DR. JILL MANNING

COMPLETE INTAKE PACKET

Welcome. Dr. Manning recognizes you have many choices in mental health care and appreciates you selecting her practice for your therapeutic and consultation needs.

The following intake packet is intended to help establish the understanding and boundaries essential for an effective therapeutic relationship. Please read each form thoroughly and bring the completed forms with you to your first session.

If you have difficulty printing these forms or need assistance with filling them out, please inform Dr. Manning of this need and she will be happy to accommodate you.

Additionally, if you have any questions or concerns regarding the forms, please discuss these with Dr. Manning prior to commencing therapy.

The following forms should be read and completed prior to your first visit:

1) Intake Form
2) Disclosure Statement Form
3) Consent to Communicate Private Health Information Form
4) HIPAA Form
5) Credit Card Authorization Form

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DR. JILL MANNING

INTAKE FORM: CLIENT INFORMATION & HISTORY

The information you provide in this intake form may be confidential; however, certain otherwise confidential information may be shared as required by law.

You are not required to supply the information contained in this Intake Form. Please provide as much information as possible.

Any request or authorization in this form to contact a Third Party, such as a medical doctor, will require a separate Authorization for Release of Information.

Client Information:

Name: _____

Gender: ☐ Male ☐ Female Birthdate: _____

Address: _____

City: _____ State: _____ Zip Code: _____

May Dr. Manning contact you (e.g., send mail) at this address: ☐ YES ☐ NO

Home Phone: _____ Cell Phone: _____ Work Phone: _____

May Dr. Manning contact you at all of the above telephone numbers provided: ☐ YES ☐ NO

_____

May Dr. Manning leave a voice message at all of the above phone numbers provided: ☐ YES ☐ NO

_____

Email Address: _____

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Do you share this email address with anyone else? If so, please list who else shares the email address:

_____

May Dr. Manning contact you at the above email address: ☐ YES ☐ NO

****Please be aware there is a risk that an unintended third-party may access information shared by electronic transmissions such as email and cell phone. By allowing Dr. Manning to contact you by email you are consenting to receive electronic communications and understand the risks involved. Dr. Manning cannot guarantee that confidential information shared using electronic communications will remain confidential.**

What is your preferred method of communication

□Telephone (H) □ Cell Phone □ Telephone (W) □ Email

Occupation: _____

Number of years at this occupation: _____

Marital Status: ☐ Single ☐ Married or Civil Union ☐ Separated ☐ Divorced ☐ Living Together

Do you have any children: ☐ YES ☐ NO How many? _____ Ages: _____

Do you have any children who live with you: ☐ YES ☐ NO

It is the policy of Dr. Manning not to treat any of your children while providing mental health services to you. Additionally, it is not within Dr. Manning's scope of practice to provide recommendation for custody arrangements.

Emergency Contact Information:

In case of an emergency, Dr. Manning may be required to contact someone on your behalf. Please list your emergency contact below, which Dr. Manning may contact on your behalf. Dr. Manning will only share the minimum amount of information necessary with your emergency contact should he or she need to be contacted.

Name: _____

Telephone Number: _____

Relationship to Client: _____

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Primary Care Physician Information:

In order to provide you with continuous and congruent care, Dr. Manning may need to contact your primary care physician. Any contact that Dr. Manning may have with your Primary Care Physician will require you to sign an Authorization for Release of Protected Health Information and Confidential Information.

Name: _____

Telephone Number: _____ Fax: _____

Address: _____

Please Provide the Date of Your Last Physical: _____

May Dr. Manning contact your physician: ☐ YES ☐ NO

Please list any medication you are currently taking (if you are not currently taking any medications, please state that you are not currently taking any medications):

_____

_____

Please list any current physical illnesses, issues, and/or ailments you have. If you do not currently have any physical illnesses, issues, and/or ailments, please state so:

_____

_____

Previous/Current Mental Health Provider(s):

In order to provide you with continuous and congruent care, Dr. Manning may need to contact your previous or current Mental Health Provider. Any contact that Dr. Manning may have with your previous or current Mental Health Provider will require you to sign an Authorization for Release of Protected Health Information and Confidential Information.

Name: _____

Telephone Number: _____ Fax: _____

Address: _____

Please provide the date of your last session: _____

May Dr. Manning contact your previous or current Mental Health Provider: ☐ YES ☐ NO

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Are you currently in therapy with the above listed mental health provider: ☐ YES ☐ NO

Have you ever sought therapy before: ☐ YES ☐ NO

If yes, please list your reason(s) for seeking mental health services (if you are currently seeing another mental health provider, please list the reason(s) here as well):

_____

_____

Have you ever been evaluated and/or treated by a Psychiatrist? ☐ YES ☐ NO

If yes, when was this evaluation conducted and what was the outcome and/or diagnosis?

_____

_____

Have you ever been admitted for in-patient, residential or rehab treatment? ☐ YES ☐ NO

Have you ever lived in a sober living facility? ☐ YES ☐ NO

If yes, please describe the nature of this care as well as the duration and name of the care facility:

_____

_____

Mental Health:

Please explain why you are seeking therapeutic treatment at this time and describe any issues/problems that led you to seek therapy:

_____

_____

_____

How have you dealt with these issues/problems in the past:

_____

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Please list any past or current psychological illnesses or other mental health issues:

_____

_____

Have you ever been, or are you currently, suicidal?:

_____

Have you ever attempted to commit suicide?:

_____

Has anyone in your family ever attempted or committed suicide?:

_____

Have you used, or do you currently use, alcohol, inhalants, nicotine products, marijuana, or any illegal drugs (if so, please indicate which ones?):

_____

If you consume any of the above listed drugs, how often do you consume them?:

_____

Does your family have a history of mental illness such as depression, anxiety, drug/alcohol abuse, addictions, eating disorders (if yes, please indicate the mental illness)?: ☐ YES ☐ NO

_____

_____

Are you currently involved in any civil or criminal legal proceedings?: ☐ YES ☐ NO

If yes, please state the circumstance(s):

_____

_____

Is there anything else you would like Dr. Manning to know?:

_____

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What would you like to accomplish through therapy and/or what goes would you like to achieve?

_____

_____

Financial Information:

1. Do you intend on using insurance benefits to pay for counseling services: ☐ YES ☐ NO

If yes, please list your insurance company: _____

****Please be informed that Dr. Manning is not an in-network provider for any insurance company and that partial or full reimbursement from your insurance provider is not guaranteed. It is a client's responsibility to inquire about possible out-of-network benefits and to manage the necessary paperwork and transactions thereby required.**

Will you need receipts for your insurance company: ☐ YES ☐ NO

2. Do you intend on a third-party (besides an insurance company) paying for counseling services:

☐ YES ☐ NO

If yes, please provide the following information:

Name: _____

Telephone Number: _____ Fax: _____

Address: _____

Relationship to Client: _____

3. Do you intend on paying for counseling services on your own: ☐ YES ☐ NO

Client Affirmation:

By signing this Intake Form, I certify that all the information is true and accurate to the best of my knowledge.

_____ _____

Client Signature Date

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Checklist of Concerns:

Client Name: _____

Please mark all of the areas of concern below that apply to you. You may add a note or details in the space next to the concerns checked.

Please be aware that Dr. Manning is ethically required to practice psychotherapy only within the scope of her training and licensure. Certain issues listed below will necessitate outside referrals for effective treatment. If Dr. Manning believes an outside referral is needed, this will be discussed with you and appropriate arrangements will be explored with you.

CONCERN	NOTES	NOW	IN THE PAST
Abortion			
Adoption			
Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals			
Addiction			
Aggression, violence			
Alcohol use			
Anger, hostility, arguing, irritability			
Anxiety, nervousness			
Attention, concentration, distractibility			
Career concerns, goals, and choices			
Childhood issues (your own)			
Codependence			
Confusion			
Compulsions			
Custody of children			
Cutting or other self-harming behavior			
Decision-making, indecision, putting off decisions			
Delusions (false ideas)			
Depression, low mood, sadness, crying			
Divorce / Separation			
Drug use (prescription, over-the-counter, street)			
Eating problems (overeating, undereating, appetite, vomiting)			
Eating disorder(s) — anorexia, bulimia, etc.			

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Emptiness			
Failure			
Fatigue, tiredness, low energy			
Fears, phobias			
Financial troubles / debt / impulsive spending			
Friendships			
Gambling			
Grieving, mourning, deaths, losses, divorce			
Guilt/Shame			
Headaches, other kinds of pains			
Health / medical concerns			
Hospitalization for mental health issue (please note if this has occurred within the last 12 months)			
Housework/chores—quality, schedules, sharing			
Inferiority feelings			
Infertility			
Interpersonal conflicts			
Impulsiveness, loss of control, outbursts			
Irresponsibility			
Judgment problems, risk taking			
Legal matters, charges, suits			
Loneliness			
Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments			
Memory problems			
Menstrual problems, PMS, menopause			
Mood swings			
Motivation, laziness			
Nervousness, tension			
Obsessions, compulsions (thoughts or actions that repeat themselves)			
Oversensitivity to rejection			
Pain, chronic			
Panic or anxiety attacks			
Parenting, child management, single parenthood			

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Personality disorder			
Perfectionism			
Pessimism			
Pornography use			
Procrastination, work inhibitions, laziness			
Relationship problems (with friends, with relatives, or at work)			
School problems (see also “Career concerns ...”)			
Self-centeredness			
Self-esteem			
Self-neglect, poor self-care			
Sexual issues, dysfunctions, conflicts, desire differences, other (see also “Abuse”)			
Shyness, oversensitivity to criticism			
Sleep difficulties			
Smoking and tobacco use			
Spiritual, religious, moral, ethical issues			
Stress management, stress disorders, tension			
Sexually Transmitted Disease or Infection			
Suspiciousness, distrust			
Suicidal thoughts (you or a relative)			
Temper problems, low frustration tolerance			
Thought disorganization and confusion			
Threats, violence			
Weight and diet issues			
Withdrawal, isolating			
Work problems, employment, workaholism/overworking, can’t keep a job, dissatisfaction, ambition			

Other concerns or issues: _____

Client Affirmation: By signing this Intake Form, I certify that all the information is true and accurate to the best of my knowledge.

_____ _____

Client Signature Date

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DR. JILL MANNING

DISCLOSURE STATEMENT & POLICIES

REGULATION OF MENTAL HEALTH PROFESSIONALS IN COLORADO:

1. Dr Jill Manning, PLLC ("DJMP") is located at 357 S. McCaslin Blvd., Suite 203; Louisville, CO 80027; Phone: 720-2096-9510. The mental health professional located at Dr Jill Manning, PLLC is Jill Manning, PhD, LMFT, CCPS, DCC. Dr Manning earned a B.A. in Communications in 1995 (University of Calgary); an M.S. in Marital & Family Therapy in 2000 (Loma Linda University); and a PhD in Marital & Family Therapy in 2006 (Brigham Young University). Dr Manning is a Colorado Licensed Marriage and Family Therapist; License #0000778. She has been involved in therapeutic work since 1997. Dr Manning also received specialty training in the Multidimensional Partner Trauma Model and has acquired the Certified Clinical Partner Specialist (CCPS) designation through The Association of Partners of Sex Addicts Trauma Specialists (APSATS). She is also a Distance Credentialed Counselor which allows her to provide secure and remote care to residents of Colorado when deemed appropriate. She has authored numerous research articles related to pornography's impact on marriage, spouses and youth and is regularly invited to speak at conferences. In addition to her professional work, Dr Manning volunteers for national organizations committed to pro-decency efforts and serves on the board of directors for Enough is Enough and APSATS.

2. Everyone fifteen (15) years and older must sign this disclosure statement. A parent or legal guardian with the authority to consent to mental health services for their minor child/ren, must sign this disclosure statement on behalf of their minor child under the age of fifteen (15) years old. This disclosure statement contains the policies and procedures of DJMP and is HIPAA compliant. No medical or psychotherapeutic information, or any other information related to your privacy, will be revealed without your permission unless mandated by Colorado law and Federal Regulations (42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164).

3. The Colorado Department of Regulatory Agencies ("DORA"), Division of Professions and Occupations ("DOPO") has the general responsibility of regulating the practice of Licensed Psychologists, Licensed Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified and Licensed Addiction Counselors, and registered individuals who practice psychotherapy. The agency within DORA that specifically has responsibility is the Mental Health Section, 1560 Broadway, Suite #1350, Denver, CO 80202, (303) 894-2291 or (303) 894-7800; DORA_MentalHealthBoard@state.co.us. The State Board of Marriage and Family Therapy Examiners regulates Licensed Marriage and Family Therapists and can be reached at the address listed above. Clients are encouraged, but not required, to resolve any grievances through DJMP's internal process.

4. You, as a client, may revoke your consent to treatment or the release or disclosure of confidential information at any time in writing and given to your therapist.

5. Levels of Psychotherapy Regulation in Colorado include licensing (requires minimum education, experience, and examination qualifications), Certification (requires minimum training, experience, and for certain levels, examination qualifications), and Registered Psychotherapist (does not require minimum education, experience, or examination qualifications.) All levels of regulation require passing a jurisprudence take-home examination.

Certified Addiction Counselor I (CAC I) must be a high school graduate, complete required training hours and 1,000 hours of supervised experience. Certified Addiction Counselor II (CAC II) must complete additional required training hours and 2,000 hours of supervised experience. Certified Addiction Counselor III (CAC III) must have a bachelor's degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience. Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. Licensed Social Worker must hold a masters degree in social work. 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. 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. Registered Psychotherapist is a psychotherapist listed in Colorado's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state. Registered psychotherapists are required to take the jurisprudence exam.

CLIENT RIGHTS AND IMPORTANT INFORMATION:

As a client you are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy, if I can determine it, and my fee structure. Please ask if you would like to receive this information.

Fees:

1. My fee structure, services, and fee policy provided are outlined as follows:

    a. Initial Intake for Individual Therapy: $175
    Partner Assessment Bundle and Relationship Inventory (PAB-RI)—to be completed post-Initial Intake Session, but prior to first Therapy Session: $50
    The PAB-RI contains the following inventories and scales that are essential for the work DJMP does with clients: Demographics; Adverse Childhood Experiences; Trauma Inventory for Partners of Sex Addicts; Post-Traumatic Stress Disorder Checklist; Multidimensional Scale of Perceived Social Support; Depression, Anxiety and Stress Scale; Intimate Justice Scale; Couples Satisfaction Index.
    PLEASE NOTE: Therapy with DJMP cannot commence until Testing has been completed.
    Individual Therapy: (50 minutes) $175.00
    Group Therapy: (90 minutes) $60.00
    Phone Calls: other than for scheduling will be billed on a prorated fee of $175.00 per 50 minutes if the call lasts more than 5 minutes.
    Out-of-Session Work: (e.g., disclosure reviews, polygraph preparation, coordination of care with physicians, clinicians, treatment centers or clergy, or filling out forms) will also be billed at the prorated fee of $175 per 50 minutes.

    b. In order for a therapist to be reimbursed by an insurance company, a diagnosis of the client must be made and submitted to the insurance carrier before the therapist is paid. Sometimes information on the presenting problem and symptoms the client is experiencing from the client's private therapy records are also required by the insurance company. Once released, this information becomes part of the client's medical records and may impact confidentiality. Consequently, Dr. Manning does not work with managed care health insurance programs. You are, however, welcome to request a detailed receipt that you may submit to your insurance company and explore a possible out-of-network reimbursement. If Dr. Manning is required to fill

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out forms or work directly with or on your behalf with your health care insurance company, prorated fees of $175 per 50 minutes will apply.

In an effort to make services more accessible to active duty military families and veterans, Dr. Manning is a certified out-of-network provider through Tricare. This allows military clients insured through Tricare to be able to submit receipts directly to Tricare and seek partial reimbursement directly from Tricare. Dr. Manning does not submit claims to Tricare for the reasons stated above and reimbursement is not guaranteed. Pre-authorization from Tricare is strongly recommended prior to commencing treatment and/or seeking partial reimbursement.

c. It is the policy of my practice to collect all fees at the time of service, unless you make arrangements for payment and we both agree to such an arrangement. In addition, I request that you fill out a "Credit Card Authorization" form to keep in your file. All accounts that are not paid within thirty (30) days from the date of service shall be considered past due. If your account is past due, please be advised that I may be obligated to turn past due accounts over to a collection agency or seek collection with a civil court action. By signing below, you agree that I may seek payment for your unpaid bill(s) with the assistance of a collections agency. Should this occur, I will provide the collection agency or Court with your Name, Address, Phone Number, and any other directory information, including dates of service or any other information requested by the collection agency or Court deemed necessary to collect the past due account. I will not disclose more information than necessary to collect the past due account. I will notify you of my intention to turn your account over to a collection agency or the Court by sending such notice to your last known address.

d. Therapy fees and treatment are based on a 45-50 minute clinical hour instead of a 60 minute clock hour so that I may review my notes and assessments on your behalf.

e. I am not a Medicaid provider. If you have Medicaid coverage that includes mental health services, I am not able to offer mental health services to you.

f. Legal Services incurred on your behalf are charged at a higher rate including but not limited to: attorney fees I may incur in preparing for or complying with the requested legal services, testimony related matters like case research, report writing, travel, depositions, actual testimony, cross examination time, and courtroom waiting time. The higher fee is $ 525.00 per hour.

Dr. Manning does not write letters pertaining to legal matters to any outside person (e.g., doctor, school, attorney, etc.) or agency regarding your treatment. If a special circumstance arrives where a letter is required by court order, it will require your written consent and will be billed to you at a pro-rated amount based on Dr. Manning's standard hourly fee. Unless court mandated, Dr. Manning reserves the right to refuse to write letters on your behalf if she does not feel this would be in your best interest, or if it places her in a dual relationship, or if it will compromise the therapeutic relationship.

Restrictions on Uses:

2. You are entitled to request restrictions on certain uses and disclosures of protected health information as provided by 45 CFR 164.522(a), however DJMP is not required to agree to a restriction request. Please review DJMP's Notice of Privacy Policies for more information.

Second Opinion and Termination:

3. You are entitled to seek a second opinion from another therapist or terminate therapy at any time.

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Sexual Intimacy:
4. In a professional relationship (such as psychotherapy), sexual intimacy between a psychotherapist and a client is **never** appropriate. If sexual intimacy occurs it should be reported to DORA at (303) 894-2291, Mental Health Section, 1560 Broadway, Suite 1350, Denver, Colorado 80202; State Board of Marriage and Family Therapist Examiners.

Confidentiality:
5. Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the psychotherapist is a Licensed Psychologists, Licensed Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified and Licensed Addiction Counselors, or a Registered Psychotherapist. If the information is legally confidential, the psychotherapist cannot be forced to disclose the information without the client's consent or in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

6. There are exceptions to this general rule of legal confidentiality. These exceptions are listed in the Colorado statutes, C.R.S. §12-43-218. You should be aware that provisions concerning disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in C.R.S § 13-90-107. There are additional exceptions that I will identify to you as the situations arise during treatment or in our professional relationship. For example, I am required to report child abuse or neglect situations; I am required to report the abuse or exploitation of an at-risk elder or the imminent risk of abuse or exploitation; if I determine that you are a danger to yourself or others, including those identifiable by their association with a specific location or entity, I am required to disclose such information to the appropriate authorities or to warn the party, location, or entity you have threatened; if you become gravely disabled, I am required to report this to the appropriate authorities. I may also disclose confidential information in the course of supervision or consultation in accordance with my policies and procedures, in the investigation of a complaint or civil suit filed against me, or if I am ordered by a court of competent jurisdiction to disclose such information. You should also be aware that if you should communicate any information involving a threat to yourself or to others, I may be required to take immediate action to protect you or others from harm. In addition, there may be other exceptions to confidentiality as provided by HIPAA regulations and other Federal and/or Colorado laws and regulations that may apply.

Additionally, although confidentiality extends to communications by text, email, telephone, and/or other electronic means, I cannot guarantee that those communications will be kept confidential and/or that a third-party may not access our communications. Even though I may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by a third-party. Please review and fill out DJMP's Consent for Communication of Protected Health Information by Unsecure Transmissions.

"No Secrets" Policy:
7. When treating a couple or a family, the couple or family is considered to be the client. At times, it may be necessary to have a private session with an individual member of that couple or family. There may also be times when an individual member of the couple or family chooses to share information in a different manner that does not include other members of the couple or family (i.e. on a telephone call, via email, or via private conversation). In general, what is said in these individual conversations is considered confidential and will not be disclosed to any third party unless your therapist is required to do so by law. However, in the event that you disclose information that is directly related to the treatment of the couple or family, it may be necessary to share that information with the other members of the couple or the family in order to facilitate the therapeutic process. Your therapist will use her best judgment as to whether, when, and to what extent such disclosures will be made. If appropriate, your therapist will first give the individual the opportunity to make the disclosure him or herself. This "no secrets" policy is intended to allow your therapist to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the couple or the family being treated. If you feel it necessary to talk about matters that you do not wish to have disclosed, you should consult with a separate therapist who can treat you individually.

Extraordinary Events:
8. In the case that I become disabled, die, or am away on an extended leave of absence (hereinafter "extraordinary event,") the following Mental Health Professional Designee will have access to my client files. If I am unable to contact you prior to the extraordinary event occurring, the Mental Health Professional Designee will contact you. Please let me know if you are not comfortable with the below listed Mental Health Professional Designee and we will discuss possible alternatives at this time.

Michael Barta, Ph.D., CSAT - S, EMDR II
Founding Director, CSRC
5277 Manhattan Circle Suite 210, Boulder, Colorado 80303
303-775-7529 | drmbarta@gmail.com |www.cosexualrecovery.com

The purpose of the Mental Health Professional Designee is to continue your care and treatment with the least amount of disruption as possible. You are not required to use the Mental Health Professional Designee for therapy services, but the Mental Health Professional Designee can offer you referrals and transfer your client record, if requested.

Maintenance of Client Record:
9. As a client, you may request a copy of your Client Record at any time. In accordance with the Rules and Regulations of State Board of Marriage and Family Therapy Examiners, DJMP will maintain your client record (consisting of disclosure statement, contact information, reasons for therapy, notes, etc.) for a period of seven (7) years after the termination of therapy or the date of our last contact, whichever is later. DJMP cannot guarantee a copy of your Client Record will exist after this seven-year period.

Electronic Records:
10. DJMP may keep and store client information electronically on DJMP's laptop or desktop computers, and/or some mobile devices. In order to maintain security and protect the record, DJMP may employ the use of firewalls, antivirus software, changing passwords regularly, and encryption methods to protect computers and/or mobile devices from unauthorized access. DJMP may also remotely wipe out data on mobile devices if the mobile device is lost, stolen, or damaged.

DJMP may also use electronic backup systems either by using external hard drives, thumb drives, or similar methods, through a cloud-based service, this includes the email service provider DJMP uses. The cloud-based backup system DJMP uses is TherapyAppointment and the email service providers DJMP uses are Microsoft Office 365, TherapyAppointment and Gmail. This helps prevent the loss or damage of electronically stored information. DJMP may maintain the security of the electronically stored information through encryption and passwords. The cloud-based backup means that the electronically stored information is stored on computers which are connected to the internet. In order to maintain security of the electronically stored information DJMP has employed the following security measures:

- Entered into a HIPAA Business Associates Agreement with the cloud-based company and with Microsoft Office 365 as an email service provider. Because of this Agreement, the cloud-based company and specified email service provider are obligated by federal law to protect the electronically stored information from unauthorized use or disclosure.
- The computers that store the electronically stored information are kept in secure data centers, where various security measures are used to maintain the protection of the computers from physical access by unauthorized persons.
- The cloud-based company and email service provider employs various security measures to maintain the protection of these backups from unauthorized use or disclosure.

It may be necessary for other individuals to have access to the electronically stored information, such as the cloud-based company or email service provider's workforce members, in order to maintain the system itself. Federal law

protecting the electronically stored information extends to these workforce members. If you have any questions about the security measures DJMP employs, please ask.

Alternative Treatment Modalities:
11. DJMPmay offer to employ alternative treatment modalities and therapeutic methods that she deems to be the most beneficial to my treatment. These modalities and methods may include, but are not limited to:fidelity polygraph testing, and Full Therapeutic Disclosure sessions. My therapist is trained and qualified to provide these alternative treatment methods and will have me sign an additional consent form, specific to each modality prior to implementing them in my treatment. I understand that I retain the right to consent to incorporating these modalities in my treatment and I may retract my consent at any point in time.

Statement Regarding Treatment of Clients with a Partner Who Has Sexually Acted Out:
12. Because of the increased volatility that is present when dealing with the deep trauma around betrayal by a partner who has acted out sexually, DJMP may, from time to time and in her sole discretion, recommend a separation. The intent of this separation is to create the necessary time and space for traumatic emotions of betrayal and anger to be properly worked through. Additionally, it is in general not the role or responsibility of a therapist to advise or recommend a divorce. However, given the high levels of trauma and/or the extremely risky nature of the sexual acting out of a partner, DJMP may, from time to time and in her sole discretion, recommend a divorce. Such a recommendation will only be for reasons of safety, whether physical, emotional, or mental, and will not be for any other reason. DJMP does not make these recommendations frequently or lightly, and takes into consideration the best interests of all involved parties, including Client, his or her partner, and any children who may be present in the home. Such a recommendation is DJMP's qualified opinion as a professional therapist, but it is subject to discussion with the Client. DJMP reserves the right to cease therapy if the Client disagrees with the separation or divorce recommendation.

AS A CLIENT:

You as a Client agree and understand the following:

1. I understand that Jill Manning, Ph.D., LMFT, CCPS may contact me to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to me in accordance with DJMP's Consent for Communication of Protected Health Information by Unsecure Transmissions.
2. I understand that if I initiate communication via electronic means that I have not specifically consented to in DJMP's Consent for Communication of Protected Health Information by Unsecure Transmissions, I will need to amend the consent form so that my therapist may communicate with me via this method.

3. I understand that there may be times when my therapist may need to consult with a colleague or another professional, such as an attorney or supervisor, about issues raised by me in therapy. My confidentiality is still protected during consultation by my therapist and the professional consulted. Only the minimum amount of information necessary to consult will be disclosed. Signing this disclosure statement gives my therapist permission to consult as needed to provide professional services to me as a client. I understand that I will need to sign a separate Authorization for Release of Information for any discussion or disclosure of my protected health information to another professional besides an attorney retained by my therapist.

4. I understand that, in general, DJMP does not provide Teletherapy, such as therapy over telephone or video chat. I understand that communications via email should be limited to administrative purposes and not used as an avenue for therapy. I understand that should I want Teletherapy, I will discuss my request with my therapist. I understand that it is in my therapist's sole discretion whether to accommodate my request for Teletherapy.

5. I understand that my therapist, does not accept personal Facebook, LinkedIn, Twitter, Instagram, and/or other friend/connection/follow requests via any Social Media. Any such request will be denied in order to maintain professional boundaries. I understand that DJMP has, or may have, a business social media account page. I

understand that there is no requirement that I "like" or "follow" this page. I understand that should I "like" or choose to "follow" DJMP's business social media page that others will see my DJMP associated with "liking" or "following" that page. I understand that this applies to any comments that I post on DJMP's page/wall as well. I understand that any comments I post regarding therapeutic work between my therapist and I will be deleted as soon as possible. I agree that I will refrain from discussing, commenting, and/or asking therapeutic questions via any Social Media platform. I agree that if I have a therapeutic comment and/or question that I will contact my therapist through the mode I consented to and **not** through social media.

6. I understand that if I have any questions regarding social media, review websites, or search engines in connection to my therapeutic relationship, I will immediately contact my therapist and address those questions.

7. I understand my therapist provides non-emergency therapeutic services **by scheduled appointment only**. If, for any reason, I am unable to contact my therapist by telephone number she provided me, 720-209-9510, and I am having a true emergency, I will call 911, check myself into the nearest hospital emergency room, or call Colorado's Crisis Hotline (844) 493-8255. DJMP does not provide after-hours service without an appointment. **If I must seek after-hours treatment from any counseling agency or center, I understand that I will be solely responsible for any fees due**. I understand that if I leave a voicemail for my therapist on the phone number provided, my therapist will return my call by the end of the next business day, excluding holidays and weekends.

8. If my therapist believes my therapeutic issues are above her level of competence, or outside of his or her scope of practice, he or she is legally required to refer, terminate, or consult.

9. **I understand that I am legally responsible for payment for my therapy services. If for any reason, my insurance company, HMO, third-party payer, etc. does not compensate my therapist, I understand that I remain solely responsible for payment. I also understand that signing this form gives permission to my therapist to communicate with my insurance company, HMO, third-party payer, collections agency or anyone connected to my therapy funding source regarding payment. I understand that my insurance company may request information from my therapist about the therapy services I received which may include but is not limited to: a diagnosis or service code, description of services or symptoms, treatment plans/summary, and in some cases my therapist's entire client file. I understand that once my insurance company receives the information I or my therapist has no control of the security measures the insurance company takes or whether the insurance company shares the required information. I understand that I may request from my therapist a copy of any report DJMP submits to my insurance company on my behalf. Failure to pay will be a cause for termination of therapy services.**

10. I understand that this form is compliant with HIPAA regulations and no medical or therapeutic information or other information related to my privacy, will be released without permission unless mandated by Colorado law as described in this form and the Notice of Privacy Policies and Practices. By signing this form, I agree and acknowledge I have received a copy of the Notice or declined a copy at this time. I understand that I may request a copy of the Notice at any time.

11. I understand that if I have any questions about my therapist's methods, techniques, or duration of therapy, fee structure, or would like additional information, I may ask at any time during the therapy process. By signing this disclosure statement I also give permission for the inclusion of my partners, spouses, significant others, parents, legal guardians, or other family members in therapy when deemed necessary by myself or my therapist. I agree that these parties will have to sign a separate **Consent for Third-Party Participation Agreement** or may have to sign a separate disclosure statement in order to participate in therapy.

12. I understand that DJMP, as an expert in the field of sexual addiction and betrayal trauma, frequently speaks at various seminars and conferences, as well as authoring research articles on the topic. As such, Dr. Manning may wish to incorporate aspects of my therapy as anecdotes or examples to illustrate principles that she is trying to teach. I give my permission to use these aspects of my therapy, knowing that Dr. Manning will change details so that identity will not be known and my confidentiality preserved.

13. I understand that the results of PAB-RI assessments administered through the online APSATS intake system may be used by DMJP, Discover and Change® and/or APSATS for research purposes. These results are used only in aggregate form for statistical analysis, and at no time will any of my confidential information be used or disclosed. All testing results shall be maintained by Discover and Change® in a HIPPA compliant manner.

14. I understand that should I choose to discontinue therapy for more than sixty (60) days by not communicating with DJMP or my therapist, my treatment will be considered "terminated." I may be able to resume therapy after the sixty (60) day period by discussing my decision to resume therapy services with DJMP. Ability to resume therapy after sixty (60) days will depend upon my therapist's availability and will be within her sole discretion. This disclosure statement will remain in effect should I resume therapy if one (1) year has not elapsed since my last session. However, I may be asked to provide additional information to update my client record. I understand "discontinuing therapy" means that I have not had a session with my therapist for at least sixty (60) days, unless otherwise agreed to in writing.

15. There is no guarantee that psychotherapy will yield positive or intended results. Although every effort will be made to provide a positive and healing experience, every therapeutic experience is unique and varies from person to person. Results achieved in a therapeutic relationship with one person are not a guarantee of similar results with all clients.

16. Because of the nature of therapy, I understand that my therapeutic relationship has to be different from most other relationships. In order to protect the integrity of the counseling process the therapeutic relationship must remain solely that of therapist and client. This means that my therapist cannot be my friend, cannot have any type of business relationship with me other than the counseling relationship (i.e. cannot hire me, lend to or borrow from me; or trade or barter for services in exchange for counseling); cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client, and cannot hold the role of counselor to her relatives, friends, the relatives of friends, people she knows socially, or business contacts.

17. I understand that when Dr. Manning schedules an appointment, a time slot is reserved exclusively for me. I understand that should I cancel within 24 hours of my appointment or fail to show up for my scheduled appointment without notice ("no-show"), excluding emergency situations, my therapist has the right to charge my credit card on file, or my account, for the full amount of my session.

18. I also affirm, by signing this form, I am at least fifteen (15) years old and consent to treatment and therapy services here at DJMP, or that I am the legal guardian for whom I am requesting therapy services here at DJMP.

19. By signing this form, I affirm that I am fully informed of the therapy services I am requesting and that DJMP is providing, and grant my consent to receive such therapy services.

My signature below affirms that the preceding information has been provided to me in writing by my primary therapist, or if I am unable to read or have no written language, an oral explanation accompanied the written copy. I understand my rights as a client/patient and should I have any questions, I will ask my therapist.

_____ _____

Client Name/Signature DATE

_____ _____

Jill Manning, Ph.D., LMFT, CCPS DATE

357 S. McCaslin Blvd., Suite 203, Louisville, CO 80027 | Phone: 720-209-9510 | Fax: 720-874-9644

DR. JILL MANNING

CONSENT FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION VIA UNSECURE TRANSMISSIONS

This consent form is for the communication of Protect Health Information ("PHI") that Dr. Jill Manning, PLLC ("DJMP") may transmit without the written authorization of the client as described in the Uses and Disclosure section of DJMP's Notice of Privacy Policies.

I, _____, hereby consent and authorize Jill Manning, PhD, LMFT, CCPS to communicate my PHI through the following unsecure transmissions (please initial all your choices):

_____ **Cellular/Mobile Phone including voicemails** (note: DJMP does **not send or receive texts** except for text appointment reminders that are generated through *Therapy Appointment*)
Please Insert Cell Phone Number: _____

_____ **Unsecured Email**
Client's Email: _____ □ Send □ Receive
Please circle one: Work Personal
Therapist's Email: jill@drjillmanning.com □ Send □ Receive

_____ **Appointment/Scheduling Reminder System (*Therapy Appointment*)**
Please select preferred type of automated appointment reminder □ Call □ Email □ Text

_____ **Other Media**: Please describe: _____

_____ **I do not wish to have my protected health information transmitted electronically**

Should we agree to communicate by the approved communications listed above, i.e. email, telephone, or any other electronic method of communication, confidentiality extends to those communications. However, DJMP cannot guarantee that those communications will remain confidential. Even though DJMP may utilize state of the art encryption methods, firewalls, and/or back-up systems to help secure communication, there is a risk that the electronic or telephone communications may be compromised, unsecured, and/or accessed by an unintended third-party. There is never a 100% guarantee information will remain confidential when transmitted electronically.

DR. JILL MANNING

I, _____, consent to DJMP transmitting the following PHI by the above selected electronic communications (please initial all of your choices):

_____ Information related to scheduling/appointments
_____ Information related to billing and payments
_____ Information related to your mental health treatment (this may contain personal materials, forms, suggested articles, homework, etc.)
_____ Information related to DJMP's operations
_____ Other information; please describe: _____

I further understand that if I initiate communication via electronic means that I have not specifically consented to in this form, I will need to amend this consent form so that my therapist may communicate with me via that method.

_____ _____
Signature of Client/Parent/Legal Guardian Date

NOTICE OF PRIVACY POLICIES AND PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL AND MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Dr. Jill Manning, PLLC ("DJMP") believes it may be a covered entity under the Health Insurance Portability and Accountability Act (HIPAA) and thus provides its clients with this Notice of Privacy Policies & Practices and complies with the procedures and protocols listed herein. If DJMP is determined not to be a covered entity under HIPAA, it will still follow this Notice of Privacy Policies & Practices regarding use and disclosure of PHI; however, the client may not be entitled to the rights set forth in the "Your Rights as a Client" section.

Given the nature of DJMP's work, it is imperative that it maintains the confidence of client information that it receives in the course of its work. DJMP is a mental health practice that provides mental health services. DJMP's practice works solely to provide the best counseling treatment options to its clients. DJMP is prohibited from releasing any client information to anyone outside immediate staff, employees, interns, and/or volunteers except in limited circumstances in accordance with this Notice of Privacy Policies and Practices. Discussions or disclosures of protected health information ("PHI") within the practice are limited to the minimum necessary that is needed for the recipient of the information to perform his/her job. Please review this Notice of Privacy Policies and Practices ("Notice of Privacy Policies"). It is my policy to:

1. Fully comply with the requirements of the HIPAA General Administrative Requirements, the Privacy and Security Rules;
2. Provide every client who receives services with a copy of this Notice of Privacy Policies;
3. Ask the client to acknowledge receipt when given a copy of this Notice of Privacy Policies;
4. Ensure the confidentiality of all client records transmitted by facsimile;
5. Obtain from each client an informed Authorization for Release of Protected Health Information form when required.

DJMP is required to follow all state and federal statutes and regulations including Federal Regulation 42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164, governing testing for and reporting of TB, HIV AIDS, Hepatitis, and other infectious diseases, and maintaining the confidentiality of PHI.

PHI refers to any information that I create or receive, and relates to an individual's past, present, or future physical or mental health or conditions and related care services or the past, present, or future payment for the provision of health care to an individual; and identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. PHI includes any such information described above that I transmit or maintain in any form, this includes Psychotherapy Notes. HIPAA and federal law regulate the use and disclosure of PHI when transmitted electronically.

YOUR RIGHTS AS A CLIENT:

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your mental health record

- You can ask to see or get an electronic or paper copy of your mental health record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee to fulfill your request.
- If we deny your request, in whole or in part, we will let you know why in writing and whether you have the option of having the decision reviewed by an independent third-party.

Ask us to correct your mental health record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.
- Please review the Consent For Communication Of Protected Health Information By Non-Secure Transmissions
- You are required to "opt-in" to receive communications electronically as set-forth in the Consent for Communication of Protected Health Information by Non-Secure Transmissions. If you choose not to "opt-in" to receive electronic communications, we will not communicate with you via electronic means.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Additional Restrictions

- You have the right to request additional restrictions on the use or disclosure of your mental health information. However, we do not have to agree to that request, and there are certain limits to any restriction. Ask us if you would like to make a request for any restriction(s).

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

- We will not retaliate against you for filing a complaint.
- You may also file a complaint with the Colorado Department of Regulatory Agencies, Division of Professions and Occupations, Mental Health Section; 1560 Broadway, Suite 1350, Denver, Colorado, 80202, 303-894-2291; DORA_Mentalhealthboard@state.co.us. Please note that the Department of Regulatory Agencies may direct you to file your complaint with the U.S. Department of Health and Human Services Office for Civil Rights listed above and may not be able to take any action on your behalf.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A use of PHI occurs *within* a covered entity (i.e., discussions among staff regarding treatment). A disclosure of PHI occurs when DJMP reveal PHI to an outside party (i.e., DJMP provides another treatment provider with PHI, or shares PHI with a third party pursuant to a client's valid written authorization).

DJMP may use and disclose PHI, without an individual's written authorization, for the following purposes:

1. Treatment: disclosing and using your PHI by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members and for coverage arrangements during your therapist's absence, and for sending appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
2. Payment: disclosing and using your PHI so that DJMP can receive payment for the treatment services provided to you, such as: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization of review activities.
3. Health Care Operations: disclosing and using your PHI to support DJMP's business operations which may include but not be limited to: quality assessment activities, licensing, audits, and other business activities.

Uses and disclosures for payment and health care operations purposes are subject to the minimum necessary requirement. This means that DJMP may only use or disclose the minimum amount of PHI necessary for the purpose of the use or disclosure (i.e., for billing purposes DJMP would not need to disclose a client's entire medical record in order to receive reimbursement. DJMP would likely only need to include a service code and/or diagnosis etc.). Uses and disclosures for treatment purposes are not subject to the minimum necessary requirement.

DJMP is required to promptly notify you of any breach that may have occurred and/or that may have compromised the privacy or security of your PHI.

Confidentiality of client records and substance abuse client records maintained are protected by federal law and regulations. It is DJMP's policy that a client must complete an Authorization for Release of Protected Health Information it provides prior to disclosing health information to another individual and/or entity for any purpose, except for treatment, payment, or health care operations in accordance with this Notice of Privacy Policies.

Absent the above referenced form, other than for treatment, payment, or health care operations purposes, DJMP is prohibited from disclosing or using any PHI outside of or within the organization, including disclosing that the client is in treatment without written authorization, unless one of the following exceptions arises:

1. Responding to lawsuit and legal actions (Disclosure by a court order, in response to a complaint filed against DJMP, etc. This does not include a request by you or another party for your records).
2. Disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation.

3. Help with public health and safety issues (Client commits or threatens to commit a crime either at DJMP's office or against any person who works for DJMP; A minor or elderly client reports having been abused or there is reasonable suspicion that abuse has or will take place; Client is planning to harm another person, including but not limited to the harm of a child or at-risk elder; Client is imminently dangerous to self or others).
4. Address workers' compensation, law enforcement, and other government requests.
5. Respond to organ and tissue donation requests.
6. Business Associates: DJMP may enter into contracts with business associates to provide billing, legal, auditing, and practice management services that are outside entities. 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.
7. In compliance with other state and/or federal laws and regulations.

The above exceptions are subject to several requirements under the Privacy Rule, including the minimum necessary requirement and applicable federal and state laws and regulations. See 45 C.F.R. § 164.512. Before using or disclosing PHI for one of the above exceptions, DJMP's staff must consult its Privacy Officer (Jill Manning, Ph.D., LMFT, CCPS, 720-209-9510, jill@drjillmanning.com) to ensure compliance with the Privacy Rule. Violation of these federal and state guidelines is a crime carrying both criminal and monetary penalties. Suspected violations may be reported to appropriate authorities, as listed above in the "Client Rights" section, in accordance with federal and state regulations. Know that DJMP will never market or sell your personal information without your permission.

SPECIAL AUTHORIZATIONS

Certain categories of information have extra protections by law, and thus require special written authorizations for disclosures.

Psychotherapy Notes: DJMP may keep and maintain "Psychotherapy Notes", which may include but are not limited to notes DJMP makes about your conversation during a private, group, joint, or family counseling session, which is kept separately from the rest of your record. These notes are given a greater degree of protection than PHI. These are not considered part of your "client record." DJMP will obtain a special authorization before releasing your Psychotherapy Notes.

HIV Information: Special legal protections apply to HIV/AIDS related information. DJMP will obtain a special written authorization from you before releasing information related to HIV/AIDS.

Alcohol and Drug Use Information: Special legal protections apply to information related to alcohol and drug use and treatment. DJMP will obtain a special written authorization from you before releasing information related to alcohol and/or drug use/treatment.

You may revoke all such authorizations to release information (PHI, Psychotherapy Notes, HIV information, and/or Alcohol and Drug Use Information) at any time, provided each revocation is in writing, signed by you, and signed by a witness. You may not revoke an authorization to the extent that (1) DJMP has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, the law provides the insurer the right to contest the claim under the policy.

As a covered entity under the Privacy and Security Rules, DJMP is required to reasonably safeguard PHI from impermissible uses and disclosures. Safeguards may include, but are not limited to the following:

1. Not leaving test results unattended where third parties without a need to know can view them.
2. Any PHI received as an employee, intern, or volunteer about a client or potential client, may not be used or disclosed for non-work purposes or with unauthorized individuals. DJMP may only use and disclose such PHI as described above.
3. When speaking with a client about his or her PHI where third parties could possibly overhear, the conversation will be moved to a private area.
4. Seeking legal counsel in uncertain situations and/or incidences.
5. Obtaining a Business Associates Agreement with those third-parties that have access to and/or store client information. 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.
6. Implementing FAX security measures
7. Obtaining your consent prior to sending any PHI by unsecure electronic transmissions
8. Providing information on my electronic record-keeping.

YOUR CHOICES:

For certain health information, you can tell DJMP (verbal authorization) your choices about what it shares. If you have a clear preference for how DJMP shares your information in the situations described below, talk to DJMP. Tell DJMP what you want it to do, and it will follow your instructions. DJMP may request you sign a separate document if you authorize it to share certain PHI. You may revoke that authorization at anytime for future disclosure.

In these cases, you have both the right and choice to tell DJMP to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell DJMP your preference, for example if you are unconscious, DJMP may go ahead and share your information if DJMP believes it is in your best interest and for your care/treatment. DJMP may also share your information when needed to lessen a serious and imminent threat to public health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Changes to the Terms of this Notice

DJMP can change the terms of this notice, and the changes will apply to all information DJMP has about you. The new notice will be available upon request, in DJMP's office, and on its web site.

This notice is effective January 1, 2018.

_____ _____

Client Signature Date

DR. JILL MANNING

CREDIT CARD AUTHORIZATION FORM

Dr. Jill Manning, PLLC ("DJMP") requests that you provide your credit card information below. If you choose to pay by credit card your credit card will be charged $_____ after each session on the day the session occurs. If you choose to pay by cash or check, your credit card will only be charged if your account is past due and/or for any additional fees you incur such as late cancellation or no-shows fees.

☐ I do not authorize DJMP to charge my credit card after each session but only for additional fees I incur as set forth in DJMP disclosure statement and policies. I will be notified of the type of additional fees I incur.

☐ I authorize DJMP to charge my credit card $_____ after each session and for any and all additional fees I incur.

If your credit card does not go through, you do not have a credit card, or you do not wish to provide your credit card information, in the event your account remains past due for sixty (60) days, your account may be sent to collections. DJMP reserves the right to send your account to collections, in accordance with DJMP policies and procedures; at any time after your account is considered past due.

By signing this authorization form, you agree to notify DJMP of any changes to your credit card information such as a new expiration date or when your credit card has been cancelled, lost, stolen, or revoked. A new form must be submitted if information such as the list of authorized users and the credit card account's expiration date is amended.

DR. JILL MANNING, PLLC
ONLY ACCEPTS THE FOLLOWING CREDIT CARDS:

VISA, MASTERCARD, AMERICAN EXPRESS & DISCOVER

Name on Credit Card: _____

Type of Credit Card: ☐ **VISA** ☐ **MASTERCARD** ☐**AMERICAN EXPRESS** ☐ **DISCOVER**

Credit Card Number: _____

Expiration Date : _____ /_____ CCV Code : _____

357 S. McCaslin Blvd., Suite 203, Louisville, CO 80027 | Phone: 720-874-9644 | Fax: 720-874-9644

Card Holder's Full Address, including zip code (the mailing address for your Credit Card statements):

_____

_____

This credit card authorization form will remain in effect and on file at DJMP unless revoked in writing or until the therapeutic relationship is terminated, at which time, authorization to charge your credit card will be revoked, unless an outstanding balance remains on your account after termination. DJMP will not share your credit card information with any third-party without your consent. Your credit card information will be kept confidential.

Please check one:

☐ Card Holder is the client (or parent/legal guardian) receiving services from DJMP.

I hereby authorize DJMP to charge the above credit card number for payment of the counseling fees I incur, which shall include late or past due fees or fees related to cancellations or no-shows. I understand that my credit card will be billed in accordance with the authorizations listed above.

_____ _____

Client/Parent/Legal Guardian Signature DATE

☐ Card Holder is a third-party payer for the client receiving services from DJMP.

I_____, hereby authorize DJMP to charge the above credit card number for payment of the counseling fees (Client)_____ incurs, which shall include late or past due fees or fees related to cancellations or no-shows. I understand that my credit card will be billed in accordance with the authorizations listed above. I understand as a third-party payer that I am only entitled to receive information concerning payment and that this Credit Card Authorization Form does not authorize me to receive any confidential and protected information about Client beyond payment.

_____ _____

Third-Party Payer's Signature DATE

I, _____, authorize DJMP to communicate with the above Third-Party Payer solely as it may relate to payment for services I receive from DJMP.

_____ _____

Client's Signature DATE