Julie Visnich, LCSW

48 CR 250 #8
Durango, CO 81303
970-404-1891
Healing@JulieVisnich.com

Please read through all the forms in this booklet and sign each one. Then use the check box below to confirm that you have done this.

Thank you,

Julie Visnich.

Forms	Read & Signed
General Welcome Information	Y/N
Disclosure Statement	Y/N
EFT Disclosure Statement	Y/N
Financial Policy	Y/N
Good Faith Estimate	Y/N
Service Tracker & Client Information	Y/N
Telehealth Consent	Y/N

Section 1: General Welcome Information -

Welcome to my therapy practice. I am honored to be working with you. In my view, we are in it together, as a team. Our job is to interpret the experiences of your life and to make sense of what it's trying to show you. My belief is that life is always trying to help us, by teaching us things. The trick is to understand what those things are, instead of fighting against them or being made miserable by them.

My goal is always to foster more *curiosity about self* and to facilitate developing higher awareness. I have found that there is much peace to be gained when one can observe oneself (in both thoughts and actions) instead of simply reacting to every thought and perception as though they are facts. This to me is the difference between being tossed around by life like a piece of driftwood in the ocean, or being in a boat with a rudder and wheel.

Much healing and positive change can occur within the client-therapist relationship. It is my practice to work from a strengths-based approach. This means that I believe it is most helpful to build on your already strong areas in the now. People sometimes have a tendency to focus on all the things that are not going well, and it's often more helpful to figure out what is working and build on that.

Following is some information about my policies and procedures.

Confidentiality

The information you discuss during a psychotherapy session is protected as confidential under law (CRS 12.43.214(I)(d) with certain limitations.

- It is my policy to report suspected child abuse without an investigation to the proper authorities who may then investigate.
- I also may take some action, such as seek an order for your emergency or involuntary commitment, without your consent if I deem you to be a serious harm to yourself or another. Any action I take without your consent will be discussed with you.
- It is my duty, under Colorado statute to warn any individual in imminent danger of harm by you, as well as to report the danger to authorities.
- If I am unable to collect my agreed upon fee, I may send your name and address to a collection agency.
- If you file an official complaint or a lawsuit against me, according to Colorado law, your right to confidentiality will be waived.
- If I seek consultation from another mental health professional, your privacy will be protected by that professional. I will reveal only the necessary private information for the purpose of the consultation.
- If another mental health professional is involved in your mental health treatment and I determine that it is important for your treatment, I may collaborate in order to coordinate care. Your authorization may not be obtained, but you will be advised of this action.

Couples, Families and Children

Whenever more than one related person is seen by me in individual, family or a combination of modalities, issues around confidentiality and conflicts of interest must be discussed. Related individuals must be fully informed about the planned work. And in order to protect my role as therapist, each person must agree to respect the confidentiality of other family members. Any release of information about family work will require signed authorizations from all adults. In addition, each person must agree to not involve Julie Visnich in litigation with the other.

Litigation

If you are involved in divorce or custody litigation, please understand that my role as a therapist is <u>not</u> to make recommendations for the court concerning parenting or custody issues, nor to testify in court concerning an opinion or

Julie Visnich, LCSW, 48 CR 250 #8, Durango, CO 81303, T: 970-404-1891. email: healing@JulieVisnich.com

issue involved in the litigation. By signing this disclosure statement you agree to not call me as a witness in any such litigation. Only court appointed evaluators can make recommendations to the court on disputed issues concerning parental responsibilities and parenting plans. Information discussed in therapy is meant for your exclusive use in healing and growth. Evaluations to be used for legal purposes should be obtained from a non-treating professional independent of the therapy.

Availability

I can only attempt to return your calls within 24 hours. However, you may leave a voice mail message 24 hours a day at 970-769-8397. In the event of an emergency or last minutes business matter, you may page me by designating your message as urgent. It is my preference to discuss issues for therapy in scheduled sessions. We will have to discuss and individually plan for any anticipated needs for help with a crisis. During my vacations or absences from my practice, we will discuss your coverage needs and make appropriate arrangements.

Records

Records may include identifying information, dates and types of sessions, an assessment and diagnosis, a treatment plan, progress notes or treatment summaries, any reports or correspondence, consultations, or collateral contacts made and informed consent disclosures. My private psychotherapy notes are kept separate and are not a part of the record. These psychotherapy notes are further protected from subpoena and unauthorized access by HIPAA. Your records will be stored safely with attention to your privacy for at least 7 years as required by Colorado statute. In the event that I am no longer able to secure and monitor access to your record, another mental health professional will act as my professional representative. That professional representative will keep your records secure and accessible for the required 7 years. Your records are protected by Colorado statute, HIPAA regulations, and professional ethics. Records can only be released with your written permission and direction. It is my policy to not release an entire record, even with your authorization. Instead, I may summarize the content related to the request. Colorado Statute, CRS 25.1.803 limits release to a summary after termination. You will be granted reasonable access to your record, but no copy of the record. If you choose to read your record, it is my policy to be present in order to respond to any questions or confusion you may have about the recordings. You may request, in writing, an amendment or addition to your record. If you were seen in couple or family sessions, all adults present will have to sign for the release of any record or information gathered from our joint work.

Termination

Termination will usually be agreed upon mutually, but you are free to terminate at any time. In a few special instances I may decide to stop working with you even though you wish to continue. The reason for this may include a failure to meet the terms of our fee agreement, or a need for special services outside of the area of my competency, or prolonged failure to make progress in our work together. Should this occur, the reason for termination will be discussed with you, and you will be helped to make different plans for yourself, including referral to more appropriate resources.

I have been informed of my therapist's degrees, credentials, and licenses. I have also read the preceding information and understand my rights and responsibilities as a client.

I have read the above information and understand my rights and responsibilities.

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date

Julie Visnich, LCSW, 48 CR 250 #8, Durango, CO 81303, T: 970-404-1891. email: healing@JulieVisnich.com

Section 2: Financial Policy and Fee Structure

- Payment is due at time of service unless otherwise agreed upon.
- I do not take insurance of any kind.
- Checks, cash, credit cards, and venmo are accepted.
- For balances outstanding I reserve the right to turn the collection over to a collection agency.
- You will be responsible for payment of legal and collection fees should such services become necessary.

Fees Due At Time of Service

1 hour = $150
90 minutes = $225

Cancellation Policy/Missed Appointments

Please provide 24 hour notice if you are unable to attend a session. If you do provide notice I will gladly waive my fee. If you miss a session without giving 24 hours notice you will be billed for that session. An emergency situation is of course understood. *Initial here*_____

*I will wait 10 minutes before considering you a no-show and billing for the session. Initial here*_____

(If no-shows or missed appointments happen more than once or twice it usually has meaning. We will talk about this together. Sometimes it means the client is not ready to move forward and in that case we can decide if we feel it's right to continue working to together.)

Insurance

I do not take insurance of any kind. It is the **client's responsibility** to pay for services at the time of delivery. The client is responsible for billing their insurance company for reimbursement. The client is also responsible for obtaining required information needed by their insurance company.

It is **my responsibility** to provide you with a *superbill*, which contains the information insurance companies require to approve your sessions, and reimburse you. *Please Note: In providing the insurance company the information needed to reimburse you, a diagnosis is required.*

You will receive a bill each time you attend a session that you may submit to your insurance company.

I have been informed of my therapist's financial policy and understand my responsibilities around payment, cancellation, and insurance.

_____ _____
Client Signature Date

_____ _____
Therapist Signature Date
xxx

Julie Visnich, LCSW, 48 CR 250 #8, Durango, CO 81303, T: 970-404-1891. email: healing@JulieVisnich.com

Section 3: Good Faith Estimate

Date of Good Faith Estimate: _____. This estimate is for psychotherapy services through _____.

Brief explanation of estimate for new patients:

The estimate below is the range of costs cost that is likely for most new clients. Until I do an initial evaluation and we start to work together, I will not have a clear picture of your specific diagnosis, issues and needs. I typically see therapy patients for 5-10 sessions for a total cost of $ 750 - $2250. But in some many a client's issues may be more complicated (or clients elect to continue working on other issues), so we may need additional sessions during the time covered by this estimate.

Brief explanation for continuing patients: The estimate below is a cost range that I think is likely for care over the time period covered by this estimate. However, depending on how treatment progresses, more or fewer sessions may be needed.

Details of the Estimate

The following is a detailed list of expected charges for psychological services scheduled for a one year period. The estimated costs are valid for 12 months from the date of this Good Faith Estimate, unless [I/we] send you an updated Estimate.

Service	**Diagnosis Code** (once determined)	**Service code**	**Quantity** **10 sessions**	**Cost per unit**	**Expected cost**
Psychotherapy 1 hour session		90837 and/or 90834	1	$150	$1150

Total estimated cost: $750 - $2250

Patient information:

Client name _____ DOB _____

Client name _____ DOB _____

Disclaimer

This Good Faith Estimate shows the costs of services that are reasonably expected for the expected services to address mental health care needs. The estimate is based on the information known to me.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute the bill.

If you are billed for $400 more (per provider) than this Good Faith Estimate (GFE), you have the right to dispute the bill

Julie Visnich, LCSW, 48 CR 250 #8, Durango, CO 81303, T: 970-404-1891. email: healing@JulieVisnich.com

Section 3: Good Faith Estimate

You may contact the Julie Visnich at the contact listed above to me them know the billed charges are at least $400 higher than the GFE. You can ask me to update the bill to match the GFE, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this GFE. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to:

www.cms.gov/nosurprises or call CMS at 1-800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call CMS at 1-800-985-3059 .

This GFE is not a contract. It does not obligate you to accept the services listed above.

Keep a copy of this Good Faith Estimate (GFE) in a safe place or take pictures of it. You may need it if you are billed more than $400 than the estimate provided above.

Julie Visnich, LCSW, 48 CR 250 #8, Durango, CO 81303, T: 970-404-1891. email: healing@JulieVisnich.com

Section 4: Disclosure Statement

The practice of both licensed and unlicensed psychotherapists is regulated by the department of Regulatory Agencies (DORA) in compliance with §12-43-214 and §12-43-224(II)(A), C.R.S., of the Mental Health Practice Act, §12-43-101 et seq., C.R.S.

DEGREES AND CREDENTIALS

MSW University of Denver Graduate School of Social Work
Licensed Clinical Social Worker, Colorado LCSW# 1375

A Licensed Clinical Social Worker must hold a master's or doctorate degree from a graduate school of social work, practiced as a social worker for at least two years, and pass an examination in social work.

- The practice of licensed or registered (unlicensed) persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Professions and Occupations.

- The Colorado State Board of Social Work Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800.

- Clients are entitled to receive information about the methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure.

- It is my practice to occasionally seek peer consultation (consulting with my peers on cases). I am also mentored by other types of clinicians and psychotherapists with many years of experience. In all of these cases your name is not disclosed. All of the other clinicians I am associated with are bound by the same laws of confidentiality that I am. The reason I make a practice of clinical supervision is because I strongly believe (and research proves) it makes me a better therapist.

- Sexual intimacy is never appropriate in a professional relationship and should be reported to the Colorado State Board of Examiners, listed above.

- The information you discuss during a psychotherapy session is protected as confidential under (CRS 12.43.214(I)(d) except for certain legal exceptions as provided in 12-43-218, identified below.

1. Client consents in writing.
2. The disclosure is subpoenaed by the court.
3. The disclosure is to protect the health or safety of any person (yourself or others). This includes child abuse and neglect, domestic abuse or violence, and threats against others.
4. The disclosure is made to medical personnel in an emergency situation.

Any person who alleges that a mental health professional has violated the mental health practice act related to the maintenance of records of a client eighteen years of age or older must file a complaint or other notice with the licensing board within seven years after the person discovered or reasonably should have discovered the misconduct.

Julie Visnich, LCSW, 48 CR 250 #8, Durango, CO 81303, T: 970-404-1891. email: healing@JulieVisnich.com

Section 4: Disclosure Statement

Mental health records may not be maintained after seven years from the date of termination of social work/psychotherapy or date of last contact, whichever is later. When the client is a child, the records will be retained for a period of seven years commencing either upon the last day of treatment or when the child reaches eighteen years of age, whichever is later, and I may not retain the records for more than twelve years.

I have read the preceding information and understand my rights as a client or as the client's responsible party.

_____ _____

Client Signature Date

_____ _____

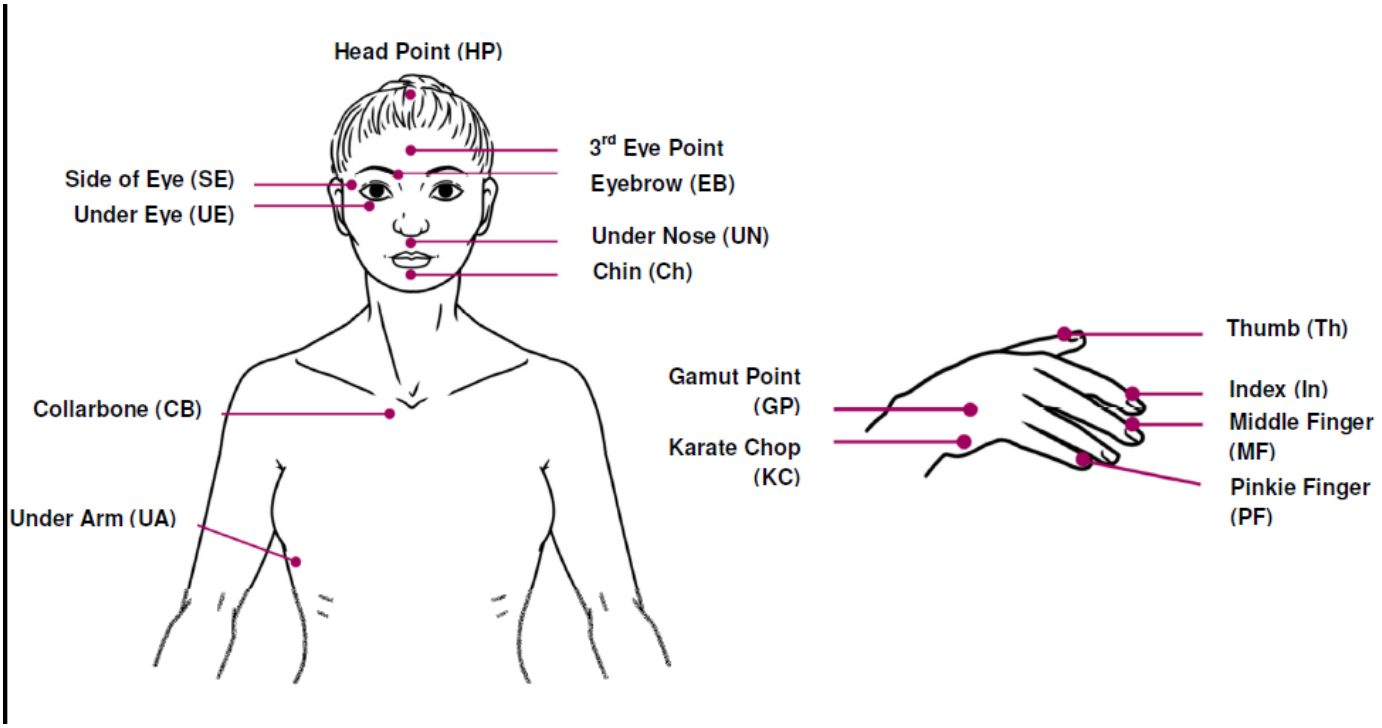
Therapist Signature Date

Julie Visnich, LCSW, 48 CR 250 #8, Durango, CO 81303, T: 970-404-1891. email: healing@JulieVisnich.com

Section 5: EFT Disclosure Statement

EFT (tapping), EMDR, and many other therapeutic techniques can include the use of touch to elicit and process subconscious information from the body. I will always ask for your permission before using such techniques, and if you give permission, you may withdraw it at any time. You may request that I refrain from using techniques involving touch at any moment. Below are the EFT touch points we may use, with the exception of under the arm. Sexual touching is never appropriate and should be reported to The Colorado State Board of Social Work Examiners at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800.

EFT Tapping Points



CONSENT TO TREAT

Psychotherapy and/or substance abuse treatment is not an exact science and as such there are no guarantees regarding your treatment.

I have been informed of the use of touch (tapping) in EFT, and understand I may opt to say yes or no to being tapped on at any time.

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date

Julie Visnich, LCSW, 48 CR 250 #8, Durango, CO 81303, T: 970-404-1891. email: healing@JulieVisnich.com

Section 6: Telehealth Consent

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that video conferencing technology that will be used to for our sessions(s) will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
2. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE Doxy.me SERVICE

Doxy.me is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. Use this link from your phone or computer https://doxy.me/julievis By signing this document, I acknowledge:

1. Doxy.me is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through Doxy.me, neither Doxy.me nor my therapist provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Doxy.me facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Doxy.me Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Doxy.me Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

That I have read or had this form read and/or had this form explained to me. That I fully understand its contents including the risks and benefits of the procedure(s).

That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date

Julie Visnich, LCSW, 48 CR 250 #8, Durango, CO 81303, T: 970-404-1891. email: healing@JulieVisnich.com

First Name _____ Last Name _____ Client #_____
(please list all parties)
Date of Birth _____Referred by?_____

Address _____ **Work Phone _____**

City _____ State___ Zip_____ **Cell Phone _____**

Calls/messages/Texts Allowed? Yes___ No___

Email Address_____ Emails allowed? Yes___ No___

Emergency Contact: Name & Phone_____

Medications(psychotropic only): Names and dosages_____

Date	Service	Charge	Client Paid	Client Balance	Comments

Julie Visnich, LCSW, 48 CR 250 #8, Durango, CO 81303, T: 970-404-1891. email: healing@JulieVisnich.com