THE MARIPOSA CENTER LLC
FOR INFANT, CHILD & FAMILY ENRICHMENT

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)

Okay to leave a voicemail? yes___no____

E-mail address(es):_____

May we add you to our monthly newsletter mailing list? Yes____No____

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 voicemail_____(please refrain from texting therapist except in the case of communicating scheduling changes)
I also realize that the contact numbers for the therapists are cell phone numbers _____

Client Signature _____ Date: _____

Parent Signature (if client is a minor)_____ Date: _____

Parent Signature (if dual custody of child)_____ Date: _____

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Informed Consent for Treatment and Disclosure Statement

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

1. More about our therapists: The Mariposa Center is an umbrella organization that provides high-quality mental health counseling. Our mental health professionals, as designated below, provide mental health services through The Mariposa Center, but have their own independent mental health practices and are sole proprietors of their own practices.The mental health professionals are all listed below here for client continuity of care.

A. Contact Information:
Emily McNeil, LPC, BC-DMT, EMDR-Certified, IMH-E-CM
4704 Harlan St., Suite 200
Denver, CO 80212
(303) 817-0730; emily@mariposacenterdenver.com

Degrees:
MA in Somatic Psychology with a Concentration in Dance/Movement Therapy; Naropa University; 2005
BA in Psychology, BA in Dance; Bryn Mawr College; 2001

Credentials and Professional Organization Memberships:
Licensed Professional Counselor, #5265, State of Colorado
Board Certified Dance/Movement Therapist, #2005-DTR-1444, American Dance Therapy Association
EMDR Certified Level 1 - trained by John Hartung, PhD; EMDRIA approved trainer;2012
Endorsed Infant Mental Health Clinical Mentor
Member of the American Dance Therapy Association
Member of the Colorado Association of Infant Mental Health

B. Contact information:
Megan Hall, MA, LPC, R-DMT
4704 Harlan St., Suite 200
Denver, CO 80212
303-630-9761; megan@mariposacenterdenver.com

Degrees:
MA in Dance/Movement Therapy & Counseling; Columbia College Chicago; 2011
BA in Psychology, Minor in Dance; Knox College; 2008

Credentials and Professional Organization Memberships:
Licensed Professional Counselor, #12326, State of Colorado
Registered Dance/Movement Therapist, R-DMT-1834, American Dance Therapy Association
Member of the American Dance Therapy Association

C. Contact Information:

Amy Jones, MA, LPC, ATR-BC
4704 Harlan St., Suite 200
Denver, CO 80212
(720) 515-9018; amy@mariposacenterdenver.com

Degrees:
MA in Art Therapy, Saint Mary-of-the-Woods College, 2012
BA in Psychology, University of Texas, 1993

Credentials and Professional Organization Memberships:
Licensed Professional Counselor, #12945, State of Colorado
Licensed Teacher, Elementary Education (K-6), #24380594, Colorado Department of Education
Registered and Board-Certified Art Therapist, #16-251, Art Therapy Credentials Board
Member of the American Art Therapy Association, Colorado Chapter

D. Contact Information:

Amanda Chatelain, MA, LPC, ATR
4704 Harlan St., Suite 200
Denver, CO 80212
(720) 689-4683; amanda@mariposacenterdenver.com

Degrees:
MA in Clinical Mental Health Counseling: Transpersonal Art Therapy; Naropa University, 2022
Bachelor of Science in Psychology; University of New Orleans, 2018

Credentials and Professional Organization Memberships:
Licensed Professional Counselor, #LPC.0020779, State of Colorado
Registered Art Therapist, #: 24-239, Art Therapy Credentials Board, Inc.
Member of the American Art Therapy Association

E. Contact Information:

Mary Anna Stepanek, MS, LCSW
4704 Harlan St., Suite 200
Denver, CO 80212
(720) 316-3452; maryanna@mariposacenterdenver.com

Degrees:
MA in Social Work, University of Tennessee, 2019
BA of Health and Human Science, University of Tennessee, 2017

Credentials and Professional Organization Memberships:
Licensed Clinical Social Worker, #CSW.09930749, State of Colorado
Member of National Association of Social Work

F. Contact Information:

Shannon Boarman, MA, LPCC, R-DMT
MA in Somatic Counseling: Dance/Movement Therapy; Naropa University, 2023
4704 Harlan St., Suite 200
Denver, CO 80212
(720) 288-5090; Shannon@mariposacenterdenver.com

Degrees:
BA in Integrative Therapeutic Practices; Metropolitan State University of Denver, 2018

Credentials and Professional Organization Memberships:
Licensed Professional Counselor Candidate, #LPCC.0020745, State of Colorado
Member of the American Dance Therapy Association
Certified Hatha Yoga and Meditation Instructor

G. Contact Information:

Ruthie Cartwright, Intern (supervised by Amy Jones, MA, LPC, R-DMT)
4704 Harlan St., Suite 200
Denver, CO 80212
(720) 288-5090; info@mariposacenterdenver.com

Degree:
BA in Anthropology, Haverford College, 2015

Degree in Progress:
Master of Arts in Clinical Mental Health Counseling and Transpersonal Art Therapy; Naropa University; Projected May 2025

Credentials and Professional Organization Memberships:
Member of the American Art Therapy Association.

H. Contact Information:

Alexandra Walker, Inter(supervised by Megan Hall, MA, LPC, R-DMT and Amanda Chatelain, MA, LPC, ATR)
4704 Harlan St., Suite 200
Denver, CO 80212
(720) 288-5090; admin@mariposacenterdenver.com

Degree:
BA in Kinesiology, University of Nevada, Reno, 2021

Degree in Progress:
Master of Arts in Clinical Mental Health Counseling specializing in Dance/Movement Therapy; Naropa University; Projected May 2025

Credentials and Professional Organization Memberships:
Member of the American Dance Therapy Association

I. Contact Information:

Katie Wiegman, Intern (supervised by Emily McNeil, LPC, BC-DMT, EMDR-Certified, IMH-E-CM)
4704 Harlan St., Suite 200
Denver, CO 80212
(720) 288-5090; support@mariposacenterdenver.com

Degree:

BFA in Dance Performance, New World School of the Arts, Miami, Fl 2010

Degree in Progress:

Master of Arts in Clinical Mental Health Counseling specializing in Dance/Movement Therapy; Naropa University; Projected May 2025

Credentials and Professional Organization Memberships:

Member of the American Dance Therapy Association

Your primary therapist is: _____

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 and licensed addiction counselors, 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
DORA_MentalHealthBoard@state.co.us

The levels of Psychotherapy Regulation in Colorado include licensing (requires minimum education, experience, and examination qualifications), Certification (requires minimum training, experience, and for certain levels, examination qualifications), and Registered Psychotherapist (does not require minimum education, experience, or examination qualifications). All levels of regulation require passing a jurisprudence take-home examination.

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

Our clinical interns and clinical externs are authorized to practice psychotherapy as they are participating in approved counseling/psychology or similar graduate training programs.They are not licensed psychotherapists and are not required to satisfy any standardized educational or testing requirements to obtain registration in Colorado. All of our clinical interns and externs are under the supervision of licensed mental health professionals.

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 and review our financial and procedural policies.

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

c. In a professional relationship, sexual intimacy is 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 or DORA_MentalHealthBoard@state.co.us.

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 or licensed addiction counselor, psychologist candidate, registered psychotherapist, licensed professional counselor candidate, marriage and family therapist candidate, or counseling intern. If the information is legally confidential, the therapist cannot be forced to disclose information without the client's consent or in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

e. 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. If the minor is twelve (12) years of age or older, it is within your primary therapist's discretion to advise the parents of the services given to or needed by the minor.

f. You are entitled to request restrictions on certain uses and disclosures of protected health information as provided by 45 CFR 164.522(a), however, The Mariposa Center is not required to agree to a restriction request. Please review The Mariposa Center's Notice of Privacy Practices.

g. There are exceptions to this confidentiality, some of which are listed in the Notice of Privacy Practices you were provided. 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 reasonably suspects or has proof of child abuse and/or neglect.
   iii. The therapist reasonably suspects or has proof of abuse, neglect, and/or exploitation of elderly or disabled individuals.

iv. You are in imminent danger of harming yourself and/or others, including those identifiable by their association with a specific location or entity. In this situation, your primary therapist is required to disclose such information to the appropriate authorities or to warn the party, location, or entity you have threatened.
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 or grievance against the therapist.
vii. The therapist is being reviewed by the Mental Health Section of the Division of Registrations.
viii. These provisions do not apply in delinquency or criminal proceedings except as provided in C.R.S. 13-90-107.

There may be additional exceptions as provided by HIPAA regulations and other federal and/or Colorado laws and, regulations such as those listed in C.R.S 12-43-218 that may apply. Your primary therapist will identify these situations, if practicable, as they may arise during treatment or during the professional relationship.

h. 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:

Konter And Associates Professional Billing Services
6343 W 120th Ave Suite 105
Broomfield, CO 80020
Phone: 720-354-8033; Fax: 720-745-5682

The therapists at The Mariposa Center have entered into a Business Associates Agreement with Konter And Associates Professional Billing Services in accordance with HIPAA requirements.

i. There may be times when your primary therapist may need to consult with a colleague or another professional such as an attorney or supervisor, about issues raised by you in therapy. Your confidentiality is still protected during consultation by your primary therapist and the professional consulted. Only the minimum amount of information necessary to consult will be disclosed. Signing this disclosure statement gives your primary therapist permission to consult as needed to provide professional services to you as a client. You will need to sign a separate Authorization for Release of Information for any discussion or disclosure of your protected health information to another professional besides an attorney retained by your primary therapist.

j. 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. This means that there may be times when individual sessions would be beneficial to the therapeutic process in the course of family counseling. If your therapist meets with one or multiple members of the family in individual sessions, the contents of those meetings will likely be shared with the non-attending members at the next group/family session. The information shared in individual sessions is **not** confidential from the other participating members. Should you reveal information that may be harmful to other participating members and you refuse to disclose the information, therapy services, among other things, may be terminated. Your primary therapist may choose to disclose information revealed in the individual sessions if s/he, in his/her sole discretion, determines that the information must be disclosed for therapy to be effective. If appropriate, your primary therapist will give you the opportunity to disclose the information first. However, your primary therapist will not lie or refuse to answer any question posed by the other family members. Should you feel it is necessary to disclose something to your primary therapist and keep that information confidential, your primary therapist can refer you to another therapist who can treat you individually. Please be aware that information you choose to share with

your primary therapist that is particularly pertinent to all participating members of the family may come out in counseling. This pertains to all face-to-face, written, and phone conversations and messages. Your primary therapist cannot be subpoenaed to testify or produce records without consent and authorization from all participating members of the family.

k. The therapists provide non-emergency psycho-therapeutic services by scheduled appointment only. If one of the therapists believes your psychotherapeutic issues are above his/her level of competence or outside of his/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 true physical or mental health emergency, please dial 911, go to your nearest emergency room, or call Colorado's Crisis Hotline (844) 493-8255. If you must seek afterhours treatment from any counseling agency, center, emergency room, hospital or similar facility, you are solely responsible for any fees due. The Mariposa Center does not provide after-hours service without an appointment.

l. In the case that your primary therapist becomes disabled, dies, or is away on an extended leave of absence (hereinafter "extraordinary event,") another therapist ("the Mental Health Professional Designee") at The Mariposa Center will have access to your client files. If your primary therapist is unable to contact you prior to the extraordinary event occurring, The Mariposa Center will contact you. Please let your primary therapist know if you are not comfortable with the other therapists listed above and you can discuss possible alternatives with primary therapist at this time.

The purpose of the Mental Health Designee is to continue your care and treatment with the least amount of disruption as possible. You are not required to use the Mental Health Professional Designee for therapy services, but the Mental Health Professional Designee can offer you referrals and transfer your client record, if requested.

m. Paper patient records (including client clinical artwork) are kept in locked file cabinets at The Mariposa Center. Electronic records are stored on the computer of your primary therapist. Information is backed-up regularly through additional harddrives and on "the cloud." The timeframe for record retention is seven years and there is the possibility that records will be destroyed after this time.

n. Although confidentiality extends to communications by text, email, telephone, and/or other electronic means, The Mariposa Center cannot guarantee that those communications will be kept confidential and/or that a third-party may not access the communications. Even though The Mariposa Center utilizes current encryption methods, firewalls, and back-up systems to help secure communications, there is a risk that the electronic or telephone communications may be compromised, unsecured, and/or accessed by a third-party. It is very important to be aware that email and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. Emails and texts, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through them. Faxes can easily be sent erroneously to the wrong address. Please limit communication by text or email to administrative purposes only and do not use them as an avenue for therapy. NEVER use email or text for emergencies. Please note that the business numbers for all of the therapists are cell phone numbers.

o. This form is compliant with HIPAA regulations and no medical or therapeutic information or other information related to your privacy will be released without permission unless mandated by Colorado law as described in this form and the Notice of Privacy Policies and Practices. Consistent with HIPAA guidelines authorizations for release and consent for treatment will be automatically revoked one year after signing date. You received The Mariposa Center's Notice of Privacy Policies and Practices, and acknowledge receipt of the policy.

4. <u>Surprise Balance/Billing:</u>

The following disclosure is required by Colorado law. However, please note that practitioners at The Mariposa Center are individually credentialled with a variety of different insurance companies. Please ask your individual provider which insurance companies with whom they are in-network. If you are not covered by one of these companies and are intentionally choosing to receive non-emergency services from an out-of-network provider, you will be responsible for payment of the entire bill or may be balance-billed. If you intend to submit invoices to your insurance company for out-of-network reimbursement, be sure to check with your insurer so you understand the limits of such coverage.

Beginning January 1, 2020, Colorado state law protects you* from "surprise billing," also known as "balance billing." These protections apply when:

- You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or
- You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado.

If you are seen by a health care provider or use services in a facility/agency that is not in your health insurance plan's provider network, sometimes referred to as "out-of-network," you may receive a bill for additional costs. Out-of-network health care providers often bill you for the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

You cannot be balance-billed for:

a. Emergency Services: If you are receiving emergency services, the most you can be billed for is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility where you receive emergency services and any providers that see you for emergency care.
b. Nonemergency Services at an In-Network or Out-of-Network Health Care Provider: The health care provider must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. They must also tell you what types of services that you will be using may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for covered services is your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance. These providers cannot balance bill you for additional costs.

Additional Protections:

- Your insurer will pay out-of-network providers and facilities directly.
- Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.
- Your provider, facility, hospital, or agency must refund any amount you overpay within sixty days of being notified.
- No one, including a provider, hospital, or insurer can ask you to limit or give up these rights.

If you receive services from an out-of-network provider or facility or agency in any OTHER situation, you may still be balance-billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be balance billed.

If you want to file a complaint against your health care provider, you can submit an online complaint by visiting this website: https://www.colorado.gov/pacific/dora/DPO_File_Complaint.

If you think you have received a bill for amounts other than your copayments, deductible, and/or coinsurance, please

contact the billing department, or the Colorado Division of Insurance at 303-894-7490 or 1-800-930-3745.

*This law does NOT apply to ALL Colorado health plans. It only applies if you have a "CO-DOI" on your health insurance ID card. Please contact your health insurance plan at the number on your health insurance ID card or the Colorado Division of Insurance with questions.

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

I have read the preceding information and it has also been provided verbally if I am unable to read or have no written language. 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 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:_____

Therapist Signature:_____ Date:_____

Supervisor Signature (if applicable) :_____Date:_____

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Release of Information

Client Name:_____D.O.B.: _____

Release to/from (circle one or both):
Name: _____
Address: _____
_____
Phone: _____
Email (if applicable): _____

Dates of Relevant Care: From:_____ To:_____Present_____
I, _____(client name or parent/guardian if client is a minor), 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, BC-DMT, EMDR-Cert.; Megan Hall, LPC, R-DMT; Shannon Boarman, LPCC, R-DMT; Amanda Chatelain, LPC; Amy Jones, LPC, ATR-BC; Mary Anna Stepanek, MS, LCSW and The Mariposa Center for Infant, Child, and Family Enrichment, as well as its' master level interns and externs 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.

THE MARIPOSA CENTER LLC

FOR INFANT, CHILD & FAMILY ENRICHMENT

Client or Parent/Guardian Signature:_____ Date:_____

Therapist Signature: _____ Date: _____

Supervisor Signature(if applicable): _____Date: _____

4704 Harlan St. Suite 200 Denver, CO 80212 ▫ Phone: 720-288-5090 ▫ Fax: 720-541-6936 ▫ www.MariposaCenterDenver.com

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Consent For Communication of Protected Health Information By Unsecure Transmissions

This consent form is for the communication of Protected Health Information ("PHI") that the therapists at The Mariposa Center may transmit without the written authorization of the client as described in the Uses and Disclosure section of its Notice of Privacy Policies.

I, _____, hereby consent and authorize the Mariposa Center to communicate my PHI through the following unsecure transmissions (please initial all your choices):

_____ Cellular/Mobile Phone this includes text messaging
(Please Insert Cell Phone Number: _____)
_____ Unsecured Email
(Client's Email: _____ Send ____Receive_____)
(Therapist's Email: _____ Send ___ Receive_____)
Please Circle One: Work Personal
_____ Appointment/Scheduling Reminders
_____ Other Media:
(Please describe: _____)
_____ I do not wish to have my protected health information transmitted electronically

Should you agree with The Mariposa Center to communicate by the approved communications listed above, i.e. text, email, telephone, or any other electronic method of communication, confidentiality extends to those communications. However, The Mariposa Center cannot guarantee that those communications will remain confidential. Even though the therapists at The Mariposa Center may utilize state of the art encryption methods, firewalls, and 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, _____, understand that my therapist at The Mariposa Center may not use and disclose the following PHI without my written authorization. However, I consent to The Mariposa Center transmitting the following PHI by the above selected electronic communications (please initial all your choices):

_____ 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 The Mariposa Center's operations
_____ Other Information; Please Describe: _____

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.

_____	_____
Signature of Client/Parent/Legal Guardian	DATE
_____	_____
Signature of Therapist	DATE
_____	_____
Signature of Supervisor (if applicable)	DATE

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4704 Harlan Street, Suite 200
Denver, CO 80212
720-288-5090

INFORMED CONSENT FOR TELETHERAPY

This Informed Consent for Teletherapy contains important information concerning engaging in electronic psychotherapy or teletherapy. Please read this carefully and let me know if you have any questions. This consent shall only apply to clients physically within the State of Colorado seeking therapeutic treatment within the State of Colorado.

Benefits and Risks of Teletherapy

Teletherapy refers to the remote provision of psychotherapy services using telecommunications technologies such as video conferencing or telephone. One of the benefits of teletherapy is that the client and therapist can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or therapist moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It can also increase the convenience and time efficiency of both parties.

Although there are benefits of teletherapy, there are some fundamental differences between in-person psychotherapy and teletherapy, as well as some inherent risks. For example:

- Risks to confidentiality. Because teletherapy sessions take place outside of the typical office setting, there is potential for third parties to overhear sessions if they are not conducted in a secure environment. I will take reasonable steps to ensure the privacy and security of your information, and it is important for you to review your own security measures and ensure that they are adequate to protect information on your end. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are risks inherent in the use of technology for therapy that are important to understand, such as: potential for technology to fail during a session, potential that transmission of confidential information could be interrupted by unauthorized parties, or potential for electronically stored information to be accessed by unauthorized parties.

- Crisis management and intervention. As a general rule I will not engage in teletherapy with patients who are in a crisis situation. Before engaging in teletherapy, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our teletherapy work.

- Efficacy. While most research has failed to demonstrate that teletherapy is less effective than in person psychotherapy, some experienced mental health professionals believe that something is lost by not being in the same room. For example, there is debate about one's ability when doing remote work to fully process non-verbal information. If you ever have concerns about misunderstandings between us related to our use of technology, please bring up such concerns immediately and we will address the potential misunderstanding together.

Electronic Communications
We will discuss which is the most appropriate platform to use for teletherapy services. You may be required to have certain system requirements to access electronic psychotherapy via the method we choose. You are solely responsible for any cost to you to obtain any additional/necessary system requirements, accessories, or software to use electronic psychotherapy.

For communication between sessions, I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not include any clinical material by email and prefer that you do not as well.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions, however if an urgent issue arises, you should feel free to attempt to reach me by phone. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Confidentiality:
I have a legal and ethical responsibility to make my best efforts to protect all communications, electric and otherwise, that are a part of our teletherapy. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential and/or that a third party may not gain access to our communications. Even though I may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic communications may be compromised, unsecured, and/or accessed by a third party.

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Disclosure Statement/Informed Consent still apply in teletherapy. Please let me know if you have any questions about exceptions to confidentiality.

Appropriateness of Teletherapy
If at any time while we are engaging in teletherapy, I determine, in my sole discretion, that teletherapy is no longer the most appropriate form of treatment for you, we will discuss options of engaging in face-to-face in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology
Assessing and evaluating threats and other emergencies can be more difficult when conducting teletherapy than in traditional in-person therapy. In order to address some of these difficulties, I will ask you where you are located at the beginning of each session and I will ask that you identify emergency resources that are near your location that I may contact in the event of a crisis or emergency to assist in addressing the situation. I may also ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session cuts out, meaning the technological connection fails, and you are having an emergency do not call me back, but call 911, the Colorado Crisis Hotline at 844-493-TALK (8255), or go to your nearest emergency room. Call me after you have called or obtained emergency services.

If the session cuts out and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the teletherapy platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call me on the phone number I provided you at the top of this form.

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

Fees:
The same fee rates shall apply for teletherapy as apply for in-person psychotherapy. <u>However, insurance or other managed care providers may not cover sessions that are conducted using electronic psychotherapy. If your insurance, HMO, third-party payer, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session.</u> Please contact your insurance company prior to our engaging in teletherapy sessions in order to determine whether these sessions will be covered.

Informed Consent:
This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together. Your signature below indicates agreement with its terms and conditions. This agreement is supplemental to my general informed consent and does not amend any of the terms of that agreement.

I, _____, the client, having been fully informed of the risks and benefits of teletherapy; the security measures in place, which include procedures for emergency situations; the fees associated with teletherapy; the technological requirements needed to engage in teletherapy; and all other information provided in this informed consent, agree to and understand the procedures and policies set forth in this consent.

Signature of Client: _____ Date: _____

Therapist Signature:_____ Date: _____

Supervisor Signature (if applicable):_____ Date: _____

Communication Agreement

In order for _____ (client's name) to have the most effective therapy experience possible, and for therapy time to have its main focus on the best interest of the child, I agree to the following by initialing after each item and signing full name below:

Therapist holds a **'no secrets' policy**, which means that all communication directed to me will be relayed/copied to the other parent. Therapist asks that parents choose a means of communication that works best for both of them (email or other) and communicate with the therapist in this manner, making sure to include the other parent in these conversations. _____ _____

Therapist will provide occasional brief updates on the therapy process without violating the client's confidentiality via e-mail to both parents. Therapist asks that any replies, questions, etc. be copied to both parents. _____ _____

Therapist asks that both parents refrain from making negative comments about the other parent in the presence of the client both in the office, and also at all other times. This includes, but is not limited to talking on the phone, or to others when the child may overhear, etc. _____ _____

Therapist asks that both parents refrain from questioning child about the content of their therapy sessions, as the child has a right to confidentiality and must feel that they have a safe place where they can honestly express their feelings. Your child has been informed of their right to confidentiality and therapist must uphold this confidentiality unless the therapist the information revealed may pose a threat to client or others. _____ _____

At any time if either parent desires to make revisions to this agreement, all members will discuss and agree upon these revisions. _____ _____

Parent signature: _____ Date: _____

Parent Signature: _____ Date: _____

Therapist Signature: _____ Date:_____

Supervisor Signature: _____Date:_____

THE MARIPOSA CENTER LLC
FOR INFANT, CHILD & FAMILY ENRICHMENT

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

THE MARIPOSA CENTER LLC
FOR INFANT, CHILD & FAMILY ENRICHMENT

Policies and Procedures Agreement

This Agreement is made and entered into by and between _____ (therapist), who is a sole proprietor at The Mariposa Center, and the Client. This Agreement shall be read in conjunction with The Mariposa Center's Informed Consent and Disclosure Statement and is incorporated by reference into this Agreement.

Financial Policies

- The initial phone intake with the intake coordinator and an initial 30-minute phone call with a clinician to determine the "fit" between the family and the therapist are both offered free of charge.
- If you are a client not utilizing insurance or other payment programs, the fees for the initial 60-minute in-person intake session at The Mariposa Center are:
  $202.00 for a Licensed Professional Counselor or Licensed Clinical Social Worker
  $187.00 for a Licensed Professional Counselor Candidate
  $37.00 for an Intern or $67.00 for an Extern

- If you are a client not utilizing insurance or other payment programs, the fees for a 50-minute individual, family, or parenting psychotherapy session at The Mariposa Center are:
  $135.00 per 50 min. for a Licensed Professional Counselor or Licensed Clinical Social Worker
  $125.00 per 50 min. for a Licensed Professional Counselor Candidate
  $25.00 per 50 min. for an Intern or $45.00 per 50 min. for an Extern

- Your therapist at The Mariposa Center may be in-network with several different insurance companies and Medicaid BHOs, so please ask us about your insurance situation. We can provide statements for out-of-network insurance reimbursements. We will bill your insurance the top rate included for the services listed here. This is known as our "insurance rate." We also work with several Early Interventions Programs and Victim's Compensation Programs.
  - By signing this Agreement, you understand that you are legally responsible for payment for your therapy services. If for any reason, your insurance company, HMO, third-party payor, etc. does not compensate your therapist, you understand that you remain solely responsible for payment. You also understand that signing this form permits your therapist to communicate with your insurance company, HMO, third-party payor, collections agency, or anyone connected to your funding source regarding payment. You understand that your insurance company may request information from your therapist about the therapy services you received, which may include, but is not limited to: a diagnosis or service code, description of services or symptoms, treatment plans/summary, and in some cases your entire client file. You understand that once your insurance company receives the information you or your therapist has no control over the security measures the insurance company takes or whether the insurance company shares the required information. You understand that you may request from your therapist a copy of any report s/he submits to your insurance company on your behalf. Failure to pay will be a cause for termination of therapy services. _____(Initial)

- Each therapist has limited spaces available for reduced-fee clients. Please talk to your therapist to check this availability. Typically, our licensed professional counselor candidates offer a sliding scale, when needed, that

ranges from $100.00-$125.00 per 50 min. session. Our intern rates also slide between $5.00-$25.00 per 50 min. session and extern rates slide between $5.00-$45.00 per 50 min. session. Intern/extern rates are considered a pay-it-forward donation. More information can be found on the intern/extern contract form.

- Based upon this payment information, your fee will be:_____. If your financial situation changes, please inform your therapist_____(Initial).

- **Payments are due** at the beginning of the session via cash, check, or credit card and will go directly to your therapist. Please be aware that fees and policies are subject to change every 6 months. You will be notified 30 days before any change in fees. All accounts that are not paid within 30 days from the date of service for self-pay clients, shall be considered past due. If your account is past due, please be advised that your therapist at The Mariposa Center may be obligated to turn your account over to a collection agency or seek collection with a civil court action. By signing below, you agree that your therapist at The Mariposa Center may seek payment for your unpaid bills with the assistance of a collections agency. Should this occur, your therapist at The Mariposa Center will provide the collection agency or court with your name, address, phone number, and any other directory information, including dates of service or any other information requested by the collection agency or court deemed necessary to collect the past due account. Your therapist at The Mariposa Center will not disclose more information than necessary to collect the past-due account. Your therapist at The Mariposa Center will notify you of its intention to turn your account over to a collection agency or the court by sending such notice to your last known address._____(Initial).

- **No-show and Cancellation Policy**: Your visit has been reserved especially for you. 24-hour notice is required in order to cancel your appointment at no charge, excluding emergencies. 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 (and most insurance companies do not), 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 but will be prorated to the nearest quarter hour. _____(Initial) Out-of-session emails and phone calls lasting longer than 15 minutes will be charged the normal hourly rate and tallied in 15-minute increments. ____ (Initial)
  Court and/or legal-related matters on your behalf are charged at a higher rate of $350.00 per hour for all levels of clinicians at The Mariposa Center. This includes but is not limited to attorney fees your therapist may incur in preparing for the requested legal services, case research and preparation, report writing (including CFI reports), travel, depositions, actual testimony, 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. There is no guarantee that psychotherapy will yield positive or intended results. Although every effort will be made to provide a positive and healing experience, every therapeutic experience is unique and varies from person to person. Results achieved in a therapeutic relationship with one person are not a guarantee of similar results with all clients. Therapy is a collaborative effort and requires commitment from you/your child. 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 respectfully towards your/your child's therapist, that you remain on the premises during your child's session, that you/your child will not come to therapy under the influence of any substances, 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 revealed to the therapist by one family member must be revealed to all family members, as it is neither therapeutically beneficial nor ethically correct for family members to be kept unaware of family secrets. The therapist will guide the family and model good communication skills if this situation occurs. Please see your therapist's disclosure statement for more information. _____(Initial)

- **If your family is in the process of a divorce**, please keep in mind that both parents have the right to information about their child/children, unless a court determines otherwise. All parents are asked to sign a communication agreement that 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. If you are consenting to treatment and therapy services for your minor child/ren, you must produce the Court Order Custody Agreement and/or Parenting Plan that grants you the authority to consent to mental health services for your minor child/ren. Further, you understand and agree to keep your therapist informed of any proceedings or supplemental court orders that affect your parenting rights, custody arrangements, and decision-making authority. You understand that failing to provide the Court Order Custody Agreement and/or Parenting Plan will prohibit your therapist from providing therapy to your minor child/ren. Please keep in mind that it is outside the guidelines and beyond the scope of ethical practice for a therapist to give opinions about custody and parenting time. Any request for custody recommendations will be denied. The court can appoint professionals with the expertise to make such recommendations. By initialing here and signing below, you agree not to subpoena records or ask your therapist to testify in court or to provide letters or documentation expressing an opinion about custody or visitation. Despite this, a Court may still require your therapist to testify or to provide treatment information to an evaluator. Your therapist will comply with these requests as legally required and you will be required to compensate your therapist for time spent providing these services as indicated in the "Financial Policies" section above. _____(Initial)

- **Additionally, therapists at The Mariposa Center are only able to work with divorced/uncoupled parents who are willing to co-parent civilly**, and who can participate in parenting sessions together. This is supportive to the best interest of your child(ren). If you are struggling with a highly conflictive relationship or are battling for custody and are not willing to co-parent effectively, we are, unfortunately, not able to see your child._____(Initial)

- **When more than one person is responsible for payment,** all parties' credit cards must be on file. If there is nonpayment for 2 sessions by any party, treatment will stop until payment disputes are resolved. The therapists at The Mariposa Center will not be responsible for resolving payment disputes; this must be worked out amongst the paying parties. Please be aware that your appointment time may not be reserved for you during this time. _____(Initial)

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

- **Choosing a "best fit" therapist is the client's right** and if during a time when 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)

- **Non-emergency Services.** Therapist self-care is vital to ensure the highest quality of care is provided to our clients. You must be aware that therapists will not answer emails 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. The therapists at The Mariposa Center provide non-emergency services during stated business hours and by scheduled appointment only. Therapists will return calls during stated business hours only. If you must seek after-hours treatment from any counseling agency or center, emergency room, or hospital, you understand that you remain solely responsible for any fees that arise from that care. _____(Initial)

- **Discontinuing Therapy.** You understand that should you choose to discontinue therapy for more than 60 days by not communicating with your therapist at The Mariposa Center, your treatment will be considered terminated. You may be able to resume therapy after 60 days by discussing your decision to resume therapy services with your therapist. The ability to resume therapy after 60 days will depend upon your therapist's availability and will be within his/her sole discretion. Your Disclosure Statement/Informed Consent for Treatment and these Policies will remain in effect should you resume therapy if one (1) year has not elapsed since your last session. However, you may be asked to provide additional information to update your client record. You understand that "discontinuing therapy" means that you have not had a session with your therapist for at least 60 days unless otherwise agreed to in writing._____(Initial)

- **Social Media.** You understand that your therapist does not accept personal Facebook, LinkedIn, Twitter, Instagram, and/or other friend/connection/follow requests via any social media. Any such request will be denied to maintain professional boundaries. You understand that The Mariposa Center has, or may have a business social media account page. You understand that there is no requirement that you "like" or "follow" this page. You understand that should you "like" or choose to "follow" The Mariposa Center's business social media page others will see your name associated with "liking" or "following" that page. You understand that this applies to any comments that you post on The Mariposa Center's page/wall, as well. You understand that any comments you post regarding therapeutic work between you and your therapist will be deleted as soon as possible. You agree to refrain from discussing, commenting, and asking therapeutic questions via social media. You agree that you will contact your therapist with any therapeutic comments and/or questions through the mode you have consented to and not through social media. If you have any questions regarding social media, review websites, or search engines in connection to your therapeutic relationship, you agree to immediately contact your therapist and address those questions._____(Initial)

- **Teletherapy and Technology.** In general, The Mariposa Center and its therapists do not provide Teletherapy, such as therapy over the phone or video chat. You understand that communications via email and text should be limited to administrative purposes (like scheduling or notification of delayed arrival), and not used as an avenue for therapy. You agree to discuss any request you make for Teletherapy with your therapist. You understand that it is in your therapist's sole discretion whether to accommodate your request for Teletherapy. _____(Initial)

- **Communication by Unsecure Transmissions.** By signing this Agreement you allow The Mariposa Center to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any information that is not provided in person shall be provided in accordance with The Mariposa Center's form: Consent for Communication of Protected Health Information By Unsecure Transmissions. You understand that if you initiate communication via electronic means that you have not specifically consented to in the Consent for Communication of Protected Health Information By Unsecure Transmissions form, you will need to amend the consent form so that your therapist may communicate with you via that method._____(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 for Treatment/Disclosure Statement and the Notice of Privacy Practices._____(Initial)

- **I understand that this version** of The Mariposa Center's policies goes into effect on January 9, 2024, and replaces all former policy documents. _____(Initial)

Client('s) Name(s):_____

Client or Parent/Guardian Signature: _____Date:_____

Therapist Signature: _____Date:_____

Supervisor Signature: _____Date:_____

THE MARIPOSA CENTER LLC
FOR INFANT, CHILD & FAMILY ENRICHMENT

Credit/Debit Card Payment Consent Form

Please re-check your information. Giving incorrect credit/debit card information is considered fraud. Your therapist at The Mariposa Center requests that you provide your credit card information below. If you choose to pay by credit card, your card will be charged $_____ after each traditional session or as outlined in The Mariposa Center's Policy Agreement. If you choose to pay by cash or check, your credit card will only be charged if your account is past due and/or for any additional fees you and/or your minor child/ren incur such as late cancellation or no-show fees.

Client Name: _____

Cardholder Name (if different from client): _____

I, _____(Cardholder Name), authorize Emily McNeil, LPC, BC-DMT, EMDR-Cert./ Amy Jones, LPC, ATR-BC/ Megan Hall, LPC, R-DMT/Amanda Chatelain, MA, LPC/Shannon Boarman, LPCC, R-DMT/The Mariposa Center for Infant, Child, and Family Enrichment/Colorado Medical Billing, LLC (Medical Billing Service) (hereinafter collectively known as "The Mariposa Center") to charge my card for professional services, NO SHOWS, failure to give 24 hours cancellation notification, and/or 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.

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, including zip code (where card statement is sent):
_____
_____

If I have questions about these charges, I agree to contact my therapist 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.

By signing this authorization form, I agree to notify The Mariposa Center of any changes to my credit card information such as a new expiration date or when my credit card has been cancelled, lost, stolen, or revoked. A new form must be submitted if information such as the list of authorized users and the credit card account's expiration date is amended.

This credit card authorization form with remain in effect and on file at The Mariposa Center unless revoked in

writing or until the therapeutic relationship is terminated, at which time, authorization to charge your credit card will be revoked unless an outstanding balance remains on your account after termination. The Mariposa Center will not share your credit card information with any third-party payor without client consent. Your credit card information will be kept confidential.

If cardholder is a third-party payor:

I_____, hereby authorize The Mariposa Center to charge the above bank credit card for payment of the counseling fees (client)_____ incurs; which shall include late or past due fees or fees related to cancellations or no-shows. I understand that my card will be billed in accordance with the authorizations listed above. I agree to notify The Mariposa Center of any changes to my credit card information including a new expiration date or when my credit card has been cancelled, lost, stolen, or revoked. I understand as a third-party payor that I am only entitled to receive information concerning payment and that this Credit Card Authorization Form does not authorize me to receive any confidential and protected information about the client beyond payment.

Third-Party Payor's Signature:_____

Date:_____

I_____, authorize The Mariposa Center to communicate with the above third-party payor solely as it may relate to payment for services I receive at The Mariposa Center.

Client/Parent/Legal Guardian Signature:_____

Date:_____

If cardholder is client/parent/legal guardian:

I_____, hereby authorize The Mariposa Center to charge the above bank credit card for payment of the counseling fees I or my minor child/ren incur; which shall include late or past due fees or fees related to cancellations or no-shows. I understand that my card will be charged in accordance with the authorizations listed above. I agree to notify The Mariposa Center of any changes to my credit card information including a new expiration date or when my credit card has been cancelled, lost, stolen, or revoked.

Client/Parent/Legal Guardian/Cardholder Signature:_____

Date:_____

Charges will read as one of the following: Emily McNeil, LPC, BC-DMT, EMDR-Cert./ Amy Jones, LPC, ATR-BC/ Megan Hall, LPC, R-DMT/Sloan Solomon, LPC/Erin Mudgett, LPCC, The Mariposa Center for Infant, Child & Family Enrichment/Colorado Medical Billing, LLC.

THE MARIPOSA CENTER LLC
FOR INFANT, CHILD & FAMILY ENRICHMENT

Notice of Privacy Policies and Practices

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

Given the nature of The Mariposa Center's work, it is imperative that The Mariposa Center maintains the confidence of client information that it receives in the course of its work. The Mariposa Center is a mental health counseling practice that is composed of several independent mental health professionals providing mental health services through The Mariposa Center. The practice works solely to provide the best counseling treatment options to its clients. All the mental health practices and therapists abide by this Notice of Privacy Policies and Practices. The Mariposa Center prohibits the release of any client information to anyone outside immediate staff, employees, interns/externs, and/or volunteers except in limited circumstances in accordance with this Notice of Privacy Policies and Practices. Discussions or disclosures of protected health information ("PHI") within the organization are limited to the minimum necessary that is needed for the recipient of the information to perform his/her job. Please review this Notice of Privacy Policies and Practices ("Notice of Privacy Policies"). It is the policy of The Mariposa Center to:

1. fully comply with the requirements of the HIPAA General Administrative Requirements, the Privacy and Security Rules;
2. provide every client who receives services at The Mariposa Center with a copy of this Notice of Privacy Policies;
3. ask the client to acknowledge receipt when given a copy of this Notice of Privacy Policies;
4. ensure the confidentiality of all client records transmitted by facsimile;
5. obtain from each client an informed Authorization for Release of Protected Health Information form when required.

The Mariposa Center is required to follow all state and federal statutes and regulations including Federal Regulation 42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164, governing testing for and reporting of TB, HIV AIDS, Hepatitis, and other infectious diseases, and maintaining the confidentiality of PHI.

PHI refers to any information that is created or received by The Mariposa Center, and relates to an individual's past, present, or future physical or mental health or conditions and related care services or the past, present, or future payment for the provision of health care to an individual; and identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual.

PHI includes any such information described above that The Mariposa Center transmits or maintains in any form, this includes Psychotherapy Notes. HIPAA and federal law regulate the use and disclosure of PHI when transmitted electronically.

YOUR RIGHTS AS A CLIENT:

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your mental health record

- You can ask to see or get an electronic or paper copy of your mental health record and other health information we have about you. Ask us how to do this.

- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee to fulfill your request.

- If we deny your request, in whole or in part, we will let you know why in writing and whether you have the option of having the decision reviewed by an independent third-party.

Ask us to correct your mental health record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.

- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

- We will say "yes" to all reasonable requests.

- Please review the Consent For Communication Of Protected Health Information By Non-Secure Transmissions

- You are required to "opt-in" to receive communications electronically as set-forth in the Consent for Communication of Protected Health Information by Non-Secure Transmissions. If you choose not to "opt-in" to receive electronic communications, we will not communicate with you via electronic means.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

- We will not retaliate against you for filing a complaint.

- You may also file a complaint with the Colorado Department of Regulatory Agencies, Division of Professions and Occupations, Mental Health Section; 1560 Broadway, Suite 1350, Denver, Colorado, 80202, 303-894-2291; DORA_Mentalhealthboard@state.co.us. Please note that the Department of Regulatory Agencies may direct you to file your complaint with the U.S. Department of Health and Human Services Office for Civil Rights listed above and may not be able to take any action on your behalf.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A use of PHI occurs *within* a covered entity (i.e., discussions among staff regarding treatment). A disclosure of PHI occurs when The Mariposa Center reveals PHI to an outside party (i.e., The Mariposa Center provides another treatment provider with PHI, or shares PHI with a third party pursuant to a client's valid written authorization).

The Mariposa Center may use and disclose PHI, without an individual's written authorization, for the following purposes:

1. Treatment: disclosing and using your PHI by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members and for coverage arrangements during your primary therapist's absence, and for sending appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
2. Payment: disclosing and using your PHI so that The Mariposa Center can receive payment for the treatment services provided to you, such as: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization of review activities.
3. Health Care Operations: disclosing and using your PHI to support The Mariposa Center's business operations which may include but not be limited to: quality assessment activities, licensing, audits, and other business activities.

Uses and disclosures for payment and health care operations purposes are subject to the minimum necessary requirement. This means that The Mariposa Center may only use or disclose the minimum amount of PHI necessary for the purpose of the use or disclosure (i.e., for billing purposes, a therapist would not need to disclose a client's entire medical record in order to receive reimbursement. A therapist would likely only need to include a service code and/or diagnosis etc.). Uses and disclosures for treatment purposes are not subject to the minimum necessary requirement.

The Mariposa Center is required to promptly notify you of any breach that may have occurred and/or that may have compromised the privacy or security of your PHI.

Confidentiality of client records and substance abuse client records maintained are protected by federal law and regulations. It is The Mariposa Center's policy that a client must complete an Authorization for Release of Protected Health Information provided by The Mariposa Center, prior to disclosing health information to another individual and/or entity for any purpose, except for treatment, payment, or health care operations in accordance with this Notice of Privacy Policies.

Absent the above referenced form, other than for treatment, payment, or health care operations purposes, The Mariposa Center is prohibited from disclosing or using any PHI outside of or within the organization, including disclosing that the client is in treatment without written authorization, unless one of the following exceptions arises:

1. Responding to lawsuit and legal actions (Disclosure by a court order, in response to a complaint filed against a counselor of The Mariposa Center, etc. This does not include a request by you or another party for your records).
2. Disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation.
3. Help with public health and safety issues (Client commits or threatens to commit a crime either at The Mariposa Center or against any person who works for The Mariposa Center; A minor or elderly client reports having been abused; Client is planning to harm another person, including but not limited to the harm of a child or at-risk elder; Client reports suicidal ideations or self harm).
4. Address workers' compensation, law enforcement, and other government requests.
5. Respond to organ and tissue donation requests.
6. In compliance with other state and/or federal laws and regulations.

The above exceptions are subject to several requirements under the Privacy Rule, including the minimum necessary requirement and applicable federal and state laws and regulations. See 45 C.F.R. § 164.512. Before using or disclosing PHI for one of the above exceptions, The Mariposa Center's staff must consult the Mariposa Center's Privacy Officer (Emily McNeil, 720-288-5090) to ensure compliance with the Privacy Rule. Violation of these federal and state guidelines is a crime carrying both criminal and monetary penalties. Suspected violations may be reported to appropriate authorities, as listed above in the "Client Rights" section, in accordance with federal and state regulations. Know that The Mariposa Center will never market or sell your personal information without your permission.

SPECIAL AUTHORIZATIONS

Certain categories of information have extra protections by law, and thus require special written authorizations for disclosures.

Psychotherapy Notes: The Mariposa Center may keep and maintain "Psychotherapy Notes", which may include but are not limited to notes your primary therapist has made about your conversation during a private, group, joint, or family counseling session, which is kept separately from the rest of your record. These notes are given a greater degree of protection than PHI. These are not considered part of your "client record." The Mariposa Center will obtain a special authorization before releasing your Psychotherapy Notes.

HIV Information: Special legal protections apply to HIV/AIDS related information. The Mariposa Center will obtain a special written authorization from you before releasing information related to HIV/AIDS.

Alcohol and Drug Use Information: Special legal protections apply to information related to alcohol and drug use and treatment. The Mariposa Center will obtain a special written authorization from you before releasing information related to alcohol and/or drug use/treatment.

You may revoke all such authorizations to release information (PHI, Psychotherapy Notes, HIV information, and/or Alcohol and Drug Use Information) at any time, provided each revocation is in writing, signed by you, and signed by a witness. You may not revoke an authorization to the extent that (1) The Mariposa Center has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, the law provides the insurer the right to contest the claim under the policy.

As a covered entity under the Privacy and Security Rules, The Mariposa Center is required to reasonably safeguard PHI from impermissible uses and disclosures. Safeguards may include, but are not limited to the following:

1. Not leaving test results unattended where third parties without a need to know can view them.
2. Any PHI received as The Mariposa Center employee, intern/extern, or volunteer about a client or potential The Mariposa Center client, may not be used or disclosed for non-work purposes or with unauthorized individuals. The Mariposa Center may only use and disclose such PHI as described above.
3. When speaking with a client about his or her PHI where third parties could possibly overhear, the conversation will be moved to a private area.
4. Seeking legal counsel in uncertain situations and/or incidences.
5. Obtaining a Business Associates Agreement with those third-parties that have access to and/or store client information. Some of the functions of the practice may be provided by contracts with business associates. For example, some of the billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services.
6. Implementing FAX security measures
7. Obtaining your consent prior to sending any PHI by non-secure electronic transmissions
8. Providing information on The Mariposa Center's electronic record-keeping.

YOUR CHOICES:

For certain health information, you can tell us (verbal authorization) your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. We may request you sign a separate document if you authorize us to share certain PHI. You may revoke that authorization at anytime for future disclosure.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest and for your care/treatment. We may also share your information when needed to lessen a serious and imminent threat to public health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

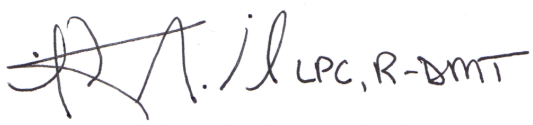
In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

This notice is effective 6-23-2016.



Emily McNeil, LPC, BC-DMT

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

Client's Name:_____

Client or Parent/Guardian Signature(s):_____Date:_____

Client or Parent/Guardian Signature(s):_____Date:_____

Therapist Signature:_____Date: _____

Supervisor Signature:_____Date: _____