Patrick J. Schwartz, Psy.D.
Licensed Clinical Psychologist
3597 S Pearl St, Ste 100
Englewood, CO 80110
(303) 643-8847

CLIENT INFORMATION

(Please Print)

Client's Name: _____ (Last) _____ (First) _____ (MI)

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Date of Birth: __/__/__ Phone: (____)_____ (Home) /(____)_____ (Work)

Client's Employer/School: _____

Employer/School Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Client's Children (or Siblings): _____ (Name) _____ (Age) _____ (Name) _____ (Age)

_____ (Name) _____ (Age) _____ (Name) _____ (Age)

Name of Spouse (or Parent): _____

Spouse's (or Parent's) Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Spouse's (or Parent's) Phone: (____)_____ (Home) /(____)_____ (Work)

Emergency Contact: _____ (Name) _____ (Phone)

Client's Primary Care Physician: _____

Who referred you to our office? _____

Is condition related to employment? _____ Accident? _____

Other? (Please explain) _____

Marital Status: _____ Student _____ Full or part time? _____

Please briefly describe the reasons for seeking treatment:

_____

If you have sought previous treatment for this condition, please describe the type of treatment, who provided this treatment and approximate dates of treatment:

_____

_____

_____

INSURANCE INFORMATION

Insurance Company: _____

Policy Number: _____ Group Number: _____

Policy Holder's Full Name: _____

Policy Holder's Social Security Number: _____

Policy Holder's Date of Birth: ___/___/___

Policy Holder's Employer: _____

Policy Holder's Relationship to the Client: _____

RELEASE OF INFORMATION

I certify to the accuracy of the above client information and authorize the release of any medical information necessary to process claims, including affiliated management care subsidiaries (or other agency)

_____ _____

Client's Signature Date

PAYMENT AGREEMENT

The undersigned agrees, whether signing as an agent or as the client, that in consideration of services to be rendered to the client, he/she is hereby obligated to pay Patrick J Schwartz, Psy.D. the deductibles, copays and other charges as incurred over the course of treatment, unless otherwise specified in you particular insurance contract. We ask that the person Responsible make payment at each visit unless arranged.

Please discuss these matters with the Doctor if you have any further questions.

_____ _____

Signature of Responsible Person
(Parent if client is under 21 years old) Date

For Office Use Only: Chart # _____ DX: _____

Charge/Session: _____ Copay Amount _____

Date entered: _____

Patrick J Schwartz, Psy.D.
Licensed Clinical Psychologist
3597 S Pearl St, Ste 100
Englewood, CO 80113
303-643-8847

MEDICAL INFORMATION

NAME: Hospitalizations/Medical Conditions/Major Illnesses

Hospitalizations or Surgeries (last 2 years)	Serious Illnesses/Injuries:
Chronic Medical Conditions:	**Current Medical Conditions:**

Current Medications: Dosage:
Prescribed:

Over the Counter:

My Physician's Name: _____ Phone Number: _____

My Psychiatrist's Name: (if applicable) _____ Phone : _____

Allergies (Drug Sensitivity):

Alcohol Consumption: Amount _____ Frequency _____
Family History of Alcohol/Drug use, Mental Health, Physical Conditions:
Member: History:

Mandatory Disclosure Statement

Patrick J. Schwartz, Psy.D.
303-643-8847

3597 S Pearl St, Ste 100
Englewood, CO 80113

6081 S Quebec, Ste 103
Englewood, CO 80111

8778 Wolff Ct #202
Westminster, CO 80031

Can you read the document: Please mark with X: ☐ Yes ☐ NO

1. You are herby informed that I am a Licensed Clinical Psychologist (Psy.D.), licensed to practice in the State of Colorado under license number 1510, first issued in September of 1990. 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. The Board of Licensed Professional Counselor Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. To obtain standing as a Licensed Psychologist in the State of Colorado, I am required to have received a Doctorate in Clinical Psychology from an accredited institution, have 1 year of post-doctorate supervision, and pass a licensing exam.

2. I received the degree of Clinical Psychologist from the University of Denver, School of Professional Psychology, Denver, CO in August 1989. To meet the requirements for this degree, I completed 4 years of academic coursework at the University of Denver and 12 months of a Clinical Internship at the Seattle VA Hospital in Seattle, Washington. I also hold a Masters Degree in Counseling Psychology (MA) from St. Thomas University in St. Paul, Minnesota (December, 1983), and a Bachelor of Arts Degree (BA) from the University of Minnesota (June, 1976). Additionally, I have received a Certificate of Competency in Chemical Dependency Counseling from the Parkview Treatment Center in St Louis Park, Minnesota in 1979. I have held membership in the American Psychological Association (APA) and the Colorado Psychological Association (CPA).

3. 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. The Board of Licensed Professional Counselor of Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado, 80202, (303) 894-7800. As to the regulatory requirements applicable to mental health professionals:

- Registered 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.
- Certified Addiction Counselor I (CAC I) must be a high school graduate, complete required training hours and 1000 hours of supervised experience.
- Certified Addiction Counselor II (CAC II) must complete additional required training hours and 2000 hours of supervised experience.
- Certified Addition Counselor III (CAC III) must have a bachelors degree in behavioral health, complete additional required training hours and 2000 hours of supervised experience.
- Licensed Addition Counselor must have a clinical masters degree and meet the CAC III requirements
- Licensed Addiction Counselor must have a clinical masters degree and meet the CAC III requirements
- Licensed Social Worker must hold a masters degree in social work.
- 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.
- Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist and a Licensed Professional Counselor must hold a masters degree in their profession and have two years of post-masters supervision.

- A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.

4. You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of you therapy (if known), and the fee structure for your therapy. You can seek a second opinion from another therapist or terminate therapy at any time. You are further informed that I am an independent contractor with the Brief Therapy Institute of Denver, Inc. (BTID), and therefore, BTID cannot be held liable for my actions. In the practice of psychotherapy, successful outcomes cannot be guaranteed. However, cooperation between client and therapist should help in identifying and achieving improvement. Please feel free to ask your therapist any questions you may have.

   The methods of therapy I primarily use are: Brief Therapy/Solution-focused, Cognitive Behavioral, Psychodynamic, and Psycho-education. All of these methods involve talk therapy, some homework, and occasional experiential exercises taught in-session. The fee structure is as follows: I accept many insurances if I have been contracted as a provider, health saving plans (HSA), and self-pay. Insurance is a contracted rate with individual companies and self-pay is $120 per 50 minute session. Co-pays and/or full payment are expected at the time of appointment. When available, I may negotiated a sliding scale on an individual basis.

   I ask you give a minimum of 24 hours notice if you are going to miss an appointment. When 24 hours notice is not given, you will be charged $75.00 for the session.

5. 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.

6. Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes and the HIPAA Notice of Privacy Rights provided, as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report suspected child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly. The Mental Health Practice Act (CRS 12-43-101, et seq.) is available at: http://www.dora.state.co.us/mental-health/Statute.pdf

7. I have read the preceding information. It has also been provided verbally, and I understand my rights as a client or as the client's responsible party.

_____ _____

Print Client Name Partner/Spouse Print Name

_____ _____

Client/Responsible Party Signature Date Partner/Spouse Signature Date

If signed by Responsible Party, please state relationship to client and authority to consent:

_____

_____ _____

Therapist Signature Date

Patrick J Schwartz, Psy.D.
Licensed Clinical Psychologist
3597 S Pearl St, Ste 100
Englewood, CO 80113
303-643-8847

FINANCIAL DISCLOSURE

The professional service of psychotherapy is a reimbursed service for face-to-face and telephone consults. As a client of Dr. Patrick Schwartz, Pys.D., you understand:

1. You will be billed $75 for not giving a minimum of 24 hours notification of cancellation. This outstanding balance must be paid prior to additional psychotherapy services being delivered.

2. All telephone consults exceeding five minutes duration regarding your clinical situation <u>will</u> be billed to you at a rate or $2.00 per minute. These telephone consults include any calls between you and Dr. Schwartz regarding clinical issues; telephone consults with attorneys and other legal constituents (probation officer, social services, diversion case worker); telephone consults with school personnel.

3. Telephone calls related to typical case management or rescheduling <u>will not</u> be billed to you. These consults include: coordinating with your insurance company; discussing your clinical situation with your primary care physician; discussing your clinical situation with your psychiatrist; consulting with another psychotherapist involved in your care.

_____ _____

Signature Date

Informed Consent for Telehealth Services

Therapist: _____

Definition of Telehealth

Telehealth involves the use of electronic communications to enable BTID's mental health professionals to connect with individuals using interactive video and audio communications.

Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. BTID utilizes secure, encrypted audio/video transmission software to deliver telehealth.

4. I understand that if my counselor believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a mental health professional associated with any form of psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not improve, and in some cases may even get worse.

5. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my counselor, I may be directed to "face-to-face" psychotherapy.

6. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.

7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my counselor in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the consultation at any time.

8. I understand that my express consent is required to forward my personally identifiable information to a third party.

9. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.

10. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

Payment for Telehealth Services

BTID will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. In the event that insurance does not cover telehealth, the individual wishes to pay out-of-pocket, or when there is no insurance coverage, we will provide you with a statement of service to submit to your insurance company if you wish.

Patient Consent to the Use of Telehealth I have read and understand the information provided above regarding telehealth, have discussed it with my counselor, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

_____

Print Name

_____ _____

Client's Signature **Date**

_____ _____

Parent or Guardian Signature **Date**