DISCLOSURE STATEMENT

Can you read this document? Please mark: _____yes _____no

1. Marne Wine, M.A., LPC, P.C. 950 S. Cherry St., Ste 410, Denver, CO 80246 Tel: 720.234.9058
2. **Degrees:** University of Colorado at Denver Counseling/Psychology Masters Degree, 1995, requiring the following: 60 credit hours education course work, 150 hours practicum lab, 600 hours internship.
   License: State of Colorado Licensed Professional Counselor #1983, requiring the following: Masters degree from CACREP approved program, 2500 hours post-degree experience, 200 hours of supervision.
   Certifications: Certified Sex Therapist and Supervisor by American Association of Sex Educators, Counselors and Therapists (AASECT) requiring the following: AASECT membership, adhere to AASECT Code of Ethics, Masters degree from accredited college or university, minimum 1,000 clinical hours of experience, valid state license in counseling, completion of minimum of 90 hours of education in core areas from accredited college or university, completion of minimum of 60 hours of sex therapy training for psychosexual disorders found in DSM-IV/V, 10 hours of structured group experience. AASECT approved Sexual Attitude Reassessment (SARS) training, minimum of 250 supervised clinical treatment of patients/clients who present with sexual concerns, and minimum of 50 hours of individual supervision with an AASECT approved supervisor.
3. The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The Board of Licensed Professional Counselor Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. As to the regulatory requirements applicable to mental health professionals:
   - 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.
   - Certified Addiction Counselor I (CAC I) must be a high school graduate, complete required training hours and 1, 000 hours of supervised experience.
   - Certified Addiction Counselor II (CAC II) must have a bachelors degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience.
   - Licensed Addiction Couonselor must have a clinical masters degree and meet the CAC III requirements.
   - Licensed Social Worker must hold a masters degree in social work.
   - Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Couonselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.
   - Licensed Clincial Social Worker, a Licensed Marriage and Family therapist, and a **Licensed Professional Counselor** must hold a masters degree in their profession and have two years of post-masters supervision.
   - A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.

Office Use Only: Name: _____ Chart#: _____

4. You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy (if known), and the fee stsructure. You can seek a second opinion from another therapist or terminate therapy at any time.

The methods of therapy: I primarily use Brief Therapy/Solution Focused, Cognitive Behavioral, Differentiation Approach, Psychodynamic, and Psycho-education. All of these methodsinvolvve talk therapy, some homework, and occasional experiential exercises taught in session (i.e. mindfulness, meditation). The **fee structure** is as follows: I accept some insurances if I have been contracted as a provider health savings plans (HSA) and self-pay. Insurance is a contracted rate determined by individual companies, for 45-50 minute sessions. Self-pay rate is $150 for an intake appointment, 60-90

Office use only:
Name: _____ Chart #: _____

minutes, and $120 for follow up appointments, per 60 minutes. Co-pays and/or full payment, are expected at the time of the appointment. When available, I maintain a small percentage of my practice for sliding scale, for those in need. *I ask that you give at least 24 hours notice if you are going to miss an appointment. When 24 hours is not given, you will be charged for the session.*

5. 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.
6. Generally speaking, the information provided by and to the lient during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes, and the HIPAA Notice of Privacy Rights you were provided, as well as other exceptions in Colorado and Federal Las. For example, mental health professionals are required to report suspected child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly. If you are a threat to self or others, confidentiality will be breached to get you help. The Mental Health Practice Act (CRS 12-43-101, et seq.) is available at: http://wwwdora.state.co.us/mental-health/Statuted.pdf.
7. I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the client's responsible party.

_____ _____

Print Client Name Partner/Spouse Print Name

_____ _____ _____ _____

Client Responsible Party signature date Partner/Spouse Signature Date

If signed by responsible party, please state relationship to client and authority to consent:

_____ _____

Therapist signature Date

Office use only:

Name: _____ Chart #: _____

BRIEF THERAPY INSTITUTE OF DENVER
www.btid.com

FIRST APPOINTMENT ORIENTATION

Thank you for choosing the Brief Therapy Institute of Denver, Inc for your behavioral healthcare services. We recognize you have many choices and we appreciate your trust in us.

We appreciate your downloading and completing the paperwork prior to your fist session. Completing the paperwork allows your therapist the opportunity to spend a greater amount of time on clinical rather than administrative issues.

Some things to keep in mind:

- ✓ Remember, you can download and print, review, or ask for a complete set of Brief Therapy Institute of Denver, Inc. Privacy Policies.
- ✓ Your therapist will review and answer any questions about this paperwork or other matters.
- ✓ Please bring your authorization number, if given to you by your insurance company.
- ✓ Please bring your insurance card.
- ✓ We will need information about your copayment and/or deductible. If you do not know this information, please contact your insurance company and ask for an explanation of benefit coverage for mental/behavioral health issues.
- ✓ We will need your primary care physician's telephone number.
- ✓ If you have seen a counselor or psychiatrist within the last two years, we will need a telephone number to contact them.
- ✓ It is very helpful for the therapy process if you bring a list of goals for therapy. This will help you and your therapist make better use of the first session.

GOALS FOR THERAPY, PLEASE LIST.

Office use only:
Name: _____ Chart #: _____

Brief Therapy Institute of Denver, Inc.

All Information is kept in strict confidence

CLIENT INFORMATION

NAME:_____

ADDRESS:_____

STREET CITY STATE ZIP

BIRTH DATE:_____ AGE:_____ GENDER: ____ MALE ____ FEMALE

SOCIAL SECURITY #:_____

RELATIONSHIP STATUS: ____ MARRIED ____ SEPARATED ____ SINGLE ____ PARTNERED

____ DIVORCED ____ COHAB. ____ CHILD

I AGREE TO PAY MY CO-PAY OF _____ AT THE END OF EACH SESSION

IF I AM SELF PAYING, I WILL PAY _____ AT THE END OF EACH SESSION

WHOM SHOULD WE THANK FOR THE REFERRAL? _____

CONTACT INFORMATION

HOME/CELL PHONE:_____ BEST TIME TO CALL:_____

Can we leave a message?_____

WORK PHONE:_____ MAY WE CALL YOU IN CONFIDENCE AT WORK:_____

Can we leave a message?_____

PARENT TO CONTACT IF PATIENT IS CHILD: _____

INSURANCE INFORMATION

NAME OF INSURED (if different than patient) :_____

ADDRESS OF INSURED (if different than patient): _____

GENDER: ____ MALE ____ FEMALE BIRTHDATE:_____ SS#: _____

INSURANCE COMPANY:_____ PHONE: _____

ADDRESS: _____

MEMBER ID# _____ GROUP NUMBER:_____

INSURED'S EMPLOYER:_____ STATUS: EMPLOYED TERMINATED LOA

AUTHORIZATION # _____ INSURANCE TYPE: HMO PPO OTHER DEDUCTIBLE: _____

WHO WOULD YOU LIKE NOTIFIED IN CASE OF EMERGENCY?

NAME:_____ RELATIONSHIP TO YOU:_____

ADDRESS:_____

HOME/CELL PHONE:_____ WORK PHONE: _____

Office use only:

Name: _____ Chart #: _____

AGREEMENTS AND DISCLOSURES

(for all participants over 18 years of age)

AGREEMENTS

1. I authorize the Brief Therapy Institute of Denver, Inc. to contact the referral source for treatment, payment, or health care operations, **understanding that personal information will need to be released to my insurance company or the company that manages my benefits**.

   _____ yes _____ no

2. I authorize the Brief Therapy Institute of Denver, Inc. to bill my insurance/managed care company for the psychotherapy. The Brief Therapy Institute of Denver may need to disclose clinical information necessary to process all claims.

   _____ yes _____ no

3. I authorize _____ to make payment directly to
   (insurance/managed care company)
   the Brief Therapy Institute of Denver, Inc. for the benefit specified and otherwise payable to me, but not to exceed the usual and customary charges for the services.

   _____ yes _____ no

4. I authorize the Brief Therapy Institute to mail any correspondence regarding my treatment, satisfaction with treatment, updates about my treatment and educational programs during and after the completion of my treatment to my home mailing address.

   _____ yes _____ no

5. I want my primary care physician to be notified of my treatment at the Brief Therapy Institute of Denver?

   _____ yes _____ no

DISCLOSURES

1. I realize that the Brief Therapy Institute of Denver, Inc conducts research and I understand that all research is calculated, reported, and described in a manner that maintains my confidentiality and total anonymity.

   _____ yes _____ no

2. I understand the Brief Therapy Institute of Denver, Inc cannot be held responsible for being unable to access me due to telephone devices that may block their calls, my use of a pager system in which I cannot be directly reached, any form of caller identification**, or any type of device that does not allow my therapist to make direct telephone contact with me.**

   ____ yes ____ no

FINANCIALS *(Please review this section with your therapist at the first session)*

1. My usual and customary rate for providing direct face-to-face psychotherapy services is $____ per hour, $___ per 45 minutes.
2. You will be billed **$ for not giving a minimum of 24 hours notification** of cancellation. This outstanding balance must be paid prior to additional psychotherapy services being delivered.
3. You will be billed for non covered and non routine services such as extended telephone consultation, crisis intervention, report writing, extended care coordination with other providers at a rate of $____ per minute. You will be informed of events involving additional billing prior to the event.
4. Any legal reporting, consultation, or coordination will be billed at a rate of $____ per minute.

Additional comments/special conditions:

SIGNATURE:_____ DATE:_____

Office use only:

Name: _____ Chart #: _____

Privacy Notice

To comply with federal health insurance portability and accountability act guidelines the Brief Therapy Institute of Denver, Inc. has implemented the following policy regarding patient privacy and confidentiality. You may request a copy of our complete set of guidelines, you can review the guidelines posted in the waiting room, or you may review and download the policies from our web site. Our office holds patient record information confidential and we will only use your information for the following reasons: **treatment, payment and health care operations**. The following is a partial list of whom your information can be disclosed, if needed, to:

- Primary care physicians
- Psychiatrists
- Medical specialists
- Diagnostic facilities
- Hospitals, including psychiatric
- Labs
- Insurance companies
- Billing and collection services
- School officials: administrators, counselors, teachers

Disclosing Record Information

Release of information to any other entity not listed above will require a signed authorization from you or your guardian. This request must be dated, show who the information is to be released to or requested from, the specific information to be released or acquired. These authorizations will have an end date. Additional requests beyond the end date will require a new authorization. We will keep a record of all disclosures in your file. This information will be available for you to review.

You Have a Right to Access Your Records

You can review and obtain copies of your records. Our office requires a written request, and we will make the records available within 10 days of your request.

Record Storage

The Brief Therapy Institute of Denver, Inc stores paper copies of **administrative** records for the appropriate length of time per clinician regulations. **Clinical records** are stored **electronically** for the appropriate length of time per clinician regulations.

Miscellaneous

If we need to contact you by telephone and leave a message we will only leave our name and our phone number. We will not leave any information on an answering machine or with anyone other than the patient or guardian unless we have your consent. It will be your responsibility to return the call.

Acknowledgment

I acknowledge that I have reviewed this privacy notice and that I may request or download the Brief Therapy Institute of Denver's full privacy policy.

_____ _____

Signature Date

Office use only:

Name: _____ Chart #: _____

Medical Information – Please complete for all participants in therapy

Name	Last 2 years Major medical events	Current medications Prescribed and over the counter	Dosage	Allergies? To what?

Family Physician: _____ **Phone:** _____

Psychiatrist: _____ **Phone:** _____

Pediatrician Name: _____ **Phone:** _____

Tobacco Use: **Cigarettes** ____ **Chewing** ____ **Other** ____ **How much** _____

Who _____

Alcohol and Drug Use:

Who? **Type?** **Amount?** **Frequency?**

If you use herbal supplements or vitamins, please list:

Family history of alcohol/drug use, mental health, physical conditions:

Member: **History:**

Office use only:
Name: _____ Chart #: _____