SOL
MENTAL HEALTH

Adult Patient Questionnaire

Please complete and return this questionnaire 48 hours prior to your scheduled intake.

Date:

Demographics:
Legal Name

Preferred Name

Gender Identity

Sexual Orientation

Pronoun(s)

Ethnicity

Religion

Relationship status [choose one]
- Single
- Partnered
- Married
- Separated
- Divorced
- Widowed
- Other: _____

Education/Job:
Employment status [choose one]
- Unemployed
- Part-time
- Full-time
- Contractor/free-lancer
- Full-time student
- Part-time student
- Other: _____

Employer/school:

Describe what brings you in for treatment today:

Which of the following are you experiencing (choose all that apply)?
- Depression
- Anxiety
- Panic attacks
- Inattention
- Hyperactivity/Impulsivity
- Nightmares/flashbacks

- Changes in sleep
- Repetitive behaviors
- Alcohol or substance use
- Intrusive thoughts
- Impulsive behaviors
- Difficulty navigating social situations
- Relationship conflicts
- Self-harm or suicidal thoughts
- Thoughts of hurting others
- Traumatic event(s)
- Other _____

Medical History:

Primary care clinician:

Last visit:

Medical diagnoses:

Current medical medications:

Medication	Dose	Frequency	Who prescribes?

Allergies:

Concussion History: ☐ Yes ☐ No; if yes please describe:

Seizure History: ☐ Yes ☐ No; if yes please describe:

If you are sexually active, please describe birth control use / safe-sex practices you utilize:

If applicable, pregnancy history/due date: (pregnancies, miscarriages, any complications):

Health History:

Please describe health in the following areas:
Nutrition, diet, and appetite (for example, changes in appetite or dietary restrictions): _____
Physical activity (for example, how much exercise do you get each week): _____
Sleep (for example, how many hours do you sleep each night): _____

Family Health History

1. Family Medical History: _____
2. Family Psychiatric History: _____
3. Family Substance Use History: _____

[ ] If family health history unknown, check here

Childhood/Family History:

Birth place:

Siblings:

Places lived:

Relationship with family members:

PSYCHIATRIC HISTORY:

Have you even been diagnosed with a mental health condition? Please describe.

Please list all current and past psychiatric medications you have been prescribed. Include approximate years.

Current psychiatric medications (include dose)	Previous psychiatric medications (include dose)

Psychiatric Treatment History: (Include dates, clinician name, outcome)

☐ Outpatient (office-based):

☐ Inpatient (emergency room / hospital-based):

☐ Residential:

☐ Partial Hospitalization:

☐ Intensive Outpatient:

☐ Other:

Please check substances you currently use/have used in the past: (describe how recent/often)

☐ Caffeine: ☐ Alcohol: ☐ Benzodiazepines:
☐ Nicotine: ☐ Stimulants: ☐ Opioids:
☐ Cannabis: ☐ Psychedelics: ☐ Other:

Have you ever experienced hearing sounds others can't hear or seeing things others can't see?

Do you have any legal history, such as charges, upcoming hearings, DUI, loss of license, current probation, incarceration history, or arrest history? Please describe if yes:

Concluding Questions

What would you describe as your strengths?

What are your goals for treatment? What do you want to be different, have more/less of?

Is there anything else you'd like us to know about you that has not been asked already?

REVISED 12/15/2022

Informed Consent for Treatment

Financial Consent & Insurance Billing

I voluntarily consent on behalf of myself or my legal dependent to participate in evaluation, consultation, and/or treatment as a patient of Sol Mental Health. I give my authorization to receive treatment and I understand that developing a treatment plan with my clinical team and regularly reviewing our work toward meeting goals is in my best interest. I agree to play an active role in this process and understand that I may address any concerns with my clinical team in a timely manner. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by Sol Mental Health. I am aware that I am free to choose treatment and may stop treatment at any time. I understand that if I choose to stop treatment, I will still be financially responsible for the services I have already received.

This agreement shows my commitment to pay for the treatment I receive. I agree to pay for the services rendered at each session or in accordance with an established payment plan. Insurance may cover part, or all the cost of treatment, and I understand that Sol Mental Health will attempt to charge the correct copay or allowable amount at time of service. However, I understand that it is **my responsibility to check my coverage and be knowledgeable about my benefits.** I also understand that there may be some types of treatment that may not be covered by insurance but may be clinically recommended. Unless otherwise specified, by me, I agree to allow submission of insurance claims to insurance (if appropriate) – this includes diagnoses and treatment information. I authorize payment of benefits to Sol Mental Health.

Out-of-Network & Out-of-Pocket

Medical Services

60-minute medication management session: **$200**

30-minute medication management session: **$150**

Therapy Services

60-minute intake session: **$200**

60-minute psychotherapy session: **$150**

60-minute group psychotherapy session: **$50**

Documentation Requests

Documentation requests must be made utilizing the following secure methods:

https://solmentalhealth.com/request-medical-records-co/

Phone: 800-659-4035

Email: status@healthmark-group.com

All documentation requests will be handled within 30 calendar days.

Documentation requests, including, but not limited to, medical records, legal letters, accommodation letters, short term disability paperwork, detailed treatment summaries, IEP documentation, ESA letters, may incur a fee based upon length, time spent, and clinicians involved.

Fee Policy

I understand that I must call to cancel an appointment **at least 48 hours** (2 business days) before the appointment time (weekend days and holiday days do not count towards the minimum 2 business day requirement). If I do not cancel or do not show up, I will be charged **$100** for individual appointments and **$50** for group appointments. I agree to pay for appointments that are not cancelled or those where I fail

to give proper notice that I will not attend. Certain exceptions for unforeseen or unavoidable situations can be made at the exclusive discretion of Sol Mental Health. I understand that insurance does not pay for appointments that are not cancelled, so I will be solely responsible for the cost. **Fees will also apply to late arrivals and requests for abbreviated appointments.**

Patient Rights & Important Information

1. Generally, the information provided by and to me during therapy sessions is legally confidential. Whenever the information is legally confidential, the clinician cannot be forced to disclose the information without your consent.

2. There are exceptions to the general rule of legal confidentiality. Be aware that legal confidentiality will not apply in a criminal or delinquency proceeding, except as provided in section 13-90-107 C.R.S. There are other exceptions: the clinician will identify these to me as the situations arise during therapy, but, briefly, these are (1) imminent threat of bodily harm to self or identifiable other; (2) gravely disabled, as a result of a mental disorder; (3) child/elder abuse or neglect; (4) When you or your representative files a lawsuit or grievance against your clinician (5) a court order requiring Sol Mental Health to turn over records; (6) if you are in treatment by order of a court of law, the results of the treatment ordered must be revealed to the court; (7) if there is suspected threat to national security to federal officials, the clinician is required to report this to law enforcement. The clinician is not required to inform you of actions in this regard, however, if a legal exception arises during therapy, if feasible, you will be informed accordingly.

3. Under Colorado law, minors under 12 years old (for therapeutic services) and under 15 years old (for medical services) have the right to consent to their own treatment. Generally, except for situations such as those mentioned above, information provided by a minor during therapy sessions is legally confidential and will not be shared with parents or guardians. This includes activities and behavior that your parent/guardian would not approve of—or would be upset by—but that do not put you at risk of serious and immediate harm. However, If the therapist, in their professional judgment, believes that you are in danger, they will communicate this information to the parent or guardian.

4. Under Colorado law, parents of children under 12 years old (for therapeutic services) and under 15 years old (for medical services) have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information, including but not limited to adjudication of parental medical decision-making authority. If you request treatment information, I may provide you with a treatment summary, in compliance with Colorado law and HIPAA standards.

5. Sol Mental Health prohibits harassment of any kind, in person, via email, or via phone, and will take appropriate and immediate action in response to complaints or knowledge of violations of this policy. For purposes of this policy, harassment is any verbal or physical conduct designed to threaten, intimidate or coerce an employee, co-worker, or any person working for or on behalf of Sol Mental Health. Violation of this policy could lead to your dismissal.

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Telehealth Behavioral Contract

1. Confidentiality cannot be guaranteed by the clinician in a virtual platform. You understand that you need to be in a quiet, private setting wherein they will not be overheard and can speak freely.

2. You understand that telehealth services bring with them the risk of technological difficulties and Sol Mental Health will do everything possible to address any issues on our end during a session. Sessions will not be extended due to technological difficulties. You understand that you have the responsibility to ensure a good connection is available for your appointment times.

3. Your clinician must know your location during every telehealth session. You agree to provide your address or location for these sessions. You agree to inform the clinician if this changes at any point throughout your care. I understand that Sol Mental Health cannot provide virtual care to patients that are located out of state.

4. You agree to take telehealth sessions seriously and present as you would in an in-person session. This includes, but is not limited to, being on time, having devices turned off, being appropriately dressed, and focusing fully on the session. You agree that you will not use substances during a telehealth therapy session.

5. Teletherapy sessions may be discontinued at any time by the therapist or by the patient if these standards are not met.

In Case of Emergency

Sol Mental Health does not provide emergency services and is not available 24/7. If I find myself or my child in a life-threatening situation, I agree to take the necessary steps to keep myself and my child safe, up to and including calling 911, going to an emergency room, or contacting the Colorado Access Crisis Line:

Colorado Access Crisis Line: (844) 493-8255 or Text: 38255

I have read and understand the above statements, I understand my rights as a patient, and consent to evaluation/treatment. If treatment is for a minor, I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of the service provider about the above information at any time.

_____	_____	_____
Patient's Signature	Patient's Printed Name	Date
_____	_____	_____
Guardian's Signature, 1 (if applicable)	Guardian's Printed Name, 1	Date
_____	_____	_____
Guardian's Signature, 2 (if applicable)	Guardian's Printed Name, 2	Date

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Revised 3/2023

Crisis Notice

Sol Mental Health is an outpatient mental health practice, and not available after-hours, on weekends, or during holidays. If you find yourself or your child in a life-threatening situation while waiting for your first appointment with us or while in treatment with us, you agree to take the necessary steps to keep yourself and your child safe. These may include **calling 911** or **proceeding directly to your closest emergency room**. Here are some additional resources within the community that may provide emergency services and support:

- **Colorado Access Crisis Line**
  Call: 1-844-493-8255
  Text: 38255

- **National Suicide Prevention Lifeline**
  Call: 1-800-273-TALK (1-800-273-8255)
  Call: 9-8-8
  Text: 741741

Or, consider proceeding to a Metro Denver Region Crisis Center:

Westminster Walk-In Crisis Services
2551 W 84th Ave
Westminster, CO 80031

Wheat Ridge Walk-In Crisis Services
4643 Wadsworth Blvd
Wheat Ridge, CO 80033

Littleton Walk-In Crisis Services
6509 S. Santa Fe Drive
Littleton, CO 80120

Boulder Walk-In Crisis Services
3180 Airport Road
Boulder, CO 80301

Denver Walk-In Crisis Services
4353 E Colfax Avenue
Denver, CO 80220

Aurora Walk-In Crisis Services
2206 Victor Street
Aurora, CO 80045

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Greeley Walk-In Crisis Services
928 12th Street
Greeley, CO 80631

Montrose Walk-In Crisis Services
300 N. Cascade Ave.
Montrose, CO 81401

Pueblo Walk-In Crisis Services
1310 Chinook Lane
Pueblo, CO 81001

Colorado Springs Walk-in Crisis Services
115 S. Parkside Drive
Colorado Springs, CO 80910

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Mandatory Disclosure Statement

1. Therapist Information

See Appendix A for a complete list of site locations and therapist details.

2. Regulation of Mental Health Professionals

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Professions and Occupations. The state boards that can be reached as follows:

The State Board of Licensed Professional Counselor Examiners regulates licensed professional counselors and can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800.

The State Board of Social Work Examiners regulates licensed social workers and clinical social workers and can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800.

The State Board of Psychologist Examiners regulates licensed psychologists and can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800.

Each type of mental health professional has regulatory requirements:

- An Unlicensed Psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.
- A Certified Addiction Technician (CAT/ACA) must be a high school graduate or equivalent, complete required training hours, 1,000 hours of supervised experience and pass the NAADAC NCAC Level I exam.
- A Certified Addiction Specialist (CAS/ACC) must have a bachelor's degree in clinical behavioral health, complete required training hours, 3,000 hours of supervised experience (may include hours completed for the CAT/ACA) and pass the NAADAC NCAC Level II exam.
- A Licensed Addiction Counselor (LAC/ACD) must have a clinical master's degree, meet the CAS/ACC requirements OR complete 2,000 additional hours of supervised experience, and pass the NAADAC MAC exam.
- A Licensed Social Worker must hold a master's degree from a graduate school of social work and pass an examination in social work.
- A Licensed Clinical Social Worker (LCSW/CSW) must hold a master's or doctorate degree from a graduate school of social work, practice as a social worker for at least two years, and pass an examination 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 Licensed Marriage and Family Therapist must hold a master's or doctoral degree in marriage and family counseling, have at least two years post-master's or one-year post-doctoral practice, and pass an exam in marriage and family therapy.
- A Licensed Professional Counselor must hold a master's or doctoral degree in professional counseling, have at least two years post-master's or one-year postdoctoral practice, and pass an exam in professional counseling.
- A Licensed Psychologist must hold a doctorate degree in psychology, have one year of post-doctoral supervision, and pass an examination in psychology.
- An unlicensed psychotherapist is a psychotherapist listed in the state's database and is authorized to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain registration from the state.

3. Patient Rights and Important Information

a. You are entitled to receive information from your therapist about methods of therapy, the techniques used, and the duration of your therapy, and fees. Please ask your therapist if you would like to receive this information.
b. You can seek a second opinion from another therapist or terminate therapy at any time.
c. In a professional relationship, sexual intimacy between a therapist and a patient is never appropriate. If sexual intimacy occurs, it should be reported to the Board that licenses, certifies or registers the therapist.
d. As required by Colorado law I am informing you that your patient records will be destroyed seven (7) years after the termination of psychotherapy as pursuant to DORA Rules and the Colorado Mental Health Practice Act.
e. Generally speaking, information provided by a patient during therapy sessions is legally confidential in the case of licensed marriage and family therapists, social workers, professional counselors, and psychologists; licensed or certified addiction counselors; and unlicensed psychotherapists, except as provided in the Mental Health Practice Act and except for certain legal exceptions that will be identified by your therapist should any such situation arise during therapy. Exceptions include:
    - Known or suspected child abuse and/or neglect of any kind, child molestation or incest
    - Danger of suicide
    - Danger of violence or other behavior constituting danger to self or others.
    - Possible abuse and/or neglect of any kind of the elderly or others unable to care for themselves
    - Subpoenaed testimony in criminal court cases
    - Judicial Orders to violate privilege

There may be times when your therapist needs to consult with a colleague, supervisor, or another professional about issues raised by patients in counseling. Patient confidentiality is still protected during consultation between your therapist and the professional consulted. By signing this

statement, you acknowledge that your therapist may consult as needed to provide professional services to you as a patient.

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

_____	_____	_____
Patient's Signature	Patient's Printed Name	Date
_____	_____	_____
Guardian's Signature, 1 (if applicable)	Guardian's Printed Name, 1	Date
_____	_____	_____
Guardian's Signature, 2 (if applicable)	Guardian's Printed Name, 2	Date

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Appendix A

Collective Cherry Creek 400 S. Colorado Blvd. Suite 530 Denver, CO 80246 P: 720-262-2644	**Collective Greenwood Village** 7400 E. Orchard Rd. Suite 2850N Greenwood Village, CO 80111 P: 720-262-2644
Collective Central Park 3401 Quebec St. Suite 8000 Denver, CO 80207 P: 720-262-2644	**Collective Lakewood** 200 Union Blvd. Suite 200 Lakewood, CO 80228 P: 720-262-2644
Collective Boulder 4770 Baseline Rd. Suite 200 Boulder, CO 80303 P: 720-262-2644	

Full Name	State	License Number	Duration Type	Certificate Type	Status	Issue Date	Expiration Date
Allison Alexander	CO	LSW.0009923062	Permanent	LSW	Active	7/14/2020	8/31/2023
Allison Laber	CO	LSW.0009923278	Permanent	LSW	Active	11/2/2020	8/31/2023
Amanda Cerini	CO	LPCC.0019413	Permanent	LPCC	Active	4/11/2022	4/11/2026
Amber Byrne	CO	LPC.0017140	Permanent	LPC	Active	5/7/2021	8/31/2023
Anastacia Winter	CO	LPC.0017645	Permanent	LPC	Active	10/5/2021	8/31/2023
Andres Reinhard	CO	MFT.0001996	Permanent	LMFT	Active	7/28/2021	8/31/2023
Ann Heckman-Davis	CO	LPC.0017699	Permanent	LPC	Active	10/20/2021	8/31/2023
Bonnie Rusch	CO	LSW.009923241	Permanent	LSW	Active	10/13/2020	8/31/2023
Catherine Maria	CO	LPC.0017773	Permanent	LPC	Active	11/1/2021	8/31/2023
Dawn Darnell	CO	LPC.0017773	Permanent	LPC	Active	11/16/2021	8/31/2023
Emma Rowe	CO	LPC.0012014	Permanent	LPC	Active	7/17/2014	8/31/2023
Erin Loffredo	CO	ACC.0021059	Permanent	ACC	Active	2/3/2021	8/31/2023
Esra Nutku-Bilir	CO	LPC.0018978	Permanent	LPC	Active	12/21/2022	8/31/2023
Gabrielle May-Shinagle	CO	MFT.0001458	Permanent	LMFT	Active	9/13/2017	8/31/2023
Jennifer Jackson	CO	ACD.0001492	Permanent	LCADC	Active	9/1/2021	8/31/2023
Jordan Gonzales	CO	LPCC.0019729	Temporary	LPCC	Active	6/16/2022	6/16/2026
Jorge Borda	CO	LPC.0013545	Permanent	LPC	Active	2/3/2017	8/31/2023
Katharyn Burke	CO	LPC.0016049	Permanent	LPC	Active	2/10/2020	8/31/2023
Kelly Tyrer	CO	LPCC.0018594	Permanent	LPCC	Active	6/17/2021	6/17/2025
Lauren Jouzapaitis	CO	LPCC.0019431	Temporary	LPCC	Active	4/13/2022	4/13/2026
Lily Colley	CO	LPC.0016673	Permanent	LPC	Active	11/6/2020	8/31/2023
Madlena Todorova	CO	LPC.0018444	Permanent	LPC	Active	7/1/2022	8/31/2023
Mary Sullivan	CO	LPC.0015903	Permanent	LPC	Active	12/3/2019	8/31/2023
Melner Bond	CO	LSW.0009923585	Permanent	LSW	Active	5/24/2021	8/31/2023
Nicholetti White	CO	CSW.09928221	Permanent	CSW	Active	4/25/2022	8/31/2023
Rebekka Jacobs	CO	CSW.09928267	Permanent	CSW	Active	5/16/2022	8/31/2023
Sarah Sheets	CO	LPC.0012930	Permanent	LPC	Active	3/14/2016	8/31/2023
Seth Mudd	CO	CSW.09926218	Permanent	CSW	Active	9/1/2021	8/31/2023
Shannon Wallace	CO	LPCC.0018348	Temporary	LPCC	Active	4/13/2021	4/13/2025

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Payment Authorization Form

I, _____ , Date of Birth: ____/____/_____ ,

agree and authorize Sol Mental Health to save the cards indicated below on file. I acknowledge that two active cards must be kept on my file. I acknowledge that, even if I do not have a co-pay due at time of service, I must keep two active cards on file. By signing this agreement, I understand that any co-pay, co-insurance, deductible amount, no-show fee, or any other fee charged by my insurance or the practice will be charged using my preferred payment method. If my preferred payment method is not successfully charged, I authorize Sol Mental Health to charge my second payment method on file.

Cardholder Name: _____

Billing Address: _____

_____

Card #1 (Preferred Payment Method):

Type of Card: ☐ Visa ☐ Mastercard ☐ Amex ☐ Discover ☐ Other:

Number: _____

Expiration Date (mm/yy): _____/_____ CVC: _____

Card #2:

Type of Card: ☐ Visa ☐ Mastercard ☐ Amex ☐ Discover ☐ Other:

Card Number: _____

Expiration Date (mm/yy): _____/_____ CVC: _____

I authorize Sol Mental Health to process the card above as "Card on File" and charge in accordance with the agreed upon payment plan between the practice and me (e.g. one time charge, monthly payment plan, etc). I understand this authorization will remain in effect until the expiration of the credit card account. I may also revoke this form by submitting a written request to the medical practice.

_____ _____ _____

Cardholder's Signature Cardholder's Printed Name Date

REVISED 12/15/2022

Notice of Privacy Practices Acknowledgement Form

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

About Sol Mental Health:

- The Privacy Officer at Sol Mental Health is Andrew Kuykendall, reachable by email at privacy@solmentalhealth.com.
- We never market or sell your personal information.
- We will never share any substance use treatment records without your written permission.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

We will not use your information in these ways without a signed authorization from you under 45 C.F.R. § 164.508(a)(2)(a)(4).

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

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

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

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

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we 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 us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'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. We 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.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we 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/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

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 us your preference, for example if you are unconscious, we may go ahead and share your

information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we 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:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind as provided by 45 C.F.R. § 164.508(b)(5).

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

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

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy.

_____	_____	_____
Patient's Signature	Patient's Printed Name	Date
_____	_____	_____
Guardian's Signature, 1 (if applicable)	Guardian's Printed Name, 1	Date
_____	_____	_____
Guardian's Signature, 2 (if applicable)	Guardian's Printed Name, 2	Date

SOL
MENTAL HEALTH

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network healthcare facility, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network healthcare facility
When you get services from an in-network healthcare facility, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia,

pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the Colorado Division of Insurance at 303-894-7499 or email: dora_insurance@state.co.us The federal phone number for information and complaints is: 1-800-985-3059.

Visit *www.cms.gov/nosurprises/consumers* for more information about your rights under federal law.