The Neurofeedback Clinic of Northern Colorado

Neurofeedback Clinic of Northern Colorado
4115 Boardwalk Drive, Ste 100
Fort Collins, CO 80525
P970-493-4580

Client Information Form

Your cooperation in completing this questionnaire will be helpful in planning services for you. Please answer each item carefully and ask questions if something is not clear. The information provided on this questionnaire is confidential and will not be released without your permission.

Client Name (yourself or your child): _____

Parent or legal guardian (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ OK to leave messages? Yes No

Work Phone: _____ OK to leave messages? Yes No

Cell/Other: _____ OK to leave messages? Yes No

Email Address: _____

Date of Birth: _____ Age: _____ Ethnicity: _____

Adopted? Yes No Age of Adoption: _____

Relationship Status: Single Married Divorced Widowed

Employer: _____

Do you have a health insurance policy? Yes No

Insurance Company:_____ Policy Holder:_____

Who referred you to our clinic? _____

May we thank them for the referral? Yes No

The Neurofeedback Clinic of Northern Colorado

Neurofeedback Clinic of Northern Colorado
4115 Boardwalk Drive, Ste 100
Fort Collins, CO 80525
P970-493-4580

Email Communication Consent Form

Risks of using email

Our therapists offer patients the opportunity to communicate by email. Transmitting patient information poses several risks of which the patient should be aware. The patient should not agree to communicate with the physician via email without understanding and accepting these risks. The risks include, but are not limited to, the following:

- The privacy and security of email communication cannot be guaranteed.
- Employers and online services may have a legal right to inspect and keep emails that pass through their system.
- Email is easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the email once it has been sent.
- Emails can introduce viruses into a computer system, and potentially damage or disrupt the computer.
- Email can be forwarded, intercepted, circulated, stored or even changed without the knowledge or permission of the physician or the patient. Email senders can easily misaddress an email, resulting in it being sent to many unintended and unknown recipients.
- Email is indelible. Even after the sender and recipient have deleted their copies of the email, back-up copies may exist on a computer or in cyberspace.
- Use of email to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- Email can be used as evidence in court.

Conditions of using email

Our therapists will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, the physician cannot guarantee the security and confidentiality of email communication. Thus, patients must consent to the use of email for patient information and communication. Consent to the use of email includes agreement with the following conditions:

- Emails to or from the patient concerning diagnosis or treatment may be printed in full and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those emails.
- Our therapists may forward emails internally to the to those involved, as necessary, for diagnosis, treatment, reimbursement, healthcare operations, and other handling. Our therapists will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
- Although our therapists will endeavor to read and respond promptly to an email from the patient, **the therapist cannot guarantee that any particular email will be read and responded to within any particular period of time. Thus, the patient should not use email for medical emergencies or other time-sensitive matters.**
- Email communication is not an appropriate substitute for therapeutic sessions. The patient is responsible for following up on the therapist's email and for scheduling appointments where warranted.
- If the patient's email requires or invites a response from the therapist and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the email and when the recipient will respond.
- The patient is responsible for informing the therapist of any types of information the patient does not want to be sent by email. Such information that the patient does not want communicated over email includes:

  _____

  _____

  The patient can add to or modify this list at any time by notifying the physician in writing.

The Neurofeedback Clinic of Northern Colorado

Neurofeedback Clinic of Northern Colorado
4115 Boardwalk Drive, Ste 100
Fort Collins, CO 80525
P970-493-4580

Our therapists are not responsible for information loss due to technical failures associated with the patient's email software or internet service provider.

Instructions for communication by email

To communicate by email, the patient shall:

- Limit or avoid using an employer's or other third party's computer.
- Inform the therapist of any changes in the patient's email address body
- Review the email to make sure it is clear and that all relevant information is provided before sending to the therapist.
- Take precautions to preserve the confidentiality of emails, such as using screen savers and safeguarding computer passwords.

Should the patient require immediate assistance, or if the patient's condition appears serious or rapidly worsens, the patient should not rely on email. Rather, the patient should call the therapist's office for an appointment or take other measures as appropriate.

Patient acknowledgment and agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the therapist and me, and consent to the conditions outlined herein, as well as any other instructions that the therapist may impose to communicate with patients by email. I acknowledge the therapist's right to, upon the provision of written notice, withdraw the option of communicating through email. Any questions I may have had were answered.

Patient Name: _____

Patient Email: _____

Patient Signature _____ Date _____

Therapist Signature _____Date _____

The Neurofeedback Clinic of Northern Colorado

Neurofeedback Clinic of Northern Colorado
4115 Boardwalk Drive, Ste 100
Fort Collins, CO 80525
P970-493-4580

AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

Appointment scheduling:
We ask your cooperation in maintaining a schedule and keeping appointments. We may not be able to schedule a regular appointment time. If a regular appointment time is of interest to you, we will make every effort to ensure that happens. New appointments are scheduled after each session.

Appointment cancellation, late arrival, and no show policy:
We ask that you provide at least **24-hour** notice if you need to cancel an appointment. Other clients may be able to fill a canceled appointment time. You may be charged for the full session fee if we do not receive 24-hour notice of cancellation. If you do not show up for an appointment and fail to notify your therapist beforehand, you will be responsible for the full session fee at your next scheduled appointment.
It is important that you allow yourself enough time to arrive on time for your appointment. We require all of the time scheduled to provide the best possible services. If you arrive more than **10 minutes late** for your appointment, we will not be able provide services. The appointment will be treated as a late cancellation and you will be responsible for the full session fee. This applies to **all** self-pay, health insurance and victim compensation clients. Please feel free to inquire about your rate. We recognize there are times when emergencies arise, and we ask your cooperation in notifying us as soon as possible if you have an emergency.

_____ Initials

Payment agreement:
Payment in full is expected at the time of service. Payment may be made using cash, check, or credit card. Please note that this is a fee for service institution. **Full fees are due regardless of health insurance benefits, allowable rates, existing insurance contracts, etc.** If you have any questions regarding your payment amount, please contact the office manager or your therapist.

Insurance reimbursements:
We will submit claims to all insurance companies that we are in-network with. Clients with out-of-network insurance companies are responsible for full payment at the time of service and for submitting claim forms to their insurance company. Upon request we will supply clients with the information needed by the insurance company in order to file and process a claim. It is the responsibility of the client to determine what their insurance will cover. By signing this form, you are acknowledging that you are responsible for the fees incurred in treatment in the event the insurance claim is denied.

Clinic staff are **NOT** able to define your insurance coverage. If you have coverage questions, you are advised to call your insurance carrier. **It is your responsibility to be knowledgeable regarding your insurance coverage.**

I certify that I am the patient or that I am financially responsible for the services rendered and do hereby unconditionally guarantee the payments of all amounts when and as due.

Release of Information and authorization to pay insurance benefits:
By signing this form, I am giving permission to release any information relating to treatment to any third-party payers or insurance companies that may be required or requested to assist in the processing of claims. I am also giving permission for the payment of any medical benefit, or insurance claim, or victim compensation to be paid directly to the Neurofeedback Clinic of Northern Colorado, should they bill directly for services provided.

By signing this form, I acknowledge my understanding of payment policies and this agreement to pay for professional services.

_____ _____
Signature of client or guardian of minor child **Date**

_____ _____
Printed name of signer and minor child **Relationship**

The Neurofeedback Clinic of Northern Colorado

Neurofeedback Clinic of Northern Colorado
4115 Boardwalk Drive, Ste 100
Fort Collins, CO 80525
P970-493-4580

NOTICE OF HIPAA PRIVACY RIGHTS

The Notice of Privacy Rights 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 this information carefully. During the process of providing services to you, the provider/psychotherapist will obtain, record, and use mental health and medical information about you that is protected health information. Ordinarily, that information is confidential and will not be used or disclosed, except as described below.

USES AND DISCLOSURES OF PROTECTED INFORMATION

I. General Uses and Disclosures Not Requiring the Client's Consent.

A. The provider will use and disclose protected health information in the following ways:

1. **Treatment**. Treatment refers to the provision, coordination, or management of health care [including mental health care] and related services by one or more health care providers. For example, the provider will use your information to plan your course of treatment. As to other examples, the provider will consult with professional colleagues in this practice or ask professional colleagues to cover calls or the practice for the provider and will provide the information necessary to complete those tasks.
2. **Payment**. Payment refers to the activities undertaken by a health care provider [including a mental health provider] to obtain or provide reimbursement for the provision of health care. The provider will use your information to develop accounts receivable information, bill you, and with your consent, provide information to your insurance company or other third party payers for services provided. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnosis, type of service, date of service, provider name/identifier, and other information about your condition and treatment.
3. **Health Care Operations**. Health Care Operations refers to activities undertaken by the provider that are regular functions of management and administrative activities of the practice. For example, the provider may use or disclose your health information in the monitoring of service quality, staff evaluation, and obtaining legal services.
4. **Contacting the Client.** The provider may contact you to remind you of appointments and to tell you about treatments or other services that might be of benefit to you. The provider does not guarantee confidentiality if you are discussing issues via cell phone, cordless phone etc. and you must give consent for provider to leave a message on an answering machine. Confidentiality cannot be guaranteed if you choose to communicate with your therapist or the clinic via email.
5. **Required by Law.** The provider will disclose protected health information when required by law or necessary for health care oversight. This includes, but is not limited to: (a) reporting suspected child abuse or neglect; (b) when court ordered to release information; (c) 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, or regulatory compliance; (d) when a coroner is investigating the client's death; (e) when there is a legal duty to warn or take action regarding imminent danger to others. The provider is required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (f) The provider is 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; (g) The provider is required to report any suspected threat to national security to federal officials.
6. **Crimes on the premises, observed, or reported to the provider.** Crimes that are observed by the provider or the provider's staff, crimes that are directed toward the provider or the provider's staff, crimes that occur on the premises, or crimes reported to law enforcement.

Neurofeedback Clinic of Northern Colorado
4115 Boardwalk Drive, Ste 100
Fort Collins, CO 80525
P970-493-4580

7. **Business Associates.** Some of the functions of the provider 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. 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.
8. **Research.** The provider may use or disclose protected health information for research purposes if the relevant limitations of the Federal HIPAA Privacy Regulations are followed. 45 CFR § 164.512(i).
9. **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.
10. **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. 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, the therapists may provide you with a treatment summary, in compliance with Colorado law and HIPPA Standards.
11. **Welfare Checks.** When we are concerned about a client's safety, it is our policy to request a Welfare Check through local law enforcement. In doing so, we may disclose to law enforcement officers information concerning our concerns. By signing this Disclosure Statement and agreeing to treatment at the Neurofeedback Clinic of Northern Colorado, you consent to this practice, if it should become necessary.
12. **Hold Harmless.** I agree to hold harmless, and I will not institute or be part of any claim or suit against the therapists, evaluators, staff and clinic in their provision and administration of my services and treatment program.
13. **Release of Information**. Information in your case may be shared with the Neurofeedback Clinic of Northern Colorado therapists listed in this document for case consultation and supervision purposes. This information is considered confidential for each of these professionals. Your signature gives consent for this consultation and supervision.

B. Client Authorization or Release of Information.

The provider may not use or disclose protected health information in any other way without a signed authorization or release of information. When you sign an authorization, or a release of information, it may later be revoked provided that the revocation is in writing. The revocation will apply, except to the extent the provider has already taken action in reliance thereon.

II. YOUR RIGHTS AS A CLIENT

A. Access to Protected Health Information.

You have the right to inspect and obtain a copy of the protected health information the provider has regarding you, in the designated record set. However, you do not have the right to inspect or obtain a copy of psychotherapy notes. There are other 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 your therapist.

The Neurofeedback Clinic of Northern Colorado

Neurofeedback Clinic of Northern Colorado
4115 Boardwalk Drive, Ste 100
Fort Collins, CO 80525
P970-493-4580

B. Amendment of Your Record.
You have the right to request that the provider amend your protected health information. The provider 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 your therapist.

C. Accounting of Disclosures.
You have the right to receive an accounting of certain disclosures the provider 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. There are other exceptions that will be provided to you, should you request an accounting. To make a request, ask your therapist.

D. Additional Restrictions.
You have the right to request additional restrictions on the use or disclosure of your health information. The provider 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 your therapist.

E. Alternative Means of Receiving Confidential Communications.
You have the right to request that you receive communications of protected health information from the provider by alternative means or at alternative locations. For example, if you do not want the provider 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 your therapist. F. Copy of this Notice. You have the right to obtain another copy of this Notice upon request.

III. ADDITIONAL INFORMATION

A. Privacy Laws.
The provider is required by State and Federal law to maintain the privacy of protected health information. In addition, the provider is required by law to provide clients with notice of the provider's legal duties and privacy practices with respect to protected health information.

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

Neurofeedback Clinic of Northern Colorado
4115 Boardwalk Drive, Ste 100
Fort Collins, CO 80525
P970-493-4580

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HIPPA PRIVACY RIGHTS

I hereby acknowledge that I have received a copy of the provider/psychotherapist **Notice of HIPAA Privacy Rights**. I further agree to read this **Notice of HIPAA Privacy Rights**. I will talk with my therapist if I have any concerns.

_____ I **WOULD** like a copy of this disclosure for my records.

_____ I **DO NOT** want a copy of this disclosure for my records.

_____
Name of client

_____ _____
Signature of client or guardian of minor child Date

_____ _____
Printed name of guardian Relationship

_____ _____
Signature of therapist Date

The Neurofeedback Clinic of Northern Colorado

Neurofeedback Clinic of Northern Colorado
4115 Boardwalk Drive, Ste 100
Fort Collins, CO 80525
P970-493-4580

Professional Disclosure and Informed Consent

Informed Consent

We offer psychological therapy supported by EEG biofeedback training to clients in connection with a variety of conditions that appear to be associated with dysregulation of brain activity. These conditions include hyperactivity and attention deficits, behavior problems, sleep disorders, depression, anxiety, chronic pain, brain injury, seizures, PTSD, and other conditions. Therapy supported by EEG biofeedback training is also provided for clients who wish to enhance brain regulation for improved performance.

Scientific investigation is ongoing to determine the mechanism by which benefits from EEG biofeedback are achieved. At present, we recommend the training on the basis of empirical observations and research evidence of improvement in clients with similar conditions. As with any treatment symptoms may temporarily get worse before they get better.

No guarantee is made that any individual will improve with training. It is possible that for a few clients who do experience benefits, the improvement may fall off after the cessation of training. Those individuals would benefit from periodic follow-up for booster sessions. The training appears to be a harmless procedure as far as known at present. No injuries are known in the experience of the literature reviewed. It is a noninvasive procedure. Nevertheless, we do not make any representation concerning the safety or efficacy of training. Any questions should be addressed to the prospective client's physician. The client should continue ongoing therapies and maintain care with any established medical health provider, including prescribing physicians, unless otherwise advised by a physician.

It is the client's responsibility to monitor the subjective effects of training and to continue training so long as a benefit is perceived. The research literature indicates that there are some individuals who are apparently unaffected by the training. There are also clients who report vast benefits over the entire course of training. Accordingly, we encourage the client to evaluate progress after about 10 sessions to determine if further training is indicated. We invite discussion at this point or any point in the training.

The Neurofeedback Clinic of Northern Colorado does not engage in emergency or crisis therapy. In the case of an emergency please call 911 or go to the nearest emergency room.

Client Rights

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed social workers, licensed professional counselors, licensed marriage and family therapists, licensed school psychologists practicing outside the school setting, licensed or certified 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
Division of Registrations
Mental Health Section
1560 Broadway, Suite 1350
Denver, Colorado 80202 (303)-894-7766

The Neurofeedback Clinic of Northern Colorado

Neurofeedback Clinic of Northern Colorado
4115 Boardwalk Drive, Ste 100
Fort Collins, CO 80525
P970-493-4580

(a) You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your treatment (if it can be determined), and the fee structure. Please ask if you wish to receive this information from your therapist.
(b) You may seek a second opinion from another therapist and may terminate your therapy at any time. (c) In a professional relationship (such as ours), sexual intimacy is never appropriate. If sexual intimacy occurs, it should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

Confidentiality

Information disclosed to a licensed psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, licensed or certified addiction counselor, or an unlicensed psychotherapist is confidential and considered privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

There are exceptions to the general rule of legal confidentiality. These exceptions are listed in the Colorado statutes (C.R.S. 12-43-218). You should be aware that provisions concerning disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in section 13-90-107 C.R.S. Matters regarding your psychotherapy will be kept confidential except in the following circumstances:

1) You sign a release of information giving permission to release information to a specific individual or agency;
2) Intent to harm self or others;
3) Abuse, neglect, or suspected abuse or neglect of children, elderly, or others unable to care for themselves.
4)If the client poses a reasonable risk to national security

Under these conditions the proper authorities will be notified.
Information in your case may with shared with Neurofeedback Clinic of Northern Colorado therapists listed in this document. Your signature below constitutes your permission for such consultations. I will not testify in court on any case, if asked, due to the damage this can do to the therapeutic relationship.

Clinical Staff

Lisa Pendleton, MS, LMFT #983
Clinical Director
EMDR II, Neurotherapy Practitioner
970-493-4580, Ext 302

Monica Rowell, MA, LPC #12332
Neurotherapy Practitioner
970-493-4580, Ext 306

Barbara Stutsman, MA, MS, LMFT #974
EMDR II, Neurotherapy Practitioner
970-493-4580, Ext 308

Jennifer Wayman, MEd, CAC II, LPC #0012237
Neurotherapy Practitioner
970-493-4580, Ext 311

Jinny Mortensen, MA, LPC #12377
EMDR II, Neurotherapy Practitioner
970-493-4580, Ext 303

Andrea Ewing, MS, LCSW #9923938
Neurotherapy Practitioner
970-493-4580, Ext 307

Whitney Bosley, MA, LAC, LPC #0012299
Neurotherapy Practitioner
970-493-4580, Ext 315

Vanessa Baltazar Schneider, MA, LPC #12471
Neurotherapy Practitioner
970-493-4580, Ext 319

Neurofeedback Clinic of Northern Colorado
4115 Boardwalk Drive, Ste 100
Fort Collins, CO 80525
P970-493-4580

Melissa Fuller, MS, LPC #0011928
Neurotherapy Practitioner
970-493-4580, Ext 331

Kiara Dixon, MA, LPC #0012526
Neurotherapy Practitioner
970-493-4580, Ext 320

Julianne Graul, MSW, LCSW #00000149
Neurotherapy Practitioner
970-493-4580, Ext 314

Amy Grauberger, MA, LPC #0012146
Neurotherapy Practitioner
970-493-4580, Ext 321

Rebecca Craig, MA, LPC #0004479
Neurotherapy Practitioner
970-493-4580, Ext 305

Heather Meyer, MA, LPC #0012680
Neurotherapy Practitioner
970-493-4580, Ext 304

Rachael McGonegal, MA, LPC # 0005099
Neurotherapy Practitioner
970-493-4580, Ext 332

Administrative Staff

Jeff Andersen
Business Manager
970-493-4580, Ext 309

Tristin Hammel
Office Manager
970-493-4580, Ext 312

Kelsey Wayman
Office Assistant
970-493-4580, Ext 301

Rachel Knox-Stutsman
Office Assistant
970-493-4580, Ext 310

_____ _____
Signature of Client (15 and over) or Guardian of minor child — Date

_____ _____
Printed name of client or child — Relationship

_____ _____
Signature of therapist — Date

NCNOCO Client Paperwork Checklist

For Staff Use Only

___ Client Information Form
___ Adult, Child or Adolescent (13 and up) Information Packet
Informed Consent & Therapist Disclosure
    ___ Clinic Copy
    ___ Client Copy
___ Agreement to Pay for Professional Services & Appointment Cancellation
___ Acknowledgement of Receipt of Notice of HIPAA Privacy Rights
___ Consent for Release of Non-Identifying Information (they can decline)
___ E-Mail Communication Consent Form (they can decline)

Client Specific Paperwork

___ Consent for TX of Minor for children under 15
___ Release of Information (as needed per client request)

The Neurofeedback Clinic of Northern Colorado

Neurofeedback Clinic of Northern Colorado
4115 Boardwalk Drive, Ste 100
Fort Collins, CO 80525
P970-493-4580

CONSENT FOR RELEASE OF NON-IDENTIFYING INFORMATION

By signing this consent, I give my permission for The Neurofeedback Clinic of Northern Colorado to release non-identifying information regarding data obtained in the context of Neurofeedback. This information may include but not limited to symptom graphing data as well as general, non-identifying, anecdotes related to the symptom graphing.

Information released may be singular or compiled with other clients and released in an aggregate fashion.

Released information will NOT include any information obtained during traditional psychotherapy without a specific consent for release of information.

This release is valid until the end of neurofeedback treatment unless otherwise specified but can be revoked at any time.

Information released will be for the strict purpose of education and/or grant writing. Information may also be released in the context of professional consultation and/or professional supervision for certification.

_____

Name of client

_____ _____

Signature of client or guardian of minor child Date

_____ _____

Printed name of guardian Relationship