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NEW CLIENT PACKET

Name: _____ Birthdate: __ /__ /_____

Address: _____

Zip Code: _____ Email Address: _____

Home Phone: _____ May We leave messages here: Yes or No

Mobile Phone: _____ May We leave messages here: Yes or No

Work Phone: _____ May We leave messages here: Yes or No

Members of Household

Name: _____ Age: ____ Relationship: _____

Name: _____ Age: ____ Relationship: _____

Name: _____ Age: ____ Relationship: _____

Name: _____ Age: ____ Relationship: _____

Any medical professionals on your team you would like us to be in contact with:

Name: _____ Phone: _____

Name: _____ Phone: _____

How were you referred to Holistra?

_____

May Holistra LLC contact this person(s) to thank them for their referral: Yes or No

Referrals Contact: Phone: _____ Email: _____

By signing below, you are allowing me to contact the referral source:

Client or Parent Signature: _____ Date: __ /__ /_____

Ethnicity check all that apply to family members:

_____ African American _____ Asian-American _____ Caucasian-Anglo

_____ Hispanic American/Latino _____ Native-American _____ Multiracial

_____ Other: _____

Income Level for Family per year:

____ $1 to 10,000 _____ $10,001-20,000 ____ $20,001-30,000 ____ $30,001-40,000

____ $40,001-50,000 _____ $50,001-60,000 ____ $60,001-70,000 ____ $70,001-80,000

____ $80,001-90,000 _____ $90,001 or more

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Please indicate your religious affiliation if any. List more than one if more than one in the family:

Have you participated in therapy or counseling in the past. Yes or No
If yes, tell me about your experience of therapy (positive, negative, mixed, etc.)

What would you like to gain from our work together (therapy goals):

Psychiatric Medications being taken by yourself and/or family members (name the medications and purpose):

Session Taping & Observation

Holistra LLC Therapists participating in the postgraduate externship program are in training and under supervision as a part of their learning process. To assure the highest quality services, and to better serve you, your sessions may be taped, or you may participate in live observation of your therapy sessions for clinical supervision and peer consultation Your therapist will always inform you if a session is being observed, and you can request to meet the observers if you would like to. By signing below, you are acknowledging your understanding that by choosing to receive treatment by a therapist in our externship program you are consenting to having your treatment either taped, or potentially observed for training purposes.

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Client name: _____

If client is under 18, guardian name: _____

Client or guardian signature: _____

Date: __ /__ /_____

Client name: _____

If client is under 18, guardian name: _____

Client or guardian signature: _____

Date: __ /__ /_____

MANDATORY DISCLOSURE/INFORMED CONSENT FOR HOLISTRA LLC CLIENTS

Holistra LLC offers specialized, graduate, and post-graduate level training in working with individuals, couples, and families. We work from a systemic, strength-based, solution-focused, and relational focused approach. The approach may be adjusted on a case-by-case basis as clinically indicated. Graduate and post-graduate students provide reduced fee therapy to families and individuals. Supervision is provided by Holistra LLC clinicians who are licensed and have extensive experience. Your therapist will share information about you and your case with their supervisors at Holistra LLC and other trainees in supervision or peer consultation.

Your therapist receives supervision from one or more of the Licensed Clinical Members at Holistra LLC. By signing this document, you give permission for your therapist to discuss your case information with supervisors and colleagues at Holistra LLC for professional and educational purposes only.

We do not provide medications, psychiatric services, custody evaluations, mediation, or psychological testing. If you are involved in a divorce or custody litigation, you need to understand that my role as a therapist is not to make recommendations for the court concerning custody or parenting issues or to testify in court concerning opinions on issues involved in the litigation. By signing this disclosure statement, you agree not to call me as a witness in any such litigation. Experience has shown that testimony by therapists in domestic dispute cases causes damage to the clinical relationship between a therapist and client. Only court-appointed experts, investigators, or evaluators can make

recommendations to the court on disputed issues concerning parental responsibilities and parenting plans.

Cancellation Policy

All appointments must be cancelled 24 hours in advance, with exceptions made for medical illness or emergencies. If an appointment is missed without 24-hour notification, you will be billed for the full hourly fee through an automatic credit card charge.

Notice of Privacy Practices

This notice describes how medical information (including mental health) about you may be used and disclosed and how you can get access to this information.

During the process of providing services to you, I will obtain, record, and use mental health and medical information about you that is protected health information. Ordinarily that information is confidential and will not be used or disclosed, except as described below.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

A. **General Uses and Disclosures Not Requiring the Client's Consent.** I may use and disclose PHI about you without your authorization in the following circumstances:
   a. Treatment. Treatment refers to the provision, coordination, or management of health care and related services by one or more health care providers. For example, I may use your information to plan your course of treatment and to consult with another health care provider to ensure the most appropriate methods are being used to treat you.
   b. Payment. Payment refers to the activities undertaken by a health care provider to obtain or provide reimbursement for the provision of care. I may use and give your information to others to bill and collect payment for the treatment and services provided to you. For example, I may share portions of your information with billing services and billing personnel, collection services, insurance companies, health plans, and third-party payers that provide you coverage. The information provided to insurers and other third-party payers may include information that identifies you, as well as your diagnoses, type of service, date of service, provider name/identifier, and other information about your condition and treatment.
   c. Health Care Operations. Health Care Operations refers to activities that are regular functions of the management and administrative activities. For example, I may use your health information in monitoring of service quality, training and education, medical

reviews, legal services, auditing functions, compliance programs, business management and general administrative activities, and planning for future operations.

d. Contacting the Client. I may contact you to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.

e. Required by Law. I will disclose protected health information when required by law. This includes but is not limited to the following situations.

   i. Reporting child abuse or neglect;

   ii. When the disclosure is for judicial and administrative proceedings, for example in response to an order of a court or administrative tribunal;

   iii. When there is a legal duty to warn or take action regarding imminent danger of others;

   iv. When the client is a danger to self or others or gravely disabled;

   v. When required to report certain communicable diseases and certain injuries;

   vi. When a Coroner is investigating the client's death; and vii. To government regulatory and oversight agencies which are authorized by law to oversee my operations.

f. Crimes on the premises or observed by Denver Family Institute. Crimes observed by me, which are directed toward me or occur on the premises of our office, will be reported to law enforcement.

g. Business Associates. Some of the functions of the health care providers are provided by contracts with business associates. For example, some clinical, quality assurance, legal, auditing, and practice management services may be provided by contracting with outside entities to perform these services. In those situations, protected health information will be provided to those contractors as is needed to perform their contracted tasks. In those situations, the business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.

B. *Research*. I may use or disclose protected health information for research purposes if the relevant limitations of the Federal HIPAA Privacy Regulations are followed. 45CFR §164.512(i).

C. *Family Members*. Except for certain minors, incompetent clients, 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 that discussion. However, if the client objects, protected health information will not be disclosed.

D. *Emergencies*. In life threatening emergencies, I will disclose information necessary to avoid serious harm or death.

E. *Client Authorization or Consent*. I may not use or disclose protected health information in any other way without a signed Authorization or Release of Information. When you sign an Authorization or Release of Information, it may later be revoked, provided that revocation is in writing. The revocation will apply except to the extent that I have already relied on it.

F. *Psychotherapy Notes*. I may maintain psychotherapy notes separately from the remainder of my records. Use or disclosure of these notes will only occur under these circumstances. (a) you specifically authorize their use or disclosure in a separate written authorization; (b) I use them for your treatment; (c) I may use them for my own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family or individual counseling; (d) if you bring a legal action and I have to defend myself; and (e) certain limited circumstances defined by law.

B. YOUR RIGHTS AS A CLIENT

A. *Additional Restrictions*. You have the right to request additional restrictions on the use or disclosure of your health information. I am not required to agree to your request, and there are certain limits to any restriction, which will be provided to you at the time of your request. To exercise your right, discuss it with me.

B. *Alternative Means of Receiving Confidential Communications*. You have the right to request that you receive communications of protected health information by alternative means or alternative locations. For example, if you do not want to receive bills or other materials at your home, you may request that this information be sent to another address. To exercise this right, discuss it with me.

C. *Access to Protected Health Information*. You have a right to inspect and obtain a copy of the protected health information contained in clinical, billing and other records used to make decisions about you. Your request must be in writing. We may charge you related fees. There are some limitations to this right, which will be provided with you at the time of your request, if any such limitation applies. To exercise this right, discuss with me.

D. *Amendment to Your Record*. You have the right to request amendment of your protected health information. Your request must be in writing, and it must explain why the information should be amended. We are not required to amend the record if it is determined that the record is accurate and complete. There are other exceptions, which will be provided to you at the time of your request, relevant, along with the appeal process available to you. To exercise this right, discuss this with me.

E. *Accounting of Disclosures*. You have the right to receive an accounting of certain disclosures I have 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 October 2, 2022. There are other exceptions that will be provided to you, should you request an accounting. To exercise this right, discuss with me.

F. *Copy of the Notice*. You have a right to request a paper copy of this Notice at any time.

C. ADDITIONAL INFORMATION

A. *Privacy Law*. We are required by law to maintain the privacy of your protected health information. We are also required to provide clients with notice of my legal duties and privacy practices with respect to protected health information. That is the purpose of this notice.

B. *Terms of the Notice*. We are required to abide by the terms of this Notice, or any amended Notice that may follow.

C. *Changes to the Notice*. We reserve the right to change our privacy practices and the terms of this Notice at any time, and to make the new Notice provisions effective for all protected health information that we maintain. When changes are made, the revised Notice will be posted in my office. Copies of this Notice will be available upon request.

D. *Complaints Regarding Privacy Rights*. If you are concerned that I have violated your privacy rights, you may file a complaint with me directly, in writing, using the contact information provided at the end of this Notice. You also have the right to complain to the United States Secretary of Health and Human Services, 200 Independence Avenue, SW, Room 515F, HHH Bldg., Washington, DC 20201. It is our policy that there will be no retaliation for your filing such a complaint.

E. *Effective Date*. This Notice is effective October 2, 2022.

F. *Additional Information*. If you want more information about our privacy practices or have any questions or concerns, please contact Olivia Woodring at liv@holistra.com or 303-434-6036.

D. NOTICE OF RIGHT TO PRIVACY AND MANDATORY DISCLOSURE/CONSENT

I, _____ (print names), have received a copy of the LLC Privacy Practices form in compliance with federal HIPAA regulations. I/We have also received a copy of the "Informed Consent" form for LLC. I/We understand that it is our responsibility to read this document. We had the opportunity to ask questions regarding these two documents and consent to services with LLC according to the stipulations named above.

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Client name: _____

If client is under 18, guardian name: _____

Client or guardian signature: _____

Date: __ /__ /____

Client name: _____

If client is under 18, guardian name: _____

Client or guardian signature: _____

Date: __ /__ /____

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Fee Agreement and Credit Card Authorization

I _____ (print name)
understand that I am responsible to pay the hourly fee of $_____at the time of each session for whatever amount of time I use in a session. In the event that I forget my form of payment, or do not give the required 24 hours' notice for a non-emergency cancellation, or prefer to have my credit card
automatically charged, I consent to have LLC automatically charge my credit card using the information provided below.

Please complete the following credit card information. This form will be securely stored in your clinical file and may be updated upon request.

In case of late cancellations without 24 notices, and/or no shows for scheduled sessions, you will be charged the session fee for whatever amount of time you had booked at the agreed upon hourly rate using the credit card information you provide in this form. All credit card transactions processed by LLC LLC, will be performed through Square merchant services.

Circle Type of Card.
VISA MasterCard American Express Discover
Card Number: _____- _____-_____-_____
Verification/Security Code: _____ Exp. Date: _____/_____
Billing
Address:_____
City: _____ ZIP: _____
Email: _____@_____
Phone: _____

By signing below, I am authorizing Holistra LLC to charge the credit card detailed above for late cancellations missed appointments or any outstanding balances.

Client or guardian signature: _____
Date: __ /__ /_____

Client Signature if not card holder: _____
Date: __ /__ /_____

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Consent for Email and/or Text Message or Video Conferencing Communication

Email and text messaging allows Holistra LLC therapists to exchange information efficiently for the benefit of our clients. At the same time¨ we recognize that email and text messaging are not a completely secure means of communication because these messages can be addressed to the wrong person or accessed improperly while in storage or during transmission.

If you would like us to send you email and/or text messages that contains your health information (such as corresponding about scheduling¨ providing invoices and receipts for services¨ or addressing issues regarding treatment planning or payment, video recordings), please complete and sign this Consent below. You are not required to authorize the use of email and/or text messaging and a decision not to sign this authorization will not affect your services at the Holistra LLC in any way. If you prefer not to authorize the use of email and/or text messaging, we will continue to use U.S. Mail or telephone to communicate with you.

_____

Email address(s) and/or text messaging number(s) to which your therapist may send you your health information.

Client name: _____
If client is under 18, guardian name: _____

Client or guardian signature: _____
Date: __ /__ /_____

Client name: _____
If client is under 18, guardian name: _____

Client or guardian signature: _____
Date: __ /__ /_____

If you do not consent for communication via text message or email¨ then you understand that your therapist will not be permitted to respond to any emails or text messages that you send to them. Outside of session you will only be able to communicate via phone or US mail.