

DFTC, Inc. CLIENT INFORMATION

Dx: _____
(office use only)

Client Name: _____ Date of Birth: _____ Sex: M or F

Street Address: _____ City: _____ State _____ Zip _____

Social Security #: _____ - _____ - _____ Marital Status: M S D W Spouse Name: _____

Parents: Father _____ Mother: _____

(if client is child)

Step-mother _____ Step-Father: _____

Describe custodial arrangement (if applicable): _____

Non-custodial parent : Name: _____ Address: _____

City: _____ State: _____ Zip: _____

message?	Whose #?	OK to Call?	OK to leave
Home Phone: _____	_____	Yes No	Yes No
Home Phone: _____	_____	Yes No	Yes No
Work Phone: _____	_____	Yes No	Yes
No			
Work Phone: _____	_____	Yes No	Yes
No			
Cell Phone: _____	_____	Yes No	Yes
No			
Cell Phone: _____	_____	Yes No	Yes
No			

Address where we can send information: Name: _____ Relationship to Client _____
(If different than above)

Address: _____ City: _____ State: _____ Zip: _____

Any special requests for leaving messages or for billing arrangements? Yes No If Yes, please describe:

INSURANCE INFORMATION

All statements will be sent to Policy Holder unless otherwise indicated

Policy Holder _____ DOB: _____ Relationship to Client _____

Street Address: _____ City _____ State _____ Zip _____

Policyholder's Social Security #: _____ - _____ - _____ Employer: _____

Insurance Company Name: _____ Insurance Phone: _____

Group #: _____ ID# _____



PLEASE READ AND SIGN THE FOLLOWING

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS: Person or Organization granted this consent:

Denver Family Therapy Center, Inc.
4891 Independence, Suite 200
Wheat Ridge, CO 80033

THERAPIST: _____

Federal regulations allow us to use or disclose protected health information from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities known as "health care operations" (for example, quality improvement activities).

With this consent form, we are asking you to make this permission explicit. By signing this consent, you are giving us permission to use or disclose your protected health information for these activities.

These uses and disclosures are described more fully in our Notice of Privacy Practices. You have the right to review that notice before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the waiting room. You may ask for a printed copy of our Notice at any time.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary: you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my protected health information as specified above.

Signature of Client or Personal Representative

Date

Relationship of Personal Representative to the client: _____

**AUTHORIZATION OF ASSIGNMENT OF BENEFITS & DFTC FINANCIAL AND BILLING POLICIES
PLEASE READ AND INITIAL:**

_____ I/we authorize direct payment of insurance payments from my insurance company to Denver Family Therapy Center for services rendered.

_____ It is understood that the responsible party should obtain an authorization number prior to the initial therapy session depending on the insurance company policy, otherwise the responsible party will accept responsibility for payment of full cost of services rendered.

_____ For office and home based psychotherapy, medication consultations, psychiatric evaluations and other professional services, payment is required at the time services are rendered unless prior arrangements are made. I/we agree to be responsible for all charges for professional services rendered on behalf of the identified client, including any charges not reimbursed (copay, deductible and coinsurance, collateral services) by my insurance carrier unless a special arrangement has been agreed upon in writing.

_____ It is further understood that I/we will be financially responsible for missed appointments unless a 24-hour notice is given prior to scheduled appointment.

_____ It is understood that Denver Family Therapy Center does not bill to secondary insurance company and that I/we will be responsible for charges after the primary insurance has made payment.

_____ It is understood that any checks written to Denver Family Therapy Center that are returned from the bank for any reasons, will incur a charge from Denver Family Therapy Center.

_____ It is understood that if I/we change address, phone number, insurance companies or any other pertinent information, I/we will notify Denver Family Therapy Center as soon as changes are made.

_____ It is understood that if I/we change insurance companies and that information is not given to Denver Family Therapy Center

I/we will be responsible for any charges for professional services incurred.

My/Our signature(s) below indicate that I/we understand DFTC financial policies and certifies that I/we are financially responsible for services provided. I/we will be responsible for any collection or attorney fees or court costs associated with the use of outside agencies required for collection of my/our account.

Client Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

TO PAY WITH A CREDIT CARD

This card is a: debit card credit card flex spending card

(please circle one)

- CREDIT CARD NUMBER

- EXPIRATION DATE __ __ / __ __

- DOLLAR AMOUNT YOU INTEND TO PAY \$ _____.

- 3 DIGIT SECURITY CODE FOUND ON THE BACK OF YOUR CARD __ __ __

- PRINT YOUR NAME AS IT APPEARS ON THE CARD

- ADDRESS & ZIP CODE WHERE THE CREDIT CARD BILL IS SENT

I authorize DENVER FAMILY THERAPY CENTER, INC. to charge my account

Cardholder Signature: _____ Date: _____

Please keep my credit card number on file and charge my card:

___ each time I come for a visit or automatically.

___ charge my credit card this time only.

___ charge my card only when I specify that I want my card charged by writing it on the yellow check-in sheet.

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.

This Notice is effective 7-1-07.

We are required by law to maintain the privacy of protected health information, and must inform you of our privacy practices and legal duties. You have the right to obtain a paper copy of this Notice upon request.

We are required to abide by the terms of the Notice of Privacy Practices that is most current. We reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that we maintain. The revised Notice will be posted in the waiting room (IF APPLICABLE: and on our web site). You may request a copy of the revised Notice at any time.

We have designated a Privacy Officer to answer your questions about our privacy practices and to ensure that we comply with applicable laws and regulations. The Privacy Officer also will take your complaints and can give you information about how to file a complaint.

Our Privacy Officer is David Blair, LCSW. You can contact the Privacy Officer at 303-456-0600 ext. 122.

Use and disclosure of your protected health information that we may make to carry out treatment, payment, and health care operations.

We may use information in your record to provide treatment to you. We may disclose information in your record to help you get health care services from another provider, a hospital, etc. For example, if we want an opinion about your condition from a specialist, we may disclose information to the specialist to obtain that consultation.

We may use or disclose information from your record to obtain payment for the services you receive. For example, we may submit your diagnosis with a health insurance claim in order to demonstrate to the insurer that the service should be covered.

We may use or disclose information from your record to allow “health care operations.” These operations include activities like reviewing records to see how care can be improved, contacting you with information about treatment alternatives, and coordinating care with other providers. For example, we may use information in your record to train our staff about your condition and its treatment.

Your rights

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions.

You have a right to receive confidential communications from us. For example, if you want to receive bills and other information at an alternative address, please notify us.

You have a right to inspect the information in your record, and may obtain a copy of it. This may be subject to certain limitations and fees. Your request must be in writing.

If you believe information in your record is inaccurate or incomplete, you may request amendment of the information. You must submit sufficient information to support your request for amendment. Your request must be in writing.

You have the right to request an accounting of certain disclosures made by us.

You have the right to complain to us about our privacy practices (including the actions of our staff with respect to the privacy of your health information). You have the right to complain to the Secretary of the Department of Health and Human Services about our privacy practices. You will not face retaliation from us for making complaints.

Except as described in this Notice, we may not make any use or disclosure of information from your record unless you give your written authorization. You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by us before the revocation. In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization.

Use or disclosure of your protected health information that we are required to make without your permission

In certain circumstances, we are required by law to make a disclosure of your health information. For example, state law requires us to report suspected child abuse or neglect. Also, we must disclose information to the Department of Health and Human Services, if requested, to prove that we are complying with regulations that safeguard your health information.

Use or disclosure of your protected health information that we are allowed to make without your permission

There are certain situations where we are allowed to disclose information from your record without your permission. In these situations, we must use our professional judgment before disclosing information about you. Usually, we must determine that the disclosure is in your best interest, and may have to meet certain guidelines and limitations.

If you receive mental health care, including treatment for substance abuse, information related to that care may be more protected than other forms of health information. Communications between a psychotherapist and patient in treatment are privileged and may not be disclosed without your permission, except as required by

law. For example, psychotherapists still must report suspected child abuse, and may have to breach confidentiality if you appear to pose an imminent danger to yourself or others, in order to reduce the likelihood of harm to you or others.

We may use or disclose information from your record if we believe it is necessary to prevent or lessen a serious and imminent threat to the safety of a person or the public. We may report suspected cases of abuse, neglect, or domestic violence involving adult or disabled victims.

If you tell us that you have committed a violent crime that caused serious physical harm to the victim, we may disclose that information to law enforcement officials. However, if you reveal that information in a counseling or psychotherapy session, or in the course of treatment for this sort of behavior, we may not disclose the information to law enforcement officials.

We may use or disclose information from your record for research only with your consent.