Andrea Rojas, MS, LPCC

world color hypnosis LLC
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Lone Tree, Colorado 80124

850-665-0671

New Client Information Sheet

The information that you present here will serve as a basis to get to know you as well as serve you better. Information will be kept in the strictest of professional confidence.

Name: _____

Phone: (Home)_____ (Cell)_____

Address: _____ City: _____

State: _____ Zip: _____

Email Address:_____

May I have permission to call, text and email? YES _____ NO _____

Date of Birth: _____

Others living at home: _____

Education: (Highest level attained):_____ Occupation:_____

Place of Employment:_____

Primary Physician or Psychiatrist: _____Phone: _____

List any health conditions or problems: _____

List medications you are currently taking including dosage: _____

Have you see this type of therapist before: YES_____ NO_____

If yes, when and with whom? _____

Please give a brief description of treatment received:
_____

How did you hear about world color hypnosis LLC? (if internet, what search engine? Psychology Today, Yelp, Good Therapy, Theravive, Network Therapy, Google or friend) _____
_____

Emergency contact: _____ Phone: _____

Person financially responsible for client:

_____Phone: _____

NOTICE OF PRIVACY PRACTICES
of Andrea Rojas, MS, LPCC

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.

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 medical/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 healthcare; 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 medical/mental health information may be used and disclosed in the following ways.

• Treatment: Your medical/medical/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 medical/medical/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 medical/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 medical/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 coach/therapist or the coach/therapist's staff, crimes that are directed toward the coach/therapist or the coach/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 medical/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.

Coaching/Psychotherapy/Hypnotherapy Notes: Coaching/Psychotherapy/Hypnotherapy notes are maintained separate from your mental health record. These notes will be used only by your coach/therapist/hypnotherapy and disclosure will occur only under these circumstances (a) the coach/therapist who wrote the notes uses them for your treatment; or (b) they may be used for training programs in which students, trainees, or coaching/ mental health learn under supervision to practice or improve their skills; or (c) if you bring a legal action and we have to defend ourselves; and (d) 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 medical/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 Mental Health Information: C.R.S. 25-1-801 requires health care facilities to allow a patient or patient's designated representative to inspect, at reasonable times and upon reasonable notice, the patient's medical records. However, records pertaining to coaching problems may be withheld from a patient. A summary of records pertaining to a patient's problems may, upon written, signed, and dated request, be made available to the patient or his or her designated representative following termination of the treatment program. C.R.S. 25-1-802 states that records pertaining to a client's problems maintained by a coaching/psychotherapist need not be made available to a patient. Instead, a summary of records concerning mental health problems may, upon request and signed, and dated authorization, be made available to the patient or a designated representative.

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 October 7, 2017. Other exceptions will be provided to you, should you request an accounting. Ask your coach/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 medical/mental health information, except for action that has already taken place under your consent or authorization.

Social Media Sites: I have several social media sites to share helpful information about therapeutic subjects. Feel free to join them, but know that others may see you as a client if you join them and if you comment on any posts.

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 provided by coach/therapist 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 coach/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.

Disclosure Statement

Andrea Rojas, MS, LPCC earned her Master's in Clinical Mental Health Counseling from Stetson University in Deland, Florida. To learn more about Andrea and the therapeutic modalities she utilizes please visit her website at http://www.worldcolorhypnosis.com/

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed and unlicensed individuals who practice psychotherapy. Please be mindful that at this moment I am providing coaching services. I am currently in the process of obtaining my LPC licensure as I am transitioning from Florida and meeting Colorado State requirements. The agency within the Department that has responsibility for psychotherapists is: State Grievance Board, 1560 Broadway, Suite 1340, Denver, CO 80202, (303) 894-7766.

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 1000 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 and Confidentiality Continued:

As stated in the Colorado Revised Statutes (specifically section 12.43.214), you as a client are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of therapy (if I can determine it) and my fee structure. Please feel free to ask me questions about this information at any time. You are also entitled to seek a second opinion from another therapist or terminate coaching/therapy at any time. However, it is preferred that ending coaching/therapy will be mutually agreed upon between counselor and client. I may also end your counseling, even though you wish to continue, if I believe you need services which are outside my competency, if there has been prolonged failure to make progress in our work together, if I believe you pose a threat to my safety, or if you fail to meet the terms of our fee agreement. Should any of these occur, I will explain my decision to you and will recommend other appropriate resources.

In a professional relationship such as ours, sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the State Grievance Board.

Generally speaking, the information provided by a client during a therapy session is legally confidential. Therefore, a coach/therapist generally cannot be forced to disclose information shared by a client to another party without the client's written consent. However, there are exceptions to the general rule of legal confidentiality. These exceptions are listed in the Colorado statutes (see section 12-43-218, C.R.S., in particular.)

You should be aware that legal confidentiality does not apply in criminal or delinquency proceedings. Other exceptions include information given to a coaching/therapist regarding the abuse or neglect of a child or elderly person, or a specific threat of harm made towards oneself or others. I will report any suspicion or incidence of child abuse or neglect to the proper authorities. If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, I am required to report this information to the appropriate social service and/or legal authorities. I may also take some action without your consent if I deem you to be in danger of doing serious harm to yourself or another,

or if you are gravely unable to care for yourself. In cases in which you disclose or imply a plan of suicide, I will be required to notify legal authorities and make reasonable attempts to notify your family.
In the event that I provide therapy services and you need to use your health care benefits, I will be required to release certain information to the insurance company for payment, authorization of services, and utilization review. I cannot control the storage of confidential information nor access to your confidential information when it is given to a third party.
Due to limits regarding the confidentiality of email, it is not recommended to communicate therapeutic information through email and should be used only to schedule appointments if needed. I use a cell phone as my main means of connection for my business. Cell phones do not guarantee confidentiality. By signing this form, you are allowing me to use a cell phone for our out of office communication.
There will be times when I need to consult with other professional colleagues about your case for purposes of consultation, guidance, and clinical supervision, however only first names will be used, identifying information will be kept at a minimum and your privacy will be protected by this professional. When I am away from my office for a few days, I may ask another coach/therapist to cover emergencies for me. Generally, I will tell this coach/therapist only what he or she needs to know for an emergency.
If you are involved in a divorce or custody litigation, you need to understand that my role as a coach/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 and agreeing to receive services from me, you agree not to subpoena me to testify or produce records in court in any type of litigation. You also agree not to ask me to write any reports for the court or for your attorney. By signing this disclosure statement and agreeing to receive services from me, you agree that currently I am not be delivering counseling or therapy sessions but I will be utilizing coaching as I am a Certified Life Coach and Certified Hypnotherapist. Feel free to request verification of these licensures as well as my masters degree in Clinical Mental Health and Provisional license with the state of Colorado.
If you file a complaint or a lawsuit against me, according to Colorado law, your right to confidentiality is waived. If I am unable to collect my agreed upon fee, I may send your name and address to a collection agency. Records include copies of forms you have signed, identifying information, dates of sessions, an initial assessment and treatment plan, brief notes regarding progress, copies of correspondence, verification of any consultations or collateral contacts made, etc. All records are stored safely under lock and key, or other security measures, with attention to privacy.

You may leave a voicemail message 24 hours a day and I will attempt to return your call within 24 hours. In the event of a life-threatening emergency, please call 911 or go to your nearest emergency room.

Having read the preceding information, I agree that I have been informed of my coach/therapist's degrees, credentials and licensure status. I understand my rights as a client and agree to all the terms presented in this disclosure statement. I have discussed this disclosure statement with my coach/therapist.

_____ _ _____
Client Signature Date

_____ __ _____
Parent Signature (if applicable) Date

_____ _ _____
Coach/Therapist Signature Date

Consent to Treatment

I do hereby seek and consent to take part in the treatment by the coach/therapist named below. I understand that developing a treatment plan with this coach/therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this coach/therapist. I am aware that I may stop my treatment with this coach/therapist at any time. The only thing I will still be responsible for is paying for the services I have already received.

**I know that I must call to cancel an appointment at least 48 hours before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

Please note that the therapist only uses email for scheduling appointments as well as VSEE confidential video calling system. Due to confidentiality, we do not discuss any clinical information over email.

My signature below shows that I understand and agree with all of these statements.

_____ _____
Signature of Client Date

_____
Printed Name

_____ _____
Signature of Parent (if applicable) Date

I, the coach/therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of Therapist Date

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.

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world color hypnosis
Agreement to Pay for Services

I request that the therapist named below provide professional services to me and I agree to pay this therapist's fee of $199 per single 45-60 minute session of hypnotherapy. Coaching services are available and recommended to support the hypnotherapy sessions at a rate of $100 an hour (please notice that this is for coaching session not hypnosis). Extra time will also be agreed on payment according to rate. Telehealth (VSEE) sessions, phone sessions and case management will be billed at the same rate. I agree that this financial relationship with this coach/therapist will continue as long as the coach/therapist provides services. I agree to pay for services provided to me (or this client) up until the time I end the relationship. Therapist has the right to collect unpaid sessions through small claims court action or by obtaining a creditor. The client will be responsible for the fees incurred if this action is taken.

Please provide a minimum of 48 hours advance notice if you need to reschedule or cancel your appointment. If clients do not provide 48 hours to cancel their appointment they will be charged for the session. This policy is in place to help all clientele access the care they need. Each morning I receive calls from clients who wish to access open slots for emergencies and immediate treatment needs, when clients call in advance I can ensure that all clients can get in when they need it most. One day you may be the client who calls for that extra appointment. I appreciate you understanding this policy as it is built to ensure that all clients respect one another and get the assistance they deserve.

I agree to pay for the scheduled session if I do not provide 48 hours notice and I need to cancel the appointment.

In order to ease the stress of remembering to bring payment please include your credit card information below. This helps if you forget payment or cancel within 48 hours your card will be charged. All information is securely stored.

Circle card type: Visa MasterCard Discover

CVC (three digits on the back of the card) #: _____

Card Number: _____ Exp. Date: _____

My signature below indicates I understand and agree with the statements above and authorize world color hypnosis LLC to run my card for payment of therapy services.

_____ _____
Signature of Client (or person acting for client) Date

_____
Printed Name

I, the coach/therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent. In case of needing higher level of care I will refer the patient appropriately.

_____ _____
Signature of Therapist Date