The Center for Learning and Psychological Services

6658 Gunpark Dr Suite 201
Boulder CO 80301

Understanding of Insurance

I hereby acknowledge and understand that, although The Center for Learning and Psychological Services may have provided me with information concerning my insurance benefits and coverage for services provided, I am ultimately responsible for investigating and understanding those benefits and coverage. I further understand that I am responsible for payment of all services I have requested and have been provided to me by The Center, regardless of insurance benefit coverage.

__________________________________ ____________________________________

Print Name (responsible party)   Client name

____ ________________

Signature   Date

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Receipt of Notice of Privacy Practice and Psychological Evaluation Agreement

I have read or had read to me the information in the *Psychological Evaluation Agreement* and agree to abide by its terms. I acknowledge that I have received the HIPAA *Notice of Psychologist's Practices to Protect the Privacy of Your Health Information* described in this agreement. I have discussed all questions and concerns I have about this document with Dr. Brown and/or a representative of her office and have received satisfactory answers or explanations. I understand that no guarantee or about evaluation results is being offered or implied. I understand that no specific promises have been made to me about the results of treatment, the effectiveness of the procedures that may be used, or the number of sessions necessary for therapy to be effective.

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Client Name (Printed)

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Client or Parent/Guardian Signature   Date
(if client under 18 years of age)
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720 883 8849

Digital Communication – HIPAA & TCPA Compliance

Unencrypted Text Message, Email Language, Voicemail and Video Conference

We offer helpful administrative information via text messaging, emails, phone and conduct some video appointments. There is some level of risk, that information in a regular text message or email could be read by someone besides you. Please indicate below your communication preferences.

_____ **YES** – please communicate with me by **email**. My email address is:

_____

_____ **NO** – please do not communicate with me by regular (unencrypted) email

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_____ **YES** – please communicate with me by **text** message. My cell phone number is:

_____

_____ **NO** – please do not communicate with me by regular (unencrypted) text message

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_____ **YES** – I give permission for unencrypted **video** appointments.
_____ **NO** – please do not schedule video appointments with an unencrypted platform.

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_____ **YES** – I give permission for **voicemail** messages to be left on the phone number on file.
_____ **NO** – please do not leave voicemail messages.

I am aware of the risks associated with digital communication and allow The Center for Learning and Psychological Services (CLPS) to contact me as indicated above. It is my responsibility to alert CLPS in writing of any changes to my contact information or if I want to opt-out of these options.

PRINT Client Name: _____
And Guardian name (if applicable)

_____ Date: _____
Client and/or Guardian Signature

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Teletherapy Agreement & Informed Consent

1. You understand that "teletherapy" includes consultation, treatment, transfer of medical data, emails, telephone conversations, and education using interactive audio, video, or data communications. You also understand that teletherapy/coaching also involves the communication of your medical/mental health information, both orally and visually.

2. Unless we explicitly agree otherwise, our teletherapy exchange is strictly confidential. Any information you choose to share with me will be held in the strictest confidence. Just like my face to-face clients, I will not release your information to anyone without your prior approval unless I am required to do so by law. In Colorado, we are required to notify authorities if we become convinced a client is about to physically harm someone, or if they are abusing or about to abuse children, the elderly, or the disabled.

3. You understand that our teletherapy services are furnished in the state of Colorado, (USA), and the services I provide are governed by the laws of that state. In a manner of speaking, you are using this modality to visit me in my Colorado office, where we meet to do our work.

4. You have the right to withdraw or withhold consent from teletherapy services at any time. You also have the right to terminate treatment at any time.

5. You understand that there are risks and consequences with teletherapy services including, but not limited to, the possibility, despite reasonable efforts on my part, that: the transmission of your medical information could be disrupted or distorted by technical failures; the transmission of your information could be intercepted by unauthorized persons, and/or the electronic storage of your medical information could be accessed by unauthorized persons.

6. In addition, you understand that teletherapy based services and care may not be as complete as traditional face-to-face services. While teletherapy is a great way to get help with many of life's problems, overwhelming and potentially dangerous challenges are best met with face-to-face professional support. You understand that teletherapy is neither a universal substitute, nor the same as face-to-face psychotherapy. If I believe that your needs would best be served by a local professional, you will be referred to a professional who can provide such services in your area. Finally, you understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts or the efforts of any such provider, your condition may not improve, and in some cases may even get worse.

7. You understand that you may benefit from teletherapy, but that results cannot be guaranteed or assured.

8. You understand and accept that teletherapy does not provide emergency services. If you are experiencing an emergency situation, you understand that the protocol would be to call 911 or proceed to the nearest hospital emergency room for help. If you are having suicidal thoughts or making plans to harm yourself, you may also call the National Suicide Prevention Lifeline at 1- 800-273-TALK (8255) for free 24 hour hotline support.

9. You will be responsible for the following: (1) providing the computer and/or necessary telecommunications equipment and internet access for your teletherapy sessions, (2) securing or encrypting protected health information (PHI) transmitted to or stored on your computer/telecommunications device, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for your teletherapy sessions.

10. You understand that while email may be used as a form of communication with me, that confidentiality of emails cannot be guaranteed due to complexities and abnormalities involved with the Internet, including, but not limited to, viruses, Trojans, worms, and other involuntary intrusions that have the ability to obtain and disseminate information you wish to keep private.

11. You have the right to access your medical information and copies of your medical records in accordance with HIPAA privacy rules and applicable state law.

12. If you reside out of your e-therapist's state of professional licensure, you understand and agree that you are soliciting the services of a professional outside of your state of residence. By doing this, you agree that the "point-of-service" of therapy is to occur in the therapist's state of professional licensure, and that you are using your computer/telecommunications device to virtually travel to that state. Hence, therapists are accountable to and agree to abide by the ethical and legal guidelines prescribed by their state of professional licensure. By agreeing to solicit the out-of-state therapist's services, you agree to these terms. I have read and understand the information provided above.

I have discussed it with my Psychologist, and all of my questions have been answered to my satisfaction.

Print Client Name: _____
And parent/guardian/other authorized signatory

Signature of client (or parent/guardian/other authorized signatory)

_____

Date: _____

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Mandatory Disclosure Statement for Holly Brown, PhD

My academic degrees include a PhD from the University of Denver, a CAGS from North Eastern University in Boston, M.A. in School Psychology and a Masters from Westchester University in PA in Clinical Psychology. I am licensed as a Psychologist in the state of Colorado since 2010 and in Rhode Island since 2004.

In order to comply with § 12-245-216(1)(b)(I), C.R.S I must inform you about the following professions:

A Registered Psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado, but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.
- A Certified Addiction Counselor I (CAC I) must be a high school graduate or equivalent, complete required training hours and 1,000 hours of supervised experience.
- A Certified Addiction Counselor II (CAC II) must be a high school graduate or equivalent, complete the CAC I requirements, and obtain additional required training hours, 2,000 additional hours of supervised experience, and pass a national exam.
- A Certified Addiction Counselor III (CAC III) must have a bachelor's degree in behavioral health, complete CAC II requirements, and complete additional required training hours, 2,000 additional hours of supervised experience, and pass a national exam.
- A Licensed Addiction Counselor must have a clinical master's degree, meet the CAC III requirements, and pass a national exam.
- A Licensed Social Worker must hold a master's degree from a graduate school of social work and pass an examination in social work.
- A Licensed Clinical Social Worker must hold a master's or doctorate degree from a graduate school of social work, practiced as a social worker for at least two years, and pass an examination 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 Licensed Marriage and Family Therapist must hold a master's or doctoral degree in marriage and family counseling, have at least two years post-master's or one year post-doctoral practice, and pass an exam in marriage and family therapy.
- A Licensed Professional Counselor must hold a master's or doctoral degree in professional counseling, have at least two years post-master's or one year postdoctoral practice, and pass an exam in in professional counseling.
- A Licensed Psychologist must hold a doctorate degree in psychology, have one year of post-doctoral supervision, and pass an examination in psychology.

The practice of licensed and unlicensed persons in the field of psychology, is regulated by the Department of Regulatory Agencies. Questions or complaints should be addressed to: State Grievance Board, Department of Regulatory Agencies, 1560 Broadway, Suite 1340, Denver, CO 80202. Their phone number is (303) 894-7800. In a professional relationship such as ours, sexual intimacy between a therapist and patient is never appropriate. If sexual intimacy occurs, it should be reported to the State Grievance Board.

You are entitled to receive information about my methods of therapy, the techniques used, the duration of therapy (if known), and the fee structure. You may seek a second opinion from another therapist at any time.

Generally speaking, the information provided by a patient during psychotherapy sessions is legally confidential if the therapist is a licensed psychologist. If the information is legally confidential, the therapist can not be forced to disclose the information without the patient's consent.

There are certain exceptions to the general rule of legal confidentiality, including: if a patient appears to be a danger to self or others; or when treatment is provided pursuant to criminal or delinquency proceedings. Additionally, in the event of actual or suspected child abuse or neglect, I am required by law to report this to the Department of Social Services.

No information about you will be released to a third party without your written permission.

As a sole provider in independent practice, I am unable to provide extensive or frequent emergency care. If you believe that you will need frequent emergency attention between scheduled sessions, please discuss this with me immediately so that I can refer you to a provider who can better serve your needs.

If you have questions or would like additional information, please feel free to ask.

I have read the preceding information and understand my rights as a patient.

_____ _____

Print CLIENT name Print Parent/Guardian Name

_____

Signature Date