Statement of Counseling Policies and Procedures at Four Winds Counseling Center

COUNSELING SESSIONS: Counseling sessions last fifty 50 to 55 minutes unless previously arranged with your therapist. Sessions typically begin on the hour and end on time. Therefore, it will be to your advantage to arrive on time so that you can benefit from a full-length session. Please remember the importance of keeping your appointment.

CANCELLATIONS AND RESCHEDULING: • If for some reason you must cancel your appointment, notify the office at 720-279-4631 as soon as you know you cannot keep the appointment. You may leave a voicemail. A 24-hour business day notice is required in order to avoid payment for the scheduled session. Business days constitute Monday-Friday. Therefore, if an appointment is scheduled for Monday at 9 am then notice in regard to cancelation MUST be received by 9 am on the Friday prior to Monday appointment. • Repeated cancellations or frequent "no-shows" will mean that further appointments may not be scheduled.

FEES FOR COUNSELING: The fee for your counseling sessions is $ _____ per clinical hour. Counseling fees are due at the end of each session. You may pay by MasterCard, Visa, cash, or check (please make checks payable to Four Winds Counseling Center) either before or immediately following your session. *Please be aware that phone communications are considered appointments and will be charged per quarter hour. Further, e-mail correspondence may be charged at the discretion of your counselor.

INSURANCE AND RECEIPTS: We accept Cigna, Anthem Blue Cross and Beacon Health Insurance. All insurance claims will be processed through C & L Billing Management at 303-280-6262. Co-payment is required at every session preferably with cash or check. If using a credit card, it will have a processing fee of $3 per co-payment session.
If you are out of network, we offer an insurance claim form for you to file with your insurance company. Cash or check is preferred at the time of session. If using a credit card, it will be subject to a small processing fee.

EMERGENCY SITUATIONS: If at any time you become extremely emotionally distressed or are in danger of hurting yourself or someone else, please call 911 for assistance immediately. We have a 24 hour policy of responding to the emergency.

CONTACTING US: You may email your counselor at: mhunt@fourwindscounselingcenter.com. You may also contact our office at 720-279-4631.

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

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations. ■ Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc. ■ Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services. ■ Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc. In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to

do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFOR¬MATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below: ■ The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. ■ The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations. ■ The right to request an amendment to your PROTECTED HEALTH INFORMATION. ■ The right to receive an accounting of disclosures or PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations. ■ The right to obtain a paper copy of this notice for us upon request. We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECED HEALTH INFORMATION. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact: The Privacy Officer Four Winds Counseling Center 4891 Independence St. Suite 170 Wheat Ridge, CO 80033 720-279-4631 mhunt@fourwindscounselingcenter.com

For more information about HIPAA or to file a complaint: The U.S. Department of Health & Human Services Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 877.696.6775 (Toll-Free) Acknowledgement of Receipt: Privacy Practice Notice 4891 Independence St. Suite 170, Wheat Ridge, CO 80033 mhunt@fourwindscounselingcenter.com 720-279-4631

CLIENT FULL NAME PARENT / GUARDIAN FULL NAME I, _____ have received a copy of Four Winds Counseling Center, LLC Notice of Privacy Practices. Street Address:

_____

_____ City: _____ State: _____ Zip: _____ I, _____ have received a copy of Four Winds Counseling Center, LLC Notice of Privacy Practices. If Different from Above Street Address:

_____

_____ City: _____ State: _____ Zip: _____

CLIENT (Signed) : _____ Date: _____ PARENT / GUARDIAN (Signed) : _____ Date: _____

WITNESSED (Signed) : _____ Date: _____ Informed Consent and Release of Liability 4891 Independence St. Suite 170, Wheat Ridge, CO 80033 mhunt@fourwindscounselingcenter.com 720-279-4631 Client Name (please print): _____

1) I understand that my counselor is working under Colorado laws, rules and statutes as a Licensed Professional Counselor. 2) I understand that my counseling records are kept confidential, except where disclosure is required by law or the ethics of the counseling profession (i.e. abuse of a child, elderly or disabled person; potential harm or threat to self or others; child custody cases that go before a court of law; and specific information subpoenaed by a court of law). 3) In consideration of the benefits to be derived from the counseling, the receipt whereof is hereby acknowledged, I hereby release, remise and forever discharge and covenant not to sue or hold legally liable Four Winds Counseling Center, LLC., its employees or officers from any and all claims, demands, actions, or causes of action of whatsoever kind and nature related to the counseling process. 4) The clinical records are the property of Four Winds Counseling Center, LLC and are deemed records of confidential sessions between therapists and clients. I waive any right I may otherwise have to seek to use the clinical records of the counseling center as evidence in any judicial proceedings. I understand that if anyone from this office is subpoenaed or court ordered to testify in court as an expert witness, court fees are separate from the counselor's regular counseling rates and I will need to contact the Four Winds Office for the court fees. 6) Counseling sessions last approximately 50-55 minutes. Please remember the importance of keeping your appointment. If for some reason you must cancel your appointment, notify our office as soon as you know you cannot keep the appointment. 24-hour business day notice is required in order to avoid payment for the scheduled session. Business days constitute Monday-Friday. Therefore, if an appointment is scheduled for Monday at 9AM then notice in regard to cancelation MUST be received by 9AM on the Friday prior to Monday appointment. Repeated cancellations or frequent "no-shows" will mean that further appointments may not be scheduled. Counseling fees are due at the end of each session by cash, check made payable to Four Winds Counseling Center, or credit card. MasterCard or VISA is accepted with processing fees added separate from the counseling fee. If at any time you become extremely emotionally distressed or are in danger of hurting yourself or someone else, please call 911 for assistance immediately. We provide a 24 hour response time.

My signature below indicates that I grant informed consent for Four Winds Counseling Center to provide psychological services and counseling to myself and/or minor members of my family.

_____ _____

Client Signature Date

_____ _____

Parent / Guardian Signature Date