Heidi Fedor,
LPC, LMFT 1369 Forest Park Circle, Suite 203
Lafayette, CO 80026
303-579-6673
heidifedor1@gmail.com

Personal Information

Date: _____

Name of client/DOB: _____

Address: _____

Parents of client: _____

Phone numbers: _____

Emails: _____

Name and ages of siblings (if client is a minor): _____

_____

Current school and grade: _____

Parental occupations: Mother: _____ Father: _____

What is the primary reason therapy is being requested: _____

_____

What have been the particular stress factors in your overall situation in recent months/years:

_____

_____

Please list any medications and dosages client is on:_____

_____

Professional Disclosure and Consent for Mental Health Treatment

Degrees and Credentials
BA, 1993, University of North Dakota
MA, 1995, University of Colorado at Denver

LPC – Licensed Professional Counselor #1931
LMFT – Licensed Marriage and Family Therapist #460

Therapy/Counseling:
It is hoped that the professional relationship between you and Ms. Fedor will be one where you receive the maximum benefit. Psychotherapy may be tremendously beneficial to some individuals while, at the same time, it is important to know that there are some risks. The risks may include the experience of intense and unwanted feelings such as sadness, anger, guilt, fear, or anxiety. Please remember that these feelings may be natural and an important part of the therapy process. Other risks may be recalling unpleasant memories and facing strong feelings and thoughts. When the "client" is a child, it is important to share with Ms. Fedor any changes in behavior, mood, or routines following therapy so that she will know the best rate to work with the child in therapy so that the child is not overwhelmed.

Depending on the age of the client, therapy may look different. For example, when the "client" is a child, therapy may involve play therapy sessions for the child, consultation & coaching for their parents or caregivers, and family therapy. For adults, therapy may be individual therapy or couples therapy for relationship related concerns.

Confidentiality:
Minors & Parents: In the state of Colorado children less than 12 years of age cannot independently consent to or receive mental health treatment without parental consent. While privacy in psychotherapy is very important, particularly with adolescents, parental involvement is also essential to successful treatment and this may require that some private information be shared with parents or guardians.

Children & Treatment Consent: To provide consent for treatment for a child you must either have sole legal custody OR shared legal custody OR legal guardianship. If you share legal custody and your divorce decree notes that you must inform the other parent of health appointments, my services fall under this, and you may be in violation of a court order if you fail to inform the other parent of my services with your child. By signing this form you are stating that you have the legal right to consent for this child.

Confidentiality & Patients' Rights: Confidentiality is your expectation that the information you disclose to Ms. Fedor will be kept private, including the fact that you consult with her at all. Please note that Ms. Fedor does discuss cases in peer supervision (client names are not shared), and by signing you give permission for these discussions when consultation is to aid Ms. Fedor in providing effective therapy. Peer supervision is clinical consultation with another professional who is also bound to keep client information confidential. As a general rule, outside of peer supervision, she will not disclose information regarding a client unless authorized to do so by the client in writing. One exception to this is if she employs outside services to collect past due accounts; by signing this form you give permission for such disclosure if necessary. There are also legal exceptions to confidentiality; these are described in the attached Notice of Privacy Practices, The Health Insurance Portability and Accountability Act. HIPAA is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information used for the purpose of treatment, payment, and health care operations. The law requires she obtain your signature

acknowledging she has provided you with this information; by signing below you are certifying that you have been given a copy of the Notice. You may revoke this Agreement in writing and that will be binding on her unless: she has taken action in reliance on it; if there are obligations imposed on Ms. Fedor by your health insurer in order to process or substantiate claims; or if you have not satisfied any financial obligations. Please understand that all files are kept confidential. Your written consent is required for any release of information. There are important exceptions to confidentiality that are legally mandated. Exceptions include: (1) If Ms. Fedor believes the client intends to harm himself or someone else; (2) if she suspects child abuse, elder abuse, or neglect; and, (3) if subpoenaed and ordered to share confidential information. In addition, when the client is a child in the custody of DSS or when DSS is conducting an investigation, DSS and the Guardian Ad Litem Program have the legal authority to access any confidential records related to the child.

Rates:

Counseling/Therapy sessions are by appointment only. One "clinical" hour is 50 minutes in session and 10 minutes for the therapist to write the progress note. The rate for individual, couples, and family therapy is $150 per session. Payment is expected at the beginning of each session unless an agreement has been made prior to the session to bill insurance. There is a charge of $100 for missed appointments although this fee may be waived on one occasion. No charge will be made if: (1) you are ill, (2) you have an emergency, or (3) driving conditions are hazardous due to inclement weather.

Participating in court for custody or any other matter is not an expected service. If you are seeking therapy in any way related to a legal matter (current or anticipated), you are not at the right place. Please inform Ms. Fedor immediately & she will do her best to refer you to an appropriate professional. In cases involving a CFI, Ms. Fedor will be willing to converse with that person at her hourly rate, however, please respect that speaking with the attorney of either side of a custody dispute is often harmful for therapeutic relationship with the child. Part of this consent to treatment is the agreement that Ms. Fedor will not be asked to talk with attorneys. Should Ms. Fedor be subpoenaed, the rate is $300 per hour for all time related to responding to the subpoena regardless of whether she is called to testify. This may include time reviewing notes and talking with attorneys, as well as any phone calls or letters written on your behalf. If required to appear in court, she must cancel all other clients for that day, even when she is on "stand-by" status. You will be charged for the entire day. The rate is the same for depositions of fact or expert witness, as well as testimony.

Important Insurance Information:

Generally, mental health benefits are reimbursed differently than general medical benefits so it is important that you check on your benefits by calling your insurance company prior to the initial appointment. If you have not called prior to arriving at the appointment today, please take a few minutes to make the call now so that you know how much to pay today and are not surprised by an unexpected bill. There are many different plans and Ms. Fedor will not be able to answer specific questions related to your insurance. Some insurance cards read that mental health services are "covered." This is misleading because it does not mean that sessions are covered at 100%. As a therapist, my relationship is with you and not your insurance company. All charges are your responsibility from the date services are rendered, and payment for services is due in full on the date services are rendered. Payment is expected at the beginning of each session.

At your request, Ms. Fedor may agree to file the claim to your insurance plan if she is a contracted provider for that plan. If she agrees, Ms. Fedor will need a copy of your insurance card. Your signature & consent is needed to allow her to do so. She will release relevant information to facilitate reimbursement. Please complete the following information only if you

would like Ms. Fedor to file the claim with your insurance: (If the child is in foster care & has Medicaid, the insurance information is not needed here as it was provided on page one; however, the legal guardian's signature is needed at the bottom of the page to give authorization to Ms. Fedor to file the claim.)

Client's Name_____
Insurance Plan _____
Insurance ID #:_____
Insurance group #:_____
Insured's Name & Date of Birth (For instance, if a child has coverage through their parent's insurance plan, then information is needed related to the parent who holds the policy):_____
Name: _____
DOB: _____
Relationship to client: (parent, grandparent, guardian) _____

I hereby authorize Heidi Fedor, LPC, LMFT to submit claims for mental health services. I authorize the release of any information relating to all claims and benefits submitted on my behalf or on behalf of my child or minor in my legal custody. I further acknowledge that my signature here authorizes Ms. Fedor to submit claims for services rendered without obtaining my signature on every claim. I understand that I am responsible for paying the co-pay at the time of service. If the claim is denied, I agree to pay for the service. I authorize payment of medical benefits for counseling/psychotherapy to Heidi Fedor, LPC, LMFT for services rendered. Further, I acknowledge receipt of HIPAA Notice of Privacy Practices.

_____ _____
Signature of client or person authorized to sign Date

Mental Health Benefits for Out-Patient Care / Office Visits
**FOLLOWING ARE QUESTIONS FOR YOU TO ASK IF YOU CALL YOUR INSURANCE PLAN TO CHECK ON YOUR MENTAL HEALTH BENEFITS (this is mainly for your information - Heidi will submit billing and let you know what is covered when she receives payment).

1. Is there a deductible? Yes No
2. If yes, amount of deductible?
   If yes, how much of the deductible have you met to date?
3. Is Pre-authorization required for counseling? Yes No
   If yes, request the authorization number: _____
4. What is the co-pay for each session? _____
5. If instead of "co-pay" the insurance covers a percentage, what percent of each session does insurance cover and what percent is left for the client to cover?
   Insurance pays: _____ Patient pays: _____
6. Number of sessions allotted per year?_____
7. Does the plan cover family therapy in addition to individual therapy?

Referrals, Complaints, & Informed Consent:
You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy (if known), and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time.

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 at any time for any reason you feel we may not be a good therapeutic "match," I encourage your feedback and will attempt to adjust my approach. If I am not able to resolve your concerns, I encourage you to seek counseling services from another counselor. I will give you three referrals.

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. They may be reached at:

Department of Regulatory Agencies State Grievance Board
1560 Broadway, Suite 1350
Denver, CO 80202
(303) 894-7800.

Consent for Therapy:
Please sign below to indicate that you have read the preceding information in full, and understand the information. Please ask for clarification of any information you are unclear about. Your signature indicates that you have read this document & agree to its terms during our professional relationship.

I have read and understand the policies and agree to the conditions. I agree to the statements herein and terms of payment, to include payment of all fees listed. If minor patient, I certify that I have the legal right to consent to treatment. Further, I acknowledge receipt of HIPAA Notice of Privacy Practices.

_____ _____

Signature Date