Your signature represents an agreement between us. Please take the time to read these documents carefully and write down any questions you might have to discuss at our first meeting. Below are some of my qualifications:

DEGREES:
• M.A. Counseling and Psychology, Pacifica Graduate Institute, 2002
• B.S. Psychology, Montana State University, 1998

LICENSES:
• Licensed Marriage and Family Therapist, State of Colorado, 2007 - Present (License #MFT-791)
• Licensed Marriage and Family Therapist, 2007- Present (Inactive)

OFFICE POLICIES/SCHEDULING
• All sessions are by appointment and are 50 minutes (and ten minutes for additional note-taking or case review) unless other arrangements have been made.
• It is the responsibility of the client to keep track of their next appointment time. No reminder calls will be made.

PAYMENT
• Client is responsible for paying agreed upon charge of $120/session. If I take your insurance, the co-payment designated by the insurance company is expected at time of service. Should the insurance company deny payment for any reason, the client is responsible for full payment of the session.
• Payment is required at time of each session unless other arrangements have been made previously.
• If it is financially difficult, charges can be billed monthly, with payment due no later than the end of the following month.
• A 10% late fee will be applied for every month late thereafter.
• A $25.00 penalty will be charged for returned checks.

CANCELLATIONS
• At least 24 hours notice is required for cancelled or rescheduled appointments in order to use the available spot for other clients. You can call (720)587-9092 to leave a message for non-emergency matters and your call will be returned within 24 hours.
• Missed appointments not cancelled within 24 hours will be charged at the regular rate, with the exception of a serious emergency.
• If a client is late for an appointment, as much of the session remaining will be completed so that other clients are not inconvenienced or delayed.

I have read and understand the above information and agree to abide by these policies and procedures. I have been informed about my therapists degrees, credentials and licenses. I understand my rights as a client and I have received copies of the Office Policies, Disclosure Statement and Notice of Privacy Rights.

Client Signature: _____ Date: _____

Lindsey D. Geiger, MA, LMFT
Signature: _____ Date: _____

DISCLOSURE STATEMENT

Client Rights and Important Information:
The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of mental health professionals. The agency within the department that has the specific responsibility for licensed and unlicensed psychotherapists is the State Grievances Board, 1560 Broadway, Suite 1340, Denver CO, 80202, (303) 894-7800.

A client is entitled to receive information from their therapist about his/her methods of practice, techniques used, the approximate duration of therapy if it can be determined, and fees.

A client is entitled to seek a second opinion or terminate therapy at any time.

In a client/therapist relationship, inappropriate conduct that might damage the relationship, such as sexual intimacy, is never appropriate. If inappropriate conduct occurs, it should be reported to the State Grievance Board.

The information between therapist and client during sessions is legally confidential and can not be disclosed without your consent. There are some limits to client confidentiality such as the threat to harm yourself or others, threat to cause destruction of property, if emergency treatment is needed, if child abuse or neglect is suspected or if a guardian has been appointed for you.

The exceptions to the confidentiality rule are listed in detail in the Colorado statutes (section 12-43-218, C.R.S. [1988]) and can be found at http://www.dora.state.co.us/Insurance/ under “General Information”, “Colorado Laws”.

A client is entitled at any time to ask for further information on these subjects.

CLIENT INFORMATION

Name: _____

Address: _____
_____

Home Phone: _____

Cell Phone: _____

E-mail address: _____

Date of Birth: _____

Marital Status: _____

Do you have any physical problems I need to know about?
_____
_____

In case of emergency contact:
_____

What is your preferred method of being contacted?
_____

Where can I leave a phone message for you?
_____

How did you hear about my practice?
_____

Informed Consent

Introduction

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask me any questions that you may have regarding its contents.

Information about Me

At an appropriate time, we will discuss my professional background with you and provide you with information regarding my experience, education, special interests, and professional orientation. You are free to ask questions at any time about my background, experience and professional orientation. I am a Licensed Marriage and Family Therapist, License number MFT-791.

Fees and Insurance

The fee for service is $120.00 per individual therapy session.
The fee for service is $120.00 per conjoint (marital /family) therapy session.

Individual Sessions and conjoint (marital /family) sessions are 50 minutes in length. Fees are payable at the time that services are rendered. Please ask me if you wish to discuss a written agreement that specifies an alternative payment procedure. Please inform me if you wish to utilize health insurance to pay for services. If I am a contracted provider for your insurance company, payment will be provided by you at the time of service and I will provide a Super Bill at the end of each month for which you will submit to your insurance for reimbursement. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain Diagnosable Mental Disorders. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Although I am happy to assist your efforts to seek insurance reimbursement, we are unable to guarantee whether your insurance will provide payment for the services provided to you. Please discuss any questions or concerns that you may have about this with me. If for some reason you find that you are unable to continue paying for your therapy, you should inform me. I will help you to consider any options that may be available to you at that time.

If other insurance arrangements are made due to financial hardship, you are responsible for the full bill if reimbursement has not been provided by insurance within 60 days of billing. This is typically due to a simple delay in processing by the insurance company.

Minors and Confidentiality

Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, I, in the exercise of my professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. I may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify me at least 24 hours in advance of your appointment. If you do not provide me with at least 24 hours notice in advance, you are responsible for payment for the missed session.

Please understand that your insurance company will not pay for missed or cancelled sessions.

Therapist Availability/Emergencies

Telephone consultations between office visits are welcome. However, I will keep those contacts brief due to my belief that important issues are better addressed within regularly scheduled sessions. Any discussions lasting longer than 15 minutes will require a full session fee. You may leave a message for me at any time on my confidential voicemail. If you wish me to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are returned during normal workdays (Monday through Friday) within 24 hours. If you have an urgent need to speak with me, please indicate that fact in your message and follow any instructions that are provided by my voicemail. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

Therapist Communications

I may need to communicate with you by telephone, mail, or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform me if you do not wish to be contacted at a particular time or place, or by a particular means.

My therapist may call me at my home. My home phone number is:
My therapist may call me on my cell phone. My cell phone number is:
My therapist may call me at work. My work phone number is:
My therapist may send mail to me at my home address.
My therapist may send mail to me at my work address.
My therapist may communicate with me by email. My email address is:
My therapist may send a fax to me. My fax number is:

About the Therapy Process

It is my intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to me and the specifics of your situation, I will provide recommendations to you regarding your treatment.

I believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. I will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion. Due to the varying nature and severity of issues and the individuality of each patient, I am unable to predict the length of your therapy or to guarantee a specific outcome or result.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with me. I will discuss a plan for termination with you as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives.

Your signature indicates that you have read this agreement for services carefully and understand its contents. Please ask me to address any questions or concerns that you have about this information before you sign.

_____ _____

Signature Date

HIPAA NOTICE

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.

I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, that provision of health care to you, or the payment of this health care. I must provide you with this notice about my privacy practices, and such notice must explain how, when and why I will 'use' and 'disclose' your PHI. A 'use' of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice: PHI is 'disclosed' when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this notice.

However, I reserve the right to change the terms of this notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this notice and provide you with a new copy.

I. HOW MAY I USE AND DISCLOSE YOUR PHI?
I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior written authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and disclosures relating to treatment, payment or health care operation do not require your written consent. I can use and disclose your PHI without your consent for the following reasons:

1. For treatment.
I can use your PHI within my practice to provide you with mental health treatment. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.

2.To obtain payment for treatment.
I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide you PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

3.For health care operations.
I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.

4. Patient incapacitation or emergency.
I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in sever pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain other uses and disclosures also do not require your consent or authorization. I can use and disclose your PHI without your consent or authorization for the following reasons:

1.When federal, state, or local law requires disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect.

2.When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim for worker's compensation benefits, I may have to use or disclose your PHI in response to a court or administrative order, I may also have to use or disclose your PHI in response to a subpoena.

3.When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in response to a search warrant.

4.When public health activities require disclosure. For example, I may have to use or disclose your PHI to report to a government official an adverse reaction that you have to a medication.

5.When health oversight activities require disclosure. For example, I may have to use or disclose your PHI to assist the government in conducting an investigation or inspection of a health care provider or organization.

6.To avert a serious threat to health or safety. For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of yourself or others. However, any such disclosures will only be made to someone able to prevent the threatened arm from occurring.

7.For specialized government functions. If you are in the military, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.

8.To remind you about appointments and to inform you of health related benefits or services. For example, I may have to use or disclose your PHI to remind you about your appointments, or to give you information about treatment alternatives, other health care services, or other health care benefits that I offer that may be of interest to you.

C. Certain uses and disclosures require you to have the opportunity to object.

1.Disclosures to family, friends or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care,

unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.
2.Other uses and disclosures require your prior written authorization.
In any other situation not described in the above sections, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action to rely on such authorization) of your PHI by me.

II. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI:
You have the following rights with respect to your PHI:

A. The right to request restrictions on my uses and disclosures.
You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members or friends or to others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests, but I am not legally required to accept them. If I do accept your requests, I will put them in writing and I will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that I am legally required to make.

B. The right to choose how I send PHI to you.
You have the right to request that I send confidential information to you to an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for examples, email instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and, when appropriate, you provide me with information as to how payment for such alternate communication will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications.

C. The right to inspect and copy your PHI.
I most cases, you have the right to inspect and copy the PHI that I have for you, but you must make the request to inspect and copy such information in writing. I will respond to your request within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. If you request copies of your PHI, I will charge you not more than $.25 for each page.
Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The right to receive a list of the disclosures I have made.
You have the right to receive a list of instances, i.e., an accounting disclosure, in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incidents to a use or disclosure permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel.
I will respond to your request for an accounting of disclosures within 60 days of receiving such request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, but if you make more than one request in the same year, I may charge you a reasonable, cost based fee

for each additional request.

E. The right to amend your PHI.
If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. The right to receive a paper copy of this notice.
You have the right to receive a copy of this notice.

III. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES
If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section IV below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave, S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

IV. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES.
If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at 720-587-9092.

This letter is intended to inform you of current billing procedures. Please feel free to discuss the information in this letter with me.

My policy policy is to securely store a form of payment on file for all of your sessions. I am deeply committed to the therapeutic climate and want your therapeutic experience to be focused on you and your treatment goals. By allowing you to use a credit or debit card, I can avoid taking time away from your therapeutic work to check you in and process payment. Additionally, I want clients focused on their clinical work before session, during session and after you leave – paying each week disrupts this process and can distract you from focusing on getting better. With this method each session you attend is 100% focused on treatment. Each month you will receive an automated statement by email. Statements will show that you have paid for your services in full and are ready for you to forward to your insurance company if you wish to seek reimbursement.

Forms of Payment:
I accept the following forms of payment:
Cash, Check, Visa, MasterCard, and Discover.

Please indicate your preferred form of payment on the Electronic Payment Authorization form.
The Electronic Payment Form will be securely stored in your clinical file and may be updated upon request at any time.

I will deduct your session fees from the account designated on this form. I utilize a secure and HIPPA compliant program for my records and billing. This program is called My Clients Plus. You will receive an e-mailed statement with every charge.

Beginning May 1st, 2008, a $30 fee will be assessed for all Charge-backs initiated by any cardholder. Charge-backs occur when a cardholder disputes a credit card transaction.

Please feel free to discuss any billing matters with me.

Sincerely,

Lindsey Geiger, MA LMFT

ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the card you wish to use for all services rendered through this practice. Charges for services rendered will be deducted from the card designated below at the time services are rendered. We accept: Visa, MC and Discover.

Client Information:

Client Name: _____

Date of Birth: _____

Address: _____ City_____ State: _____

Zip: _____

Home Number: _____ Mobile Number: _____

SSN:_____

Email:_____

Billing Information:

Please indicate the information associated with the credit card you wish to use.

Name:_____

Address: _____ City_____ State: _____

Zip: _____

Email:_____

I authorize all service fees to be deducted from the card ending in _____ (last four digits of the card)

Please enter the CVV code _____ (last three digits on back of card)

I authorize the use of this card for all services and fees at the time they are rendered for the following parties:

Full Name(s)_____

I understand that this form authorizes my provider to charge this card for varying session types, across multiple dates of service. *By authorizing use of this card, and signing this electronic payment authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.

_____ _____

Cardholder Signature Date

Payments are processed by Therapy Partner.

Therapy Partner is a registered ISO/MSP of Fifth Third Bank, Cincinnati, OH and HSBC Bank USA National Association, Buffalo, NY.

Card Information:

Please provide your payment information below. The card information you provide on this form will be destroyed once your information has been securely encrypted and stored.

Card (circle one): Visa MasterCard Discover

Card Number: _____

Expiration Date: _____

NEW PATIENT INSURANCE INFORMATION

Provider Name: _____

Patient Name: _____

Address: (Street) _____

(Apt/Unit) _____

(City / State / Zip) _____

Phone: _____

Date of Birth: _____

Gender: Male ( ) Female ( )

(Check One) Employed ( ) Student ( ) None ( )

Insurance Company Name:

Member ID #: _____

Group Number (If Available)**:** _____

How are you related to the policy holder? Self ( ) spouse ( ) child ( ) other ( )

If the answer to the above question is someone other than "Self", please answer the below questions:

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Policy Holder's Employer: _____

Policy Holder's Address (if different): _____

(OFFICE USE ONLY)

Diagnosis Code(s): _____

Copy of Front and Back of Card: Yes ( ) No ( )

NOTES: