Lindsey Geiger, LMFT

720-587-9092

Informed Consent for Psychotherapy

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:

- Diplomate Jungian Analyst, C.G. Jung Institute of Colorado, 2023

- 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)

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by signing the end of this document.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a

specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Lindsey Geiger, LMFT

PRACTICE POLICIES

PAYMENT

Client is responsible for paying agreed upon charge of $150/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.

Please inform me if you wish to utilize health insurance to pay for services. 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 my billing service will run the insurance and can give us a good idea of what can be expected around coverage.

Although I am happy to bill your insurance if I am credentialed with them, 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.

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.

APPOINTMENTS AND CANCELLATIONS
Please remember to cancel or reschedule 24 hours in advance. You will be responsible for the entire fee if cancellation is less than 24 hours. Please keep in mind that insurance will not cover late cancellations or no-shows.

The standard meeting time for psychotherapy is 50 minutes. It is up to you, however, to determine the length of time of your sessions. Requests to change the 50-minute session needs to be discussed with the therapist in order for time to be scheduled in advance.

A $10.00 service charge will be charged for any checks returned for any reason for special handling.

Cancellations and re-scheduled session will be subject to a full charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session

time. If you are more than 20 minutes late, the session will be late-canceled as there will not be enough time to do therapeutic work.

TELEPHONE ACCESSIBILITY
If you need to contact me between sessions, please leave a message on my voice mail. I am often not immediately available; however, I will attempt to return your call within 24 hours. If a true emergency situation arises, please call 911 or any local emergency room.

SOCIAL MEDIA AND TELECOMMUNICATION
Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

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.

ELECTRONIC COMMUNICATION
I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies. You can utilize Jituzu for a secure communication, but I cannot guarantee immediate response.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered telemedicine by the State of California. Under the California Telemedicine Act of 1996, telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that:
(1) You retain the option to withhold or withdraw consent at any time without affecting the

right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
(2) All existing confidentiality protections are equally applicable.
(3) Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.
(4) Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.
(5) There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally the therapist.

MINORS
If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

TERMINATION
Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive months, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

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.

Signature and 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.

information between therapist and client during sessions is legally confidential and cannot 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 to ask for further information on these subjects at any time.

PAYMENT POLICY

My 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.

You will receive an automated statements and invoices by email. All information will be available to you in Jituzu, a portal where you can schedule appointments, pay balances, and see me for video sessions. I utilize a billing service for insurance billing. The employees of this billing service are bound by the same confidentiality requirements that I am. If you are using an insurance for which I am out of network, statements will show that you have paid for your services in full. You can 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, of which Jituzu is a part. A $30 fee will be assessed for all Charge-backs initiated by any cardholder. Chargebacks occur when a cardholder disputes a credit card transaction. Please feel free to discuss any billing matters with me.

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: _____
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 and Date

Payments are processed by My Clients Plus

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: _____

If you are using insurance for payment, please fill out the following in full. This will be shared with my insurance billing service.

NEW PATIENT INSURANCE INFORMATION

Provider Name: Lindsey Geiger

Patient Name: _____

Address: (Street) _____

(Apt/Unit) _____

(City / State / Zip) _____

Phone: _____

Date of Birth: _____

Gender: Male ( ) Female ( ) Prefer not to answer ( )

(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:

HIPPA 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.