Mountain Mental Health Clinic

Sandra Eisemann, PhD, RN
970-403-4223

Jessica Reed, LCSW
970-426-9221

Lindsay Stonecash-Bauer, LCSW
970-946-8002

Welcome, I look forward to working with you and/or your family. I work with both children and adults, so please complete this applications for you or your child's file based on who is the primary client.

If the primary client is a CHILD OR ADOLESCENT:

First and last name_____

Date of Birth_____/_____/_____

Social Security #_____-_____-_____

Gender_____

Marital status of parents:

Married__ Committed__Divorced__Separated__Widowed__

Mother_____

Address_____City_____Zip_____

Phone number/s: Home_____Cell_____

Email address:_____

Date of Birth:_____/_____/_____

Father_____

Address_____City_____Zip_____

Phone number/s: Home_____Cell_____

Email address:_____

Date of Birth:_____/_____/_____

If the primary client is an **ADULT**:

First and last name_____

Full address:_____

Phone numbers: Home_____Cell_____

Email address:_____

Date of Birth_____/_____/_____

Social Security #_____-_____-_____

Gender_____

How did you hear about me?

Billing information:

Responsible party (if different from above)_____

Address_____

Phone number_____

If you are responsible party and you are paying up front, would you like to pay each visit or be billed?

Is billing address same as home address? If not, please give address where you would like to be billed

Address_____

INSURANCE INFORMATION

I am paneled with a number of insurance companies, but it is possible that I am an out of network provider for yours. I generally ask my clients to check with their insurance companies to find out about mental health coverage on their plan. If I am not a provider with your insurance company, I ask for payment up front, bill your insurance company and they pay **you** back at their out of network rate. If you have any questions about this, please feel free to ask. Please read carefully and sign:

Assignment of insurance and release of information

I hereby assign all medical benefits, to include major medical benefits to which I am entitled including private insurance and other health plans to Mountain Mental Health Clinic (Jessica Reed, LCSW; Lindsay Stonecash-Bauer, LCSW; Dr. Sandra Eisemann, PhD). This assignment will remain in effect until revoked by me in writing. I hereby authorize Jessica Reed, Lindsay Stonecash-Bauer and/or Sandra Eisemann to release to said insurance all information necessary to secure payment in full.

Signature_____Date_____

Printed name_____

Notice of Privacy Rights

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

The information you discuss during psychotherapy sessions is protected as confidential under law (CR 12-43-214(I)(d)) with certain limitations.

- It is my policy to report suspected child abuse to the proper authorities, who may then investigate. I do not investigate.
- I also may take some action, such as seek an order for your emergency or involuntary commitment without your consent if I deem you to be a serious harm to yourself or others. Any action I take without your consent will be discussed with you.
- If I am unable to collect my fee, which we agree upon, I may send your name and address to a collection agency.
- If you file an official complaint or lawsuit against me, according to Colorado law, your right to confidentiality will be waived.
- I will not go to court to represent your child in a child custody case. If you chose to subpoena me, my cost includes all time spent on work related to the case, including supervision, writing documents, time spent with custody evaluators, etc. and can cost thousands of dollars. I collect this fee up front.
- If you choose to use your health benefit plan, you will have given your insurance or managed care company consent to obtain required confidential information for the purpose of determining eligibility for reimbursement.
- I may seek consultation from another mental health professional; your identity will not be revealed without your consent, and your privacy will be protected by that professional.

Treatment Contract

Client name:_____DOB:_____

Parent/Guardian:_____

Therapeutic relationships are generally more productive if boundaries and expectations are clear. Please initial before each section to indicate that you understand and agree to the the outlined terms. If you have any questions about the information presented, please feel free to ask.

1)_____SESSIONS: Sessions are generally 50 minutes long. Longer sessions may be negotiated in advance. I want you or your child to get the most out of your work in the office. Please come to sessions on time unless there are events which are beyond your control.

2)_____LATE CANCELLATIONS AND NO SHOWS: If for any reason you need to cancel a therapy appointment, I need to hear from you at least 24 hours in advance so that I have the opportunity to schedule someone else who may be in need of a session. Emergencies and major illness are exceptions to this rule. If I do not hear from you within 24 hours of your scheduled time or do not hear from you at all, my policy is to charge my full fee for the missed session. If we are able to find another time in the same week that you can come in for a session I will not charge you twice. Be aware that it is often difficult for me to find times later in the week to schedule at the last minute.

3)_____EMERGENCIES: In the case of a true emergency where you or your child are at risk of seriously harming or killing yourself or someone else, it is your responsibility to either get to an emergency room or call 911. If I talk to you on the phone and there is still a risk of serious harm and you refuse to call yourself, I will call 911 and give them your address and phone number.

4)_____PHONE AVAILABILITY: Our work will take place within sessions. I carry a cell phone that you can use in times of crisis or if you are needing to cancel or change an appointment. This number for Jessica Reed is: 970-426-9221, Dr. Sandra Eisemann is: 970-403-4223. Lindsay Stonecash-Bauer is: 970-946-8002. I do charge for phone calls over 15 minutes long.

5)_____HEALTH CARE BENEFITS: In the event that you choose to use your health care benefits I ask that you call your insurance company to find out about your benefits. You may have a deductible, co-pay or need preauthorization, and need to find out about your plan as soon as possible. If my services are reimbursable I will bill your insurance for you. You will also be required to give me consent to release information, diagnosis and dates of sessions to complete assessment with treatment goals and progress reports.

6)_____RECORDS: Records include identifying information, dates of sessions, an initial assessment and treatment plan, and any consultations of collateral contacts

made. Your records will be stored safely with attention to your privacy. They can only be released with your written permission and directions, and it is my policy not to release the entire record, even with your consent. Instead, I may summarize the content related to the request.

7)_____ CHILDREN AND ADOLESCENTS: It is important for children and adolescents to have a private person to talk with. Please respect your child's privacy. I will inform you immediately of any potential harm to them or others. I will work with them around how to disclose risky behaviors that is not an immediate threat to health or life.

8)_____TERMINATION: Termination will usually be agreed upon mutually, but you are free to terminate at any time. However, in a few special instances I may decide to stop working with you even though you wish to continue. These include failure to meet the terms of our fee agreement, a need for special services outside of the area of my competency, and prolonged failure to make progress in our work together. Should this occur, the reasons for termination will be discussed with you, and you will be helped to make different plans for yourself, including referral to a more appropriate resource.

I have read and initialed all aspects for this contract and understand my rights and responsibilities as a client. I have been informed of my therapist's degrees, credentials and licenses.

Client, parent or guardian signature_____

Date_____

Therapist signature_____

Date_____

Informed Consent and Disclosure

Welcome to my practice, I look forward to working with you and/or your child. Before we begin therapy there are a few things that it is important to be aware of. These include my training, cost of therapy, how long therapy may last, what you might expect from therapy, and my cancellation and no-show policy. All of this information will be available to you. If you have any questions about me as a therapist, please feel free to ask.

DEGREES AND CREDENTIALS

Jessica Reed, Licensed Clinical Social Worker
MSW University of Wisconsin, Madison
LCSW, Colorado License # 863

Dr. Sandra Eisemann, PhD. RN
Doctorate of Philosophy University of Wisconsin, Madison
Clinical Psychology, Colorado License # 3355

Lindsay Stonecash-Bauer, LCSW
MSW Smith College
LCSW, Colorado License # 09924365

The private practice of psychotherapists is regulated by the state of Colorado through the Department of Regulatory Agencies. Should you have any reason to complain about the services or representation of this therapist, you are to contact:

Department of Regulatory Agencies
Colorado Mental Health Section
1560 Broadway St., Suite 1340
Denver, CO. 80202
303-894-7766

I am obligated to inform you that in a professional relationship, sexual intimacy is never appropriate and should be reported to the grievance board. Generally speaking, what you and I talk about is legally confidential."Confidential" means that I cannot be forced to disclose information without your consent. There are other exceptions to the general rule of confidentiality. (See following "Privacy Notice". These exceptions are listed in the Colorado Revised Statutes section 12-43-218). I am legally obligated to break confidentiality if it is disclosed to me that a child is being physically or sexually abused or neglected, or an individual has the intention of hurting themselves or someone else. If you have any questions or would like more information, please feel free to ask.

I have read the therapist disclosure statement required by the state of Colorado.

Client, parent or guardian signature_____

Date_____

Therapist signature_____

Date_____

Treatment of a minor child

I give Jessica Reed, LCSW, or Lindsay Stonecash-Bauer, or Dr. Sandra Eisemann PhD permission to treat my minor child:(name)_____

I am willing to give my child confidentiality within the limits of the law. The releasing of records for legal purposes related to child custody or visitation is a violation of the privacy of the child. I understand that Jessica Reed, LCSW, and Dr. Sandra Eisemann do not release records to attorneys or to the court.

Parent or guardian signature_____ Date_____

Court and child custody

Jessica Reed, LCSW, Lindsay Stonecash-Bauer, LCSW and Dr. Sandra Eisemann do not go to court to represent clients. If you chose to ask me to speak with a CFI or attorney, to write a document for court or to subpoena me, I charge for these services and expect payment before any services are rendered.

I understand and agree to follow through on this court related agreement, if applicable.

Signature_____ Date_____