the right to:**

You have the following rights regarding your PHI that Legacy maintains. To exercise any of these rights, please submit your request in writing to our Privacy Officer, Molly M. White, Ph.D.

- **Inspect and obtain a copy of your health record.** Legacy maintains full client records electronically. You have the right, which may be restricted only in exceptional circumstances (e.g., evidence that access would cause serious harm), to inspect and copy your PHI that may be used to make decision about your care. Legacy uses secure internet portals and methods of encryption to assure compliance with confidential communications to protect Legacy from any unauthorized disclosure of confidential client data.
- **Request an amendment to your health records.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
- **Obtain an accounting of disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Request communication of your health information in a certain way or at a certain location.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Revoke your authorization to use or disclosure** health information except to the extent that action has already been taken.

**Legacy Comprehensive Counseling & Consulting has the duty to:**

- Maintain the privacy of your protected health information as required by law;
- Provide you through this notice with information as to her legal duties and privacy practices with respect to information Legacy collects about you;
- Abide by the terms of the notice currently in effect;
- Notify you if Legacy is unable to agree to a requested restriction;
- Follow reasonable requests you make to communicate with you as you instruct—for example, contact you at a certain telephone number or address.
- Provide you a paper copy of this notice of privacy practices upon request.

**For More Information or to Report a Problem or Complaint**

If you have any questions about your rights, our duties, or our practices and procedures regarding protected health information, please contact the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. Complaints to the Secretary must be filed in writing on paper or electronically and must be made within 180 days of when you became aware of, or should have been aware of, the incident giving rise to your complains. By law, you cannot be penalized for filing a complaint.

Your signature below indicates that you have read this document and have had the opportunity to have any questions answered to your satisfaction.

Signature\_\_\_\_\_ Printed Name\_\_\_\_\_ Date \_\_\_\_\_  
Client's Signature (15 years or older)

Signature\_\_\_\_\_ Printed Name\_\_\_\_\_ Date \_\_\_\_\_  
Signature of Parent, Guardian or Personal Representative (if patient under 15)

Signature\_\_\_\_\_ Date \_\_\_\_\_  
Therapist's Signature, Legacy Comprehensive Counseling & Consulting