



Averill Hovey, MA, MA, LPC, ATR-BC, EMDR
970-235-0075
averillhoveylpc@gmail.com
www.averillhoveylpc.com

Client Intake Form (Minor/ Child)

Client Name: _____

Client DOB: _____

Caregiver Name (s):

Does this minor/ child reside in multiple households? Yes No (designate one)
If yes, please explain:

Is there a current custody agreement? Yes No (designate one)

*If yes, please explain (and please provide copies of these agreements as well as parenting plans. **IMPORTANT: All medical decision makers must approve of therapy and :***

Does this minor/ child have a history of adoption or foster care? Yes No (designate one)
If yes, please explain:

Physician's Name & Agency: _____

Psychiatrist's Name & Agency: _____

Other Therapist Name & Agency: _____

Chronic Medical Conditions: _____

Sexual Orientation: _____

Gender Identity: _____

Summarize briefly why you/ your child are seeking treatment at this time.

What symptoms or problems are most concerning?

When did you first notice the problem? How often does it occur?

Does your child have any experience with Art Therapy or art making?

YES or NO (designate one)

if yes, please explain

(Please note: Art experience or art interest is not required to participate. Art therapy is also not the only modality offered. Talk is also utilized.)

Describe your child's previous therapy/counseling/mental health treatment experiences:

List any mental health diagnosis your child has been given and the most current if applicable:

How would you rate your child's current physical health?

Poor Unsatisfactory Satisfactory Good Very good (designate one)

How would you rate your child's current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very good (designate one)

Please explain any specific sleep problems they are currently experiencing (this can include troubles falling asleep, waking, or nightmares):

What was your child's birth experience like?

Have they experienced any traumatic events (ranging from pet loss, to bullying, to accidents)?

What are their friend relationships like? Explain the dynamics of their friend group.

Has your child experienced difficulties at school? Yes No (designate one)

If yes, please explain:

Would you be interested in me communicating with the school to help support your child?

Yes No (designate one)

If yes, how might that look for you?

What do they like to do for fun?

Do they follow a special diet or have any eating problems? If so, please explain.

Is your child experiencing now (or have they ever experienced) the following? (Please check all that apply. If checked, please briefly explain and designate whether past or present.)

- ADHD (Past/ Present)_____
- Aspergers (Past/ Present)_____
- Autism (Past/ Present)_____
- Chronic pain (Past/ Present)_____
- Brain Injury (Past/ Present)_____
- Seizure disorder (Past/ Present)_____
- Dissociative Identity Disorder (Past/ Present)_____
- Experiences of Imaginary Friends or Other Personalities Past/ Present)_____
- Headaches, Dizziness (Past/ Present)_____
- Bowel Trouble (Past/ Present)_____
- Pain (Past/ Present)_____
- Tremors or Tics (Past/ Present)_____
- Feeling apart from others (Past/ Present)_____
- Low Energy (Past/ Present)_____
- Feeling Worthless (Past/ Present)_____
- Memory Problems (Past/ Present)_____

- Crying Often (Past/ Present)_____
- Unable To Enjoy Anything (Past/ Present)_____
- Restlessness(Past/ Present)_____
- Mood swings (Past/ Present)_____
- Excess Energy (Past/ Present)_____
- Confusion (Past/ Present)_____
- Excessive Spending (Past/ Present)_____
- Elated Euphoric Mood (Past/ Present)_____
- Racing Thoughts (Past/ Present)_____
- Impulsive Behavior (Past/ Present)_____
- Anger/ Explosiveness (Past/ Present)_____
- Violent Behavior (Past/ Present)_____
- Thoughts of harming others (Past/ Present)_____
- Concentration Problems (Past/ Present)_____
- Always Worried (Past/ Present)_____
- Unwanted Thoughts (Past/ Present)_____
- Seeing Things Others Do Not (Past/ Present)_____
- Hearing Voices (Past/ Present)_____
- Depression (Past/ Present)_____
- Trauma / PTSD (Past/ Present)_____
- Physical abuse/ Emotional abuse/ Sexual abuse or Assault (Past/ Present)_____
- Sexual Problems (Past/ Present)_____
- Relationship Problems (Past/ Present)_____
- Anxiety / panic (Past/ Present)_____
- OCD / Phobias (Past/ Present)_____
- Suicidal thoughts or plans (Past/ Present)_____
- Suicide attempts (Past/ Present)_____
- Eating disorders (Past/ Present)_____
- Self-injury (Past/ Present)_____
- Postpartum depression / anxiety (Past/ Present)_____
- Addictions/Substance Abuse (Past/ Present)_____
- Other addictions (gaming, gambling, sex) (Past/ Present)_____
- Bipolar disorder (Past/ Present)_____
- Schizophrenia (Past/ Present)_____
- Identity issues (Past/ Present)_____
- Grief (Past/ Present)_____
- Personality disorder (borderline, histrionic, anti-social) (Past/ Present)_____
- Homelessness (Past/ Present)_____
- Bullying (Past/ Present)_____
- Discrimination (Past/ Present)_____
- Legal issues (Past/ Present)_____
- Employment Issues (Past/ Present)_____

Please briefly answer the following. If they do not apply put N/A.

What medications is your child currently taking for physical and/or mental health related issues?

Family Mental Health, Addictions, or Suicide History

Please list any significant (positive or negative) life changes or stressful events your child has experienced recently:

How would you know that I have helped your child?

What do you consider your child's greatest strength(s)?

What do you consider your child's edges/ challenges?

Please describe your spiritual/religious orientation:

Is there anything else you'd like me to know about your child:

Thank you for your time and transparency in filling out the intake form and I look forward to working with you! On occasion after review of this form, I may openly refer you to someone else if I feel there is someone better suited to work with you. If this happens I will tell you up front at no charge or penalty to you. I just want you to get the most appropriate services for your needs.



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Art Therapy Media Release Form

My permission is granted to:

Display (First, Last Name) _____'s artwork.

Photograph (First, Last Name) _____'s artwork.

I understand that images may be used on educational (trainings, supervision, degree education) and promotional (website, media, brochures, etc...) materials and that comments and case material may be used for scientific and educational purposes.

I have been assured that such artwork or reproductions will be presented in a respectful and professional manner for educational purposes, research, publication, or presentation.

Confidentiality of the client's name and identifying information will be maintained unless otherwise agreed upon.

Client's name _____ Age _____ DOB _____

Parent/ Guardian Name _____

Address: _____

Phone: _____

Client's Signature

Signature of Parent/Guardian
(if applicable)

Signature of Witness

Date



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Assignment of Benefits

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical/therapy benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare/Medicaid, private insurance, and any other health/medical plan, to issue payment check(s) directly to Averill Hovey for medical/therapy services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Averill Hovey to: (1) release any information necessary to insurance carriers regarding my diagnosis and treatments; (2) process insurance claims generated in the course of assessment or treatment; and (3) allow a photocopy of my signature to be use to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical/therapy services from Averill Hovey on behalf of me and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature

Date

Witness

Date



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Credit/Debit Card Payment Consent Form

Please re-check your information. Giving incorrect credit/debit card information is considered fraud. Your therapist, Averill Hovey, requests that you provide your credit card information below. If you choose to pay by credit card, your card will be charged \$_____ after each traditional session or as outlined in The Policy Agreement. If you choose to pay by cash or check, your credit card will only be charged if your account is past due and/or for any additional fees you and/or your minor child/ren incur such as late cancellation or no-show fees.

Client Name: _____

Cardholder Name (if different from client): _____

I, _____ (Cardholder Name), authorize Averill Hovey, MA, LPC, ATR-BC, EMDR to charge my card for professional services, NO SHOWS, failure to give 24 hours cancellation notification, and/or co-payments, deductibles, co-insurance and any other payments not covered by my insurance carrier that is my financial responsibility as the responsible party for the above referenced client account.

Type of card: _____ Visa _____ MasterCard _____ Discover _____ AMEX
_____ FSA/HSA Medical Card (*you may only use this card for co-payments, all other charge must be applied to another credit/debit card*)

Cr/Debit Card #: _____ - _____ - _____ - _____ CVV Number: _____
Expiration Date _____

FSA/HSA Card #: _____ - _____ - _____ - _____ CVV Number: _____
Expiration Date _____

Name on Card: _____

Billing Address, including zip code (where card statement is sent):

If I have question about these charges, I agree to contact Averill Hovey. I agree that I will not pursue a refund/credit directly through my credit or debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider.

By signing this authorization form, I agree to notify Averill Hovey of any changes to my credit card information such as a new expiration date or when my credit card has been cancelled, lost, stolen, or revoked. A new form must be submitted if information such as the list of authorized users and the credit card account's expiration date is amended.

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This credit card authorization form with remain in effect and on file unless revoked in writing or until the therapeutic relationship is terminated, at which time, authorization to charge your credit card will be revoked unless an outstanding balance remains on your account after termination. Averill Hovey will not share your credit card information with any third-party payor without client consent. Your credit card information will be kept confidential.

If cardholder is a third-party payor:

I _____, hereby authorize Averill Hovey, MA, LPC, ATR-BC, EMDR to charge the above bank credit card for payment of the counseling fees (client) _____ incurs; which shall include late or past due fees or fees related to cancellations or no-shows. I understand that my card will be billed in accordance with the authorizations listed above.

I agree to notify Averill Hovey of any changes to my credit card information including a new expiration date or when my credit card has been cancelled, lost, stolen, or revoked. I understand as a third-party payor that I am only entitled to receive information concerning payment and that this Credit Card Authorization Form does not authorize me to receive any confidential and protected information about the client beyond payment.

Third-Party Payor's Signature: _____

Date: _____

I _____, authorize Averill Hovey MA, LPC, ATR-BC, EMDR to communicate with the above third-party payor solely as it may relate to payment for services I receive with her.

Client/Parent/Legal Guardian Signature: _____

Date: _____

If cardholder is client/parent/legal guardian:

I _____, hereby authorize Averill Hovey to charge the above bank credit card for payment of the counseling fees I or my minor child/ren incur; which shall include late or past due fees or fees related to cancellations or no-shows. I understand that my card will be charged in accordance with the authorizations listed above. I agree to notify Averill Hovey of any changes to my credit card information including a new expiration date or when my credit card has been cancelled, lost, stolen, or revoked.

Client/Parent/Legal Guardian/Cardholder Signature: _____

Date: _____

Charges will read as one of the following: Averill Hovey; Averill S Hovey; Averill Hovey, LPC, LLC; Averill S Hovey, MA, LPC, ATR-BC, EMDR; Averill Hovey, MA, LPC, ATR-BC, EMDR



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Client Contact Information

Client's Name: _____ Age: _____ Gender: _____
Race/Ethnicity: _____ Date of Birth: _____

Adult's Name (if client is a minor) _____
Employer: _____ Occupation: _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Phone: (Home) _____ (Work) _____ (Cell) _____

(circle all numbers above at which you give permission to be contacted)
Okay to leave a voicemail? yes ___ no ___

E-mail address(es): _____

May I add you to my mailing list? Yes ___ No ___

Health Insurance information: Name of insurance _____
Phone number# _____ Policy and/or Member # _____
Group _____

List the preferred way(s) for me to reach you _____

Person(s) to Contact in Case of an Emergency:

1. Name _____
Relationship to you _____
Best way to contact this person _____
2. Name _____
Relationship to you _____
Best way to contact this person _____

I realize that there is a possibility that I may compromise the level of confidentiality when using cell phones and e-mail to communicate. Please indicate by placing your initials next to each means of communication to which you give your consent to use: E-mail _____ Cell phone _____ Cell voicemail _____ (please refrain from texting therapist

except in the case of communicating scheduling changes) I also realize that the contact numbers for Averill Hovey is a Google Voice number_____

Client Signature _____ Date: _____

Parent Signature (if client is a minor)_____ Date: _____

Parent Signature (if dual custody of child)_____ Date: _____



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Disclosure Statement and Informed Consent

The following describes how mental health information about you may be used, disclosed, and how to gain access to this information. Please review the following information carefully.

Contact Information:

Averill Hovey, LPC, ATR-BC, EMDR-Certified
102 E Cleveland Street, Suite 201
(970) 235-0075; averillhoveylpc@gmail.com
www.averillhoveylpc.com

Degrees:

MA in Transpersonal Counseling Psychology, Naropa University; MA in Educational Psychology; University of Colorado, Denver; BA in Mass Communications, University of Denver

Credentials and Professional Organization Memberships:

Licensed Professional Counselor, #12756, State of Colorado
Board Certified Art Therapist, #17-045, Art Therapy Credentials Board
EMDR Certified- trained by Julie Greene, MA, LPC, EMDR; EMDRIA approved trainer
Member of the American Art Therapy Association (AATA)
Member of the Art Therapy Credentials Board (ATBC)
Member of the American Counseling Association (ACA)
Member of EMDRIA (the Eye Movement Desensitization and Reprocessing International Association)

Regulation of the Practice of Psychotherapy:

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed clinical social workers, **licensed professional counselors**, licensed marriage and family therapists, certified and licensed addiction counselors, and unlicensed individuals who practice psychotherapy. The agency within the Department that has responsibility specifically for licensed and unlicensed psychotherapists is the:

Department of Regulatory Agencies
Mental Health Section
1560 Broadway, Suite 1350
Denver, CO 80202
(303) 894-7766
DORA_MentalHealthBoard@state.co.us

The levels of Psychotherapy Regulation in Colorado include licensing (requires minimum education, experience, and examination qualifications), Certification (requires minimum training, experience, and for certain levels, examination qualifications), and Registered Psychotherapist (does not require minimum education, experience, or examination qualifications). All levels of regulation require passing a jurisprudence take-home examination.

As to the regulatory requirements applicable to mental health professionals: 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 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 masters 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 1000 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 registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required.

Client Rights, Policies, and Important Information:

- a. You are entitled to receive information about the methods of psychotherapy, the techniques used, the duration of the therapy (if known), and the fee structure. Please ask at any time and review my financial and procedural policies.
- b. You may seek a second opinion from another therapist or terminate therapy at any time.
- c. In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder. If sexual intimacy occurs, it should be reported to the Department of Regulatory Agencies, Mental Health Section at (303) 894-7766 or DORA_MentalHealthBoard@state.co.us .

d. Generally speaking, the information provided by and to a client during therapy is legally confidential if the therapist is a licensed psychologist, licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, certified or licensed addiction counselor, psychologist candidate, registered psychotherapist, licensed professional counselor candidate, marriage and family therapist candidate, or counseling intern. If the information is legally confidential, the therapist cannot be forced to disclose information without the client's consent or in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

e. When working with a minor, a summary of the child's progress will be provided to the parent(s) or guardian(s) upon request, but information provided during therapy by the minor is also protected by law. If the minor is fifteen (15) years of age or older, it is within your primary therapist's discretion to advise the parents of the services given to or needed by the minor.

f. You are entitled to request restrictions on certain uses and disclosures of protected health information as provided by 45 CFR 164.522(a), however, I am not required to agree to a restriction request. Please review The Notice of Privacy Practices.

g. There are exceptions to this confidentiality, some of which are listed in The Notice of Privacy Practices you were provided. The following are exceptions to the legal rule of confidentiality:

- i. You sign a release of information form giving permission for the therapist to provide specified information about your treatment to a particular individual or agency.
- ii. The therapist reasonably suspects or has proof of child abuse and/or neglect.
- iii. The therapist reasonably suspects or has proof of abuse, neglect, and/or exploitation of elderly or disabled individuals.
- iv. You are in imminent danger of harming yourself and/or others, including those identifiable by their association with a specific location or entity. In this situation, your primary therapist is required to disclose such information to the appropriate authorities or to warn the party, location, or entity you have threatened.
- v. Therapist testimony is subpoenaed in criminal court cases and orders to violate privilege by judges in child-custody, divorce, and other court cases.
- vi. You file a suit or grievance against the therapist.
- vii. The therapist is being reviewed by the Mental Health Section of the Division of Registrations.
- viii. These provisions do not apply in delinquency or criminal proceedings except as provided in C.R.S. 13-90-107.

There may be additional exceptions as provided by HIPAA regulations and other federal and/or Colorado laws and, regulations such as those listed in C.R.S 12-43-218 that may apply. Your primary therapist will identify these situations, if practicable, as they may arise during treatment or during the professional relationship.

h. There may be times when I may need to consult with a colleague or another professional such as an attorney or supervisor, about issues raised by you in therapy. Your confidentiality is still protected during consultation by me and the professional consulted. Only the minimum amount of information necessary to consult will be disclosed. Signing this disclosure statement gives your primary therapist permission to consult as needed to provide professional services to you as a client. You will need to sign a separate Authorization for Release of Information for any discussion or disclosure of your protected health information to another professional besides an attorney retained by me.

i. In therapy where a family is the “client,” I hold a “no secrets” policy. All members of the family are treated equally and secrets are not kept that require differential or discriminatory treatment of family members. This means that there may be times when individual sessions would be beneficial to the therapeutic process in the course of family counseling. If I meet with one or multiple members of the family in individual sessions, the contents of those meetings will likely be shared with the non-attending members at the next group/family session. The information shared in individual sessions is not confidential from the other participating members. Should you reveal information that may be harmful to other participating members and you refuse to disclose the information, therapy services, among other things, may be terminated. I may choose to disclose information revealed in the individual sessions if I, in my sole discretion, determine that the information must be disclosed for therapy to be effective. If appropriate, I will give you the opportunity to disclose the information first. However, I will not lie or refuse to answer any question posed by the other family members. Should you feel it is necessary to disclose something to me and keep that information confidential, I can refer you to another therapist who can treat you individually. Please be aware that information you choose to share with me that is particularly pertinent to all participating members of the family may come out in counseling. This pertains to all face-to-face, written, and phone conversations and messages. I cannot be subpoenaed to testify or produce records without consent and authorization from all participating members of the family.

j. I provide non-emergency psycho-therapeutic services by scheduled appointment only. 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, and you are having a true physical or mental health emergency, please dial 911, go to your nearest emergency room, or call Colorado’s Crisis Hotline (844) 493-8255. If you must seek after hours treatment from any counseling agency, center, emergency room, hospital or similar facility, you are solely responsible for any fees due. I do not provide after hours service without an appointment.

k. In the case that your I become disabled, die, or am away on an extended leave of absence (hereinafter “extraordinary event,”) another therapist (“the Mental Health Professional Designee”) will have access to your client files. If I am unable to contact you prior to the extraordinary event occurring, The Mental Health Professional Designee

will contact you. Please let me know if you are not comfortable with this and you can discuss possible alternatives with me at this time.

The purpose of the Mental Health Designee is to continue your care and treatment with the least amount of disruption as possible. You are not required to use the Mental Health Professional Designee for therapy services, but the Mental Health Professional Designee can offer you referrals and transfer your client record, if requested.

l. Paper patient records are kept in locked file cabinets at my office. Electronic records are stored on my computer. Information is backed-up regularly through additional hard drives and on “the cloud.”

m. Although confidentiality extends to communications by text, email, telephone, and/or other electronic means, I cannot guarantee that those communications will be kept confidential and/or that a third-party may not access the communications. There is a risk that the electronic or telephone communications may be compromised, unsecured, and/or accessed by a third-party. It is very important to be aware that email and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. Emails and texts, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through them. Faxes can easily be sent erroneously to the wrong address. Please limit communication by text or email to administrative purposes only and do not use them as an avenue for therapy. NEVER use email or text for emergencies. Please note that the business number for me is a Google Voice phone number.

n. Regarding and acknowledging social media, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). Adding clients as friends or contacts can compromise your confidentiality and respective privacy. Please feel free to discuss your questions with me at this time.

o. I regard client artwork as a form of protected information and the property of the client. In some practice settings client artwork, or representations of artworks, may be considered a part of the clinical record retained by the therapist and/or agency for a reasonable amount of time consistent with state regulations and sound clinical practice. Client artwork may be released to the client during the course of therapy and upon its termination, in accordance with therapeutic objectives and therapeutic benefit.

i. The client is notified in instances when the I retain copies, photographic reproductions or digital images of the artwork in the client file as part of the clinical record.

ii. If termination occurs as a result of the death of the client, the original artwork is released to relatives if (a) the client signed a consent specifying to whom and under what circumstances the artwork should be released; (b) the client is a minor or under guardianship and I determine that the child's artwork does not violate the confidentiality the child entrusted to me; (c) I received and

documented clear verbal indications from the client that the client wanted part or all of the artwork released to family members; or (d) mandated by a court of law.

p. I obtain written informed consent from clients or, when applicable, legal guardians, in order to keep client artwork, copies, slides, or photographs of artwork, for educational, research, or assessment purposes. I do not make or permit any public use or reproduction of client art therapy sessions, including dialogue and artwork, without written consent of the clients. I obtain written informed consent from clients or legal guardians (if applicable) before photographing clients' artwork or video-taping, audio recording, otherwise duplicating, or permitting third party observation of art therapy sessions. I obtain written, informed consent from clients or legal guardians (if applicable) before using clinical materials and client artwork in any teaching, writing, and public presentations. Reasonable steps are taken to protect client identity and to disguise any part of the artwork or videotape that reveals client identity.(See Art Therapy Release Form.)

q. All client artwork will be stored digitally while the client is receiving art therapy services and the duration of retention for the actual artwork, photographs or digital images is in accordance with the Colorado Department of Regulatory Agencies storage of clinical notes (7 years.)

r. Any person concerned about a possible violation of the Art Therapy Credentials Board (ATCB) Standards of Ethics and Conduct, or other ATCB standard, policy or procedure, may initiate a written grievance, in as much detail and specificity as possible, including identifying the person(s) alleged to be involved and the facts concerning the alleged conduct. The written grievance should be accompanied by all available documentation. The grievance should be addressed to the Executive Director. A person initiating a grievance shall be referred to as the complainant:

Executive Director
ATCB
7 Terrace Way
Greensboro, NC 27403-3660
Toll Free: 877.213.2822
Phone: 336.482.2858
Fax: 336.482.2852
Email: atcbinfo@atcb.org

s. This form is compliant with HIPAA regulations and no medical or therapeutic information or other information related to your privacy will be released without permission unless mandated by Colorado law as described in this form and the Notice of Privacy Policies and Practices. Consistent with HIPAA guidelines authorizations for release and consent for treatment will be automatically revoked one year after signing date. You received my Notice of Privacy Policies and Practices, and acknowledge receipt of the policy.

If you have questions or would like more information, please ask at any time.

I have read the preceding information and it has also been provided verbally if I am unable to read or have no written language. I understand my rights as a client or parent of a client. By signing below I acknowledge my understanding and agree to all the terms discussed in this disclosure statement. I also affirm, by signing this form, that I am the legal guardian and/or custodial parent with legal right to consent to treatment for any minor child or children for whom I am requesting psychotherapy services.

Client('s) Name(s):

Client or Parent/Guardian Signature:

Date: _____

Date: _____

Therapist Signature:

Date: _____



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Notice of Privacy Policies and Practices

THIS NOTICE DESCRIBES HOW MEDICAL AND MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Given the nature of my work, it is imperative that she maintain the confidence of client information that she receives in the course of its work. I, Averill Hovey, am an independent mental health professional providing mental health services. I work solely to provide the best counseling treatment options to my clients. I and all my mental health practices abide by this Notice of Privacy Policies and Practices. I prohibit the release of any client information to anyone except in limited circumstances in accordance with this Notice of Privacy Policies and Practices. Discussions or disclosures of protected health information (“PHI”) are limited to the minimum necessary that is needed for the recipient of the information to perform my job. Please review this Notice of Privacy Policies and Practices (“Notice of Privacy Policies”). It is the policy of I, Averill Hovey, to:

1. fully comply with the requirements of the HIPAA General Administrative Requirements, the Privacy and Security Rules;
2. provide every client who receives services from me with a copy of this Notice of Privacy Policies;
3. ask the client to acknowledge receipt when given a copy of this Notice of Privacy Policies;
4. ensure the confidentiality of all client records transmitted by facsimile;
5. obtain from each client an informed Authorization for Release of Protected Health Information form when required.

I, Averill Hovey, am required to follow all state and federal statutes and regulations including Federal Regulation 42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164, governing testing for and reporting of TB, HIV AIDS, Hepatitis, and other infectious diseases, and maintaining the confidentiality of PHI.

PHI refers to any information that is created or received by me, and relates to an individual’s past, present, or future physical or mental health or conditions and related care services or the past, present, or future payment for the provision of health care to an individual; and identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual.

PHI includes any such information described above that I transmit or maintain in any form, this includes Psychotherapy Notes, and art imagery. HIPAA and federal law regulate the use and disclosure of PHI when transmitted electronically.

YOUR RIGHTS AS A CLIENT:

When it comes to your health information, you have certain rights. This section explains your rights and some of my responsibilities to help you.

Get an electronic or paper copy of your mental health record

- You can ask to see or get an electronic or paper copy of your mental health record and other health information I have about you. Ask me how to do this.
- I will provide a copy or a summary of your health information, usually within 30 days of your request. I may charge a reasonable, cost-based fee to fulfill your request.
- If I deny your request, in whole or in part, I will let you know why in writing and whether you have the option of having the decision reviewed by an independent third-party.

Ask me to correct your mental health record

- You can ask me to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- I may say “no” to your request, but I’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- I will say “yes” to all reasonable requests.
- Please review the Consent For Communication Of Protected Health Information By Non-Secure Transmissions.
- You are required to “opt-in” to receive communications electronically as set-forth in the Consent for Communication of Protected Health Information by Non-Secure Transmissions. If you choose not to “opt-in” to receive electronic communications, I will not communicate with you via electronic means.

Ask me to limit what I use or share

- You can ask me not to use or share certain health information for treatment, payment, or my operations. I am not required to agree to your request, and I may say “no” if it would affect your care.

- If you pay for a service or health care item out-of-pocket in full, you can ask me not to share that information for the purpose of payment or our operations with your health insurer. I will say “yes” unless a law requires me to share that information.

Get a list of those with whom I’ve shared information

- You can ask for a list (accounting) of the times I’ve shared your health information for six years prior to the date you ask, who I shared it with, and why.
- I will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked me to make). I’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. I will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- I will make sure the person has this authority and can act for you before I take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel I have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- I will not retaliate against you for filing a complaint.
- You may also file a complaint with the Colorado Department of Regulatory Agencies, Division of Professions and Occupations, Mental Health Section; 1560 Broadway, Suite 1350, Denver, Colorado, 80202, 303-894-2291; DORA_Mentalhealthboard@state.co.us. Please note that the Department of Regulatory Agencies may direct you to file your complaint with the U.S. Department of Health and Human Services Office for Civil Rights listed above and may not be able to take any action on your behalf.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A use of PHI occurs *within* a covered entity (i.e., discussions among staff regarding treatment). A disclosure of PHI occurs when I reveal PHI to an outside party (i.e., I provide another treatment provider with PHI, or share PHI with a third party pursuant to a client’s valid written authorization).

I, Averill Hovey, may use and disclose PHI, without an individual's written authorization, for the following purposes:

1. Treatment: disclosing and using your PHI by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members and for coverage arrangements during my absence, and for sending appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
2. Payment: disclosing and using your PHI so that I can receive payment for the treatment services provided to you, such as: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization of review activities.
3. Health Care Operations: disclosing and using your PHI to support my business operations which may include but not be limited to: quality assessment activities, licensing, audits, and other business activities.

Uses and disclosures for payment and health care operations purposes are subject to the minimum necessary requirement. This means that I may only use or disclose the minimum amount of PHI necessary for the purpose of the use or disclosure (i.e., for billing purposes, a therapist would not need to disclose a client's entire medical record in order to receive reimbursement. I would likely only need to include a service code and/or diagnosis etc.). Uses and disclosures for treatment purposes are not subject to the minimum necessary requirement.

I, Averill Hovey, am required to promptly notify you of any breach that may have occurred and/or that may have compromised the privacy or security of your PHI.

Confidentiality of client records and substance abuse client records maintained are protected by federal law and regulations. It is my policy that a client must complete an Authorization for Release of Protected Health Information provided by me, prior to disclosing health information to another individual and/or entity for any purpose, except for treatment, payment, or health care operations in accordance with this Notice of Privacy Policies.

Absent the above referenced form, other than for treatment, payment, or health care operations purposes, I am prohibited from disclosing or using any PHI outside of therapy, including disclosing that the client is in treatment without written authorization, unless one of the following exceptions arises:

1. Responding to lawsuit and legal actions (Disclosure by a court order, in response to a complaint filed against me, Averill Hovey, etc. This does not include a request by you or another party for your records).
2. Disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation.
3. Help with public health and safety issues (Client commits or threatens to commit a crime either at my office or against me; A minor or elderly client reports having been abused; Client is planning to harm another person, including but not limited to the harm of a child or at-risk elder; Client reports suicidal ideations or self harm).

4. Address workers' compensation, law enforcement, and other government requests. 5. Respond to organ and tissue donation requests.
5. In compliance with other state and/or federal laws and regulations.

The above exceptions are subject to several requirements under the Privacy Rule, including the minimum necessary requirement and applicable federal and state laws and regulations. See 45 C.F.R. § 164.512. Violation of these federal and state guidelines is a crime carrying both criminal and monetary penalties. Suspected violations may be reported to appropriate authorities, as listed above in the "Client Rights" section, in accordance with federal and state regulations. Know that I, Averill Hovey, will never market or sell your personal information without your permission

SPECIAL AUTHORIZATIONS

Certain categories of information have extra protections by law, and thus require special written authorizations for disclosures.

Psychotherapy Notes: I may keep and maintain "Psychotherapy Notes", which may include but are not limited to notes I have made about your conversation during a private, group, joint, or family counseling session, which is kept separately from the rest of your record. These notes are given a greater degree of protection than PHI. These are not considered part of your "client record." I, Averill Hovey, will obtain a special authorization before releasing your Psychotherapy Notes.

HIV Information: Special legal protections apply to HIV/AIDS related information. I, Averill Hovey, will obtain a special written authorization from you before releasing information related to HIV/AIDS.

Alcohol and Drug Use Information: Special legal protections apply to information related to alcohol and drug use and treatment. I, Averill Hovey will obtain a special written authorization from you before releasing information related to alcohol and/or drug use/treatment.

You may revoke all such authorizations to release information (PHI, Psychotherapy Notes, HIV information, and/or Alcohol and Drug Use Information) at any time, provided each revocation is in writing, signed by you, and signed by a witness. You may not revoke an authorization to the extent that (1) I, Averill Hovey, have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, the law provides the insurer the right to contest the claim under the policy.

As a covered entity under the Privacy and Security Rules, I, Averill Hovey, am required to reasonably safeguard PHI from impermissible uses and disclosures. Safeguards may include, but are not limited to the following:

1. Not leaving test results unattended where third parties without a need to know can view them.
2. Any PHI received as your therapist, may not be used or disclosed for non-work purposes or with unauthorized individuals. I may only use and disclose such PHI as described above.
3. When speaking with a client about his or her PHI where third parties could possibly overhear, the conversation will be moved to a private area.

4. Seeking legal counsel in uncertain situations and/or incidences.
5. Obtaining a Business Associates Agreement with those third-parties that have access to and/or store client information. Some of the functions of the practice may be provided by contracts with business associates. For example, some of the billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services.
6. Implementing FAX security measures
7. Obtaining your consent prior to sending any PHI by non-secure electronic transmissions
8. Providing information on my electronic record-keeping.

YOUR CHOICES:

For certain health information, you can tell us (verbal authorization) your choices about what I share. If you have a clear preference for how I share your information in the situations described below, talk to me. Tell me what you want me to do, and I will follow your instructions. I may request you sign a separate document if you authorize me to share certain PHI. You may revoke that authorization at anytime for future disclosure.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell me your preference, for example if you are unconscious, I may go ahead and share your information if I believe it is in your best interest and for your care/treatment. I may also share your information when needed to lessen a serious and imminent threat to public health or safety.

In these cases I never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- I may contact you for fundraising efforts, but you can tell me not to contact you again.

Changes to the Terms of this Notice

I can change the terms of this notice, and the changes will apply to all information I have about you. The new notice will be available upon request, in my office, and on my web site.

This notice is effective 6-12-2018.

Averill S Hovey, MA, LPC, ATR-BC, EMDR

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Client's Name: _____

Client or Parent/Guardian Signature(s): _____ Date: _____

Therapist Signature: _____ Date: _____



Averill Hovey, MA, MA, LPC, ATR-BC, EMDR
970-235-0075
averillhoveylpc@gmail.com
www.averillhoveylpc.com

Policies and Procedures Agreement

This Agreement is made and entered into by and between Averill Hovey, MA, LPC, ATR-BC, EMDR, who is a sole proprietor at Averill Hovey, LPC, LLC, and the Client. This Agreement shall be read in conjunction with Averill Hovey's Informed Consent and Disclosure Statement and is incorporated by reference into this Agreement.

Financial Policies

- If you are a client not utilizing insurance or other payment programs, the fees for a varying individual, family or couple psychotherapy session with Averill Hovey, MA, LPC, ATR-BC, EMDR are:

\$125.00 per 50 min. therapy session
\$165.00 per 75 min. therapy session
\$ 75.00 per 90 min. therapy group
\$ 85.00 per 50 min. individual supervision session
\$ 75.00 per 90 min. group supervision session

- I am in-network with several different insurance companies, so please ask me about your insurance situation. I am able to provide statements for out-of-network insurance reimbursements.
- By signing this Agreement, you understand that you are legally responsible for payment for your therapy services. If for any reason, your insurance company, HMO, third-party payor, etc. does not compensate me, you understand that you remain solely responsible for payment. You also understand that signing this form gives permission for me to communicate with your insurance company, HMO, third-party payor, collections agency, or anyone connected to your funding source regarding payment. You understand that your insurance company may request information from your therapist about the therapy services you received, which may include, but is not limited to: a diagnosis or service code, description of services or symptoms, treatment plans/summary, and in some cases your entire client file. You understand that once your insurance company receives the information you or I have no control of the security measures the insurance company takes or whether the insurance company shares the required information. You understand that you may request from me a copy of any report I submit to your insurance company on your behalf. Failure to pay will be a cause for termination of therapy services. _____(Initial)

- I have limited spaces available for reduced fee clients. Please talk to me to check this availability.
- Based upon this payment information, your fee will be:_____. If your financial situation changes, please inform me_____(Initial).
- Payments are due at the beginning of the session via cash, check, or credit card and will go directly to me. Please be aware that fees and policies are subject to change every 6 months. You will be notified 30 days prior to any change in fees. All accounts that are not paid within 30 days from the date of service for self-pay clients, shall be considered past due. If your account is past due, please be advised that I may be obligated to turn your account over to a collection agency or seek collection with a civil court action. By signing below, you agree that I may seek payment for your unpaid bills with the assistance of a collections agency. Should this occur, I will provide the collection agency or court with your name, address, phone number, and any other directory information, including dates of service or any other information requested by the collection agency or court deemed necessary to collect the past due account. I will not disclose more information than necessary to collect the past due account. I will notify you of my intention to turn your account over to a collection agency or the court by sending such notice to your last known address._____(Initial).

● **No-show and Cancellation Policy :**

Your visit has been reserved especially for you. 24-hour notice is required in order to cancel your appointment with no charge, excluding emergencies. If you do not call to cancel or reschedule your appointment, it is considered a “no-show.” The fee for the first no-show is waived. You will be charged the full rate for all subsequent no-shows_____(Initial).

If your insurance company does not cover this cost (and most insurance companies do not), you will be required to self-pay for the missed appointment. Please complete the **Credit/Debit Card Information Form** – this information can be utilized for your regular payment and/or in the case of a no-show. In the event of sudden illness or an emergency, please contact me to determine if an exception can be made to this policy.

- **Additional charges will be made for the following services provided at the rates listed:** Attending meetings, report writing, and client-requested consultation with other professionals will be charged at the normal hourly rate, but will be prorated to the nearest quarter hour. _____(Initial)

Out of session e-mails and phone calls lasting longer than 15 minutes will be charged the normal hourly rate and tallied in 15-minute increments. _____ (Initial)

Court and/or legal-related matters on your behalf are charged at a higher rate of \$300.00 per hour. This includes, but is not limited to: attorney fees your therapist may incur in preparing for the requested legal services, case research and preparation,

report writing, travel, depositions, actual testimony, cross examination time, and courtroom waiting time. _____ (Initial)

Additional Policies

- Therapy is a unique journey for you/your child that can lead to health and healing. There is no guarantee that psychotherapy will yield positive or intended results. Although every effort will be made to provide a positive and healing experience, every therapeutic experience is unique and varies from person to person. Results achieved in a therapeutic relationship with one person are not a guarantee of similar results with all clients. Therapy is a collaborative effort and requires commitment from you/your child. The therapist's role in your/your child's journey is not to "fix" but to facilitate your/your child's journey towards health. This requires that you communicate in a respectful manner towards me, that you **remain on the premises during your child's session, that you/your child will not come to therapy under the influence of any substances**, and **that you/your child will maintain a commitment to therapy "homework" agreed upon** with me. _____(Initial)
- If you are receiving family therapy , please know that, "the family is the client," and that I maintain a strict "no secrets" policy. This means that information revealed to the therapist by one family member must be revealed to all family members, as it is neither therapeutically beneficial nor ethically correct for family members to be kept unaware of family secrets. The therapist will guide the family if this situation occurs and will model good communication skills. Please see my disclosure statement for more information. _____(Initial)
- If your family is in the process of a divorce, please keep in mind that both parents have the right to information pertaining to their child/children, unless a court determines otherwise. All parents are asked to sign a communication agreement which allows (but does not require) me to communicate with both parents and share any communications between one parent and the therapist with the other parent. If you are consenting to treatment and therapy services for your minor child/ren, you must produce the Court Order Custody Agreement and/or Parenting Plan that grants you the authority to consent to mental health services for your minor child/ren. Further, you understand and agree to keep your therapist informed of any proceedings or supplemental court orders that affect your parenting rights, custody arrangements, and decision-making authority. You understand that failing to provide the Court Order Custody Agreement and/or Parenting Plan will prohibit your therapist from providing therapy to your minor child/ren. Please keep in mind that it is outside the guidelines and beyond the scope of ethical practice for a therapist to give opinions about custody and parenting time. Any request for custody recommendations will be denied. The court is able to appoint professionals with the expertise to make such recommendations. I do not provide reports to Child and Family Investigators. _____(Initial)

- When more than one person is responsible for payment, all parties' credit cards must be on file. If there is nonpayment for 2 sessions by any party, treatment will stop until payment disputes are resolved. I will not be responsible for resolving payment disputes; this must be worked out amongst the paying parties. Please be aware that your appointment time may not be reserved for you during this time. _____(Initial)
- Clients who indicate self-harming, suicidal, or homicidal thoughts or behaviors will be asked to sign a safety plan outlining a specific plan of action to be followed during the course of therapy. _____(Initial)
- Choosing a "best fit" therapist is the client's right and if during a time where you may be experiencing covered support in my absence (i.e., maternity leave, vacation, illness) you identify the covering therapist to be a better match for you/your child, I respectfully ask that you attend two (2) termination sessions with me.
- **Non-emergency Services.** Therapist self-care is vital to ensure the highest quality of care is provided to our clients. It is important that you be aware that I will not answer emails or phone calls after hours or on the weekends. I host an outpatient practice and therefore do not provide emergency psychotherapeutic services or transportation to/from the hospital. I provide non-emergency services during stated business hours and by scheduled appointment only. I will return calls during stated business hours only, unless otherwise scheduled. If you must seek after hours treatment from any counseling agency or center, emergency room, or hospital, you understand that you remain solely responsible for any fees that arise from that care. _____(Initial)
- **Discontinuing Therapy.** You understand that should you choose to discontinue therapy for more than 60 days by not communicating with me, your treatment will be considered terminated. You may be able to resume therapy after the 60 day period by discussing your decision to resume therapy services with me. Ability to resume therapy after 60 days will depend upon my availability and will be within my sole discretion. Your **Disclosure Statement/Informed Consent for Treatment** and these Policies will remain in effect should you resume therapy if one (1) year has not elapsed since your last session. However, you may be asked to provide additional information to update your client record. You understand that "discontinuing therapy" means that you have not had a session with me for at least 60 days, unless otherwise agreed to in writing. _____(Initial)
- **Social Media.** You understand that I, Averill Hovey, do not accept personal Facebook, LinkedIn, Twitter, Instagram, and/or other friend/connection/follow requests via any social media. Any such request will be denied in order to maintain professional boundaries. You understand that I have, or may have, a business social media account page. You understand that there is no requirement that you "like" or "follow" this page. You understand that should you "like" or choose to "follow" my business social media page that others will see your name associated with "liking" or "following" that page. You understand that this applies to any comments that you post on the page/wall, as well. You understand that any comments you post regarding therapeutic

work between you and your therapist will be deleted as soon as possible. You agree to refrain from discussing, commenting, and/or asking therapeutic questions via any social media platform. You agree that you will contact me with any therapeutic comments and/or questions through the mode you have consented to and not through social media. If you have any questions regarding social media, review websites, or search engines in connection to our therapeutic relationship, you agree to immediately contact me and address those questions. _____(Initial)

- **Teletherapy and Technology.** In general, I do not provide Teletherapy, such as therapy over the phone or video chat. You understand that communications via email and text should be limited to administrative purposes (like scheduling or notification of delayed arrival), and not used as an avenue for therapy. You agree to discuss any request you make for Teletherapy with me. You understand that it is in my sole discretion whether to accommodate your request for Teletherapy. _____(Initial).
- **Communication by Unsecure Transmissions.** By signing this Agreement you allow me, Averill Hovey, to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any information that is not provided in-person shall be provided in accordance with the **Consent for Communication of Protected Health Information By Unsecure Transmissions** form. You understand that if you initiate communication via electronic means that you have not specifically consented to in the **Consent for Communication of Protected Health Information By Unsecure Transmissions** form, you will need to amend the consent form so that I may communicate with you via that method. _____(Initial)
- I acknowledge that in addition to this form, I have seen, been offered a copy of, and agree with the terms of both the **Informed Consent for Treatment/Disclosure Statement** and the **Notice of Privacy Practices**. _____(Initial)

I understand that this version of my, Averill Hovey, MA, LPC, ATR-BC, EMDR's, policies go into effect June 13, 2018 and replaces all former policy documents.

_____(Initial)

Client('s) Name(s): _____

Client or Parent/Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____



Averill Hovey, MA, MA, LPC, ATR-BC, EMDR

970-235-0075

averillhoveylpc@gmail.com

www.averillhoveylpc.com

Release of Information

Client Name: _____ D.O.B.: _____

Release to/from (circle one or both):

Name: _____

Address: _____

Phone: _____

Dates of Relevant Care: From: _____ To: _____

I, _____ (client name or parent/guardian if client is a minor), hereby authorize and consent to the release of information to/from (circle one or both) Averill Hovey and the person/agency listed above.

I authorize the following information to be released and exchanged to/from (circle one or both):

Assessment and Treatment Plan _____ Session Progress Notes _____

Session Progress Summary _____ Termination Summary _____

Demographic/Historical Information _____

Such disclosure of information is for the purpose of establishing and coordinating effective treatment. Specifically, the information will be used/disclosed for the following purposes:

Assessment _____ Coordination/Continuation of Care _____

Benefits Coordination/Acquisition _____ Payment of Insurance Claims _____ Other:

Service Planning _____ Referral _____ Disability Determination _____ Legal Purposes _____

I hereby relieve and release Averill Hovey, MA, LPC, ATR-BC, EMDR from any and all damages, claims, and causes arising out of, or in connection with, any release of this information.

If I am the parent/guardian, I understand that my child's records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for. I further understand that I may I may revoke this consent at any time by sending a letter to Averill Hovey, MA LPC, ATR-BC, EMDR.

If I do not withdraw my consent, this release will expire within one year of the undersigned date.

Client or Parent/Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____