



1041 Lincoln Avenue, #310

Steamboat Springs, CO 80487

Mission: To provide a comprehensive whole body/mind approach to mental wellness that incorporates a multidisciplinary team working in collaboration in one facility that fosters resilience, optimism, wisdom, social engagement, mindfulness, and brain science education, to help clients grow and flourish.

OFFICE POLICY STATEMENT/AGREEMENT

This agreement document contains important information about our professional services and business policies. It also contains a summary information about HIPPA (Health Insurance Portability and Accountability Act), a federal law that provides strict privacy protections and patient rights with regard to the use and disclosure of your PHI (Personal Health Information). Your signature is required on the agreement, and although these documents are long and complex, it is important that you read them carefully; they are written to protect you.

HOW OFTEN CAN I EXPECT TO HAVE AN APPOINTMENT?

Clients normally choose to come once or twice a week for counseling, depending on what their goals are. For medication management and monitoring (which can include blood draw follow up), anywhere from 3 sessions total to meeting with your nurse practitioner every 6-12 weeks will be appropriate. In the later phases of treatment, appointments are sometimes scheduled less frequently. Sessions can be 30-60 minutes long for counseling, and 30-120 minutes long with the nurse practitioner.

HOW MIGHT I REACH YOU IF I FEEL A NEED?

You may contact your therapist/NP/coach by telephone, email or a note. Clients occasionally need to speak with us between sessions. You will know intuitively if that is the case, and brief phone conversations are more than welcome. To make or change an appointment, contact your therapist/NP/Coach directly

WHAT HAPPENS IF AN APPOINTMENT IS FORGOTTEN?

Coming regularly and on time is an indication of your commitment to meeting your goals and the therapeutic process. Once an appointment is made, that time is set aside for your use. Late cancellations frequently block making an appointment available to another client. Any cancellations for appointments must be received more than 24 hours notice. You will get one “freebie” appointment where you are a “no show/late cancellation”. After that, except in the case of an emergency, you will be charged a full session fee for any missed or late Cancellation appointments. Remember that scheduling an appointment means that it will be held only for you, and therefore, cannot be used by another person.

WHAT TO DO IN THE EVENT OF AN EMERGENCY: please call us first, and we will try to help. If we are not able to return your call as soon as you need, please call 911, or go to your closest Emergency Department.

WHAT ARE MY RESPONSIBILITIES?

You are expected to pay in full at the time of the visit unless other arrangements have been made with your practitioner. Longer telephone calls (15” or more) that end up being “therapy” will be billed as a therapeutic session. Many of the techniques that are used at Minds in Motion expect you to do “homework” to help in your progress. This may include but is not limited to: logging, journaling, reading recommended books, breathing practices, taking supplements or medications or attending classes. It is your responsibility to follow through with out of office duties that are part of your plan of care.

TERMINATION:

Termination will usually be agreed upon mutually, but you are free to terminate at anytime. In a few special circumstances the decision to discontinue treatment may be made, even though you wish to continue. These circumstances may include, but are not limited to, a failure to meet the terms of the fee agreement, a conflict of interest, or a need for special services outside the area of our competency.

PAYMENT/ BILLING STATEMENTS:

Payment at the time of service is required and a receipt will be provided for insurance and/or your own personal records. We take cash, check or credit cards. We will keep a credit card on file for you in the case of a no show/cancellation fee, or the option of billing your credit card at the end of each session or month.

If you maintain health insurance, part of your therapy expenses may be covered through your “Out of network” coverage. If we are out of network with your insurance company, you will be required to pay the full fee at the time of service and submit your own insurance claims as instructed by your insurance carrier noting: “reimbursement to be paid to the insured”. Mental health coverage differs from health care coverage, therefore it is your responsibility to contact your insurance carrier regarding coverage and/or authorization. We will provide you with a 1500 form to send to your insurance company after every 5 sessions.

We are committed to providing quality care for our clients and we charge fees that are usual and customary for our specialty of practice. Insurance companies have their own determination of rates. These are often arbitrary and unrealistic. You may be responsible for payment in full regardless of any insurance company's determination of rates.

PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSEMENT TO THE CLIENT, AND NOT A FORM OF PAYMENT TO YOUR PRACTITIONER.

I understand that I am financially responsible for all the amount of my sessions, regardless of the insurance coverage that may be involved.

Signature: _____

Date: _____

CLIENT RIGHTS

RIGHTS TO REQUEST HOW WE MAY CONTACT YOU:

It is our normal practice to communicate with you at your home and daytime phone number/email address you gave us when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes we may leave messages on your voicemail. You have the right to request how our office communicates with you:

May we contact you at home? Yes No # _____

May we contact you at work? Yes No # _____

May we contact you by cell? Yes No # _____

May we contact you by email? Yes No _____

Mailing address: _____

Physical Address: _____

How would you like to be contacted for appointment reminders? (please circle preferences)

Text Cell Email Home Phone Work

RIGHT TO RELEASE YOUR MEDICAL RECORDS:

You may consent in writing to release your records to others outside of Minds in Motion. You have the right to revoke this authorization, in writing, anytime. However, a revocation is not valid to the extent that we have acted in reliance on such authorization. By receiving services at Minds in Motion you are consenting to allow practitioners at Minds in Motion to collaborate your care who directly work with you.

RIGHT TO INSPECT AND COPY YOUR MEDICAL AND BILLING RECORDS:

You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact your therapist or nurse practitioner directly. Under limited circumstances we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and or supplies.

RIGHT TO ADD INFORMATION OR AMMEND YOUR MEDICAL RECORDS:

If you feel that information contained in your medical records is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request within 30 days. Under certain circumstances, we may deny your request to add or amend information. If we deny your request, you have the right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact your therapist directly. We will require you to submit your request in writing and provide an explanation for your request.

RIGHT TO REQUEST RESTRICTIONS ON USES AND DISCLOSURES OF YOUR HEALTH INFORMATION:

Request must be in writing and submitted to your therapist directly. However, we are not required to agree to such a request.

RIGHT TO COMPLAIN/GRIEVANCE:

If you believe your privacy rights have been violated, or are not happy with your treatment, please contact your therapist directly, and discuss your concerns. Minds in Motion is committed to learning and improving from our client feedback, so we want to hear how we are doing. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Human Services or DORA. An individual will not be retaliated against for filing such a grievance.

Signature: _____

Date: _____

Physical

Address:

Minds in Motion
1041 Lincoln Avenue, #310
Steamboat Springs, CO 80487

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to information. Please review it carefully.

Minds in Motion and your therapist/NP/coach is totally committed to maintaining your confidentiality. Your therapist/NP/coach will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes office policies related to the use and disclosure of your information.

FOR THE PURPOSE OF PROVIDING SERVICES:

Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care.

TREATMENT:

Minds in Motion and your therapist/NP/coach may need to use or disclose information to provide, manage, or coordinate your care or related services to other Minds in Motion providers. Any providers outside of Minds in Motion will need to have a release signed.

TOUCH THERAPY:

The practitioners of Minds in Motion have training, certifications and the education to use therapeutic touch if clinically relevant. This includes a practitioner touching a client only after verbal consent has been granted, and the client knows where and why he/she is being touched. Therapeutic touch is used for a variety of reasons, including but not limited to: stabilizing the nervous system, supporting the nervous system, stabilizing a client so she/he doesn't flood the system with a traumatic response or for evaluation or monitoring. By signing this consent form, you are signing your written agreement that Minds in Motion practitioners can use therapeutic touch with you during your treatment at Minds in Motion.

OTHER USES OR DISCLOSURE OF YOUR INFORMATION, WHICH DOES NOT REQUIRE YOUR CONSENT:

These are some instances your therapist/NP/coach may be required to use and disclose information without your consent. For example, but not limited to: Mental health professionals are required to report child physical or sexual abuse, or if you are in danger of harming yourself or others, and information shared with law enforcement if a crime is committed on our premises or against our staff as required by law such as a subpoena or court order. You may find out more information about disclosure of information at the Mental Health Practice Act. You can find this through CRS 12-43-101 at www.dora.state.co.us/mental-health/statute.pdf.

Signature: _____

Date: _____