INTAKE FORMS

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information.
Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)
Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female
Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated
□ Divorced □ Widowed
Please list any children/age:

_____

_____

Address:
(Street and Number)

_____

_____
(City) (State) (Zip)

Home Phone: _____ May we leave a message? □Yes □No

Cell: _____ May we leave a message? □Yes □No

Work Phone: _____ May we leave a message? □Yes □No

E-mail: _____ May we email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication.
Referred by (if any):

_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No

□ Yes, previous therapist/practitioner:

_____

Are you currently taking any prescription medication?
□ Yes
□ No
Please list:
_____

_____

Have you ever been prescribed psychiatric medication?
□ Yes
□ No
Please list and provide dates:

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION
1. How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (Please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in: _____?
4. Please list any difficulties you experience with your appetite or eating patterns.

_____

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes
If yes, for approximately how long? _____
6. Are you currently experiencing anxiety, panic attacks or have any phobias?

□ No
□ Yes
If yes, when did you begin experiencing this? _____
7. Are you currently experiencing any chronic pain?
□ No
□ Yes
If yes, please describe? _____
8. Do you drink alcohol more than once a week? □ No □ Yes
9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never
10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____
On a scale of 1-10, how would you rate your relationship? _____
11. What significant life changes or stressful events have you experienced recently?

_____

FAMILY MENTAL HEALTH HISTORY:
In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).
Please Circle List Family Member
Alcohol/Substance Abuse yes/no
Anxiety yes/no
Depression yes/no
Domestic Violence yes/no
Eating Disorders yes/no
Obesity yes/no
Obsessive Compulsive Behavior yes/no
Schizophrenia yes/no
Suicide Attempts yes/no

ADDITIONAL INFORMATION:
1. Are you currently employed? □ No □ Yes
If yes, name and address of your employer:

_____

_____
Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

4. What do you consider to be some of your weakness?

_____

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____

HEALTH INSURANCE INFORMATION

If you are using or may use in the future, health insurance, the following information is necessary in order to bill the insurance company.

PATIENT INFORMATION:

1. PATIENT'S FULL NAME _____
2. STREET ADDRESS _____
3. CITY _____
4. STATE & ZIP CODE _____
5. PATIENT'S DATE OF BIRTH _____
6. TELEPHONE _____
7. PATIENT'S SEX M_____ F_____
8. PATIENTS' RELATIONSHIP TO INSURED:
   SELF___ SPOUSE____ CHILD_____ OTHER_____
9. PATIENTS' STATUS:
   SINGLE____ MARRIED___ OTHER_____
   EMPLOYED_____ FULL-TIME STUDENT_____ PART-TIME
   STUDENT_____
10. SOCIAL SECURITY # _____

INSURED'S INFORMATION (the "insured" is the person who owns the policy or is the employee to whom a group policy is applicable)

1. NAME OF INSURED _____
2. STREET ADDRESS OF INSURED _____
3. CITY _____
4. STATE & ZIP CODE _____
5. INSURED'S DATE OF BIRTH _____
6. SOCIAL SECURITY # _____
7. TELEPHONE _____

8. INSURED'S PLACE OF EMPLOYMENT: _____

9. INSURANCE PLAN NAME OR PROGRAM NAME. _____

10. INSURED'S INSURANCE ID NUMBER_____

11. POLICY GROUP NUMBER _____

I authorize the release of any medical or other information necessary to process insurance claims. I further authorize the payment of medical or insurance benefits to Marjorie Laird, LLC, and authorize Marjorie Laird, LLC to obtain or release therapy records and treatment plans to my insurance company for the purpose of evaluation, treatment and payment.

_____ Date _____

Signature of Insured

IF YOU HAVE AN INSURANCE CARD
PLEASE BRING IT WITH YOU
TO FIRST APPOINTMENT

EMPLOYEE ASSISTANT PROGRAMS

If you are using your Employee Assistant Program (EAP) to pay for your counselling sessions, you must contact them to obtain a referral to me (Marjorie Laird). I cannot do this for you. You will be given a limited number of sessions. You should be clear on the number of sessions authorized. This counseling is provided at no cost to you; however, if you need continued counseling beyond the number of sessions authorized by your EAP or if you need mental health treatment beyond the scope of the type of counseling provided through the EAP, it will be your responsibility to determine whether or not those outside services are covered under your medical benefit plan and to pay any charges for services not covered by your medical benefit plan.

PHYSICIAN NOTICE AND RELEASE OF INFORMATION

Most insurance plans request that the therapist notify the physician that their patient is being seen in counseling. Please complete and sign. If you do not wish for your physician to have this notice in your medical files, please indicate below.

_____
Name of MD

_____
Address of MD

_____
City, State and zip of MD

The client named below is receiving psychotherapy at this office with Marjorie Laird, Ph.D. The client has indicated that you are the primary physician _____ or psychiatrist_____.

The client's insurance has requested that you be notified, and the client has authorized this notice. I look forward to working with you in a team effort for the benefit of the client.

If you wish to contact me, please call (303) 358-3377.

Thank you.

Marjorie Laird, Ph.D.
LMFT, LPC
Clinical Supervisor
RPT Supervisor

I_____ authorize _____ (do not authorize _____) that this
Print Your Name

notice be sent to the above-named doctor and further authorize consultations between the patient's doctor and therapist relative to my medical and psychological care.

_____ Date _____
Signature of patient or guardian of minor.

Marjorie Laird
950 Wadsworth Blvd, Suite 202
Lakewood, Colorado 80214
303.358.3372 Schedule
303.358.3377 Phone
marjorielaird1@gmail.com

The State of Colorado and the Code of Ethics of the American Association of Marriage and Family Therapists require that you know the credentials of the professional you are seeing in therapy. Please read this Disclosure Statement, sign and date the consent for treatment. If you have any questions, please ask your therapist.

Licenses/Certifications

Licensed Marriage & Family Therapist (CO #475)
Licensed Professional Counselor (CO #3609)
Licensed Marriage & Family Therapist (CA #M12992)
Certified Addictions Counselor (CAC III) (CO #7096)
AAMFT Clinical Supervisor, (AAMFT #86697)
Registered Play Therapist Supervisor (Association of Play Therapy # 98-040)

Education

Tennessee Temple University – BA- Psychology/Bible
California Graduate School – MA - Theology
Goddard College – MA – Counseling/Psychology
California Graduate School – Theology/Counseling
Colorado School for Family Therapy – CAC III
Colorado School for Family Therapy – AAMFT Clinical Supervision
Colorado School for Family Therapy – Play Therapy Certification Training

Professional Organizations

I am a clinical member and clinical supervisor of AAMFT (American Association of Marriage and Family Therapy). I was president of a local chapter of CAMFT in California for two years, and was on the executive board of EDAP (Eating Disorders Awareness and Prevention, Inc.) for ten years. I served as President of the Colorado Association of Marriage and Family Therapists.

Therapist of the Year presented by COAMFT
Co-Founder: Second Wind Fund,
Woman of Achievement Los Angeles County
AAMFT National Award
2016 Colorado Community Health Hero of the Year

Regulatory Requirements Applicable to Mental Health Professionals

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Division of Professions and Occupations. The regulatory boards can be reached at 1560 Broadway, Suite 1350, Denver, CO 80202, (303) 894-7800. The regulatory requirements for mental health professionals provide that a Licensed Clinical Social Worker, a Licensed Marriage and Family therapist, and a Licensed Professional Counselor must hold a master's 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. A Licensed Social Worker must hold a master's degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate

must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1,000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelor's degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. A Registered Psychotherapist is 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.

Client Rights and Important Information

a. You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy, and my fee. Please ask if you would like to receive this information.

b. You can seek a second opinion from another therapist or terminate therapy at any time.

c. In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Board that licenses, certifies, or registers the therapist.

d. Generally speaking, information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and the therapist cannot disclose the information without the client's consent. There are several exceptions to confidentiality, which include: (1) I am required to report any suspected incident of child abuse or neglect to law enforcement; (2) I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (3) I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental disorder; (4) I am required to report any suspected threat to national security to federal officials; (5) I am required to report abuse of a senior, who is 70 years of age or older, which I believe has probably occurred, including institutional neglect, physical injury, financial exploitation, or unreasonable restraint; and (6) I may be required by Court Order to disclose treatment information. (7) I am required by law to report any threats against locations such as churches, schools, theatres, workplaces, etc. to law enforcement in which case confidentiality may be breached. (7) CRS 12-43-218 allows confidentiality to be breached if a mental health professional believes a client is a potential school shooter.

e. When I am concerned about a client's safety, it is my policy to request a Welfare Check through local law enforcement. In doing so, I may disclose to law enforcement officers information concerning my concerns. By signing this Disclosure Statement and agreeing to treatment with me, you consent to this practice, if it should become necessary.

f. Under Colorado law, C.R.S. § 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information. If you request treatment information from me, I may provide you with a treatment summary, in compliance with Colorado law and HIPAA Standards.

g. I agree not to record our sessions without your written consent; and you agree not to tape record a session or a conversation with me without my written consent.

h. There may be times when I need to consult with a colleague or another professional about issues raised by clients in therapy. Client confidentiality is still protected during consultation by me and the professional consulted. Signing this disclosure statement gives me permission to consult as needed to provide professional services to you as a client.

i. In marriage and family counseling, the therapist holds to a "no secrets" policy. All members of the couple or family system are treated equally and "secrets" are not kept by the therapist. There is no differential or discriminatory treatment of family members.

j. Your client records will be destroyed seven years after termination of psychotherapy pursuant to DORA Rules and the Colorado Mental Health Practice Act, CRS 12-43-218

k. Any staff member and/or therapist acting on behalf of Marjorie Laird, LLC will be authorized to communicate with you by telephone, text message, email and mail. In spite of efforts to keep the contents of the telephonic or text communication confidential, due to the nature of certain types of telephones, such as cell phones or mobile phones operating on radio transmissions, the possibility exists that other parties may overhear the contents of the transmission.

Children and Adolescents

A child fourteen or younger seen in this office must have the signature of a parent. In the case of divorce, the authorization must be signed by both parents or the court document presented giving sole custody. When a client is 15 years of age or older, that client is the privilege holder for himself or herself.

Disclosure Regarding Divorce and Custody Litigation

If you are involved in divorce or custody litigation, my role as a therapist is not to make recommendations to the court concerning custody or parenting issues. By signing this Disclosure Statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that I write any reports to the court or to your attorney, making recommendations concerning custody. The court can appoint professionals, who have no prior relationship with family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interests of the family's children.

Services

I provide non-emergency psychotherapeutic services by scheduled appointment. If I believe your psychotherapeutic issues are above my level of competence, or outside of my scope of practice, I am legally required to refer, terminate or consult. If, for any reason, you are unable to contact me by telephone (303) 358-3377, and you are having a true emergency, please call 911 or go to the nearest hospital emergency room.

Insurance and Payment

I am on a number of managed care and EAP programs. Additionally, many insurance companies refer to me as a provider. I will work with your insurance carrier as a courtesy to you. It is YOUR responsibility to contact your insurance company, EAP, or managed care company relative to eligibility and payment. All information about fees and payments are contained in the STATEMENT OF FEE POLICY which you will be requested to read and sign.

My fee is $90.00 per session for clinical services and any related paper work.

If you have any questions or would like additional information, please feel free to ask during the initial session or anytime during the psychotherapy process.

INFORMED CONSENT FOR TREATMENT

I have read the preceding information, and it has been presented to me verbally. I understand the disclosures that have been made to me. I also acknowledge that I have received a copy of this Disclosure Statement.

_____ _____

Client or Responsible Party Date Client or Responsible Party Date

STATEMENT OF FEE POLICY

It is important that you understand the Fee Policy. Please read-complete the section which states you insurance and your co-pay-Sign and Date. If you are a cash pay, you and your therapist will complete the section relative to fee.

Marjorie Laird, LLC provides psychotherapy, educational and consultation services. I am requesting that you read and sign this statement to acknowledge your understanding of my policy. Your signature does not bind you to therapy. It does make you responsible for charges incurred.

Insurance Billing: This will be handled on a case by case basis. You are asked to contact your insurance company relative to your benefits. This office has made every effort to be a provider for a variety of managed care companies. As a service to you, Marjorie Laird, LLC or Marjorie Laird, may bill Client's insurance company on Client's behalf. **If for any reason a claim is denied, it is the Client's responsibility to contact the insurance company and clear up any reasons for its denial. Client is responsible for verifying insurance coverage, obtaining any necessary pre-authorization, and resolving any claim denials.** If Client fails to do so, Client will pay provider's full customary fee for all services rendered. For managed care claims and EAP referrals, we will bill as per the agreement with the managed care company. (Example: United Behavioral, Mines and Associates, Cigna, etc.) Because Marjorie Laird is a licensed psychotherapist, most insurance companies will accept claims.

Co-Pay: If your managed care policy requires a co-pay, it is the individual's responsibility to bring the co-pay to each session or make other arrangements. This office does NOT send out statements for co-pay.

Deductable: Your health insurance may also have a deductible. If it is applied by your insurance company to any claim we submit, you are responsible for these amounts also. You should check with your insurance to see if a deductible applies.

Auxiliary Service: Occasionally requests are made for mental health evaluations and other reports. A fee will be charged for these reports.

Telephone Calls and E-mail: There is no charge for telephone calls and e-mail unless you and the therapist have prearranged a formal session.

Cancellations: The time of your scheduled appointment is reserved for you. It is our policy to charge $50 when the appointment is canceled within three hours of the appointed time. It is our policy to charge for the entire session for a no show. We understand that circumstances arise that make it difficult to keep an appointment. We will work with you relative to these charges.

Length of Session: A session is generally **45** minutes. Children sometimes will only have a 30 minute session. There is no extra charge for other individuals such as spouse, children, relatives or friends who may need to attend at your request.

Fees: Please speak opening to me about my fees. It is my desire to work with you as much as possible as to payment.

Fees are payable to **MARJORIE LAIRD, LLC.**
(We have a stamp for your convenience)
Insurance will be billed when requested

I give my consent and authorization to Marjorie Laird, LLC and Marjorie Laird to bill my insurance noted above and I further acknowledge that my co-pay is _____to be paid at the time of the

session or at the time otherwise arranged. My signature also represents my understanding of the above fee policies.

Signed:_____ Date:_____

MEDICAL HISTORY

Please complete: This is very important information. Please feel free to add any additional information that you feel is needed.

Name_____

Current Physician and/or Primary Care Physician_____

Address:_____City_____Zip_____

Phone:_____

Medications prescribed by this M.D. (Name and dosage)_____
_____
_____

Are you are under the care of a psychiatrist? Yes_____ No_____

Name of Psychiatrist or Psychiatric Nurse
_____

Address:_____City:_____Zip_____

Medication and dosage prescribed by Psychiatrist:_____
_____

Have you been hospitalized for emotional problems? Yes_____-No_____

If so: When_____Where_____

Have you had previous individual therapy? Yes____No_____ Dates:_____

Name of Therapist:_____Address:_____

City:_____Zip_____Telephone_____

Name of Therapist:_____Address:_____

City:_____Zip_____Telephone_____

Have you been treated for substance abuse? Yes _____Date: _____

Are you being treated now for substance abuse? Yes _____No_____

Please list any and all physical illnesses that are now being treated by M.D.

_____
_____
_____
_____
_____

What would you want your therapist to know about your physical or emotional health:_____
_____
_____
_____
_____

I authorize Marjorie Laird to contact by telephone or mail the following medical professionals for the purpose of consulting and coordinating care for my therapy and treatment.

Name_____Address:_____

City:_____State_____Zip_____

Phone: ( )_____Fax: ( ) _____

Name_____Address:_____

City:_____State_____Zip_____

Phone: ( )_____Fax: ( )_____

_____Date_____
Authorization Signature

_____Date_____
Your Signature

COURT APPEARANCE POLICY

I am a Licensed Marriage & Family Therapist, who provides clinical services to parents, families and children. This clinical work takes the form of individual counseling, marital counseling, and services to children. In my clinical role, I cannot assist my clients in divorce or custody litigation, and I disclose this fact to each client and client family who come to me for services. As a Marriage & Family Therapist, I cannot disclose any marital therapy, couples counseling or family therapy information without the consent of all my clients. This is required by Colorado law, HIPAA Standards, and the AAMFT Code of Ethics.

Please do not ask me to write any reports for the court as I cannot do so. Do not ask me to testify in court, because this will destroy my professional relationship with my clients. I am not a custody evaluator and do not do Child and Family Investigation work or Parental Responsibility/Parenting Time evaluations. If the court has appointed a CFI or a PR/PT evaluator, those are the individuals that can make recommendations to the court. I cannot make recommendations to the court concerning parental responsibility or parental time issues. That would exceed my role as a therapist, and would adversely affect my ability to help families, parents and children.

I/we have read and fully understand the forgoing statement and agree to its terms as a condition of counseling services.

_____ Date _____

_____ Date _____

Marjorie Laird, LLC,
950 Wadsworth Blvd., Suite 202,
Lakewood, CO 80214

HIPAA DISCLOSURES RE CONFIDENTIAL INFORMATION

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. PLEASE REVIEW IT CAREFULLY AND LET US KNOW ANY QUESTIONS THAT YOU MAY HAVE CONCERNING THIS NOTICE. During the process of providing services to you, **Marjorie Laird, LLC** 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.

I. USES AND DISCLOSURES OF PROTECTED INFORMATION

A. General Uses and Disclosures Not requiring the Client's Consent. **Marjorie Laird, LLC, 950 Wadsworth Blvd., Suite 202, Lakewood, CO 80214** 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, **Marjorie Laird, LLC** Therapists and staff involved with your care 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, **Marjorie Laird, LLC** 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*. **Marjorie Laird, LLC** 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*. **Marjorie Laird, LLC** 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 **Marjorie Laird, LLC** *personnel*. Crimes that are observed by **Marjorie Laird, LLC** staff that are directed toward staff, or occur on **Marjorie Laird, LLC** 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 **Marjorie Laird, LLC** staff will disclose information necessary to avoid serious harm or death.

B. Client Release of Information or Authorization. **Marjorie Laird, LLC** 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 **Marjorie Laird, LLC** has already taken action in reliance thereon.

II. YOUR RIGHTS AS A CLIENT

A. 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, ask **Marjorie Laird, LLC** staff for the appropriate request form.

B. Amendment of Your Record. You have the right to request that **Marjorie Laird, LLC** or your health care professionals amend your protected health information. **Marjorie Laird, LLC** 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 **Marjorie Laird, LLC** staff for the appropriate request form.

C. Accounting of Disclosures. You have the right to receive an accounting of certain disclosures **Marjorie Laird, LLC** 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 request an accounting. To make a request, ask **Marjorie Laird, LLC** staff for the appropriate request form.

D. Additional Restrictions. You have the right to request additional restrictions on the use or disclosure of your health information. **Marjorie Laird, LLC** 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 **Marjorie Laird, LLC** staff for the appropriate request form.

E. Alternative Means of Receiving Confidential Communications. You have the right to request that you receive communications of protected health information from **Marjorie Laird, LLC** by alternative means or at alternative locations. For example, if you do not want **Marjorie Laird, LLC** 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 **Marjorie Laird, LLC** staff for the appropriate request form.

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

III. NOTICE REGARDING USE OF TECHNOLOGY

1. *E-mail Communications*. Unencrypted e-mail may not be confidential, and any information regarding PHI sent by e-mail may not be confidential.

2. *Skype, FaceTime, or Other Similar Video Conferencing Technology*. Communication through Skype or FaceTime may not be confidential.

3. *Internet Communications*. Counseling or communication through the Internet may not be confidential.

4. *Storage of Health Care Information*. Health care records and information maintained on a Cloud may not be confidential, depending on the number of servers involved.

5. *Voicemail*. Telephone messages left through voicemail may not be confidential, if they may be accessed by individuals other than the client. Please let me know if you do **not** want me to use voicemail in contacting you.

6. *Facsimile Communication*. The submission of health care information or records by fax may not be confidential, and may lead to a disclosure of confidential information to third parties if the wrong fax number is used to send the information.

7. *Communication by U.S. Mail*. Communication of information by U.S. mail may lead to disclosure of private information to third parties, depending on who may open the mail. Please let me know if you do **not** want me to send you correspondence, billing invoices, or other information through the U.S. mail.

IV. ADDITIONAL INFORMATION

A. Privacy Laws. **Marjorie Laird, LLC** is required by State and Federal law to maintain the privacy of protected health information. In addition, **Marjorie Laird, LLC** 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.

B. Terms of the Notice and Changes to the Notice. **Marjorie Laird, LLC** is required to abide by the terms of this Notice, or any amended Notice that may follow. **Marjorie Laird, LLC** 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 **Marjorie Laird, LLC**'s service delivery sites and will be available upon request.

C. Complaints Regarding Privacy Rights. If you believe **Marjorie Laird, LLC** has violated your privacy rights, you have the right to complain to **Marjorie Laird, LLC** management. Please submit a statement, in writing, addressed to **Marjorie Laird, LLC, 950 Wadsworth Blvd., Suite 202, Lakewood, CO 80214**, 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 **Marjorie Laird, LLC** that there will be no retaliation for your filing of such complaints.

D. Additional Information. If you desire additional information about your privacy rights at **Marjorie Laird, LLC**, please ask us any questions that you may have.

V. CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

A. The confidentiality of alcohol and drug abuse patient records maintained by **Marjorie Laird, LLC** 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 consents 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.

B. 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.

C. 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.

D. 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.

VI. EFFECTIVE DATE, THIS NOTICE IS EFFECTIVE _____, 2____.

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

_____

Client Signature

ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Signature

_____
Date

_____
For Office Use Only

Marjorie Laird, LLC, attempted to obtain written acknowledgment of receipt of the Notice of Privacy Practices, but acknowledgment could not be obtained because:

____ Individual refused to sign

____ Communications barriers prohibited obtaining the acknowledgment

____ An emergency situation prevented us from obtaining acknowledgment

____ Other

_____

_____

_____

_____