Deborah Kawakami, MA LPC LLC

Date of First Visit:_____ (Castle Rock ___ Centennial ___) Dx Code (office use only) _____

Are you coming for Employee Assistance Program visits? Yes___ No___
(If yes, please provide the authorization information from your EAP.)

Patient's Name:_____ DOB:_____ Gender: Male__ Female__
(first) (middle / initial) (last)

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

Phone (home)_____ Married ___ Single ___ Divorced ___ Separated ___ Widow(er) ___

(cell)_____ Social Security # _____

Emergency Contact: _____ Relationship:_____ Phone:_____

Student Status: Non-student ___ Full-time ___ Part-time ___

Patient's Employer:_____ Full-time__ Part-time__ Work Phone: _____

EAP:_____ Phone:_____ ID#:_____
(Company Name)

Primary Insurance:_____ Phone:_____
(Company Name)

Insurance ID # / Claim # :_____ Group #_____ Adjuster:_____
(Name, if applicable)

Patient's Relationship to Policyholder: Self ___ Spouse ___ Child ___ Other Dependent ___

Policyholder's Name_____ DOB:_____ SSN:_____
(first) (middle / initial) (last)

Policyholder's Address:_____ Phone:_____
(Street) (City) (State) (Zip)

Policyholder's Employer_____

Secondary Insurance:_____ Policyholder:_____
(Company Name)

Secondary Ins ID #:_____ Group #:_____

Is Treatment: Work Related ___ Auto Accident Related ___ (State where injury occurred ____)

Date of Injury:_____

We will not be able to bill your insurance for you unless you agree to the following terms by signing below:

I understand that I am fully responsible for, and agree to pay promptly all charges for services rendered even if my insurance does not pay, unless my insurance's contract with the provider specifically relieves me of such responsibility. **I also understand that I must pay full fee for telephone calls, and for appointments that I fail to keep, or fail to cancel at least 24 hours in advance.** (Insurance does not cover phone calls or missed appointments.) I agree that if I do not pay the amount owing, I will be responsible for all costs of collection which may include attorney's fees.
I authorize the billing of my insurance, and the release of any information necessary to process claims.
I authorize my insurance to pay directly to the provider medical benefits for services rendered.
I hereby acknowledge that I have been offered a Notice of Privacy Practices to read.

_____ _____
Patient /Insured's Signature Date

_____ _____
Patient/Other Insured's Signature Date

NOTICE OF PRIVACY PRACTICES
OF
DEBORAH S. KAWAKAMI, L.P.C., L.L.C.

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.

Effective April 14, 2003

If you have any questions or requests about this Notice, please contact Deborah Kawakami.

My Practice is required by State and Federal law to maintain the privacy of protected health information. In addition, the Practice is required by law to provide clients with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to your mental health information, and to request that you sign the attached written acknowledgement that you received a copy of this Notice. This Notice describes how the Practice may use and disclose your protected health information. This Notice also describes your rights regarding your protected health information and how you may exercise your rights.

"Protected Health Information, PHI@, is information the Practice has created or received about your physical or mental health condition, the health care we provide to you, or the payment for your health care; and identifies you or could be reasonably used to identify you. It includes your identity, diagnosis, dates of service, treatment plan, and progress in treatment.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Permissible Uses and Disclosures Not Requiring Your Written Authorization Your mental health information may be used and disclosed in the following ways.

- $ **Treatment:** Your mental health information may be used and disclosed in the provision and coordination of your healthcare. For example, this may include coordinating and managing your health care with other health care professionals. Your mental health information may be used and disclosed when I consult with another professional colleague, or if you are referred for medication, or for coverage arrangements during my absence. In any of these instances only information necessary to complete the task will be provided.
- $ **Payment:** Your mental health care information will be used to develop accounts receivable information, to bill you, and with your consent to provide information to your insurance company or other third party payer for services provided. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnosis, dates and type of service, and other information about your condition and treatment, but will be limited to the least amount necessary for the purposes of the disclosure.
- $ **Health Care Operations:** Your mental health information may be used and disclosed in connection with our health care operations, including quality improvement activities, training programs and obtaining legal services. Only necessary information will be used or disclosed.
- $ **Required or Permitted by Law:** Your mental health care information may be used or disclosed when I am required or permitted to do so by law or for health care oversight. This includes, but is not limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when there is a legal duty to warn or to take action regarding imminent danger to others; (d) when the client is a danger to self or others or gravely disabled; (e) when a coroner is investigating

the client=s death; or (f) to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, or regulatory compliance.

- $ **Contacting the Client:** You may be contacted to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.
- $ **Crimes on the premises or observed by the provider:** Crimes that are observed by the therapist or the therapist=s staff, crimes that are directed toward the therapist or the therapist=s staff, or crimes that occur on the premises will be reported to law enforcement.
- $ **Business Associates:** Some of the functions of the practice may be provided by contracts with business associates. For example, some of the billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services. In those situations, protected health information will be provided to those contractors as is needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.
- $ **Involuntary Clients:** Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.
- $ **Family Members:** Except for certain minors, incompetent client, or involuntary clients, protected health information cannot be provided to family members without the client=s consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of the discussion. However, if the client objects, protected health information will not be disclosed.
- $ **Emergencies:** In life threatening emergencies the practice will disclose information necessary to avoid serious harm or death.

Uses and Disclosures Requiring Your Written Authorization or Release of Information

Except as described above, or as permitted by law, other uses and disclosures of your mental health information will be made only with your written authorization to release the information. When you sign a written authorization, you may later revoke the authorization in writing as provided by law. However, that revocation may not be effective for actions already taken under the original authorization.

- $ **Psychotherapy Notes:** Psychotherapy notes are maintained separate from your mental health record. These notes will be used only by your therapist and disclosure will occur only under these circumstances: (a) you specifically authorize their use or disclosure in a separate written authorization; or (b) the therapist who wrote the notes uses them for your treatment; or (c) they may be used for training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills; or (d) if you bring a legal action and we have to defend ourselves; and (e) certain limited circumstances defined by the law.

YOUR RIGHTS AS A CLIENT

Additional Restrictions: You have the right to request additional restrictions on the use or disclosure of your mental health information. However, the clinician does not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. Ask your clinician for the Request Form.

Alternative Means of Receiving Confidential Communications: You have the right to request that you receive communications from the practice by alternative means or at alternative locations. For example, you may request that bills and other correspondence be sent to an address other than your home address. Ask your clinician for the Request Form.

Access to Protected Health Information: You have the right to inspect and obtain a copy of your protected health information in the mental health and billing record. However, any psychotherapy notes are for the use of your therapist, and are treated differently. If it is thought that access to your mental health records would harm you, your access may be restricted. Ask your clinician for the Request Form and the appeal process.

Amendment of Your Record: You have the right to request an amendment or correction to your protected health information. If the clinician agrees that the amendment or correction is appropriate, the Practice will ensure the amendment or correction is attached to the record. An appeal process is available if the clinician determines the record is accurate and complete as is. Ask your clinician for the Request Form and the appeal process available to you.

Accounting of Disclosures: You have the right to receive an accounting of certain disclosures the practice has made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment, or health care operations. In addition, the accounting does not include disclosures made to you, disclosures authorized by you, or disclosures made prior to April 14, 2003. Other exceptions will be provided to you, should you request an accounting. Ask your clinician for the Request Form.

Right to Revoke Consent or Authorization: You have the right to revoke your consent or authorization to use or disclose your mental health information, except for action that has already taken place under your consent or authorization.

Copy of this Notice: You have a right to obtain a copy of this Notice upon request.
The Practice is required to abide by the terms of this Notice, or any amended Notice that may follow. The Practice reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that it maintains. When changes are made, the revised Notice will be posted at the Practice=s office and copies will be available upon request.

If you believe the Practice has violated your privacy rights, you may file a complaint with the person designated within the Practice to receive your complaints, [*that is your clinician or the Privacy Officer*]. You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 515F, HHH Bldg., Washington, D.C. 20201. It is the policy of the Practice that there will be no retaliation for your filing of such a complaint.

DEBORAH S. KAWAKAMI, L.P.C., L.L.C.

Acknowledgement of Receipt of Notice of Privacy Rights

I, _____, acknowledge that I received a copy of the
Client Name
Notice of Privacy Practices for Deborah S. Kawakami

_____ _____
Signature of Client or Personal Representative Date

_____
If not the client, please print name and state legal authority to sign for client.

For Practitioner Use Only

I attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining acknowledgement
- ☐ Client was incapable of signing
- ☐ Other (Specify)_____

_____

_____ _____
Signature of Practitioner Date

April 2003

Deborah S. Kawakami, M.A, L.P.C.
Psychotherapist

6059 S. Quebec St., Ste. 203
Centennial, Colorado 80111
303-564-4575

333 Perry St.
Ste. 206D
Castle Rock, Colorado 80104

POLICY STATEMENT

-Payments must be paid at the time of service, including co-payments. If you have insurance coverage, we will bill your insurance company but you are responsible for payment.

-An interest charge of 1 1/2% per month will be assessed on all amounts owed over 30 days.

-Scheduled therapy sessions must be cancelled 24 hours in advance or there will be a charge for the full appointment fee. In case of illness or emergency, please call to reschedule the appointment by calling me at (303)564-4575.

-Promptness for therapy is imperative to allow you the full designated therapy time. Lateness on your part results in a shorter session as the time cannot be extended due to other scheduled appointments.

-In the event I default, I agree to pay, whether or not legal proceedings are instituted, a reasonable COLLECTION FEE which shall be 30% of the principal balance for any debt incurred hereunder and to pay all reasonable attorney fees as a result of my default.

I have read, understand, and agree to the conditions set forth in this policy statement.

_____
Signature

_____
Date

Deborah S. Kawakami, M.A., L.P.C., L.L.C.
Psychotherapist

Creekside Complex
6059 S. Quebec, Suite 203
Englewood, Co. 80111
(303) 415-5695

1707 Main St., Suite 403
Longmont, Co. 80501
(303)415-5695 --

Dear Valued Clients,

I'd like to take a moment to review my cancellation policy.
Many times If I have advance notice that a client is cancelling their appointment, I can book a client for an earlier time, day, or week. There are also times when I need to see a client or new client on an emergency basis, and I can see them earlier if I know what times I have available in advance.

To operate with a more efficient schedule, I require a 24 hour notice for an appointment cancellation. Because insurance and EAP companies won't cover missed appointments, the bill will be sent to the client for the total charge of the missed session. Thank you in advance for your help in this matter.

Sincerely,

Deborah Kawakami

Client Signature:

DEBORAH KAWAKAMI

LICENSED PROFESSIONAL COUNSELOR

6059 S Quebec Street. Suite 203, Centennial, Co 80111

Phone: (303) 564-4575

DISCLOSURE STATEMENT

CREDENTIALS: Licensed Professional Counselor, (l.P.C.#2292)
M.A. Counseling Psychology, Lesley College, Cambridge, Massachusetts, 1994
B.S. Sociology, Colorado State University, Ft. Collins, Colorado, 1971
Private Practice 1995-Present, National American Counseling Association Member

REGULATION OF PSYCHOTHERAPISTS: 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 Regulatory Boards can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. As to the regulatory requirements applicable to mental health professionals: a 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. A Licensed Social Worker must hold a masters degree in social work. A 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. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1,000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelors degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical masters degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required.

CLIENT RIGHTS: You are entitled, to receive information from me about the methods of therapy, the techniques used, the duration of your therapy, and the fee structure. You understand that while the course of psychotherapy is to be helpful, that the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness and anger. You also understand that this is a normal reaction to your working through unresolved life experiences and that these reactions will be worked on by you and Ms. Kawakami. You can seek a second opinion from another therapist or terminate therapy at any time. The termination decision is usually mutual and it is best practice to give a thirty day notice so that we may have a time to consolidate the gains you have made or to address your concerns. In a few instances, I may decide to stop working with you and/or your child, even though you wish to continue. These include failure to meet the terms of the fee agreement, a need for special services outside of my competency, and prolonged failure to make progress in our work together. Should this occur, reason for termination will be discussed with you, and you will be helped to make different plans for yourself and/or your child, including referral to a more appropriate resource. Additionally, in a professional relationship, sexual intimacy is never appropriate and should be reported to the Board of Licensed Professional Counselors.

 DISCLOSURE STATEMENT

CONFIDENTIALITY: Generally speaking, the information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and the therapist cannot disclose the information without the client's consent. There are several exceptions to this confidentiality, some of which are listed in section 19-3-304 of the Colorado Revised Statutes, and in the HIPAA Notice of Privacy Rights you were provided, as well as other exceptions in Colorado and Federal law. These exceptions include: 1) I am required to report any suspected incident of child abuse or neglect to authorities; 2) I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; 3) I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or others, or who is gravely disabled, as a result of a mental disorder; 4) I am required to report any suspected threat to national security to federal officials; and 5) I may be required by Court Order to disclose treatment information. If a legal exception arises during therapy, if feasible, you will be informed accordingly. Under Colorado law, a parent has the right to access mental health treatment information concerning their minor child, unless the court has restricted access to such information. If you request information from me, please do so in writing with your stated questions. It is my policy to not release the entire record, even with your consent. I will provide you with a treatment summary, in compliance with Colorado law and HIPPA Standards. There is a fee for this treatment information for the time involved to address your request.

DISCLOSURE REGARDING DIVORCE AND CUSTODY LITIGATION: If you are involved in divorce or custody litigation, my role as a therapist is not to make recommendations to the court concerning custody or parenting issues. By signing this Disclosure Statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that I write any reports to the court or to your attorney. The court can appoint professionals, who have no prior relationship with family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interest of the family's children.

AVAILABILIY: I am available by voice mail and will return your call within 24 hours or the first working day following a weekend or holiday to the phone numbers that you have provided to me. In the event of a clinical emergency, please call my voice mail, leave a message and then follow the instructions how to access me by my pager. During my vacations or absences from my practice, I will designate a backup therapist to cover any clinical crises. They will not have your confidential information, however they are available to assist you in coping and/or acquiring emergency services.

I have read the preceding information, and it has also been presented to me verbally. I understand the disclosures that have been made to me. I also acknowledge that I have received a copy of this Disclosure Statement and I understand my rights and responsibilities as a client or as the client's responsible party.

Client's name _____ Client's Signature _____

Signature of Parent or Legal Guardian (For minor child under the age of 16) _____ Date _____

Therapist's Signature _____ Date _____