***Ronald D. Welch, Psy.D. DR WELCH’s CLIENT \_\_\_\_\_\_\_\_\_\_\_***

Licensed Clinical Psychologist **AT \_\_\_\_\_\_\_\_\_\_\_\_\_ ON \_\_\_\_\_\_\_\_\_\_\_**

Transformational Marriage, PLLC

dba Transformational Marriage Counseling

Mailing Address: 6732 W. Coal Mine Avenue, #186 Littleton, CO 80123

(303) 762-6952

PATIENT AGREEMENT PACKET

*Instructions:*

1. *COMPLETE Page 1 BELOW (Client Information Sheet)*
2. *Review pages 3-13 (Patient Agreement)*
3. *After reviewing pages 3-13, then ALL PARTIES NEED TO SIGN IN TWO PLACES:*

*PAGE 2 (Signature Page)*

*PAGE 3 (Communication Consent Page)*

1. *Keep pages 15-25 as your copyof the Patient Agreement and Colorado Notice*

Client Information Sheet

**Client Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Guardian (if Minor):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client's SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other people living in Client's household:**

Name: Birth Date: Relationship:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Client Marital Status:** Single Married Separated/Divorced (Single)

Divorced (Remarried) Widowed Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Eligibility for Services Question:**

Are you currently receiving Medicaid benefits or a member of any of the Colorado Health Care Exchange programs which are subsidized by Medicaid? No \_\_\_\_\_ Yes \_\_\_\_

**\*\*\*\*\*IF YES, PLEASE STOP HERE AND SPEAK WITH ME IMMEDIATELY. \*\*\*\*\***

**I AM PREVENTED BY LAW FROM PROVIDING SERVICES TO ANY MEDICAID CLIENT OR OTHER EXCHANGE SUBSIDIZED BY FEDERAL HEALTH CARE FUNDS AND I AM REQUIRED TO REFER MEDICAID AND FEDERALLY SUBSIDIZED CLIENTS TO A MEDICAID APPROVED FACILITY/PROVIDER FOR SERVICES).**

**Billing Information:**

Payment for services is due before the services are provided and will be collected at the beginning of the session by Dr. Welch.

**Initial Screening Questions:**

Have you ever been in therapy before? Yes \_\_\_\_ No \_\_\_\_\_\_ If yes, who did you see and when were you seen?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever taken any psychiatric/mental health medications on a regular basis? If yes, please list medications, doses and timeframes taken.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to this office? Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Ronald D. Welch, Psy.D.***

Licensed Clinical Psychologist

Transformational Marriage, PLLC

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## 

### **PSYCHOLOGIST- PATIENT SERVICES AGREEMENT**

### **SIGNATURE PAGE**

1. MY SIGNATURE BELOW VERIFIES THAT I FULLY AGREE WITH ALL TERMS OF THE PSYCHOLOGIST-PATIENT AGREEMENT AFTER REVIEWING PAGES 3-13.
2. MY SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT I HAVE RECEIVED A COPY OF BOTH THE COLORADO NOTICE FORM DESCRIBED IN THE PSYCHOLOGIST-PATIENT AGREEMENT AND THE PSYCHOLOGIST-PATIENT AGREEMENT.
3. FURTHER, MY ADDITIONAL INITIALS BELOW DOCUMENT THAT I HAVE HAD THE MANDATORY COLORADO DISCLOSURE ELEMENTS EXPLAINED TO ME VERBALLY.
4. I UNDERSTAND THAT I MAY REVOKE MY SIGNATURE AND THIS AGREEMENT IN WRITING AT ANY TIME AS OUTLINED IN THE AGREEMENT.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature (or Guardian) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse Signature Date

**Transformational Marriage, PLLC**

**CONSENT FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION BY UNSECURE TRANSMISSIONS**

**This consent form is for the communication of Protect Health Information (“PHI”) that Transformational Marriage, PLLC and Dr. Ron Welch (hereafter referred to as TM) may transmit without the written authorization of the client as described in the original Psychologist-Patient Services Agreement.**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby consent and authorize TM to communicate my PHI through the following unsecured transmission means:

Cellular/Mobile Phone, including voicemail (other phone numbers may be provided by client)

Primary cell phone number to use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email sent and received (other emails may be provided by client)

Primary email to use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telemental health platforms (Doxy.me, Zoom, or other approved platforms)

Primary location clients will log in from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing this document, I understand that TM will make good faith efforts to protect my PHI and use HIPPA compliant platforms if available. I acknowledge that TM cannot guarantee that those communications will remain confidential.

Even though TM may utilize state of the art encryption methods, firewalls, and/or back-up systems to help secure our communication, there is a risk that the electronic or telephone communications may be compromised, unsecured, and/or accessed by an unintended third-party. There is never a 100% guarantee information will remain confidential when transmitted electronically.

I also understand that TM may use and disclose the following PHI without my written authorization:

Information related to scheduling/appointments

Information related to billing and payments

Information related to your mental health treatment (this may contain personal materials, forms, suggested articles, homework, etc.)

Information related to TM’s operations

I further understand that if I initiate communication via electronic means that I have not specifically consented to in this form, I will need to amend this consent form so that my therapist may communicate with me via that method.

Lastly, I affirm that I have read the attached policies on page 2 of this document regarding professional and ethical use of telemental health services and agree to abide by those policies.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Spouse DATE

Transformational Marriage Policy

On Telemental Health Services

INTRODUCTION

1. When possible, Transformational Marriage recommends in-person, direct client services.
2. However, when in-person, direct client services are not able to be provided due to illness, weather, or other unavoidable circumstance, phone counseling or video conferencing services may be provided in a HIPPA compliant manner.
3. All therapists engaging in telemental health services will be trained in both the APA ethical standards and the Colorado State Psychologist policies.

TELEMENTAL HEALTH POLICIES

1. Telemental health services need to be delivered in the state where the patient is located by a therapist located in the same state and not delivered across state lines.
2. Telemental health services are considered a normal standard of practice in the mental health field and when deemed necessary by the mental health professional do qualify for malpractice insurance coverage.
3. Therapists will ensure that the standard of care delivered by telemental health services is equivalent to in-person direct service care.
4. Therapists will bill the same rate for telemental health services as is billed for in-person, direct services.
5. Clients should be aware that the best practices possible will be utilized to assure confidentiality, but that complete confidentiality is impossible to assure in telemental health situations and they will document client agreement in the clinical record. When possible, written consent will also be collected.
6. Therapists will document the identity and location of all clients utilizing telemental health services in the clinical record.
7. Clients should find a location for the session in which other individuals are not present and distractions are minimized to ensure high quality clinical services.
8. Therapists will assure that regardless of the communication modality used, they are located in an isolated, protected environment where confidentiality is assured and communication cannot be overheard by others.
9. Therapists and clients will never conduct telemental health services while driving or engaged in any similar activity. Doing so would create a dangerous, distracting experience while driving, as well as decrease their ability to be present and focus clearly on the client’s services.
10. Therapists will follow the same emergency practices, reporting practices, and other standards that apply to in-person, direct services.
11. Therapists should be aware that the social and non-verbal cues that usually exist in in-person direct services are not available in telemental health services. Therefore, they should make every effort to assess affect, client mental status, and symptom analysis through asking additional questions and verifying data whereever possible.
12. Therapists and clients should only use technology that is verified to be in good working condition and with reception that allows clear and accurate interactions.
13. If any situations arise for either party in their specific location that interfere significantly with clinical integrity of the session, the therapist should consider rescheduling the session.

***Ronald D. Welch, Psy.D.***

Licensed Clinical Psychologist

Transformational Marriage, PLLC

dba Transformational Marriage Counseling

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Littleton, CO 80123

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## PSYCHOLOGIST- PATIENT SERVICES AGREEMENT

This document (AKA “the Agreement”) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (AKA “the Notice”) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Your signature on this form will indicate that you have received the Notice, that you have read it, that you understand it and that you agree to it. When you sign this document, it will also represent an agreement between us. However, you may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. Although these documents are long and sometimes complex, it is very important that you read them carefully before you sign them. We can discuss any questions you have about the procedures before you sign them and you can discuss them with your attorney.

**General Information**

1. Name and Contact Information:

Ronald D. Welch, Psy.D., Licensed Clinical Psychologist, Transformational Marriage, PLLC, dba Transformational Marriage Counseling, Mailing Address: 6732 W. Coal Mine Avenue, #186, Littleton, CO 80123 (303) 762-6952

# I am a licensed psychologist in the state of Colorado and have a Psy.D. degree in Clinical Psychology. The required education, experience, and training required for this license may be found on the website of the Department of Regulatory Agencies, State of Colorado, Psychologist Examiners Board (<http://www.dora.state.co.us/mental-health/psy/index.htm>). In brief, this license required a doctoral degree in psychology or its equivalent, 1500 hours of post-degree supervised experience, passage of the national psychologist Standard Examination, the EPPP, and passage of the state Jurisprudence Examination

# The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The Board of Psychologist Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. As to the regulatory requirements applicable to mental health professionals: a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a Master’s degree in their profession and have two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a Master’s degree 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 Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1,000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a Bachelor’s degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical Master’s degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required.

# You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy, if known, and the fee structure. Please ask if you would like this information.

# You can seek a second opinion from another therapist or terminate therapy at any time.

# In a professional relationship (such as this one), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

# Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client’s consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes and the Notice of Privacy Rights you were provided, as well as other exceptions in Colorado and Federal law. These exceptions to confidentiality include: 1) I am required to report any suspected incident of child or elder abuse or neglect to enforcement authorities; 2) I am required to report any threat of imminent physical harm by a client to enforcement authorities and to the person(s) threatened; 3) I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental disorder; 4) I am required to report any suspected threat to national security to federal officials; and 5) I may be required by a Court Order to disclose treatment information. If a legal exception arises during therapy, if feasible, you will be informed accordingly.

1. Under Colorado law, C.R.S. 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children under 15, unless the court has restricted access to such information. If you request treatment information from me, I may provide you with a treatment summary, in compliance with Colorado law and HIPAA Standards.
2. If you are involved in divorce or custody litigation, my role as a therapist is not to make recommendations to the court concerning custody or parenting issues. By signing this Disclosure Statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that I write any reports to the court or to your attorney, making recommendations concerning custody. The court can appoint professionals, who have no prior relationship with family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interests of the family’s children.

# PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on issues we talk about both during our sessions and outside our sessions. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings such as fear, sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. The benefits from psychotherapy may be that you will be better able to function in your roles at work and/or at school, and that you may be better able to cope with or handle your family and/or other social relationships, thus experiencing more satisfaction from these relationships. Through psychotherapy you may also come to better understand your personal goals and values, which may lead you to greater maturity and growth as a person. But there are no guarantees of what you will experience.

You are entitled to know that I received my doctorate in clinical psychology, known as a Psy.D., in 1995 from Central Michigan University. I have been licensed in the State of Colorado as a Psychologist (license #2072) since 2003. You should understand that I am NOT a psychiatrist or other medical physician, and, therefore, I cannot prescribe medication, give medical advice, nor perform any medical procedures. If I determine that medical treatment is indicated, I can recommend a physician for you or I can consult with any physician you may wish or chose to see.

The practice of Psychologists is regulated by the Colorado Department of Regulatory Agencies. The agency within the Department that has specific responsibility for Psychologists is the Colorado State Board of Psychologist Examiners. The address by which this regulatory body can be reached is: The Colorado State Board of Psychologist Examiners, 1560 Broadway, Suite #1350, Denver, CO, 80202. The phone number for the Psychologist Examiners Board is (303) 894-7766 and their website is http://www.dora.state.co.us/mentalhealth.

# MEETINGS

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and determine a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion. If you chose to begin psychotherapy, we will usually schedule a 50-minute session at a time we both agree on. Typically, my “clinical hour” is 50-minutes long. Each session is typically one clinical hour and the usual frequency is one session per week. The frequency of your sessions may vary according to your needs. The length of treatment varies widely and is often very difficult to predict ahead of time. However, we can discuss the length of treatment and I will attempt to give you my best estimate.

# PROFESSIONAL FEES

My fee is $160.00 per clinical hour. In addition to sessions, I charge this amount for other professional services you may need or request, though I will bill on a prorated basis to the nearest 15 minutes, after the first 15 minutes. Other services include report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulties of legal involvement, I charge $250 per hour for preparation and attendance at any legal proceeding and/or for any services related to legal issues, such as preparing reports, telephone conversation, and preparation of records or treatment summaries.

**NO SHOW AND LATE FEES**

You will not be charged for any appointments that are cancelled at least 24 hours in advance. Appointments not cancelled 24 hours in advance are subject to a $160 “Late Cancel” charge, regardless of the reason for the cancellation.

# BILLING AND PAYMENTS

You are expected to pay your portion of each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, I may charge an interest rate of up to 2% per month, at the beginning of each month, on the remaining balance. I also have the option of using legal means to secure the overdue payment. This may involve hiring a collection agency or going through small claims court, which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient’s treatment is his/her name, the nature of services provided, and the amount due. If such collection and/or legal action is necessary, you will be responsible for the full amount of these costs and these costs will be included in the claim.

# INSURANCE REIMBURSEMENT

I DO NOT ACCEPT ANY INSURANCE PLANS AT THIS TIME. If you do wish to use insurance reimbursement, you can contact your insurance company to receive referrals to providers that are covered by your insurance policy.

# CONTACTING ME

RESCHEDULING OR OTHER REGULAR CONTACTS

Due to the nature of my work and my schedule, I am often not immediately available by telephone. Even when I am in the office, I will often not be able to answer the phone. When I am unavailable, my telephone is answered by a voicemail system, and I check those messages at least once/day on each business day. I will not get such messages later in the day on Fridays, on any weekend day, or on any holiday.

EMERGENCY CONTACTS

I will have a contact number listed on my voicemail which will be forwarded to my personal phone in case you need to reach me. This is available for use if you need to reach me. However, as a private, outpatient psychotherapist, I do not have the capacity to provide emergency intervention. I can assist you in contacting professionals who can provide emergency intervention and assessment. If you do feel that you have any type of mental health emergency, you should immediately call 911 and ask for emergency intervention or proceed to any local emergency room. In addition, you may call the emergency contact number on my voice mail message to ask for my assistance in offering support in an emergent situation.

COVERAGE DURING MY ABSENCE

If I will be unavailable for an extended time, I will leave contact information for a colleague who will be covering for me during my absence.

OTHER COMMUNICATION POLICIES

I do not advise communicating with me by email or text, as email and text have been legally viewed as an unprotected and non-confidential means of communication. However, by signing this disclosure, you are agreeing that you understand email and text are not considered confidential, that it is highly recommended that you not share any confidential information by these mediums, and that you are assuming all liability for any email or text communication you may choose to engage in. I also do not conduct any psychotherapy sessions via email or over the telephone.

## LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements.

CONSENT FOR CURRENT PRACTICES THAT INCLUDE RELEASE OF INFORMATION

Your signature on this Agreement provides consent for the following releases of information:

1. I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don’t object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record.
2. You should be aware that I may, at times, utilize administrative staff. I may need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All mental health professionals are bound by the same rules of confidentiality and HIPPA regulations. Any administrative staff utilized will be given training about protecting your privacy and will have agreed not to release any information outside of the practice without appropriate release of information signatures.
3. If you pay by check or credit card, you are giving me consent to release any information necessary to complete this payment process, which may include the disclosure of your identity and the services that are being billed for. If any other defined business relationships, other than for direct billing practices, are formed, I will ask such business associates to sign a formal business associate contract in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law.

SITUATIONS WHICH REQUIRE ME TO RELEASE INFORMATION WITHOUT YOUR CONSENT

There are some situations where I am permitted or required to disclose information without either your consent or

Authorization. Your signature on this Agreement form indicates your understanding/acceptance of these conditions:

1. If you threaten to harm yourself, I will need to disclose information without your consent. I may be obligated to seek hospitalization for you and/or contact family members or others, include law enforcement professionals, who can help provide protection for you.
2. If you file a complaint/lawsuit against me, I will disclose information without your consent in order to defend myself.
3. If I have reasonable cause to suspect that a child has been subjected to abuse or neglect or that a child is being subjected to circumstances or conditions that would reasonably result in abuse or neglect, the law requires that I file a report with the appropriate governmental agency and disclose information without your consent. Once such a report is filed, I may be required to provide additional information.
4. If I have reasonable cause to believe that an at-risk adult over 70 years of age has been or is at imminent risk of being mistreated, neglected, harmed, or exploited in any way, the law requires that I file a report with the appropriate law enforcement agency. Once such a report is filed, I may be required to provide additional information
5. If you communicate a serious threat of imminent physical violence against a specific person or persons, I will need to disclose personal information without your consent. I will disclose this information for the purposes of making an effort to notify said person for their protection, including possibly notifying law enforcement personnel, as well as taking any other appropriate action necessary for the safety of all individuals involved, including possibly seeking your hospitalization.
6. If you are involved in a court proceeding and I receive a court order for your records, I will need to disclose information without your consent. I will attempt to work with the court to minimize the amount of information I am required to disclose, and I will attempt to work with you to have you sign a release of information approving this disclosure of information. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information and be aware I would have to disclose that information.
7. If you report any information to me that indicates a potential threat to national security, I am required to report this to enforcement authorities.
8. If a government agency is requesting information for health oversight activities, I am required to provide it for them, and will need to disclose information without your consent.
9. If a patient files a worker’s compensation claim, I am required to submit a report to the Workers’ Compensation Division and will need to disclose information without your consent.

If any such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future.

## PROFESSIONAL RECORDS

You should be aware that your records will have two distinct parts: The Clinical Record and Psychotherapy Notes.

THE CLINICAL RECORD

This may include such things as your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been released to anyone else. If you request a copy of your records, I may provide a summary of treatment in lieu of specific documents, depending on the circumstances and nature of the request. If necessary and clinically indicated, copies of the actual record can be provided if you request this in writing. You are also hereby notified that Colorado state law requires me to notify you that your clinical record is only required to be maintained for seven years and may be destroyed after that time period.

PSYCHOTHERAPY NOTES

This may include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. These notes cannot be sent to anyone else, and although I am not required to release them to you, I will usually be glad to consider doing this unless I feel it will negatively impact therapeutic progress.

**PATIENT RIGHTS**

You have the right:

1. To decide not to receive psychotherapy from me. If you wish, I can provide you with the names and phone numbers of other qualified mental health professionals.
2. To end therapy at any time without any moral or legal obligations or without incurring any further financial obligations.
3. To ask questions about the procedures used during therapy, the approximate duration of therapy (if it can be determined) and the fee structure and policies I use.
4. To prevent the use of certain therapeutic techniques. I shall inform you if I intend to use any unusual procedures and shall describe any risks involved.
5. To request that I amend your record, that I restrict what information is disclosed from your Clinical Record to others, that an accounting of such disclosure occur, that any complains you make about my policies and procedures are recorded in your record, and to request a copy of this Agreement and the attached Notice form.
6. To prevent electronic recording of any part of the therapy session; permission to record must be granted by you in writing explaining the purpose for the recording and for what time period the recording will take place. You have the right to withdraw your permission to record at any time.
7. To avoid dual relationships with your psychologist. The relationship with your psychologist should remain strictly professional. In this regard, it is unethical and illegal for a psychologist to engage in any sexual behavior with any client, at any time. If any sexual behavior occurs, a written complaint should be sent to The Colorado State Board of Psychological Examiners or a phone call can be made to that agency. The address, phone number and website for that agency are listed elsewhere in this Agreement.

## MINORS & PARENTS

Patients under 15 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child’s Clinical Records, unless I decide that such access is likely to be harmful to the child. Because privacy in psychotherapy is often crucial to successful progress, particularly with young people, it is my policy to discuss confidentiality with the parents and child at the beginning of treatment with the following plan in mind. By signing this document, parents agree to and understand that I will provide them only with general information about the progress of the child’s treatment, emergency information if their child is in any type of imminent danger, and information regarding attendance at scheduled sessions. Any other communication will require the child’s Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have. Children of divorced parents, where both parents have joint custody, will need the consent of both parties before treatment can begin.

**SHEPHERD’S GATE DISCLAIMER**

I understand that Dr. Ron Welch is the sole proprietor of her/his private counseling practice. My counselor is paid directly by me (the client) or other parties on my behalf. I understand that my counselor receives no compensation from Denver Seminary or Shepherd’s Gate Counseling Center in regards to his/her private counseling practice, nor does Denver Seminary or Shepherd’s Gate exercise any control over the manner, method, or means of therapy conducted. I understand that my counselor is permitted the use of space in Shepherd’s Gate Counseling Center to conduct counseling practice according to Denver Seminary policy. This in no way transfers liability to Denver Seminary or Shepherd’s Gate in the performance of her/his private practice, of which I am a client.

**RELIGIOUS DISCLAIMER**

You are entitled to know that I do profess belief in the Christian faith and that I do offer the option of integrating this faith into the services I provide at your discretion. I will not force my belief system on you in any way, and you are completely free to include or exclude religious issues from your treatment as you so choose. However, it is important that you know that my faith is a part of who I am as a person and a therapist. Please feel free to directly address any concerns you have about this issue with me at any time.

**PUBLICATION DISCLAIMER**

You are entitled to know that I do write professionally and that I use clinical examples in the books and articles I write. However, I am 100% committed to the professional and ethical policies outlined earlier in this document regarding the confidentiality of your clinical information. Therefore, any writing that I publish will have all names changed, identifying information changed, and any content that could in any way lead to any individual, including any client, identifying themselves, changed. In short, although clinical examples will be used in my published writing, these examples will be so extensively changed as to make it impossible for anyone, including the clients themselves, to recognize themselves in the examples.

However, by signing this disclosure, you are agreeing that you have been notified of the above information and give your consent to treatment with this knowledge.

**COLORADO NOTICE FORM**

**Notice of Psychologists’ Policies and Practices to Protect the Privacy of Your Health Information**

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

**I. Uses and Disclosures for Treatment, Payment, and Health Care Operations**

I may *use* or *disclose* your *protected health information* (*PHI*) for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

* “*PHI*” refers to information in your health record that could identify you.
* “*Treatment, Payment and Health Care Operations*”

– *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.

– *Payment* is when I 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* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

* “*Use*” applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
* “*Disclosure*” applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

**II. 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. An “*authorization*” is written permission above and beyond the general consent that permits only specific disclosures. 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 conversations during a private, group, joint, or family counseling session, which I have kept in a separate section of your chart and are not part of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) 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 (already released the information according to the 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.

**III. Uses and Disclosures with Neither Consent nor Authorization**

I may use or disclose PHI without your consent or authorization in the following circumstances:

* *Child Abuse* – If I have reasonable cause to know or suspect that a child has been subjected to abuse or neglect, I must immediately report this to the appropriate authorities.
* *Adult and Domestic Abuse* – If I have reasonable cause to believe that an at-risk adult has been mistreated, self-neglected, or financially exploited and is at imminent risk of mistreatment, self-neglect, or financial exploitation, then I must report this belief to the appropriate authorities.
* *Health Oversight* *Activities* – If the Colorado State Board of Psychologist Examiners 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 and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will only release information with a Court Order or your written authorization. The privileged does not apply when you are being evaluated for a third party or where the evaluation is court ordered. 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, I have a duty to notify any person or persons specifically threatened, as well as a duty to notify an appropriate law enforcement agency or 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.
* *Worker’s Compensation* – I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker’s compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

**IV. Patient’s Rights and Psychologist’s Duties**

Patient’s Rights:

* *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information regarding you. However, 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.

Psychologist’s Duties:

* 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 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 notify you by mail and post the revision on my website.

**V. Complaints**

Because I have such a small office, I would be the first person to speak with if you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records. If you would like an outside professional to review my decisions, I can provide a name of a person who would be willing to review your concerns.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I, or the person who is reviewing your concerns, can provide you with the appropriate address upon request.

**VI. Effective Date, Restrictions, and Changes to Privacy Policy**

This notice will go into effect on January 1, 2018.

I reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail and post it on my website if it changes.

***Ronald D. Welch, Psy.D. PATIENT COPY (PAGES 17 – 29)***

Licensed Clinical Psychologist

Transformational Marriage, PLLC

dba Transformational Marriage Counseling

Mailing Address: 6732 W. Coal Mine Avenue, #186

Littleton, CO 80123

(303) 762-6952

**Transformational Marriage, PLLCCONSENT FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION BY UNSECURE TRANSMISSIONS**

**This consent form is for the communication of Protect Health Information (“PHI”) that Transformational Marriage, PLLC and Dr. Ron Welch (hereafter referred to as TM) may transmit without the written authorization of the client as described in the original Psychologist-Patient Services Agreement.**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby consent and authorize TM to communicate my PHI through the following unsecured transmission means:

Cellular/Mobile Phone, including voicemail (other phone numbers may be provided by client)

Primary cell phone number to use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email sent and received (other emails may be provided by client)

Primary email to use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telemental health platforms (Doxy.me, Zoom, or other approved platforms)

Primary location clients will log in from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing this document, I understand that TM will make good faith efforts to protect my PHI and use HIPPA compliant platforms if available. I acknowledge that TM cannot guarantee that those communications will remain confidential.

Even though TM may utilize state of the art encryption methods, firewalls, and/or back-up systems to help secure our communication, there is a risk that the electronic or telephone communications may be compromised, unsecured, and/or accessed by an unintended third-party. There is never a 100% guarantee information will remain confidential when transmitted electronically.

I also understand that TM may use and disclose the following PHI without my written authorization:

Information related to scheduling/appointments

Information related to billing and payments

Information related to your mental health treatment (this may contain personal materials, forms, suggested articles, homework, etc.)

Information related to TM’s operations

I further understand that if I initiate communication via electronic means that I have not specifically consented to in this form, I will need to amend this consent form so that my therapist may communicate with me via that method.

Lastly, I affirm that I have read the attached policies on page 2 of this document regarding professional and ethical use of telemental health services and agree to abide by those policies.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Spouse DATE

Transformational Marriage Policy

On Telemental Health Services

INTRODUCTION

1. When possible, Transformational Marriage recommends in-person, direct client services.
2. However, when in-person, direct client services are not able to be provided due to illness, weather, or other unavoidable circumstance, phone counseling or video conferencing services may be provided in a HIPPA compliant manner.
3. All therapists engaging in telemental health services will be trained in both the APA ethical standards and the Colorado State Psychologist policies.

TELEMENTAL HEALTH POLICIES

1. Telemental health services need to be delivered in the state where the patient is located by a therapist located in the same state and not delivered across state lines.
2. Telemental health services are considered a normal standard of practice in the mental health field and when deemed necessary by the mental health professional do qualify for malpractice insurance coverage.
3. Therapists will ensure that the standard of care delivered by telemental health services is equivalent to in-person direct service care.
4. Therapists will bill the same rate for telemental health services as is billed for in-person, direct services.
5. Clients should be aware that the best practices possible will be utilized to assure confidentiality, but that complete confidentiality is impossible to assure in telemental health situations and they will document client agreement in the clinical record. When possible, written consent will also be collected.
6. Therapists will document the identity and location of all clients utilizing telemental health services in the clinical record.
7. Clients should find a location for the session in which other individuals are not present and distractions are minimized to ensure high quality clinical services.
8. Therapists will assure that regardless of the communication modality used, they are located in an isolated, protected environment where confidentiality is assured and communication cannot be overheard by others.
9. Therapists and clients will never conduct telemental health services while driving or engaged in any similar activity. Doing so would create a dangerous, distracting experience while driving, as well as decrease their ability to be present and focus clearly on the client’s services.
10. Therapists will follow the same emergency practices, reporting practices, and other standards that apply to in-person, direct services.
11. Therapists should be aware that the social and non-verbal cues that usually exist in in-person direct services are not available in telemental health services. Therefore, they should make every effort to assess affect, client mental status, and symptom analysis through asking additional questions and verifying data whereever possible.
12. Therapists and clients should only use technology that is verified to be in good working condition and with reception that allows clear and accurate interactions.
13. If any situations arise for either party in their specific location that interfere significantly with clinical integrity of the session, the therapist should consider rescheduling the session.

## PSYCHOLOGIST- PATIENT SERVICES AGREEMENT

This document (AKA “the Agreement”) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (AKA “the Notice”) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Your signature on this form will indicate that you have received the Notice, that you have read it, that you understand it and that you agree to it. When you sign this document, it will also represent an agreement between us. However, you may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. Although these documents are long and sometimes complex, it is very important that you read them carefully before you sign them. We can discuss any questions you have about the procedures before you sign them and you can discuss them with your attorney.

**General Information**

1. Name and Contact Information:

Ronald D. Welch, Psy.D., Licensed Clinical Psychologist, Transformational Marriage, PLLC, dba Transformational Marriage Counseling, Mailing Address: 6732 W. Coal Mine Avenue, #186, Littleton, CO 80123 (303) 762-6952

# I am a licensed psychologist in the state of Colorado and have a Psy.D. degree in Clinical Psychology. The required education, experience, and training required for this license may be found on the website of the Department of Regulatory Agencies, State of Colorado, Psychologist Examiners Board (<http://www.dora.state.co.us/mental-health/psy/index.htm>). In brief, this license required a doctoral degree in psychology or its equivalent, 1500 hours of post-degree supervised experience, passage of the national psychologist Standard Examination, the EPPP, and passage of the state Jurisprudence Examination

# The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The Board of Psychologist Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. As to the regulatory requirements applicable to mental health professionals: a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a Master’s degree in their profession and have two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a Master’s degree 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 Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1,000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a Bachelor’s degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical Master’s degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required.

# You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy, if known, and the fee structure. Please ask if you would like this information.

# You can seek a second opinion from another therapist or terminate therapy at any time.

# In a professional relationship (such as this one), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

# Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client’s consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes and the Notice of Privacy Rights you were provided, as well as other exceptions in Colorado and Federal law. These exceptions to confidentiality include: 1) I am required to report any suspected incident of child or elder abuse or neglect to enforcement authorities; 2) I am required to report any threat of imminent physical harm by a client to enforcement authorities and to the person(s) threatened; 3) I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental disorder; 4) I am required to report any suspected threat to national security to federal officials; and 5) I may be required by a Court Order to disclose treatment information. If a legal exception arises during therapy, if feasible, you will be informed accordingly.

1. Under Colorado law, C.R.S. 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children under 15, unless the court has restricted access to such information. If you request treatment information from me, I may provide you with a treatment summary, in compliance with Colorado law and HIPAA Standards.
2. If you are involved in divorce or custody litigation, my role as a therapist is not to make recommendations to the court concerning custody or parenting issues. By signing this Disclosure Statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that I write any reports to the court or to your attorney, making recommendations concerning custody. The court can appoint professionals, who have no prior relationship with family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interests of the family’s children.

# PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on issues we talk about both during our sessions and outside our sessions. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings such as fear, sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. The benefits from psychotherapy may be that you will be better able to function in your roles at work and/or at school, and that you may be better able to cope with or handle your family and/or other social relationships, thus experiencing more satisfaction from these relationships. Through psychotherapy you may also come to better understand your personal goals and values, which may lead you to greater maturity and growth as a person. But there are no guarantees of what you will experience.

You are entitled to know that I received my doctorate in clinical psychology, known as a Psy.D., in 1995 from Central Michigan University. I have been licensed in the State of Colorado as a Psychologist (license #2072) since 2003. You should understand that I am NOT a psychiatrist or other medical physician, and, therefore, I cannot prescribe medication, give medical advice, nor perform any medical procedures. If I determine that medical treatment is indicated, I can recommend a physician for you or I can consult with any physician you may wish or chose to see.

The practice of Psychologists is regulated by the Colorado Department of Regulatory Agencies. The agency within the Department that has specific responsibility for Psychologists is the Colorado State Board of Psychologist Examiners. The address by which this regulatory body can be reached is: The Colorado State Board of Psychologist Examiners, 1560 Broadway, Suite #1350, Denver, CO, 80202. The phone number for the Psychologist Examiners Board is (303) 894-7766 and their website is http://www.dora.state.co.us/mentalhealth.

# MEETINGS

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and determine a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion. If you chose to begin psychotherapy, we will usually schedule a 50-minute session at a time we both agree on. Typically, my “clinical hour” is 50-minutes long. Each session is typically one clinical hour and the usual frequency is one session per week. The frequency of your sessions may vary according to your needs. The length of treatment varies widely and is often very difficult to predict ahead of time. However, we can discuss the length of treatment and I will attempt to give you my best estimate.

# PROFESSIONAL FEES

My fee is $160.00 per clinical hour. In addition to sessions, I charge this amount for other professional services you may need or request, though I will bill on a prorated basis to the nearest 15 minutes, after the first 15 minutes. Other services include report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulties of legal involvement, I charge $250 per hour for preparation and attendance at any legal proceeding and/or for any services related to legal issues, such as preparing reports, telephone conversation, and preparation of records or treatment summaries.

**NO SHOW AND LATE FEES**

You will not be charged for any appointments that are cancelled at least 24 hours in advance. Appointments not cancelled 24 hours in advance are subject to a $160 “Late Cancel” charge, regardless of the reason for the cancellation.

# BILLING AND PAYMENTS

You are expected to pay your portion of each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, I may charge an interest rate of up to 2% per month, at the beginning of each month, on the remaining balance. I also have the option of using legal means to secure the overdue payment. This may involve hiring a collection agency or going through small claims court, which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient’s treatment is his/her name, the nature of services provided, and the amount due. If such collection and/or legal action is necessary, you will be responsible for the full amount of these costs and these costs will be included in the claim.

# INSURANCE REIMBURSEMENT

I DO NOT ACCEPT ANY INSURANCE PLANS AT THIS TIME. If you do wish to use insurance reimbursement, you can contact your insurance company to receive referrals to providers that are covered by your insurance policy.

# CONTACTING ME

RESCHEDULING OR OTHER REGULAR CONTACTS

Due to the nature of my work and my schedule, I am often not immediately available by telephone. Even when I am in the office, I will often not be able to answer the phone. When I am unavailable, my telephone is answered by a voicemail system, and I check those messages at least once/day on each business day. I will not get such messages later in the day on Fridays, on any weekend day, or on any holiday.

EMERGENCY CONTACTS

I will have a contact number listed on my voicemail which will be forwarded to my personal phone in case you need to reach me. This is available for use if you need to reach me. However, as a private, outpatient psychotherapist, I do not have the capacity to provide emergency intervention. I can assist you in contacting professionals who can provide emergency intervention and assessment. If you do feel that you have any type of mental health emergency, you should immediately call 911 and ask for emergency intervention or proceed to any local emergency room. In addition, you may call the emergency contact number on my voice mail message to ask for my assistance in offering support in an emergent situation.

COVERAGE DURING MY ABSENCE

If I will be unavailable for an extended time, I will leave contact information for a colleague who will be covering for me during my absence.

OTHER COMMUNICATION POLICIES

I do not advise communicating with me by email or text, as email and text have been legally viewed as an unprotected and non-confidential means of communication. However, by signing this disclosure, you are agreeing that you understand email and text are not considered confidential, that it is highly recommended that you not share any confidential information by these mediums, and that you are assuming all liability for any email or text communication you may choose to engage in. I also do not conduct any psychotherapy sessions via email or over the telephone.

## LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements.

CONSENT FOR CURRENT PRACTICES THAT INCLUDE RELEASE OF INFORMATION

Your signature on this Agreement provides consent for the following releases of information:

1. I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don’t object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record.
2. You should be aware that I may, at times, utilize administrative staff. I may need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All mental health professionals are bound by the same rules of confidentiality and HIPPA regulations. Any administrative staff utilized will be given training about protecting your privacy and will have agreed not to release any information outside of the practice without appropriate release of information signatures.
3. If you pay by check or credit card, you are giving me consent to release any information necessary to complete this payment process, which may include the disclosure of your identity and the services that are being billed for. If any other defined business relationships, other than for direct billing practices, are formed, I will ask such business associates to sign a formal business associate contract in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law.

SITUATIONS WHICH REQUIRE ME TO RELEASE INFORMATION WITHOUT YOUR CONSENT

There are some situations where I am permitted or required to disclose information without either your consent or

Authorization. Your signature on this Agreement form indicates your understanding/acceptance of these conditions:

1. If you threaten to harm yourself, I will need to disclose information without your consent. I may be obligated to seek hospitalization for you and/or contact family members or others, include law enforcement professionals, who can help provide protection for you.
2. If you file a complaint/lawsuit against me, I will disclose information without your consent in order to defend myself.
3. If I have reasonable cause to suspect that a child has been subjected to abuse or neglect or that a child is being subjected to circumstances or conditions that would reasonably result in abuse or neglect, the law requires that I file a report with the appropriate governmental agency and disclose information without your consent. Once such a report is filed, I may be required to provide additional information.
4. If I have reasonable cause to believe that an at-risk adult over 70 years of age has been or is at imminent risk of being mistreated, neglected, harmed, or exploited in any way, the law requires that I file a report with the appropriate law enforcement agency. Once such a report is filed, I may be required to provide additional information
5. If you communicate a serious threat of imminent physical violence against a specific person or persons, I will need to disclose personal information without your consent. I will disclose this information for the purposes of making an effort to notify said person for their protection, including possibly notifying law enforcement personnel, as well as taking any other appropriate action necessary for the safety of all individuals involved, including possibly seeking your hospitalization.
6. If you are involved in a court proceeding and I receive a court order for your records, I will need to disclose information without your consent. I will attempt to work with the court to minimize the amount of information I am required to disclose, and I will attempt to work with you to have you sign a release of information approving this disclosure of information. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information and be aware I would have to disclose that information.
7. If you report any information to me that indicates a potential threat to national security, I am required to report this to enforcement authorities.
8. If a government agency is requesting information for health oversight activities, I am required to provide it for them, and will need to disclose information without your consent.
9. If a patient files a worker’s compensation claim, I am required to submit a report to the Workers’ Compensation Division and will need to disclose information without your consent.

If any such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future.

## PROFESSIONAL RECORDS

You should be aware that your records will have two distinct parts: The Clinical Record and Psychotherapy Notes.

THE CLINICAL RECORD

This may include such things as your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been released to anyone else. If you request a copy of your records, I may provide a summary of treatment in lieu of specific documents, depending on the circumstances and nature of the request. If necessary and clinically indicated, copies of the actual record can be provided if you request this in writing. You are also hereby notified that Colorado state law requires me to notify you that your clinical record is only required to be maintained for seven years and may be destroyed after that time period.

PSYCHOTHERAPY NOTES

This may include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. These notes cannot be sent to anyone else, and although I am not required to release them to you, I will usually be glad to consider doing this unless I feel it will negatively impact therapeutic progress.

**PATIENT RIGHTS**

You have the right:

1. To decide not to receive psychotherapy from me. If you wish, I can provide you with the names and phone numbers of other qualified mental health professionals.
2. To end therapy at any time without any moral or legal obligations or without incurring any further financial obligations.
3. To ask questions about the procedures used during therapy, the approximate duration of therapy (if it can be determined) and the fee structure and policies I use.
4. To prevent the use of certain therapeutic techniques. I shall inform you if I intend to use any unusual procedures and shall describe any risks involved.
5. To request that I amend your record, that I restrict what information is disclosed from your Clinical Record to others, that an accounting of such disclosure occur, that any complains you make about my policies and procedures are recorded in your record, and to request a copy of this Agreement and the attached Notice form.
6. To prevent electronic recording of any part of the therapy session; permission to record must be granted by you in writing explaining the purpose for the recording and for what time period the recording will take place. You have the right to withdraw your permission to record at any time.
7. To avoid dual relationships with your psychologist. The relationship with your psychologist should remain strictly professional. In this regard, it is unethical and illegal for a psychologist to engage in any sexual behavior with any client, at any time. If any sexual behavior occurs, a written complaint should be sent to The Colorado State Board of Psychological Examiners or a phone call can be made to that agency. The address, phone number and website for that agency are listed elsewhere in this Agreement.

## MINORS & PARENTS

Patients under 15 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child’s Clinical Records, unless I decide that such access is likely to be harmful to the child. Because privacy in psychotherapy is often crucial to successful progress, particularly with young people, it is my policy to discuss confidentiality with the parents and child at the beginning of treatment with the following plan in mind. By signing this document, parents agree to and understand that I will provide them only with general information about the progress of the child’s treatment, emergency information if their child is in any type of imminent danger, and information regarding attendance at scheduled sessions. Any other communication will require the child’s Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have. Children of divorced parents, where both parents have joint custody, will need the consent of both parties before treatment can begin.

**SHEPHERD’S GATE DISCLAIMER**

I understand that Dr. Ron Welch is the sole proprietor of her/his private counseling practice. My counselor is paid directly by me (the client) or other parties on my behalf. I understand that my counselor receives no compensation from Denver Seminary or Shepherd’s Gate Counseling Center in regards to his/her private counseling practice, nor does Denver Seminary or Shepherd’s Gate exercise any control over the manner, method, or means of therapy conducted. I understand that my counselor is permitted the use of space in Shepherd’s Gate Counseling Center to conduct counseling practice according to Denver Seminary policy. This in no way transfers liability to Denver Seminary or Shepherd’s Gate in the performance of her/his private practice, of which I am a client.

**RELIGIOUS DISCLAIMER**

You are entitled to know that I do profess belief in the Christian faith and that I do offer the option of integrating this faith into the services I provide at your discretion. I will not force my belief system on you in any way, and you are completely free to include or exclude religious issues from your treatment as you so choose. However, it is important that you know that my faith is a part of who I am as a person and a therapist. Please feel free to directly address any concerns you have about this issue with me at any time.

**PUBLICATION DISCLAIMER**

You are entitled to know that I do write professionally and that I use clinical examples in the books and articles I write. However, I am 100% committed to the professional and ethical policies outlined earlier in this document regarding the confidentiality of your clinical information. Therefore, any writing that I publish will have all names changed, identifying information changed, and any content that could in any way lead to any individual, including any client, identifying themselves, changed. In short, although clinical examples will be used in my published writing, these examples will be so extensively changed as to make it impossible for anyone, including the clients themselves, to recognize themselves in the examples.

However, by signing this disclosure, you are agreeing that you have been notified of the above information and give your consent to treatment with this knowledge.

**COLORADO NOTICE FORM**

**Notice of Psychologists’ Policies and Practices to Protect the Privacy of Your Health Information**

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

**I. Uses and Disclosures for Treatment, Payment, and Health Care Operations**

I may *use* or *disclose* your *protected health information* (*PHI*) for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

* “*PHI*” refers to information in your health record that could identify you.
* “*Treatment, Payment and Health Care Operations*”

– *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.

– *Payment* is when I 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* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

* “*Use*” applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
* “*Disclosure*” applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

**II. 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. An “*authorization*” is written permission above and beyond the general consent that permits only specific disclosures. 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 conversations during a private, group, joint, or family counseling session, which I have kept in a separate section of your chart and are not part of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) 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 (already released the information according to the 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.

**III. Uses and Disclosures with Neither Consent nor Authorization**

I may use or disclose PHI without your consent or authorization in the following circumstances:

* *Child Abuse* – If I have reasonable cause to know or suspect that a child has been subjected to abuse or neglect, I must immediately report this to the appropriate authorities.
* *Adult and Domestic Abuse* – If I have reasonable cause to believe that an at-risk adult has been mistreated, self-neglected, or financially exploited and is at imminent risk of mistreatment, self-neglect, or financial exploitation, then I must report this belief to the appropriate authorities.
* *Health Oversight* *Activities* – If the Colorado State Board of Psychologist Examiners 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 and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will only release information with a Court Order or your written authorization. The privileged does not apply when you are being evaluated for a third party or where the evaluation is court ordered. 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, I have a duty to notify any person or persons specifically threatened, as well as a duty to notify an appropriate law enforcement agency or 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.
* *Worker’s Compensation* – I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker’s compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

**IV. Patient’s Rights and Psychologist’s Duties**

Patient’s Rights:

* *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information regarding you. However, 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.

Psychologist’s Duties:

* 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 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 notify you by mail and post the revision on my website.

**V. Complaints**

Because I have such a small office, I would be the first person to speak with if you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records. If you would like an outside professional to review my decisions, I can provide a name of a person who would be willing to review your concerns.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I, or the person who is reviewing your concerns, can provide you with the appropriate address upon request.

**VI. Effective Date, Restrictions, and Changes to Privacy Policy**

This notice will go into effect on January 1, 2018.

I reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail and post it on my website if it changes.

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