Alice Riley, LCSW

Arts and Insights, LLC

DISCLOSURE STATEMENT AND PSYCHOLOGICAL SERVICES AGREEMENT

This services agreement contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations.

The law requires that I obtain your signature acknowledging that I have provided you with this Information. Although these documents are long and sometimes complex, it is important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. Your experience will depend upon many different factors including the personalities of the psychologist and client and the particular issues you are seeking help for. Psychotherapy is different from traditional medical doctor visits in that 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 the things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. Since therapy 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, psychotherapy has also been scientifically shown to have many benefits. It 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.

Regular attendance will be needed to experience the fastest recovery. This means making a commitment to your child's or your own wellness journey. If there is a concern about the process, please bring this up in session. It can lead to better results when you take ownership of your healing. Please be aware that I, and most other therapists, rely on weekly attendance to support our own lives. Missing or cancelling more than 2 sessions in a row will result in losing your appointments. A missed first / intake appointment will not be made up as this is a good indicator that we are not a good fit.

PROFESSIONAL FEES

My usual fee for a 45-50 minute session is $100 *unless otherwise agreed upon or I am in your insurance's network*. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 48 hours advance

notice of cancellation, unless we agree the circumstances were beyond your control. If it is possible, I will try to find another time to reschedule the appointment.

In addition to weekly appointments, I charge $100 per hour for any other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other professional service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, my professional fees for participation in legal proceedings are different and can be discussed if the need arises.

I am in-network with Medicaid (Adams County - BHI, Denver County – ABC and Child Health Plan Plus), as well as CIGNA. Medicaid clients do not pay out of pocket; some CHP+ and CIGNA plans require a co-pay that you will be responsible for. Clients with out of network private insurance are required to pay the full fee and submit claims for reimbursement to their insurance providers. I accept cash, check, credit cards and Paypal.

CONTACTING ME

Alice Riley, LCSW
10497 Ouray Street
Commerce City, CO 80022
Phone: 720-505-1148 email: ARileyLCSW@live.com

Due to the nature of my work, I am often not immediately available by telephone. While I am usually in my office between 10 AM and 6 PM Monday through Friday, I will not answer the phone when I am with a client. If you need to reach me for non-emergent reasons outside of our scheduled sessions, please call my office phone number below and leave a voice mail.

I regularly monitor my voice mail between sessions and I will return your call as soon as I can, generally within 24 hours. Phone calls will usually be returned during regular business hours. I do not generally return phone calls evenings, nights or weekends or when I am on vacation. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

You can also contact me by email at ARileyLCSW@live.com. Please understand that email is not consistently timely and reliable and confidentiality cannot be assured when you communicate through electronic means. I strive to return all emails but if I haven't replied, please resend the original message because I might not have received it or my spam filter may have inadvertently sent it to my junk mail box. Personal social media accounts are not for client use. Please do not use social media messaging to contact me.

You can send a text to 720-505-1148 regarding simple scheduling or billing issues only. Do not use text messages for urgent messages or clinical issues.

EMERGENCIES

Please be aware that I provide non-emergency face-to-face and online psychotherapy services by scheduled appointment. As a solo practitioner in independent practice, I am unable to provide extensive or ongoing 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 I believe your psychotherapeutic issues are outside of my scope of practice, I am legally required to consult, refer, or terminate treatment. If you are unable to contact me by telephone and you are experiencing an emergency situation, please call 911, or proceed to the nearest hospital emergency room. I do not have admitting privileges at any local hospitals so I can not provide treatment if you are in the emergency room or are admitted to the hospital. Emergency room and hospital treatment may be covered through your insurance or out of pocket and is not connected to my services in any way. Established patients will be seen 24 hours after discharge from any psychiatric hospitalization.

In the event of a life-threatening emergency, do not attempt to reach me before contacting emergency services for help. Please call 911 or go to the nearest emergency room for immediate assistance.

If you are having suicidal thoughts or making plans to harm yourself, please call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.

Email is never an appropriate way to contact me in the event of an emergency as I cannot control when I will receive your email.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and a Clinical Social Worker. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

• I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Therapist's Policies and Practices to Protect the Privacy of Your Health Information).

• If a client seriously 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. Colorado law provides that a professional may disclose confidential information only to medical or law enforcement personnel if the professional determines that there is a probability of imminent physical injury by the client to the patient or others, or there is a probability of immediate mental or emotional injury to the client. There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

• If I am directed by a judge in a court of law to reveal information, then I must do so. However, if you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the provider/patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information. Legal confidentiality does not apply in criminal or juvenile delinquency proceedings.

• If a government agency is requesting the information for health oversight activities, I may be required to provide it for them. If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a client's treatment. These situations are unusual in my practice.

• If I determine that there is a probability that a client will inflict imminent harm on him/herself of another, I am required to take protective action which may involve disclosing information to medical or law enforcement personnel or by securing hospitalization of the client.

• If I have cause to believe that a child under 18 has been or may be abused or neglected (including physical injury, substantial threat of harm, mental or emotional injury, or any kind of sexual contact or conduct), or that a child is a victim of a sexual offense, or that an elderly or disabled person is in a state of abuse, neglect or exploitation, the law requires that I make a report to the appropriate governmental agency. Once such report is filed, I may be required to provide additional information.

• If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will 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 now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself and/or others, you may examine and/or receive a copy of your Clinical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge a copying fee. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon your request. I am contracted with Theranest online record keeping services for therapists. You will receive automatic 48 hour reminders of the appointment if you provide me with your email address.

CLIENT RIGHTS

HIPAA provides you with rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this agreement and my privacy policies and procedures.

MINORS & PARENTS

Clients under 18 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment records, excepting cases when a Guardian Ad Litem has been assigned therapeutic privilege. For children between 15 and 18, because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is my policy to request an agreement from the patient and his/her parents that the parents consent to give up their access to their child's records. If they agree, during treatment, 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 treatment when it is complete. 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.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested. If your account has not been paid for more than 60 days and arrangements 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 services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

COLORADO MANDATORY DISCLOSURE STATEMENT

In seeking the services of a mental health professional, you have certain legal rights. This document provides information that I am required to share with all clients before beginning treatment. Please read this document carefully. This information will also be reviewed during our first meeting.

1. Therapist Name, Credentials, and Contact Information:

Name: Alice Riley, LCSW Education: I received my Master's in Social Work from Fordham University in New York in 1998. I received my Bachelor of Arts in Psychology in 1992.

My Colorado license number is 1014 and my website is www.AliceRiley.net.

2. Concerns or complaints: The practice of both licensed and unlicensed persons in the field of psychotherapy is regulated by the Colorado State Department of Regulatory Agencies. Any questions, concerns, or complaints regarding the practice of mental health may be directed to the State Board:

Mental Health Section of the Colorado State Grievance Board, 1560 Broadway, Suite 1370, Denver, Colorado, 80202, (303) 894-7766.

You are entitled to receive information at any time about my methods of therapy, the techniques I use, the expected duration of your therapy, and my fee structure. You may seek a second opinion from another therapist or may terminate therapy at any time.

Dual roles, exploitative relationships and sexual intimacy are never appropriate in a professional relationship and should be reported to the Grievance Board. Sexual intimacy is also illegal and should be reported to the State Grievance Board at the address and phone number listed above. If you should need additional information or clarification about any of the information covered in this disclosure document, please feel free to ask me now or at any time in the future. Your signature indicates that you have read the above information, have had the opportunity to ask questions and understand your rights as a client. By signing this disclosure statement, you understand and agree to all of the terms discussed above.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.

_____ _____

Signature Date

_____ _____

Printed Name Client name (if different)

Alice Riley, LCSW

Arts and Insights, LLC

NAME: _____ DATE OF BIRTH:_____ AGE:_____

ADDRESS:_____

PHONE NUMBER (home):_____ PHONE NUMBER (work):_____

PHONE NUMBER (mobile):_____ EMAIL: _____

Best way to reach you (circle one): home cell work email

Referral Source: Friend/relative _____ Previous client ____ Internet search ____ Psychology Today ____ Insurance ____ EAP (specify)_____ other (specify)_____

Employment: Full Time _____ Part Time ____ Self Employed ____ Student ____

Marital Status: Single___ Married (#years) ___ Divorced (years)___ Living as Married (# years)___ Separated (#years)___ Widowed (# years)___

Emergency Contact Information Name:_____

Phone:_____ Relationship to you:_____

Primary Care Physician_____ phone: _____

Please check the items you would like to address in therapy (adults, teens, children):

Depression ___	Past Trauma ___	Sleep Disturbance___	Weight Management___
Anxiety ___	Parenting ___	Childhood Issues___	Self Esteem___
Behavioral Problems ___	Relationships ___	Substance Use ___	Health Management___
Work Stress:___	Goals___	Coping Skills ___	Caregiving ____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?

□ Yes □ No Have you had previous psychotherapy? □No □Yes

Are you currently taking prescribed psychiatric medication (antidepressants or others)? □Yes □No If Yes, please list:_____

If no, have you been previously prescribed psychiatric medication? □Yes □No If Yes, please list:

_____

General Health Information 1. How is your physical health at present? (please check): Poor___Unsatisfactory___ Satisfactory___ Good___ Very good___

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____

3. How many times per week do you exercise? _____ Approximately how long each time? _____

Consent for Treatment of Minors or N/A ___

Client name: _____

DOB: _____

Date: _____

Therapist: _____

I willingly consent for therapeutic treatment by the above listed therapist. I give this permission voluntarily and understand that I can terminate services at any time. If I choose to end treatment services I will be provided a referral for a new therapist.

_____ _____

Client Signature Date

Printed Name of Client _____

Therapist Signature:_____

Art & Insights

Alice Riley, LCSW

Authorization for Release of Information

Client name: _____

DOB: _____ Date: _____

I, the above named individual, hereby authorize Alice Riley LCSW to:

♦Release confidential information ___

♦Receive confidential information ___

To/From: _____

Information requested:

Social History	Discharge Summary
Assessment/Evaluation	Medical Records
Treatment plans	Child Welfare Case Notes
Drug/Alcohol Evaluation	Court Reports
	Other: _____

Reason: _____

_____

_____

(Copies may be used in lieu of original) Automatic Expiration: 6 months from date signed

_____ _____

Client signature Date

_____ _____

Therapist signature Date

Release from liability: I understand that my records are protected under the Federal regulations governing Confidentiality 43 CFR Part 2, and cannot be disclosed without written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action had been taken in reliance on it.

NOTICE TO RECIPENT (S) OF INFORMATION: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS, WHICH ARE PROTECTED, BY FEDERAL LAW. REGUALTIONS PROHIBT YOUR FUTHER DISCLOSURE WITHOUT SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS.