DISCLOSURE STATEMENT

I look forward to working with you. This document contains important information about my background and the professional service I provide to clients. Please read it carefully and make a note of any questions you might have so that we can discuss them at our next meeting. I know it is lengthy, but I feel it is important that you are fully informed of your rights as a client and have an understanding the counseling process.

SERVICE PROVIDER.

I (Raelynn Maloney, PhD) have a Doctorate in Counseling Psychology from the University of Iowa (2005). I completed my doctoral internship at The Children's Hospital in Denver, Colorado in 2005. Prior to completing my doctoral work I received a M.A. in Educational Psychology in 1998 and a B.A. in Psychology from the University of Northern Iowa (1993). I am practicing as a Licensed Psychologist in Colorado (License #3163). I am an independent practitioner, and, as such, am not legally or professionally affiliated with any other mental health professional. My office colleagues and I share a waiting room, but do not operate otherwise as a group practice.

PSYCHOLOGICAL SERVICE.

Counseling or psychotherapy (as it is sometimes called) is not easily described. It varies depending on the personalities of the psychologist/counselor and client, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Counseling is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Counseling can have benefits and risks. Since counseling often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, counseling has also been shown to have benefits for people who go through it. Counseling often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a plan to follow (if this is what will be most helpful to you and if you decide to continue with counseling). You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Counseling involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

SERVICES THAT REQUIRE REFERRAL TO OTHER PROVIDERS.

Through my practice I provide an initial evaluation of your counseling needs and counseling service designed to help you meet the goals that we will develop together. It is important to be clear that I do not provide assistance with the following issues: (1) addiction/substance abuse counseling, (2) forensic evaluation for sexual abuse or domestic assault or (3) evaluations or recommendations regarding child custody with clients receiving counseling (I do provide evaluations and recommendations to parents and the courts regarding family issues when I am specifically asked to serve as a Child and Family Investigator through the court system and there is compliance by parents and both parents are involved in the evaluation). If any of these issues are part of your primary concern, during our initial evaluation (or once they become apparent to me) I will discuss options for referring you to a provider who is able to meet these specific needs. It is important that we identify the presence of any substance-related problems early on in the process as these can significantly interfere with your progress in counseling.

YOUR RIGHTS.

As a client seeking mental health service for yourself or your child, you have certain rights. These include your right to seek a second opinion from another counselor or your right to end this counseling relationship at any time. You are also entitled to receive information regarding the methods of counseling, techniques used, the duration of our work together, if known, and the fee structure. Please ask if I do not fully provide you with this information or if you have any questions.

The practice of psychology in Colorado is regulated by the Colorado Department of Regulatory Agencies. The agency within the Department that has responsibility for licensed and unlicensed psychotherapists is the Department of Regulatory Agencies. Any questions or concerns regarding the mental health service you receive may be directed to:

State Grievance Board
1560 Broadway, Suite 1370
Denver, Colorado 80220
Phone: 303-894-7766

THERAPEUTIC RELATIONSHIP.

Your relationship with me is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that we maintain only a therapeutic relationship. Social situations where are are not clear with one another that the therapy relationship remains intact and/or conducting business together outside of our therapeautic relationships may undermine the effectiveness of the therapeutic relationship. Bringing gifts or requesting bartering, and trading service can also complicate the boundaries in the relationship while we are conducting therapy. If these occurr we will discuss what is appropriate and what crosses a boundary that we want to maintain. Additionally, sexual intimacy between therapist and a current client is never appropriate in a therapeutic relationship. Any circumstances of sexual intimacy while the therapeutic relationship is intact is in approriate.

MEETINGS.

I normally conduct an evaluation of each client or family's situation that will last from 2 to 4 sessions (the length will depend on the concerns for which you are seeking counseling). During this time, we can decide if I am the best person to provide the services you need in order to meet the goals you would like to work on. If we choose to continue our work together, I will usually schedule one 45-minute session bi-week or once per month, at a time we agree on, although some sessions may be longer or sessions may be more frequent. You may also schedule sessions on-line at www.amindfulplace.com.

CANCELLATION POLICY.

There is no charge for appointments cancelled 48 hours in advance of the scheduled time so that I am able to use that appointment time for another client. Appointments that are missed or cancelled less than 48 hours ahead of time are charged the full session fee of $165 (or $220 if it was a 60 min session scheduled).

PROFESSIONAL FEES.

My practice is a fee-for-service practice. The fee per 45 min-session for individual, family or couples counseling is $165/45 min session length or $220/60 min session length. Please note again that the **full session fee** for an appointment will be charged if an appointment is missed without a 48-hour advance notice.

Fees are subject to change each calendar year.

If a balance on your account is unpaid for longer than 30 days an additional fee will be applied to your account ($25/late fee). If charges are incurred due to insufficient funds in a clients account these charges will be billed to you as the client (typically this can range from $15 to $30 for a returned check charge).

All payments are processed through my office. If you are submitting your receipt to insurance I can provide a diagnostic code and procedure code on your receipt, which will be necessary for you to receive reimbursement. Your insurance provider may also request my Tax ID, which is included on the invoices/receipts (Raelynn Maloney, PhD, PC Tax ID: **38-3784274).** If you have any questions about this process please feel free to ask at any time during our counseling work together.

Regarding insurance, I am happy to assist you in processing claims for your insurance by providing the necessary documentation. It is your responsibility, however, to pursue the claim itself. In addition to weekly appointments, I charge this amount for other professional service you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include letter writing, report writing, letters to attorneys, telephone conversations, lengthy email exchanges, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other services you may request of me. If you are or become involved in legal proceedings that require my participation, you will be billed for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge a forensic fee of $350 per hour for preparation and attendance at any legal proceedings.

If your account has not been paid for more than 30 days and arrangement for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of service provided, and the amount due. If such legal action is necessary, its cost will be included in the claim.

CONTACTING ME.

I am often not immediately available by telephone. While I am often in my office, I do not answer the phone when I am with clients. When I am unavailable, my telephone is answered by voicemail that is monitored daily. I do not accept texts from clients. I or my office assistant will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you have an urgent need to reach me, you can call my regular office number: (303) 358-6561 and follow the directions for urgently contacting me. If you are unable to reach me and feel that you cannot wait for me to return your call, you can contact your primary care physician for assistance, call 911, or go to your nearest emergency room and ask for the psychologist or psychiatrist on-call. When I am out of town for an extended period, I will arrange emergency coverage with a professional whose telephone will be available on from my voice mail.

It is important that you determine the level of emergency care that you would like to have in a mental health provider. My practice is not designed around 24-hour care. In the event of an emergency, it may be necessary for you to contact another health care provider. If this does not seem to meet your needs, please let me know and I will provide you with the names of other providers who offer 24-hour care.

PROFESSIONAL RECORDS.

The laws and standards of my profession require that I keep client records. You are entitled to review your records, or I can prepare a summary for you of our sessions. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

CONFIDENTIALITY.

In general, the privacy of all communications between a client and a psychologist is protected by law, and I can only release information about our work to others with your written permission. At times information will be shared between us by phone or email. You are not required to provide your email to me. Please note that I am unable to ensure confidentiality and privacy with correspondence that is sent via email. If we do communicate via email I encourage you to share only what is necessary with this awareness of the limitations around protecting email content from other Internet users.

Information disclosed to a licensed psychotherapist is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado with the consent of the person to whom the testimony relates. But there are a few exceptions. In most legal proceedings, you have the right to prevent me from providing any information about our work together. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it. A reminder to you, with the information that I gather I will not be able to provide an opinions or recommendations about custody questions. I encourage parents to identify a psychologist who specializes in custody issues to address if it is needed.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, I am legally mandated to file a report with the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another, I am again legally required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If one of these situations occurs, I will make every effort to fully discuss it with you before taking any action and limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I also may occasionally consult with other experts on issues that arise within our counseling work. In the event of such a consultation, your identity or any possibly identifying information will not be revealed. It is important that we clearly outline such information to be sure that everyone understands the extent and degree of confidentiality in such cases. Please ask me any questions you may have around this issue.

MINORS AND PARENTS.

Patients under 15 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's record, unless I decide that such access is likely to injure the child. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's counseling when it is complete upon their request. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

AGREEMENT.

I want you to know that it is very important to me that in response to this form, or any time during our work together, I want you to feel free to voice questions or concerns. I look forward to working with you.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. It also indicates that you have been offered a copy of the Health Insurance Portability and Accountability Act HIPAA Privacy rule and I understand my rights as a client.

_____ _____

Client Signature (Consent/Assent) **Date**

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Raelynn Maloney, Ph.D. **Date**

Payment Information –For Billing Purposes

Like many counseling professionals, my practice is a fee for service private practice. Payment is due at the beginning or end of each session. ***The full fee for an appointment will be charged if an appointment is missed without a 48-hour advance notice.*** The fee for counseling sessions are ***$165***/45 minute session or $220/60 min session). Longer sessions, telephone phone contacts/consultations, email exchanges/review, and document review for cases involving legal issues will be billed at this rate as well (e.g., $55/15 min; $110/30 min, etc). Payments for counseling services can be made with cash, check or credit card. Payment of cash or credit card are accepted. I do not accept payment by check.

Late payments. Payments overdue by 30 days will incur an automatic $25 late charge. Payments 60 days overdue will incur an additional $25 late charge and this will continue monthly until the account is paid in full.

Statements/Documentation. I will provide a receipt to you following each payment (emailed weekly) that will have billing/payment information, insurance codes, diagnostic code and Tax ID (**Raelynn Maloney, PhD, PC Tax ID:** 38-3784274) for insurance reimbursement purposes. You will be responsible for submitting this invoice to your insurance company if you choose to seek reimbursement. I will email your billing statement unless you request otherwise. Best email address: _____

**Please note: *If duplicate invoices are needed a charge of $1 per invoice will be assessed.*

Outstanding Balances. Please provide your credit card information below. If you chose to pay by cash, I will only use this information if your account is 30 days past due. In this situation, the entire amount owed for service at that time will be billed to your credit card. If your credit card does not go through, or you do not have a credit card, your account will automatically be sent to collections once payment is 60 days past due.

If you chose to pay by credit card, your credit card will be charged following each session ($165/hr). Also, by signing this you agree to notify me if our work together is creating financial strain, at which time we will discuss our options for addressing this while also keeping you (or your child's counseling needs in mind).

Name on Credit Card:_____

Type of Credit Card: Visa _____ Mastercard_____

Credit Card Number_____

CCV Code: _____

Expiration Date: _____

Your Full Address, including zip code (the mailing address for your Credit Card statements):

_____

Please note that I keep your credit card information secure, and that I am the only person that will have access to your credit card information. If you have any questions regarding payment information provided here please feel free to talk with me about as early as is feasible.

THANK YOU.

CLIENT INFORMATION

Client's Name (child's name if child is the primary client):_____

If client is a child, Parent(s') Name(s):_____

Who has custody of this child?:_____

Client's date of birth:_____

Mailing Address:_____

Relevant Phone #'s (Home/Cell):_____

Email address:_____

Describe any confidentiality considerations you would like me to take when using the above contact numbers:

REFERRAL

Referred by: _____

I often thank referrals for sending you my way. Is this okay with you?_____

EMERGENCY CONTACT(S)

Name, relationship to you, and phone #'s of one or more emergency contacts:

1.

2.

3.

Dear Client or Parent(s) of Client,

Having you complete this form before our appointment will allow me more time to spend with you when we meet. Please bring this form, along with any testing results from previous evaluations (educational or psychological), to your first appointment.

Name of person completing this form: _____

Today's Date: _____

Reason for Visit

Reason for your visit (e.g., what is your primary concern)?_____

_____

What have you tried to resolve this concern? _____

Child Information

Client's full legal name (last, first, middle): _____
Age: _____ Date of Birth: _____/_____/_____Sex: male female
Race: American Indian or Alaskan Native Asian Black or African American
Native Hawaiian or other Pacific Islander White
Ethnicity: Hispanic or Latino Non Hispanic or Latino
Religious affiliation:_____
Involvement in Religioun: None Some/irregular Active
Names and ages of adults/children/relatives living in the home?_____

_____

Names and ages of siblings/half siblings/ step-siblings not living in the home?

_____

School (If Client is a child):

School Name: _____Teacher: _____ Grade: _____
Address: _____ City: _____ State: __ Zip: ____ Phone: _____
Grades repeated? ____ Grades skipped? ___ Expelled/Suspensions? _____
Any known learning disabilities? _____
Receiving special education service (OT, speech, reading, math)? _____
Describe peer relationships? _____

Other Providers

Primary Care Physician:
Name:_____
Address: _____ City: _____ State: ___ Zip: ____ Phone: _____

Do you feel comfortable signing a release form that will allow me to contact these individuals and obtain information that may assist with your child's/family's care? ___Yes ___No

History/Background Information

Client's Birth History (All Adult and Child Clients can Complete this section)

Parent's age at time of birth: Mother _____ Father _____
Was this a planned pregnancy? Yes No

Did mother receive prenatal care during the entire pregnancy? Yes No
Any tobacco, drug or alcohol use during pregnancy? Yes No
If yes, please explain. _____
Any complications during pregnancy, labor or delivery? Yes No
If yes, please explain. _____
Born on time? 8-10 months Premature (< 8 mos) Birth weight _____
Did mother experience post-partum blues or post-partum depression following the birth of any of her children? Yes No

Developmental History

Describe briefly your parent-child relationship _____
Experiences with traumatic losses, life events or life transitions (physical or sexual abuse, neglect or abandonment)…

Age?	Type?
_____	_____
_____	_____

Any delays in cognitive, motor or language development? Yes No
As close as you can remember were these milestones it on time?
Rolling over _____ Sitting alone _____ Crawling _____ Walking _____
Ate with utensils ____ Potty trained _____ First words ___ Talking sentences __
Tied shoelaces _____ Buttoned buttons ____ Helped get self dressed ___
Normal sleep/wake routine as an infant/toddler/child/teen? Yes No
Normal eating pattern as an infant/toddler/child/teen? Yes No
If client is currently a child or teen, describe current routines…
Bedtime_____ Time wakes _____
Bedtime ritual (if any)_____
Chores expected and performed (if any): _____
Eating behaviors/concerns? _____
(If applicable) Menstration (age? regular?, length?, pain?, other experiences during this time?)

Medical History

Health habits (exercise, eating restrictions, adequate sleep)? _____
Allergies?_____
Current prescribed medications (psychiatric or medical)? _____
_____
Current over the counter, herbal or homeopathic remedies? _____
Past prescribed medications (psychiatric or medical)? _____
_____
Childhood illnesses/surgeries? _____
Previous hospitalizations? _____

Family History

On the backside of this page please list any psychiatric (anxiety, depression, etc.) or medical illnesses that you, (your child if your child is the client), or any of your biological relatives (including parents) have experienced.

(If Client is a child) Maternal Parent Information

Mother (Please Note if Guardian, Foster Parent, Grandparent)

Full legal name (last, first, middle): _____
Relationship to child: biological parent step parent foster parent other _
Date of Birth: _____/_____/_____
Relationship status: married separated divorced remarried
Race: American Indian or Alaskan Native Asian Black or African American Native Hawaiian or other Pacific Islander White
Ethnicity: Hispanic or Latino Non Hispanic or Latino
Address (if different from child): _____ City: _____ State: __ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Employment status: full time part time unemployed
Occupation: _____ Place of Employment: _____

Please describe your previous experience with counseling/therapy:

Past trauma/abuse/losses/difficult life transitions? (Please describe)

Past legal issues? (Please describe)

Past substance use/abuse? (Please describe).

(If Client is a Child) Paternal Parent Information

Father (Please Note if Guardian, Foster Parent, Grandparent)

Full legal name (last, first, middle): _____
Relationship to child: biological parent step parent foster parent other
Date of Birth: _____/_____/_____
Relationship status: married separated divorced remarried
Race: American Indian or Alaskan Native Asian Black or African American Native Hawaiian or other Pacific Islander White
Ethnicity: Hispanic or Latino Non Hispanic or Latino

Address (if different from child): _____ City: _____ State: ___ Zip:
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Employment status: full time part time unemployed
Occupation: _____ Place of Employment: _____

Please describe your previous experience with counseling/therapy:

Past trauma/abuse/losses/difficult life transitions? (Please describe)

Past legal issues? (Please describe)

Past substance use/abuse? (Please describe).

REGARDING YOUR CONCERNS

1. What have you already tried to effect change or manage the problem you are seeking help for?

2. Why are you seeking help now?

3.___What are your strengths (list your strengths as a parent if your child is the client as well as your child's strengths)? (for example talents..hobbies..education..personality..habits..relationship skills..)

-

4.___What is/are your goal(s) for counseling?

5.___Describe the aspects of yourself (or your parenting if pertinent) that you want to change (if any)?

6.___How do think counseling will help you make these changes?

7.___How long do you think this process will take?

8.___What do you think a counselor should be like?

9.___Anything else you would like to add that is relevant or important for me to know?

BEHAVIOR/MOOD CHECKLIST

Do you (or your child if your child is the primary client) display any of the following:

O Sadness or "empty" mood
O Sleep difficulties (e.g., difficulty falling asleep, staying asleep, nightmares, night terrors)
O Change in appetite (eats more or eats less than usual)
O Problems with concentration, memory or decision making
O Frequent crying episodes
O Disinterest in things he/she once enjoyed
O Irritability/Moodiness
O Low self-esteem/Highly self-critical
O Social Withdrawal
O Report of suicidal thoughts or observations of suicidal statements or gestures
O Physical complaints (e.g., stomachaches, headaches, pain)
O Statements indicating a sense of hopelessness or helplessness

O Nervousness/On Edge/Tension
O Racing thoughts
O Worries (about …_____)
O Fears (of…_____)
O Panic Attacks

O Rituals that involve "checking" things (e.g., are the lights off, are the doors locked)
O Excessive hand washing
O Overly neat/Overly orderly
O Repetitive thoughts/Repetitive statements

O Extreme happiness or high mood (euphoria)
O Believe they are superhuman, have superpower or can do things that he/she really cannot (Grandiosity)
O Sense of invincibility
O Talks in a pressured or rapid manner
O Does not seem to need much sleep (stays up for whole night, less than 5 hrs night).
O Poor judgment/Makes poor choices

O Seems detached from reality. Mind often seems to be "somewhere else."
O Frequent and problematic day dreaming

O Sees, hears, smells, things that you know are not there or not real (hallucinations)
O Delusional
O Paranoid/paranoia
O Believes other can read his/her mind or thoughts.
O Disorganized thoughts/Thoughts are difficult to follow in a conversation.

O Short-tempered/Easily frustrated
O Reported thoughts or observed threats or gestures to hurt someone else

O Distractibility
O Disorganized
O Forgetfulness
O Avoids or refuses to do homework

O Over or undersensitive to touch, sounds, lights, tastes or smells
O Intense, out-of-proportion reactions to everyday experiences
O Seems to hear things you don't hear. (Very sensitive to sounds)
O Withdraws, "tunes out" or cries in group situations.
O Difficulty with fine motor tasks –writing, buttons, stringing beads, using scissors, etc.
O Resists grooming activities such as brushing teeth, hair washing, or nail cutting.
O Unusually high or low pain tolerance.
O Other _____

THIS NOTICE CONTAINS INFORMATION CONCERNING **HOW CONFIDENTIAL MENTAL HEALTH TREATMENT INFORMATION CONCERNING YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION**. PEEASE REVIEW IT CAREFULLY AND LET US KNOW ANY QUESTIONS THAT YOU MAY HAVE CONCERNING THIS NOTICE.

During the process of providing service to you, Raelynn Maloney, Ph.D. will obtain and use mental health and medical information concerning you that is both confidential and privileged. Ordinarily this confidential information will be used in the manner that is described in this statement, and will not be disclosed without your consent, except for the circumstances described in this Notice.

USES AND DISCLOSURES OF PROTECTED INFORMATION

General Uses and Disclosures Not requiring the Client's Consent. Raelynn Maloney, Ph.D. will use and disclose protected health information in the following ways.

1. Treatment. Treatment refers to the provision, coordination, or management of mental health care and related services by one or more health care providers. For example, Raelynn Maloney, Ph.D. may use your information to plan your course of treatment and consult with other health care professionals or their staff concerning services needed or provided to you.

2. Payment. Payment refers to the activities undertaken by a health care provider to obtain or provide reimbursement for the provision of health care. For example, Raelynn Maloney, Ph.D. and other health care professionals will use information that identifies you, including information concerning your diagnosis, services provided to you, dates of services, and services needed by you, and may disclose such information to insurance companies, to businesses that review bills for health care services and handle claims for payment of health care benefits in order to obtain payment for services. If you are covered by Medicaid, information may be provided to the State of Colorado's Medicaid program, including but not limited to your treatment, condition, diagnosis, and services received.

3. Health Care Operations. Health Care Operations means activities undertaken by health insurance companies, businesses that administer health plans, and companies that review bills for health care services in order to process claims for health care benefits. These functions include management and administrative activities. For example, such companies may use your health information in monitoring of service quality, staff training and evaluation, medical reviews, legal services, auditing functions, compliance programs, business planning and Accreditation, certification, licensing and credentialing activities.

4. Contacting the Client. Raelynn Maloney, Ph.D. may contact you to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.

5. Required by Law. Raelynn Maloney, Ph.D. will disclose protected health information when required by law. This includes, but is not limited to: (a) reporting child abuse or neglect to the Department of Human Services or to law enforcement; (b) when court ordered to release information; (c) when there is a legal duty to warn of a threat that a client has made of imminent physical violence, health care professionals are required to notify the potential victim of such a threat, and report it to law enforcement; (d) when a client is imminently dangerous to herself/himself or to others, or is gravely disabled, health care professionals may have a duty to hospitalize the client in order to obtain a 72-hour evaluation of the client; and (e) when required to report a threat to the national security of the United States.

6. Health Oversight Activities. Your confidential, protected health information may be disclosed to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, regulatory programs or determining compliance with program standards.

7. Crimes on the premises or observed by Raelynn Maloney, Ph.D. Crimes that are observed by Raelynn Maloney, Ph.D. or staff, that are directed toward staff, or occur on Raelynn Maloney, Ph.D. premises will be reported to law enforcement.

8. Business Associates. Confidential health care information concerning you, provided to insurers or to plans for purposes or payment for services that you receive may be disclosed to business associates. For example, some administrative, clinical, quality assurance, billing, legal, auditing and practice management services may be provided by contracting with outside entities to perform those services. In those situations, protected health information will be provided to those contractors as is needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.

9. Research. Protected health information concerning you may be used with your permission for research purposes if the relevant provisions of the Federal HIPAA Privacy Regulations are followed.

10. Involuntary Clients. Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed in compliance with Colorado law.

11. Family Members. Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of that discussion. However, if the client objects, protected health information will not be disclosed.

12. Emergencies. In life threatening emergencies Raelynn Maloney, Ph.D. will disclose information necessary to avoid serious harm or death.

Client Release of Information or Authorization. Raelynn Maloney, Ph.D. and other health care professionals may not use or disclose protected health information in any way without a signed release of information or authorization. When you sign a release of information, or an authorization, it may later be revoked, provided that the revocation is in writing. The revocation will apply, except to the extent Raelynn Maloney, Ph.D. has already taken action in reliance thereon.

YOUR RIGHTS AS A CLIENT

Access to Protected Health Information. You have the right to receive a summary of confidential health information concerning you concerning mental health services needed or provided to you. There are some limitations to this right, which will be provided to you at the time of your request, if any such limitation applies. To make a request, as Raelynn Maloney, Ph.D. for the appropriate request form.

Amendment of Your Record. You have the right to request that Raelynn Maloney, Ph.D. or your health care professionals amend your protected health information. Raelynn Maloney,

Ph.D. is not required to amend the record if it is determined that the record is accurate and complete. There are other exceptions, which will be provided to you at the time of your request, if relevant, along with the appeal process available to you. To make a request, ask Raelynn Maloney, Ph.D. staff for the appropriate request form.

Accounting of Disclosures. You have the right to receive an accounting of certain disclosures Raelynn Maloney, Ph.D. has made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment, or health care operations. In addition, the accounting does not include disclosures made to you, disclosures made pursuant to a signed Authorization, or disclosures made prior to April 14, 2003. There are other exceptions that will be provided to you, should you, should you request an accounting. To make a request, ask Raelynn Maloney, Ph.D. for the appropriate request form.

Additional Restrictions. You have the right to request additional restrictions on the use or disclosure of your health information. Raelynn Maloney, Ph.D. does not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. To make a request, ask Raelynn Maloney, Ph.D. for the appropriate request form.

Alternative Means of Receiving Confidential Communications. You have the right to request that you receive communications of protected health information from Raelynn Maloney, Ph.D. by alternative means or at alternative locations. For example, if you do not want Raelynn Maloney, Ph.D. to mail bills or other materials to your home, you can request that this information be sent to another address. There are limitations to the granting of such requests, which will be provided to you at the time of the request process. To make a request, ask Raelynn Maloney, Ph.D. for the appropriate request form.

Copy of this Notice. You have a right to obtain another copy of this Notice upon request.

ADDITIONAL INFORMATION

Privacy Laws. Raelynn Maloney, Ph.D. is required by State and Federal law to maintain the privacy of protected health information. In addition, Raelynn Maloney, Ph.D. is required by law to provide clients with notice of its legal duties and privacy practices with respect to protected health information. That is the purpose of this Notice.

Terms of the Notice and Changes to the Notice. Raelynn Maloney, Ph.D. is required to abide by the terms of this Notice, or any amended Notice that may follow. Raelynn Maloney, Ph.D. reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all protected health information that it maintains. When the Notice is revised, the revised Notice will be posted in T'E'S'S'A's service delivery sites and will be available upon request.

Complaints Regarding Privacy Rights. If you believe Raelynn Maloney, Ph.D. has violated your privacy rights, you have the right to complain to Raelynn Maloney, Ph.D. management. Please submit a statement, in writing, addressed to Raelynn Maloney, Ph.D. 2305 East Arapahoe Road, Suite 216, Centennial, CO, 80122-1538 concerning your complaint and the basis for it. You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 515F, HHH Bldg., Washington, D.C. 20201. It is the policy of Raelynn Maloney, Ph.D. that there will be no retaliation for your filing of such complaints.

D. Additional Information. If you desire additional information about your privacy rights

please ask us any questions that you may have.

IV. CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

The confidentiality of alcohol and drug abuse patient records maintained by Raelynn Maloney, Ph.D. is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser Unless:

1. The patient comments in writing;
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 a program is a crime.
Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime. Disclosure may be made concerning any threat made by a client to commit imminent physical violence against another person to the potential victim who has been threatened and to law enforcement.

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

V. EFFECTIVE DATE.

I understand these disclosures. I have received a copy of this Disclosure Statement and Notice of Privacy Rights.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Raelynn Maloney, Ph.D. Date

RELEASE OF CONFIDENTIAL INFORMATION OR AUTHORIZATION

Client Name (Print): _____ Date of Birth:_____

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designated, I, _____
[ ] client, [ ]parent, [ ] legal guardian do hereby request and authorize Raelynn Maloney, Ph.D. and/or her administrative and clinical staff to [ ] provide information to [ ] obtain information from [ ] exchange information with the below specified organization, agency, or individual:

Name:_____
Address:_____
Phone: _____ Fax: _____

I authorize release of the following information (please mark all that apply):

[ ] Treatment Summary/Progress/ Recommendations
[ ] Admission/Discharge Summary
[ ] Psychological Evaluation
[ ] Behavioral Assessment
[ ] Legal/Court Records
[ ] Other: .
[ ] Verification of Attendance
[ ] Psychiatric History/Evaluation
[ ] Diagnosis/Diagnostic Impression
[ ] Medical History
[ ] Academic Record

Client evaluation and continuity of care

I understand that the information to be released includes information regarding the following:
[X] Alcohol and/or Substance Abuse/Dependency, if any
[X] Psychological or Psychiatric Conditions, if any
[X] AIDS-HIV Testing, if any

AUTHORIZATION.
I understand and agree that this request and authorization has been made voluntarily and is in effect only for the person, organization or agency specified above. This authorization is valid only for the period of time over which service is provided by Raelynn Maloney, Ph.D. I understand that I may revoke this authorization, in writing, at any time. There exists the potential for the information disclosed to the above named recipient to be re-disclosed by that recipient, and may no longer be protected by the HIPAA Privacy Regulation.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date