FULLife COUNSELING James D Lewis Mdiv MA LPC • 141 West Davies Ave, Littleton, CO 80120 • 303.730.1717 x224 • jimlewis@southwestcounseling.org

CLIENT INFORMATION

Client Name _____ Date _____

Date of Birth _____ Gender _____ Relational Status _____

Phone (c) _____ Phone (h) _____ Leave message? _____

Street Address _____ City _____

State _____ ZIP _____ Email _____

Employer / School _____ _____

Religious / Spiritual Orientation _____

Church / Group Affiliation _____

Pastor / Minister / Leader _____ Phone _____

Primary Care Physician _____ Phone _____

Psychiatrist / PA _____ Phone _____

Other Health Provider _____ Phone _____

Partner Information

Name _____ Together Since _____

Include in Sessions? _____ Phone (c) _____ Phone (h) _____

VM / Text / Email? _____ Email _____

Street Address _____ City _____

State _____ ZIP _____ Living Together? _____

Emergency Contact

Name _____ Relationship to Client _____

Phone (c) _____ Phone (h) _____ VM / Text? _____

Street Address _____ City _____

State _____ ZIP _____ Email _____

Other mental health services you have received or are receiving

_____

_____

_____

_____

Please fill out page 2

James D Lewis, MDiv MA LPC Client _____

What are your reasons for seeking counseling?

_____

_____

_____

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_____

What goals do you want to accomplish in counseling?

_____

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_____

What do you expect from Jim Lewis as your counselor?

_____

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What else should Jim Lewis know in order to best serve you?

_____

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James D Lewis, MA, MDiv, LPC

DISCLOSURE AND INFORMED CONSENT

I am committed to quality time-effective treatment for all clients regardless of age, race, sex, or religious affiliation. For those who request it I offer counseling from a Christian perspective, including references to the Bible and spiritual writings, along with spiritual practices such as prayer and contemplation.

PAYMENT POLICIES

I am an independent contractor for SonderMind, an interface linking clients, therapists and payors. All my clients who use insurance to pay for services meet with me through SonderMind, which bills clients for any copays and deductibles determined by their insurance providers. Most of my self-pay clients also see me through SonderMind, and pay an out-of-pocket fee that is lower than that of most therapists. Apart from SonderMind, my **default fee is $120** for a 50-minute session. For clients with specific financial needs, I will attempt to negotiate a fee that allows them to receive treatment.

Payment is due at the time of services. Charges are agreed to be correct and reasonable unless challenged in writing within thirty days of the billing date. **A $35 administrative fee will be charged on all checks that are returned**.

If there are expenses due to legal action creating the need for me to consult with attorneys, you will be responsible for all fees, including but not limited to phone calls, written reports, or court appearances.

CANCELLATIONS / MISSED APPOINTMENTS

When you cancel or reschedule an appointment, it is important that you notify me **at least 24 hours before** the scheduled session. If canceling or rescheduling a Monday appointment, you will need to notify me by the Friday before the appointment. **Appointments rescheduled or cancelled with less than 24 hours' notice will be charged the regular per-session rate**. I may reduce or waive the fee in exceptional cases where the client explains that 24 hours' notice was impossible.

DIVORCE AND CUSTODY LITIGATION

My role is **not** to make recommendations to a court concerning custody or parenting issues. By signing this Disclosure and Consent Form, you agree not to subpoena me in child custody litigation to testify in court or to disclose information about the treatment I provided. You agree not to request that I write any reports to the court or to your attorney, making recommendations concerning custody. The court can appoint professionals who have no prior relationship with family members to investigate and evaluate what is in the best interests of the family's children, and to make recommendations to a court concerning parental responsibilities or parenting time.

REGULATION OF PSYCHOTHERAPISTS

I am a **Licensed Professional Counselor** (LPC). An LPC must hold a master's degree relating directly to the practice of psychotherapy and must have two years of post-graduate professional supervision.

Professionals in the field of psychotherapy are regulated by the Department of Regulatory Agencies. **Regulatory boards can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800**.

CLIENT RIGHTS AND THERAPIST OBLIGATIONS

1. You are entitled to receive information about my methods of therapy, the techniques I use, the expected duration of your therapy, and my fees. Please ask if you would like to receive this information.
2. You may seek a second opinion from another therapist, and you may terminate therapy at any time.

3. Sexual or romantic intimacy between a therapist and a client is never appropriate. If such intimacy occurs, it should be reported immediately to the board that licenses, certifies or registers the therapist.

4. Information exchanged during therapy sessions between the client and a licensed professional counselor (as well as other licensed/certified mental health professionals) is legally confidential except as provided in section 12-43-218 and the HIPAA Notice of Privacy Practices you were provided. I will notify you should a situation arise in which one or more of those exceptions apply.

5. Exceptions to confidentiality include the following:

   (a) I am required to report to law enforcement any suspected incident of child abuse or neglect

   (b) I am required to report any serious threat of imminent physical violence against a specific person or persons, including those identifiable by their association with a specific location or entity

   (c) I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental disorder

   (d) I am required to report any suspected threat to national security to federal officials

   (e) I may be required by court order to disclose treatment information

   (f) I am required to report suspected neglect, abuse, or exploitation of elderly individuals

   (g) I consider it an ethical obligation to report suspected or observed mistreatment, neglect, or exploitation of at-risk adults, including those with physical or mental impairment

6. In compliance with Colorado State law, all documents related to your care may be shredded seven (7) years after last clinical contact or after the client reaches the age 18 years 6 months, whichever is later.

CONSULTATION

I make it a practice to consult with other mental health professionals to ensure that I am offering my clients the best possible services. At no time during consultation will I disclose information that directly or indirectly identifies a client. Consultation involves a review and discussion of therapeutic processes, not of the specific clients involved.

AUTHORIZATION FOR TREATMENT

I have read this disclosure. I am aware of my therapist's degrees and credentials, as well as any other information I need to determine his qualifications to serve as my mental health provider. I understand the conditions as stated above, and I agree to receive counseling Jim (James) Lewis under these conditions.

_____

PRINTED Name of Client

_____ _____

SIGNATURE of Client Date of Signature

_____ _____

SIGNATURE of Partner (if in joint therapy) Date of Signature

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PAYMENT AGREEMENT

Name _____

Address _____

Phone _____ Email _____

I understand and agree that the hourly self-pay fee for psychotherapy with Jim Lewis is set by SonderMind, and will be collected at the time of service. If paid directly to Jim Lewis, the hourly fee is $120.00, also due at the time of service. Any exceptions to this policy must be arranged in writing before the session.

☐ *I choose to keep the following credit card information on file with Jim Lewis to facilitate payment at the time of service*

Check one: ☐ **Master Card** ☐ **VISA**

Name on Card _____ Exp Date _____

Card Number _____ V Code _____
3 digits on back of card

☐ *I choose not to keep credit card information on file with Jim Lewis, and instead will provide payment at the time of service by* _____

Please make checks payable to **James D Lewis**

I agree to pay the full amount for a session that I miss, cancel or reschedule without giving Jim Lewis notice at least 24 hours in advance. I will discuss with Jim Lewis any reasons I have to request modifications or exceptions to this policy.

Signature _____ Today's Date _____

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INSURANCE INFORMATION

Though Jim Lewis receives insurance payments only through SonderMind, providing your insurance information here may help resolve problems with your SonderMind account, or identify reimbursement opportunities

Name of Insurance Company _____

Insurance Company Address _____

Insurance Company Phone Number _____

Name of Policy Holder _____ Policy Holder's SS# _____

ID# _____ Group # _____

Does your policy provide mental health coverage? ☐ Yes ☐ No

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DISCLOSURE AND CONSENT FOR TELETHERAPY SERVICES

As our community navigates the COVID-19 (Coronavirus) pandemic, FULLife Counseling is offering teletherapy services to clients. "Teletherapy" is defined by the state of Colorado as "a mode of delivery of mental health services through telecommunications systems, including information, electronic, and communications technologies, to facilitate the assessment, diagnosis, treatment, education, care management, or self-management of a person's mental health care while the person is located at an originating site and the provider is located at a distant site." Teletherapy technologies include those devices and technologies that allow secure electronic communication and information exchange between a mental health professional and client located in different locations. You will agree with your provider on the type of teletherapy technology you will utilize before beginning teletherapy.

While the use of teletherapy services offers significant potential benefits during this time, there are issues unique to teletherapy that you should be aware of and consider in your decision to engage in teletherapy services with FULLife Counseling.

Location of Client and Provider at the Time of Teletherapy Service

The provision of services is considered to have occurred where the client is located at the time of service. Therefore, any ongoing teletherapeutic services may only occur when the client is present in the state their provider is licensed or authorized to practice. Exceptions may exist for those in another state, as long as residency remains in Colorado, but discuss this with your provider.

Professional Nature of Teletherapy Services

The relationship between a provider and client utilizing teletherapy at FULLife is a professional relationship between you and your provider that falls under the same conditions outlined in the FULLife Counseling Disclosure and Consent Form. This includes all matters related to the rules and regulations governing client confidentiality.

Length of Session and Fees

The length of teletherapy sessions will be identical to face-to-face therapy (45-50 minutes). Fees will be collected under the same conditions outlined in your provider's FULLife Counseling's face-to-face therapy and the alternative would otherwise be to receive no clinical services. Potential disadvantages of teletherapy, when compared to face-to-face therapy may include, but are not limited to, misunderstandings between a provider and client when the visual cues that would normally occur during a face-to-face visit do not exist, the inability of the therapist to be immediately available to provide emergency services if needed and the potential for the means or substance of communication in teletherapy being accessed by an unauthorized party despite appropriate efforts made to avoid this by both provider and client.

Disruption of Service

If services are disrupted or disconnected in the course of teletherapy, your provider will attempt to contact you as quickly as possible through the means of teletherapy you were using at the time of disruption. If service is disrupted or disconnected in the course of teletherapy when you are in a state of emergency and your provider is unable to contact you in a timely manner you may call 911, go to your local emergency room or call Colorado Crisis Services at (844) 493-8255, or text "TALK" to 38255.

Record Keeping for Teletherapy Services

Teletherapy services received by clients of FULLife Counseling will not be recorded unless mutually agreed upon by you and your provider. Client records of teletherapy services will be kept by your provider according to generally accepted standards of mental health practice.

DISCLOSURE AND CONSENT FOR TELETHERAPY SERVICES

Duration of Teletherapy Services

At this time, FULLIFE COUNSELING will provide ongoing teletherapy services for as long as circumstances related to the COVID-19 (Coronavirus) pandemic warrant and your FULLIFE COUNSELING provider is able to administer them. Because FULLIFE COUNSELING views face-to-face therapy as preferable to teletherapy, face-to-face therapy will be expected to begin/resume when your provider deems it appropriate to do so. By consenting to the terms of this agreement you are also agreeing to begin/resume face-to-face therapy at our offices under these conditions.

Confidentiality and Security

FULLIFE COUNSELING will only use teletherapy technologies deemed sufficiently confidential and secure according to generally accepted standards of practice. While FULLIFE COUNSELING and your FULLIFE COUNSELING provider can maintain generally accepted standards for confidentiality and technological security from the location they are treating you from, it is your responsibility to maintain confidentiality and technological security from your location. All clients of FULLIFE COUNSELING receiving teletherapy are advised to only receive these services in a private room where they will not experience interruption and the communication of the provider and client cannot be heard by a non-participating party.

By participating in teletherapy with FULLIFE COUNSELING you are stating that you have considered and ensured these conditions whenever teletherapy services are rendered. In addition, FULLIFE COUNSELING cannot be responsible for the security of the technological device you use to receive teletherapy. Even the most secure forms of technological communication are vulnerable to access by an unauthorized party and you accept that risk by choosing to participate in teletherapy.

It is also the client's responsibility to ensure that all necessary technological security measures are in place at their location before receiving teletherapy. Your provider cannot advise you on these specific matters and you may consult a professional for assistance if necessary. If you are unable to ensure these measures appropriately, you are advised by FULLIFE COUNSELING to not participate in teletherapy or to reschedule teletherapy services until such measures are in place.

Informed Consent

I have read this disclosure or have had it read to me. I understand the conditions for teletherapy services at FULLife Counseling as stated above and …

☐ I DO NOT intend to receive teletherapy services from my provider at this time.

☐ I AGREE to receive teletherapy services from my provider under these conditions.

Email (*required for video sessions)* _____

_____

PRINTED Name of Client

_____ _____

SIGNATURE of Client Date of Signature

_____ _____

SIGNATURE of Partner (if in joint therapy) Date of Signature

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PROCEDURE FOR CLIENT EMERGENCIES

If you are in need of immediate assistance, please contact **Colorado Crisis Services** (CCS), which offers more specialized services and quicker response time than an individual counselor can provide. Please notify me if you have called, or plan to call CSS. As always, I welcome you to contact me when a 24-hour response time is sufficient.

You can contact CCS 24/7 by phone, text or personal visit. I encourage you to enter the following contact information in your cell phone for quick reference:

COLORADO CRISIS SERVICES

Providing 24-hour Care for Mental Health Emergencies and Crises

Phone **1 (844) 493-8255**
Text **"TALK"** *to* **38255**
Visit for more information **coloradocrisisservices.org**

Six 24-hour walk-in Clinics

Westminster Walk-in
2551 W 84th Avenue
Westminster, CO 80031

Denver Walk-in
4353 E Colfax Avenue
Denver, CO 80220

Boulder Walk-in
3180 Airport Road
Boulder, CO 80301

Littleton Walk-in
6509 S Santa Fe Drive
Littleton, CO 80120

Lakewood Walk-in
12055 W 2nd Place
Westminster, CO 80228

Aurora Walk-in
2206 Victor Street
Aurora, CO 80045

I understand that in a crisis requiring immediate intervention, I am advised to contact Colorado Crisis Services, and if I do so, to notify Jim Lewis at my first opportunity.

_____
PRINTED Name of Client

_____ _____
SIGNATURE of Client Date of Signature

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James D Lewis, MA MDiv LPC

NOTICE OF PRIVACY PRACTICES

This notice describes how medical (including mental health) information about you may be used and disclosed, and how you can access this information. Please review this notice carefully.

I am required by law to maintain the privacy of protected health information, and must inform you of my privacy practices and legal duties. You have the right to obtain a paper copy of this Notice upon request.

I am required to abide by the terms of the Notice of Privacy Practices that is most current. I reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that I maintain. I will inform you promptly of any changes to this Notice. You may request a copy of the revised Notice at any time.

I am responsible to answer your questions about my privacy practices and to ensure that I comply with applicable laws and regulations. I will also take your complaints and can give you information about how to file a complaint

Use and disclosure of your protected health information that I may make to carry out treatment, payment, and health care operations:

I may use information in your record to provide treatment to you. I may disclose information in your record to help you get health care services from another provider, a hospital, etc. For example, if I want an opinion about your condition from another professional, I may disclose information to the professional to obtain that consultation.

I may use or disclose information from your record to obtain payment for the services you receive. For example, I may submit your diagnosis with a health insurance claim in order to demonstrate to the insurer that the service should be covered.

I may use or disclose information from your record to allow "health care operations." These operations include reviewing records to see how care can be improved, contacting you with information about treatment alternatives, and coordinating care with other providers.

FULLife Counseling may also contact you to remind you of appointments and to tell you about treatments or other services that may be of benefit to you.

Your Rights

You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. I will consider your request, but I have the right to refuse if I believe that is in your best interest.

You have a right to receive confidential communications from me. For example, if you want to receive bills and other information at an alternative address, please notify me.

Client Initials _____ _____

You have a right to inspect the information in your record, and may obtain a copy of it. This may be subject to certain limitations and fees. Your request must be in writing.

If you believe information in your record is inaccurate or incomplete, you may request amendment of the information. You must submit sufficient information to support your request for amendment. Your request must be in writing. FULLife Counseling is not required to amend your record if it is determined that the record is complete and accurate.

You have the right to request an accounting of certain disclosures made by me. This request must be made in writing.

You have the right to complain to me about my privacy practices with respect to the privacy of your health information (including the actions any staff I may hire). You have the right to complain to the Secretary of the Department of Health and Human Services about my privacy practices. You will not face retaliation for making complaints.

Except as described in this Notice, I may not make any use or disclosure of information from your record unless you give your written authorization. You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by me before the revocation. In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization.

You have the right to obtain another copy of this notice upon request.

Use or disclosure of your protected health information that I am <u>required</u> to make without your permission

In certain circumstances, I am required by law to make a disclosure of your health information. For example, state law requires me to report suspected child abuse or neglect. Also, I must disclose information to the Department of Health and Human Services, if requested, to prove that I am complying with regulations that safeguard your health information.

If you receive mental health care, including treatment for substance abuse, information related to that care may be more protected than other forms of health information. Communications between a psychotherapist and patient in treatment are privileged and may not be disclosed without your permission, except as required by law. For example, psychotherapists still must report suspected child abuse, and may have to breach confidentiality if you appear to pose an imminent danger to yourself or others, in order to reduce the likelihood of harm to you or others.

Use or disclosure of your protected health information that I am <u>allowed</u> to make without your permission

There are certain situations where I am allowed to disclose information from your record without your permission. In these situations, I must use my professional judgment before disclosing information about you. Usually, I must determine that the disclosure is in your best interest, and may have to meet certain guidelines and limitations.

Client Initials _____ _____

I may use or disclose information from your record if I believe it is necessary to prevent or lessen a serious and imminent threat to the safety of a person or the public. I may report suspected cases of abuse, neglect, or domestic violence involving adult or disabled victims.

I may assist in health oversight activities, such as investigations of possible health care fraud. I may disclose information from your record as authorized by workers' compensation laws.

I may disclose information from your record if ordered to do so by a court, grand jury, or administrative tribunal. Under certain conditions, I may disclose information in response to subpoena or other legal process, even if this is not ordered by a court.

I may disclose information from your record to a law enforcement official if certain criteria are met. For example, if such information would help locate or identify a missing person, I am allowed to disclose it.

If you tell me that you have committed a violent crime that caused serious physical harm to the victim, I may disclose that information to law enforcement officials. However, if you reveal that information in a counseling or psychotherapy session, or in the course of treatment for this sort of behavior, I may not disclose the information to law enforcement officials.

I may use or disclose information from your record for research under certain conditions.

Under certain conditions, I may disclose information for specialized government purposes, such as the military, national security and intelligence, or protection of the President.

Crimes on the premises or observed by SCA staff

Crimes that are observed by SCA staff, that are directed toward staff, or occur on SCA's premises will be reported to law enforcement.

Confidentiality of alcohol and drug abuse consumer information

Federal law and regulations protect the confidentiality of alcohol and drug abuse consumer records. Generally, FULLife Counseling may not disclose to a person outside of my practice that any information identifying a client as an alcohol or drug abuser, unless:

1) The client consents in writing; OR
2) The disclosure is allowed by a court order, OR
3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the federal law and regulations by FULLife Counseling is a crime. Suspected violations may be reported to the United States Attorney in the District of Colorado.

Federal law and regulations do not protect any information about suspected child abuse or neglect being reported under Colorado law to appropriate state or local authorities.

Client Initials _____ _____

Please sign next page

I have read the contents of this Notice, and have had the opportunity to ask questions and make comments. I understand and agree to the terms of this Notice.

_____

PRINTED Name of Client

_____ _____

SIGNATURE of Client Date of Signature

_____ _____

SIGNATURE of Partner (if in joint therapy) Date of Signature