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 #: _____

Informed Consent for Telehealth Services

Therapist: _____

Definition of Telehealth

Telehealth involves the use of electronic communications to enable BTID's mental health professionals to connect with individuals using interactive video and audio communications.

Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. BTID utilizes secure, encrypted audio/video transmission software to deliver telehealth.

4. I understand that if my counselor believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a mental health professional associated with any form of psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not improve, and in some cases may even get worse.

5. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my counselor, I may be directed to "face-to-face" psychotherapy.

6. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.

7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my counselor in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the consultation at any time.

8. I understand that my express consent is required to forward my personally identifiable information to a third party.

9. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.

10. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

Payment for Telehealth Services

BTID will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. In the event that insurance does not cover telehealth, the individual wishes to pay out-of-pocket, or when there is no insurance coverage, we will provide you with a statement of service to submit to your insurance company if you wish.

Patient Consent to the Use of Telehealth I have read and understand the information provided above regarding telehealth, have discussed it with my counselor, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

_____

Print Name

_____ _____

Client's Signature **Date**

_____ _____

Parent or Guardian Signature **Date**