THE MARIPOSA CENTER LLC

FOR INFANT, CHILD & FAMILY ENRICHMENT

Biographical Information – Adult

Instructions: Please fill out this form as fully and openly as possible. All information is held in strictest confidence within legal limits. If certain questions do not apply, leave them blank.

Today's Date:___________________________Client's Name: ____________________________________

Personal History

1. Have you previously been involved in therapy/counseling?_____Y _____N
   If yes, please describe what worked, what didn't: ____
____

2. Why are you coming to therapy? ____
____

3. How long has this issue be going on ?____
____

4. Under what conditions does the issue/problem get worse?____
____

5. Under what conditions does the issue/problem get better?____
____

Family History

6. Place of your birth:____________________

7. Adopted?_____________________________ 8. Foster homes?__________________________________

9. Siblings – brothers:____________________ sisters:___________________ birth order:_____________

10. Parents: _____married _____divorced - when?____

Emily McNeil, LPC, R-DMT, EMDR-I Jennifer Platt, LPC, R-DMT, EMDR-I Debbie Carter, NCC, LPCC Eli Moch, LPC, ATR, EMDR-II
2680 18th St. Suite 150A Denver, CO 80211 Phone: 720-288-5090 Fax: 303-477-9223 www.MariposaCenterDenver.com

11. What is/was their relationship like?____

12. Parent – _____living _____deceased 13. Age, current or at death:_____

14. Your age at this Parent's death or when you left home?_____

15. How did this Parent relate to you as a child?____

16. How does this Parent relate to you now?____

17. Other Parent – _____living _____deceased 18. Age, current or at death:_____

19. Your age at this Parent's death or when you left home?_____

20. How did this Parent relate to you as a child?____

21. How does this Parent relate to you now?____

22. How much contact do you have with your family of origin and how satisfying is it?___________________
____

23. Briefly describe any problems in your mother's pregnancy and/or your birth:_________________________
____
____

24. List any drugs used by your parents at your conception, and mother at time of pregnancy:
____

25. Please describe any physical, emotional, or sexual abuse you may have experienced as a child:
____
____

26. Please describe any physical, emotional, or sexual abuse you may have experienced as an adult: _________
____
____

27. What is your current relationship status? _____ married _____long-term partnership
_____ divorced _____ separated _____widow/widower _____single

28. How many times married/partnered?_____ 29. How many significant relationships?_____

30. Describe what has worked in your relationships:____
____

31. Describe what has been difficult in relationships:____
____

32. Children: Name_______________ Age_____ Sex _____ Live with you?_____ Bio/Adopted____
(old to young) Name_______________ Age_____ Sex _____ Live with you?_____ Bio/Adopted____
Name_______________ Age_____ Sex _____ Live with you?_____ Bio/Adopted____
Name_______________ Age_____ Sex _____ Live with you?_____ Bio/Adopted____

33. How have you related to them in the past?____

34. How do you relate to them now?____

35. Please describe each child's birth or adoption story: __________________________________
____
____
____

36. Were your children's arrivals in your life planned or unplanned? Please specify:___________
____

37. How did you feel when each child joined your family? Please specify child's initials/name: _____happy _____sad _____angry _____confused _____surprised _____rejecting _____accepting _____bonded _____unbonded

38. How do you feel about each child now? Please specify child's initials/name: _____happy _____sad _____angry _____confused _____surprised _____rejecting _____accepting _____bonded _____unbonded

39. Briefly describe the style of parenting used in the household:___________________________
____
____

40. List biggest challenges as a parent:____

41. List biggest joys as a parent:____

42. Do any family members have a history of physical or mental illness, including substance abuse?
Who?____
What illness(es)?____

43. What is your current spiritual path?____

4. Who are most important people in your life now?_____________________________________

Medical History

45. Primary Care Physician's Name:____

46. Physician's contact information:
Address:____________ City:____________ State:____________ Zip Code:__________
Phone:______________

47. Most recent physical exam date:__________ 60. Results:______________________________

48. Names of other significant health professionals:_____________________________________
____

49. List any major illnesses and/or operations:____
____

50. List any physical concerns occurring at present: (e.g., high blood pressure, headaches)_________________
____

51. List any physical concerns in past: (e.g., head injury, seizures)_____________________________________
____

52. List any emotional concerns occurring at present: (e.g., crying, fearful) ______________________________
____

53. List any emotional concerns in past: (e.g., angry, timid)____
____

54. Do you have a history of psychiatric hospitalizations? _____N _____Y
If yes, where and when?____

55. Do you have a history of suicidality/homicidality or self-harming behaviors? _____N_____Y
If yes, please describe:____

56. On average, how many hours do you sleep daily?____

57. Do you have trouble falling asleep at night? _____N _____Y
If yes, how long has this been a problem?____

58. Do you have any nightmares or significant dreams? _____N _____Y
If yes, please describe:____

59. Describe your current appetite: _____Poor _____Average _____Large
Is this atypical? _____N _____Y

60. How many meals/snacks do you eat per day?____

61. Does your family eat together?____

62. What medications, vitamins, and herbs (and dosages) are you taking at present, and for what purposes?
____
____
____
____
____

63. Do you have a history of substance abuse? _____Y _____N
If yes, describe behaviors, substances, degree of impact on life, coping tools:_______________________
____
____

Emotional and Behavioral History

64. What are you happy/satisfied about in your life?____
____
____
____

65. What do you really want to change in your life?____
____
____
____

66. List your three greatest strengths:
1.____
2.____
3.____

67. List your three greatest challenges or areas in need of improvement:
1.____
2.____
3.____

68. What do you like?____
Hobbies/interests?____

69. What do you dislike?____

70. Are you prone to periods of strong anxiety or panic attacks? If yes, describe:_________________________
____
____
____

71. Have you experienced severe mood swings or extended depressions? If yes, describe:__________________
____
____
____

72. Do you have problems paying attention, staying with boring tasks? If yes, describe:____________________
____
____
____

73. Do you or your friends/family consider you to have an anger problem? If yes, describe:_________________
____
____
____

74. Describe how you express the following emotions/behaviors. What does your body do?
Anger:____
Happiness:____
Sadness:____
Anxiety:____

75. How do you seek attention?____
____
____

76. How do you take care of yourself?____
____
____

77. How much and what kind of physical activity/movement do you practice?___________________________
____
____
____

78. Is there anything else you would like to share?____
____
____
____

Client Signature:____

Therapist Signature:____

Please remember to return this form to The Mariposa Center when complete. Thank you!

THE MARIPOSA CENTER LLC
FOR INFANT, CHILD & FAMILY ENRICHMENT

Informed Consent for Treatment

The State of Colorado Department of Regulatory Agencies requires that all psychotherapists inform you, the client, of the following information:

1. About the Psychotherapists:

A. Contact Information:
Emily McNeil, LPC, R-DMT, EMDR-1 cert.
2680 18th St., Suite 150A
Denver, CO 80211
(303) 817-0730; ewmcneil@hotmail.com
B. Degrees:
MA in Somatic Psychology with a Concentration in Dance/Movement Therapy;
Naropa University, 2005
BA in Psychology, BA in Dance, magna cum laude; Bryn Mawr College, 2001
C. Credentials and Professional Organization Memberships:
Licensed Professional Counselor, #5265, State of Colorado
Registered Dance/Movement Therapist, #2005-DTR-1444, American Dance Therapy Association
EMDR Certified
Member of the American Dance Therapy Association
Member of the Colorado Association of Infant Mental Health

D. Contact Information:
Jennifer Platt, LPC, R-DMT, EMDR-1 cert.
2680 18th St., Suite 150A
Denver, CO 80211
(303) 618-3095; jennplatt2@gmail.com
E. Degrees:
MA in Somatic Psychology with a Concentration in Dance/Movement Therapy;
Naropa University, 2005
BFA in Contemporary Dance, North Carolina School of the Arts, 1998
F. Credentials and Professional Organization Memberships:
Licensed Professional Counselor, #6468, State of Colorado
Registered Dance/Movement Therapist, #2009-DTR-1422, American Dance Therapy Association
EMDR Certified
Member of the American Dance Therapy Association
Member of the American Psychological Association

G. Contact Information:
Debbie Carter, NCC, LPCC
2680 18th St., Suite 150A
Denver, CO 80211
(720) 935-2440; dcartercounseling@comcast.net
H. Degrees:
MA in Counseling Psychology with a concentration in Couple and Family Therapy from the University of Colorado, Denver: 2012
MS in Family Life from Concordia University, 2005
BS in Elementary Education, major concentration in Early Childhood Education from Concordia Teachers, College, 1977
I. Credentials and Professional Organization Memberships:
National Certified Counselor # 291787
State of Colorado Licensed Professional Counselor Candidate # 0014468
Member of the American Counseling Association
Member of the Colorado Counseling Association
Member of the National Association of Play Therapy
Member of the Colorado Association of Play Therapy

J. Contact Information:
Eli Moch, LPC, ATR, EMDR-II
2680 18th Street, Suite 150A
Denver, CO 80211
(303)547-6254 elishevamoch@gmail.com
K. Degrees:
MA in Transpersonal Counseling Psychology with a Concentration in Art Therapy from Naropa University: 2004
BA in Art History with a minor in Fine Arts
L. Credentials:
Licensed Professional Counselor # 4682 State of Colorado
Registered Art Therapist #07-268
EMDR-II
Bilingual - Spanish

2. Regulation of the Practice of Psychotherapy:

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, certified school psychologists, and unlicensed individuals who practice psychotherapy.

The agency within the Department that has responsibility specifically for licensed and unlicensed psychotherapists is the:

Department of Regulatory Agencies
Mental Health Section
1560 Broadway, Suite 1350
Denver, CO 80202
(303) 894-7766

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 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 masters 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 1000 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 reregistered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required.

3. Client Rights, Policies, and Important Information:

a. You are entitled to receive information about the methods of psychotherapy, the techniques used, the duration of the therapy (if known), and the fee structure. Please ask at any time.

b. You may seek a second opinion from another therapist or terminate therapy at any time.

c. In a professional relationship, sexual intimacy in never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder. If sexual intimacy occurs, it should be reported to the Department of Regulatory Agencies, Mental Health Section at (303) 894-7766.

d. Generally speaking, the information provided by and to a client during therapy is legally confidential if the therapist is a licensed psychologist, licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, certified school psychologist, registered psychotherapist, or master's level counseling intern. If the information is legally confidential, the therapist cannot be forced to disclose information without the client's consent.

   When working with a minor, a summary of the child's progress will be provided to the parent(s) or guardian(s) upon request, but information provided during therapy by the minor is also protected by law.

   Information disclosed during therapy to one of the professionals listed above is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

   The following are exceptions to the legal rule of confidentiality:

   i. You sign a release of information form giving permission for the therapist to provide specified information about your treatment to a particular individual or agency.
   ii. The therapist suspects or has proof of child abuse and/or neglect
   iii. The therapist suspects or has proof of abuse and/or neglect of elderly or disabled individuals.
   iv. You are in imminent danger of harming yourself and/or others.

v. Therapist testimony is subpoenaed in criminal court cases and orders to violate privilege by judges in child-custody, divorce, and other court cases.
vi. You file a suit against the therapist.
vii. The therapist is being reviewed by the Mental Health Section of the Division of Registrations.
viii. There are exceptions to this confidentiality, some of which are listed in the Notice of Privacy Rights you were provided.

e. The therapists at The Mariposa Center work with a medical biller. In accordance with HIPAA, for billing purposes only pertinent information is disclosed to the biller, including name, demographic and contact information, diagnoses, social security number, and any similar information required by your insurance company or reimbursement program. If you have any questions about the medical billing process, please do not hesitate to contact:
Jessica Dennis
Colorado Medical Billing, LLC
5738 Olde Wadsworth Blvd.
Arvada, CO 80002
PH: (720) 898-8711
F: (720) 897-2833
comedbill@gmail.com

f. The therapists at The Mariposa Center will from time to time consult with each other about best practices for their clients, and may also provide in person consultation for the client on an as-needed basis.

g. In therapy where a family is the "client," the therapist holds a "no secrets" policy. All members of the family are treated equally and secrets are not kept that require differential or discriminatory treatment of family members.

h. The therapists provide non-emergency psychotherapeutic services by scheduled appointment. If one of the therapists believes your psychotherapeutic issues are above her level of competence or outside of her scope of practice, the therapist is legally required to refer, terminate, or consult. If, for any reason, you are unable to contact your therapist by telephone, and you are having a physical or mental health emergency, please dial 911 or go to your nearest emergency room.

i. It is very important to be aware that e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. E-mails and texts, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can easily be sent erroneously to the wrong address. Please notify your therapist at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Please do not use e-mail or faxes for emergencies. Please note that the business numbers for all of the therapists are cell phone numbers.

j. If you have questions or would like more information, please ask at any time.

<u>I have read the preceding information and it has also been provided verbally. I understand my rights as a client or parent of a client. By signing below I acknowledge my understanding and agree to all the terms discussed in</u>

this disclosure statement. I also affirm, by signing this form, that I am the legal guardian and/or custodial parent with legal right to consent to treatment for any minor child or children for whom I am requesting psychotherapy services.

Client('s) Name(s):____

Client or Parent/Guardian Signature:____ Date:________

____ Date:________

Therapist Signature:____ Date:________

Release of Information

Client Name:_____________________________________ D.O.B.:_________________________________

Release to/from (circle one or both):

Name:____

Address:____

Phone:____

Dates of Relevant Care: From:________________ To:________________

I, _______________________________(client name), hereby authorize and consent to the release of information to/from (circle one or both) the therapists of The Mariposa Center and the person/agency listed above.

I authorize the following information to be released and exchanged to/from (circle one or both):

Assessment and Treatment Plan _____ Session Progress Notes _____
Session Progress Summary _____ Termination Summary _____
Demographic/Historical Information_____

Such disclosure of information is for the purpose of establishing and coordinating effective treatment. Specifically, the information will be used/disclosed for the following purposes:

Assessment _____ Service Planning _____
Coordination/Continuation of Care _____ Referral_____
Benefits Coordination/Acquisition _____ Disability Determination _____
Payment of Insurance Claims _____ Legal Purposes_____
Other:____

I hereby relieve and release Emily McNeil, LPC, R-DMT, EMDR-I, Jennifer Platt, LPC, R-DMT, EMDR-I Debbie Carter, NCC, LPCC, Eli Moch, LPC, ATR, EMDR-II and The Mariposa Center for Infant, Child, and Family Enrichment, as well as its' master level interns from any and all damages, claims, and causes arising out of, or in connection with, any release of this information.

If I am the parent/guardian, I understand that my child's records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for. I further understand that I may revoke this consent at any time by sending a letter to my therapist at the Mariposa Center. If I do not withdraw my consent, this release will expire within one year of the undersigned date.

Client or Parent/Guardian Signature:____ Date:________

Therapist Signature:____ Date:________

Emily McNeil, LPC, R-DMT, EMDR-I Jennifer Platt, LPC, R-DMT, EMDR-I Debbie Carter, NCC, LPCC Eli Moch, LPC, ATR, EMDR-II
2680 18th St. Suite 150A Denver, CO 80211 Phone: 720-288-5090 Fax: 303-477-9223 www.MariposaCenterDenver.com

Assignment of Benefits

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance. Necessary forms will be completed to file for insurance carrier payments

Assignment of Benefits

I hereby assign all medical/therapy benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare/Medicaid, private insurance, and any other health/medical plan, to issue payment check(s) directly to the therapists of the Mariposa Center for medical/therapy services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize the therapists of The Mariposa Center to: (1) release any information necessary to insurance carriers regarding my diagnosis and treatments; (2) process insurance claims generated in the course of assessment or treatment; and (3) allow a photocopy of my signature to be use to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical/therapy services from the therapists of The Mariposa Center on behalf of me and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_______________________________   ___________________
Patient/Responsible Party Signature   Date

_______________________________   ___________________
Witness   Date

Emily McNeil, LPC, R-DMT, EMDR-I Jennifer Platt, LPC, R-DMT, EMDR-I Debbie Carter, NCC, LPCC Eli Moch, LPC, ATR, EMDR-II
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Client Contact Information

Client's Name:_______________________________ Age:_______ Gender:____M ____F ____Other_______

Race/Ethnicity:_____________________________________Date of Birth:___________________________

Adult's Name (if client is a minor)____

Employer:______________________________________Occupation:_______________________________

Home Address:____

City:__________________________ State:_____________________ Zip Code:_________________________

Phone: (Home) ______________________ (Work) ____________________ (Cell)______________________

(circle all numbers above at which you give permission to be contacted)

Do you give therapist permission to leave a voice mail? Yes_______No_______

E-mail address(es):____

Health Insurance information:

Name of insurance____________________________________Phone number#_________________________

Policy and/or Member #________________________________ Group#______________________________

List the preferred way(s) for therapist to reach you:____

Person(s) to Contact in Case of an Emergency:

1. Name_________________________________Relationship to you______________________________

   Best way to contact this person____

2. Name_________________________________Relationship to you______________________________

   Best way to contact this person____

I realize that there is a possibility that I may compromise the level of confidentiality when using cell phones and e-mail to communicate. Please indicate by placing your initials next to each means of communication to which you give your consent to use:

E-mail______ Cell phone______ Cell phone voicemail______ Cell phone text message____

I also realize that the contact numbers for the therapists are cell phone numbers _______

Adult Client Signature ____ Date: ___________

Parent Signature (if client is a minor)____ Date: __________

Parent Signature (if dual custody of child)_______________________________________ Date: ___________

Emily McNeil, LPC, R-DMT, EMDR-I Jennifer Platt, LPC, R-DMT, EMDR-I Debbie Carter, NCC, LPCC Eli Moch, LPC, ATR, EMDR-II
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THE MARIPOSA CENTER LLC

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Financial Policies

- If you are a client not accessing insurance or other payment programs, the fees for The Mariposa Center for a 60-minute individual, family or couple psychotherapy session are:
  $100.00 per hour for a Licensed Professional Counselor
  $80.00 per hour for a Registered Psychotherapist or Licensed Professional Counselor Candidate
  $10.00 per hour for an Intern or Extern

- Private pay clients are also entitled to an initial "meet and greet" session at no charge.

- The Mariposa Center is in-network with several different insurance companies, so please ask us about your insurance situation. We are able to provide statements for out-of-network insurance reimbursements. We also work with several Early Interventions Programs and Victim's Compensation Programs.

- Each therapist has limited spaces available for sliding fee scale clients. Please talk to your therapist to check this availability.

- Based upon this payment information, your fee will be: _________. If your financial situation changes, please inform your therapist.

- **Payments are due** at the beginning of the session via cash, check or credit card. If paying by credit card, a $3.00 service charge will be added to your regular session fee. Please be aware that fees and policies are subject to change every 6 months. If The Mariposa Center has an ongoing or significant problem collecting fees from you, we reserve the right to utilize the services of a collection agency. The Mariposa Center will only disclose relevant information about you (i.e., name, contact information) if this circumstance arises_____(Initial).

- **All billing is done through:**
  Jessica Dennis @ Colorado Medical Billing, LLC
  5738 Olde Wadsworth Blvd. Arvada, CO 80002. PH: (720) 898-8711; F: (720) 897-2833; comedbill@gmail.com
  Please ask to see a copy of our biller's privacy policy.

- **No-show and Cancellation Policy**: Your visit has been reserved especially for you. 24-hour notice is required in order to cancel your appointment with no charge. If you do not call to cancel or reschedule your appointment, it is considered a "no-show." The fee for the first no-show is waived. You will be charged the full rate for all subsequent no-shows_______(Initial). If your insurance company does not cover this cost, you will be required to self-pay for the missed appointment. Please complete the **Credit/Debit Card Information Form** – this information can be utilized for your regular payment and/or in the case of a no-show. In the event of sudden illness or an emergency, please contact your therapist to determine if an exception can be made to this policy.

- **Additional charges will be made for the following services provided at the rates listed:**
  - Attending meetings, report writing, and client-requested consultation with other professionals will be charged at the normal hourly rate. _______(Initial)
  - Out of session e-mails and phone calls lasting longer than 15 minutes will be charged the normal hourly rate and tallied in 15-minute increments. ____ (Initial)
  - Court testimony on your behalf is charged at a higher rate of $300.00 per hour. This includes related matters like case research and preparation, report writing, travel, depositions, actual testimony and cross examination time, and courtroom waiting time._____(Initial)

Additional Policies

- **Therapy is a unique journey** for you/your child that can lead to health and healing. It is a collaborative effort and requires commitment from you/your child's parent. The therapist's role in your/your child's journey is not to "fix" but to facilitate your/your child's journey towards health. This requires that you communicate in a respectful manner towards your/your child's therapist, that you remain on the premises during your child's session, and that you/your child will maintain a commitment to therapy "homework" agreed upon with your therapist. ___(Initial)

- **If you are receiving family therapy**, please know that, "the family is the client," and that our therapists maintain a strict "no secrets" policy. This means that information reveled to the therapist by one family member must be revealed to all family members, as it is neither therapeutically beneficial nor ethical for family members to be kept unaware of family secrets. The therapist will guide the family if this situation occurs and will model good communication skills. _____(Initial)

- **If your family is in the process of a divorce**, please keep in mind that both parents have the right to information pertaining to their child/children, unless a court determines otherwise. All parents are asked to sign a communication agreement which allows (but does not require) the therapist to communicate with both parents and share any communications between one parent and the therapist with the other parent. Should custody and decision-making be rewarded solely to one parent that particular parent has sole rights to information. Please keep in mind that it is outside the guidelines of ethical practice for a therapist to give opinions about custody and parenting time. _____(Initial)

- **Clients who indicate self-harming, suicidal, or homicidal thoughts or behaviors** will be asked to sign a safety contract outlining a specific plan of action to be followed during the course of therapy. _____(Initial)

- **For my safety and the safety of my children**, I agree not to attend counseling /classes at The Mariposa Center while I am under the influence of any controlled substance. I understand that if I do arrive at the Mariposa Center intoxicated, my session will be cancelled and my therapist may have to contact authorities, including but not limited to the police and child protective services. I also understand that my therapist is able connect me to additional resources that can help me, if need be. _____(Initial)

- **Choosing a "best fit" therapist is the client's right** and if during a time where one therapist is covering for another (i.e., maternity leave, vacation, illness) you identify the covering therapist to be a better match for you/your child, we respectfully ask that you follow this transition process:
    1. Attend two (2) termination sessions with your/your child's initial therapist.
    2. Attend an initial consultation session with your/your child's new therapist, realizing that you may be put on a waitlist until the new therapist has a regular opening. _____(Initial)

- **Therapist self-care** is vital to ensure the highest quality of care is provided to our clients. It is important that you be aware that therapists will not answer texts, e-mails or phone calls after hours or on the weekends. We are an outpatient practice and therefore do not provide emergency psychotherapeutic services or transportation to/from the hospital. ______(Initial)

- I acknowledge that in addition to this form, I have seen, been offered a copy of, and agree with the terms of both the Informed Consent To Treatment and the Notice of Privacy Practices._____(Initial)

Client('s) Name(s):____
Client or Parent/Guardian Signature:______________________________ Date:______________________
Therapist Signature:____ Date:______________________

Credit/Debit Card Payment Consent Form

Please re-check your information. Giving incorrect credit/debit card information is considered fraud.

Client Name: ____

Cardholder Name (if different from client): ___________________________________

I, ____(Cardholder Name), authorize Emily McNeil, LPC, R-DMT, EMDR-I/ Jennifer Platt, LPC, R-DMT-EMDR-I/ Debbie Carter, NCC, LPCC/ Eli Moch, LPC, ATR, EMDR-II/ The Mariposa Center for Infant, Child, and Family Enrichment and Colorado Medical Billing, LLC (Medical Billing Service) to charge my card for professional services, NO SHOWS, failure to give 24 hours cancellation notification, and/or late co-payments, deductibles, co-insurance and any other payments not covered by my insurance carrier that is my financial responsibility as the responsible party for the above referenced client account. All charges will also include a $3.00 convenience fee.

Type of card: _______ Visa _____ MasterCard _____ Discover _____ AMEX _____ FSA/HSA Medical Card (you may only use this card for co-payments, all other charge must be applied to another credit/debit card)

Cr/Debit Card #: _______ - _______ - _______- _______ CVV Number: _______ Expiration Date__________

FSA/HSA Card #: _______ - _______ - _______- _______ CVV Number: _______ Expiration Date_________

Name on Card:____

Billing Address (where card statement is sent):
____
____

If I have question about these charges, I agree to contact my provider and if necessary, Jessica Dennis of Colorado Medical Billing, LLC, via email at comedbill@gmail.com. I agree that I will not pursue a refund/credit directly through my credit or debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider.

Cardholder's Signature: ___________________________________ Date: ___________________________

Charges will read as one of the following: Emily McNeil, LPC, R-DMT/ Jennifer Platt, LPC, R-DMT/ Debbie Carter, MS, MA, NCC/ Eli Moch, LPC, ATR/ The Mariposa Center for Infant, Child, and Family Enrichment or Colorado Medical Billing, LLC.

THE MARIPOSA CENTER LLC
FOR INFANT, CHILD & FAMILY ENRICHMENT

Notice of Privacy Practices

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

Therapists' commitment to clients' privacy includes the following information:

This therapy practice is dedicated to maintaining the privacy of clients' personal health information as part of providing professional care. This therapy practice is required by law to keep clients' information private. These laws are complicated, but legally, therapists must give clients this important information. This notice is a shorter version of the full, legally required Notice of Privacy Practices and clients may have copies of this longer version at any time to read and reference. In this abbreviated Notice of Privacy Practices, all possible situations cannot be covered, so clients are encouraged to be in contact regarding additional questions or problems and/or visit www.hhs.gov/ocr/hipaa.

If client or therapist wants to use or disclose (send, share, release) client information for any purpose not documented in this Notice of Privacy Practices, it will be discussed with the client. The client will be asked to sign a Release of Information Form in order for private information to be distributed.

The following are examples of when the law requires the disclosing of client information without completing a Release of Information Form with a client in advance:

1. There is a serious threat to the client's health and safety, the health and safety of another individual, and/or the public. In situations like these, information will only be shared with a person or organization that is able to help prevent or reduce the threat.

2. Particular lawsuits and court proceedings are in progress.

3. A law enforcement official needs information to investigate a crime or a criminal.

4. Worker's Compensation and other benefit programs request information/medical billing.

There are some other situations like those addressed above, however, most do not arise very often. For more information, please review the longer version of the Notice of Privacy Practices or visit the website mentioned above.

Emily McNeil, LPC, R-DMT, EMDR-I   Jennifer Platt, LPC, R-DMT, EMDR-I   Debbie Carter, NCC, LPCC   Eli Moch, LPC, ATR, EMDR-II
2680 18th St. Suite 150A   Denver, CO 80211   Ph: 720-288-5090   Fax: 303-477-9223   www.MariposaCenterDenver.com

Clients' rights regarding their health information:

1. Clients can ask the therapist to communicate with them about their health and related issues in a particular way or at a certain place that feels private. For example, a client may ask the therapist to call his/her home instead of his/her work to schedule or cancel an appointment. The therapist will do her best to accommodate the clients' needs.

2. Clients have the right to ask the therapist to limit information is shared with people involved in their care or the payment of their care. This includes family members and friends.

3. Clients have the right to look at the health information the therapist has about them such as medical and billing records. Upon request, a copy of these records may be obtained for each client, however, a fee may be charged for copy costs.

4. If a client believes that the information in his/her records is incorrect or incomplete, the client can ask the therapist to make some kinds of changes (called amending) to his/her health information. A client must make this request in writing and send it to the therapist. The client must tell the therapist the reasons why s/he wants the changes made.

5. Clients have the right to a copy of this Notice of Privacy Practices. If the therapist changes this Notice of Privacy Practices, the therapist will inform the client and make new copies available upon request.

6. Clients have the right to file a complaint if they believe that their privacy rights have been violated. Clients can file a complaint with the therapist and the Department of Regulatory Agencies, Mental Health Section, 1560 Broadway, Suite 1350, Denver, CO, 80202. All complaints must be in writing. Filing a complaint will not change the health care the therapist provides to the client in any way.

Clients may contact Emily McNeil, LPC, R-DMT, EMDR-I at (303) 817-0730; Jennifer Platt, LPC, R-DMT, EMDR-I, at (303) 618-3095; or Debbie Carter, NCC, LPCC at (720) 935-2440 or Eli Moch, LPC, ATR, EMDR-II at (303)547-6254 with questions or concerns regarding this notice or health information privacy policies at any time.

The effective date of this notice is January 1, 2014.

Finally, clients may have other rights that are granted to them by the laws of this state and these may be the same or different from the rights described above. The therapist will be happy to discuss these situations with the client at any time.

Client's Name:____
Client or Parent/Guardian Signature(s):_____________________________________ Date:_______

_____________________________________ Date:________

Therapist Signature:____ Date:________